GOVERNMENT OF UGANDA

UGANDA AIDS COUNTRY PROGRESS REPORT JULY 2017-JUNE 2018

Theme ***"Enhancing HIV Mainstreaming towards ending AIDS as a Public Health threat in Uganda by 2030"***

September 2018

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List of Acronyms

ADP	AIDS Development Partner
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral
CSOs	Civil Society Organizations
DAC	District AIDS Committee
EID	Early Infant Diagnosis
eMTCT	elimination of Mother to Child Transmission of HIV
CARPR	Country AIDS Response Progress Report
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
GoU	Government of Uganda
HLM	High Level Political Meeting
HTS	HIV testing and services
HRD	Human Resource Development
JAR	Joint AIDS Review
KP	Key Populations
MARPS	Most At Risk Populations
MDAs	Ministries, Departments and Agencies
MGLSD	Ministry of Gender, Labour, and Social Development
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoLG	Ministry of Local Government
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NAFOPHANU	National Forum of People living with HIV Network in Uganda
NPAP	National Priority Action Plan
NSP	National HIV/AIDS Strategic Plan

OVC	Orphans and other Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PIASCY	The Presidential Initiative on AIDS Strategy to Youth
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child HIV Transmission
PrEP	Pre-Exposure Prophylaxis
RH	Reproductive Health
SCEs	Self-Coordinating Entities
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
ToR	Terms of Reference
TB	Tuberculosis
TWG	Technical Working Groups
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UPHIA	Uganda Population HIV Impact Assessment
USAID	United States Development Agency
VLS	Viral Load Suppression
WHO	World Health Organizations
WONETHA	Women's Organisation Network for Human Rights Advocacy

FOREWORD

This report presents a review of the Uganda's performance towards realization of the National Strategic Plan (2015/16 – 2019/20 in the four thematic areas. The report indicates that there has been a shift in the trend of the epidemic from younger to older individuals. According to UPHIA 2016/17 HIV prevalence peaks at 14.0% among men aged 45 to 49 and 12.9% among women aged 35 to 39. Among young adults, there is a disparity in HIV prevalence by sex. HIV prevalence is almost four times higher among females than males aged 15 to 19 and 20 to 24. HIV prevalence is nearly three times higher in men and women aged 20-24 compared to those aged 15-19. Urban areas continue to experience a higher prevalence rate 7.5% than rural areas 5.8% while women 7.6% are more affected than men 4.7%. There are also regional disparities in prevalence, care and treatment, social psycho support as well functionality of systems.

During the FY 2017/18 the country made significant achievements while there are also gaps and challenges that continue to daunt the response, such as weak coordination structures at the lower local government levels, continuing stigma, low response to prevention measures, and limited human resources in health facilities. The most notable achievement was the re-dedication and commitment of the top most leadership to ending HIV and AIDS by 2030. The launch of the Presidential Fast Track Initiative (PFTI) puts emphasis on involvement of men as a means of closing the tap of new infections, especially among adolescent girls and young women. This re-commitment by the H.E. the President is already being emulated by various leaders including in local governments, faith-based organizations and cultural institutions, the private sector. Innovations have been introduced to increase efficiency in procurement, distribution of ARVs and curbing stock outs.

With declining external resource flow efforts are being made to increase domestic resource mobilization and contribution to the national response. Some of the decisions that have been taken include:

- Fast tracking the operationalization of the AIDS Trust Fund following approval by Parliament
- Fast tracking NASA institutionalization and broadening it to include resource mobilization and expenditure by the Private Sector (One-dollar initiative)
- Establishing a vote output and monitor to ensure compliance with the 0.1% enshrined in the national mainstreaming strategy

I wish to express my sincere appreciation to all those individuals and institutions that have worked closely with the Uganda AIDS Commission in implementing the National HIV and AIDS Strategic Plan on HIV and AIDS for the past three years and participated in review process.

I, therefore, call upon all stakeholders and partners to reinvigorate efforts towards ending HIV and improve coordination to ensure increased efficiency in resource utilization and maximum benefits in the remaining two years of the current NSP, including implementation of the JAR undertakings which have been aligned towards the PFTI. Use the undertakings as a guide to your annual work plan for 2018/19.

For God and My Country

Dr.Eddie Mukooyo Sefuluya

CHAIRMAN

UGANDA AIDS COMMISSION

ACKNOWLEDGEMENTS

The preparation of the Joint AIDS Review and the Uganda Country Progress Report on HIV and AIDS has benefited from various inputs and it is my singular pleasure to acknowledge them.

First and foremost Uganda AIDS Commission (UAC) is very grateful to H.E. the President of the Republic of Uganda and Her Excellency the First Lady for their re-commitment to eliminate HIV and AIDS in 2030 under the Presidential Fast Track Initiative.

I appreciate the support and collaboration accorded by the Partnership Committee and Forum in its endeavour to fulfil its coordination of the national HIV and AIDS Response. Equally important is the leadership and guidance received from the UAC Board, Steering Committee and the Country Coordination Committee not only throughout the year under review but during the review process as well.

I acknowledge the contribution of the various Technical Working Groups, their respective Chairpersons and Convenors for the invaluable information obtained through consultations and documents/reports on various thematic areas and relevant topics that were made available to support the review process in terms of progress, challenges, lessons learned and key recommendations.

I further acknowledge the most useful input of all those individuals and stakeholders from the Ministries, Departments and Agencies (MDAs), and other Self-Coordinating Entities (SCEs) including local governments, civil society, cultural/traditional leaders and institutions, religious/faith-based leaders and institutions, networks of people living with HIV (PHAs), the private sector and above all the development partners for their participation in NSP implementation and the annual review.

I also acknowledge the dedication and hard work of the consultancy firm, Eastern Central and Southern Africa (ECASA) Group of Consultants while supporting the preparation of this annual review report.

Finally, I wish to appreciate the tireless contribution by all the staff of Uganda AIDS Commission for organising a highly participatory JAR 2018. The efforts of the editorial team led by Dr. Wakooba Peter with support from Mr. Otai Charles, Mr. Dan Kyeyune, Dr. Daniel Byamukama, Dr. Zepher Karyabakabo, Mr. Tom Etii, Ms. Christine Karugonjo, Dr. Mudiope Peter (MoH), Mr. Jotham Mubangizi (UANIDS), Ms. Elizabeth Mushabe (UN Women) and Ms. Rosemary Kindymunda(UNFPA) are appreciated.

For God and my Country

Dr. Nelson Musoba

DIRECTOR-GENERAL

UGANDA AIDS COMMISSION

EXECUTIVE SUMMARY

Introduction:

The report presents the country progress of the third year of Uganda's NSP (2015/16 - 2019/20) implementation that builds on previous achievements since 2016/17. It is divided into three (3) main sections which include; the introduction summarizes the review approach and report compilation process; the overview of HIV epidemic in Uganda; and, the progress made during the FY 2017/18. The report also highlights key challenges and implementation gaps as well as recommendations that could be implemented to improve the national response in the coming years.

Methodology:

This report is a result of a highly participatory and consultative process involving key stakeholders in the NSP implementation. In addition, the report utilized secondary quantitative data abstracted from the DHIS2, OVC MIS and MoES MIS, desk review of reports, spectrum estimates and some selected studies carried out during the review period. The data and report were further reviewed and validated by a Joint Thematic Technical Working Group UAC technical staff, UAC Partnership Committee, the 11th Joint AIDS Review (JAR) and 9th Partnership Forum (PF). A content analysis was done on various progress reports from the Sectors, SCEs, CSOs and partners and triangulated in order to draw the necessary conclusions and recommendations.

Status of NSP Implementation for FY 2017/18 Period

Overall the annual review has shown that the country has made some significant progress in implementing the National Strategic Plan for HIV and AIDS during FY 2017/18. The report highlights specific achievements in all the NSP Thematic areas and related sub-themes. This, notwithstanding, several daunting challenges exist and call for concerted efforts of stakeholders and partners to find and support practical solutions if the country is to realize the set targets of the Plan.

Progress towards 90- 90- 90 Targets

Uganda is among the first African countries to adopt the 90-90-90 Strategy in its National Strategic Plan for HIV and AIDS Response. Over the last 2 years Uganda has made a lot of progress towards attainment of the 90-90-90 targets. The review shows that 90% of all People Living with HIV (PLHIV) are aware of their HIV status, 96% of those diagnosed are on HIV treatment while 87% of those on treatment are virally suppressed. However, currently, 332,520 PLHIV in Uganda are not virally suppressed and need to be reached in the next implementation period. 148,255 PLHIV are on ART but not virally suppressed after 12 months of treatment. 134,874 are the HIV infected people who have not yet been tested and will in addition to the estimated 50,000 annual new infections form an annual backlog for 2018/19.

Progress in HIV Prevention

During the year, there was an improvement in linkage to care among newly tested HIV positive clients with only 2,463 not linked compared to over 76,000 in 2016/17. This could be due to the test and treat policy which has now been fully implemented across the country. However, there are still challenges; men and youths 15-24 years not being reached with HTS services.

ART provision for Pregnant Women was 84% (82,237), which is 2 percentage points lower than that achieved in 2016/17 and 1 percentage point below the 2020.target. The HIV positivity rate among the 506,000 spouses that took an HIV test through the PMTCT program was 2%. There has been consistent reduction in the number of new paediatric infections across the 3 years of this strategic period. This is in spite of the number of HIV Exposed Infants (HEI) who receive ART prophylaxis stagnating at around 42%, largely attributed to the very low health facility deliveries observed among mothers in Uganda. Other challenges include; poor retention rates for eMTCT mothers (65-75%) and uptake of male partner testing during ANC is still below the set targets.

PrEP was rolled out in a phased manner in 35 sites in Kampala and Wakiso district and as of March 2018, about 8,000 people had been screened for PrEP and over 3,000 received the service. However, there are challenges associated with stigma and adherence. HIV prevention among the key populations remains sub-optimal. During the period under review over 25,135 female sex workers were reached with HIV prevention messages and 7,662 tested for HIV and received results; 2,396 MSM were reached with HIV messages of which 394 tested for HIV and received results; 42 injection drug users were reached with messages of which 9 tested for HIV and received results. In order to reach the other categories, MoH & UNFPA supported Kampala, Wakiso, Hoima, Fort portal, Mbarara, Gulu, Mbale districts to develop MARPs SRH/HIV strategic, operational and M&E plans that are currently being implemented.

Comprehensive knowledge especially among adolescents and young people (15-24 years) remains low. Although there were no population based behavioural studies conducted during the review period, findings from LQAS done in Northern Uganda in April 2018 showed that comprehensive knowledge among adolescents and young people (15-24 years) may be as low as 33.3% and 29.3% among men and women respectively, much lower than the NSP baseline target. Furthermore, as many as 21% boys and 28.1% girls have sexual debut by age of 15, which is almost twice NSP baseline target and well above the NSP (2020) target of 7% to be achieved in the next 2 years. The trend for early sex seems to be increasing among young boys compared to their female counterpart, perhaps due to the little attention given to boys. These developments might have serious implications on the HIV prevention efforts moving forward.

Progress in Care and Treatment

The review shows annual performance was better in FY 2017/18, 87% (229,940/263,449) of people testing HIV positive were linked to care improving from 78% (220,431/256,529) in FY 2016/17. However, there is still suboptimal retention with 20% (36,374/176,645) of the cohort lost to follow up/lost and 1.6% (299/176,645) dying. Retention among mothers with the 12 months Cohort of eMTCT Mothers (Pregnant women and Lactating) started on ART showing that only 69% were still on ART. Though still reported to be low, there is an improvement from 65.2% (23,464/35,990) in 2017 (MTR).

Paediatric HIV prevalence in Uganda is estimated at 0.5% (UPHIA 2016) with 88,437 children under age 15 are living with HIV. By the end of June 2018, 8,831 extra Children LHIV were enrolled on ART implying an increase from 67% by June 2017 to 76%. An estimated 88,510 adolescents (10–19 years) are living with HIV. By the end of June 2018, 14,350 extra adolescents were enrolled on ART implying an increase from 58,227 (66%) by June 2017 to 76%.

The CPHL reports show that viral suppression rate at the national level was 88.3% in 2017/18. High HIV prevalence regions in South Western, Rwenzori and Central regions

achieved high viral suppression. Children and adolescents have much lower viral suppression. Due to high HIV pre-treatment drug resistance (PDR) to non-nucleoside reverse transcriptase inhibitors (NNRTIs) of 15.4% in 2016, Uganda revised the treatment guidelines in February 2018 and recommended Dolutegravir, Lamivudine and Tenofovir Disoproxil Fumarate Tablets (TLD) as the preferred adult first-line ARV regimen.

HIV/TB Integration program shows that 97% (1,108,047 / 1,142,124) of individuals active on ART were assessed for TB over FY 2017/18, indicating improvements in annual performance from 95% in FY 2016/17. Although there was an improvement in initiating PLHIV co-infected with TB on TB treatment (from 30.8% in FY 2016/17, this is still suboptimal since 43% of all PLWHA with TB are still not started on treatment. In FY 2017/18 paediatric TB comprised 11% (5,100 cases) of all incident TB cases up from 9%. The country introduced the new globally recommended paediatric TB friendly formulations in August 2017 and adopted and piloted integrated TB/HIV/ICCM guidelines. However, treatment success rate among children diagnosed with TB remained stagnant at 76% compared to the previous year.

HIV SRH integration at service delivery points is still weak without adequate operational guidance. Overall, 32% of HIV+ women who would like to use a modern form of contraception do not have access, well above the national average of 28%. The unmet need is attributed more to limiters (24.5%) than spacers (7.5%). Uptake of cervical screening (screened at least once) was 30.3%.

Progress in Social Support and Protection

Under social support and protection, a number of interventions have been carried out though still limited in scope and coverage. Key achievements noted during the year include; (i) enhanced efforts to eliminate stigma and discrimination for PLHIV through various interventions including revival of the PIASCY program in schools, coordination of the PLHIV networks, male engagements, and peer to peer counselling initiatives among others; (ii) introduction of new policies (one on OVCs and the other on HIV and AIDS Mainstreaming) to enhance HIV and AIDS response to OVCs and mainstreaming in all sectoral plans and budgets. The National Anti HIV and AIDS Stigma and Discrimination Policy is in its final stages of approval; (iii) increased cultural and religious leaders' commitment to implement HIV and AIDS interventions aimed at eliminating GBV and stigma and discrimination at household and community levels; and (iv) improved integration of social support services (education, economic strengthening and psycho social support) provided to some of the vulnerable categories of people mainly OVCs, Adolescent girls and women among others.

Notwithstanding, the sector has experienced a number of gaps and challenges affecting its performance in relation to NSP targets. Interventions targeting key populations and other vulnerable groups are still limited in scope with a limited number of CSOs and or partners targeting them, while rights awareness activities for KPs and PLHIV are limited as well. Cultural and Religious institutions that are often in touch with and are trusted by communities have limited funding and personnel to effectively implement anti-stigma and GBV campaigns among communities. It is thus an issue of priority to scale up interventions targeting the vulnerable population data management for social support and protection as well as their effective coordination and use remains a big challenge for the social support sector. Effective programming for the sector is extremely difficult without data.

Progress in Systems Strengthening

During the year under review, a number of strategic interventions were undertaken to ensure that strategic policy frameworks were supported by effective stewardship, oversight, coalition building, appropriate regulations and incentives as well as accountability to the NSP stakeholders. Notable achievements during the year include; (i) enhanced leadership and commitment through the PFTI. All districts and urban authorities have adopted the PFTI and signed the Declaration to implement its strategies and actions; cultural and religious institutions, private sector, labour groups, faith-based organizations, nongovernmental organizations (NGOs) and other civil society entities, have been mobilized to support the implementation of the PFTI through their structures, (ii) the Parliamentary HIV Committee has been actively involved in PFTI activity implementation; providing consistent leadership and oversight in advancing the PFTI through monitoring of services delivery and engagement of leaders (iii) a number of HIV related policies, frameworks and guidelines have been developed, reviewed and launched to provide policy guidance on various aspects of the response e.g. the National Sexuality Education Framework was launched by H.E the First Lady; PIASCY program; the National Consolidated HIV Prevention and Treatment Guidelines reviewed, validated and rolled out and, the National HIV Test and Treat Policy rolled out and is being implemented by most health facilities; HIV mainstreaming guidelines were developed and rolled out (iv) Adolescent girl and young women inter-ministerial task force (chaired by H.E the First Lady) has developed a framework under which adolescent and young women issues are being addressed (v) UAC leadership capacity has been strengthened by appointment of the new UAC Board and Director General and revival of the Partnership Committee and, (iv) HIV mainstreaming guidelines were developed and rolled out.

Despite the notable achievements, there are still a number of gaps and challenges; although the PFTI has been prioritized for its implementation, civil society has not been adequately mobilized to implement it and yet they play a big role in the national response. Although the policy and legal framework have been prioritized, there are concerns that the country is still intolerant over key population groups which might hinder their effective contribution to the national response. There is also reported resistance on sexuality education by some religious institutions which might affect its implementation and achievement of desired outcomes. Among the challenges observed include; inadequate funding for HIV and AIDS Response. Funding from GoU has remained at less than 10% of the response requirements. This is impacting on UAC capacity to fully execute its mandate. This also further explains the limited scope and coverage of interventions especially in the social and protection sector as well as reported stock out of commodities in HIV prevention, Care and treatment.

Key Recommendations

Based on the identified gaps and challenges, a number of recommendations have been proposed highlighting areas that require urgent attention in order to improve implementation of NSP in the coming year. For ease of implementation and assignment of responsibility, recommendations have been proposed at two levels; at the thematic level where specific recommendations have been made to inform programming in the different NSP thematic areas; and at general level to guide overall planning for the NSP at Sectoral and National level.

General Recommendations

(1) Institutionalize the High-Level Regional Monitoring Accountability Forum for the Presidential Fast Track Initiative as an annual event in order to track progress. Clear indicators adopted from the NSP should be developed to track progress.

(2) Improve the functionality and management of the Situation Room at UAC; the facility should be hosted in country and capacity built for operationalization and rolls out at national and sub-national level. More data sources to cover entire health sector and social indicators including OVC MIS and MIS as well linkage to mobile phones to make it more accessible to the users.

(3) Institute systems and procedures for revising National HIV and AIDS clinical guidelines and protocols at preplanned intervals, unless in emergencies to avoid frequent and rapid changes which leave service providers in suspense with no clear guidance regarding some new programs and interventions.

(4) Define the delivery elements under the life cycle sensitive comprehensive package for social support and protection and develop implementation guidelines to facilitate its effective implementation by the different actors.

(5) Recruitment and training of HWs should be continued to fill the existing vacancies of critical cadres to address human resource gaps. Annual recruitment plans should be prepared and PFPs should be covered sufficiently in the HRH audit data collection, analysis and reporting for a better understanding of the human resources for health status and needs in the country.

(6) Map out HIV funding support and investments by various partners including Government of Uganda, the Global Fund and other in-country financing mechanisms by Partners for better alignment of grants and avoid duplication

(7) Fast track operationalization of the AIDS Trust Fund to increase domestic funding and bridge the current HIV funding gap.

(8) Institutionalize NASA and broaden it to include resource mobilization and expenditure by the Private Sector. NASA should be conducted routinely to guide decision making and programming rather post audit which does serve future reprograming purposes.

(9) Strengthen the multi-sectoral data management systems and revive the National Documentation and Information Center (NADIC) as the central HIV and AIDS Information and Knowledge Management Centre. The system should include a Community Health Information Management System that integrates non-biomedical data to improve national health information management, planning, monitoring, reporting and service delivery at the community level.

(10) Streamline coordination of HIV and AIDS research and ensure utilization of findings for decision making and programming. Prioritise Annual Research Agenda in line with NSP priorities to guide partners, sectors and academia and establish a “Pipeline” to move promising innovations to implementation and scale up.

1 INTRODUCTION

This report presents the country progress of the third year of Uganda's NSP (2015/16 - 2019/20) implementation that builds on previous achievements since 2016/17. The progress has been assessed according to the four NSP thematic areas of HIV Prevention; Care and Treatment; Social Support and Protection and Systems Strengthening. The report is divided into three (3) main sections which include; the introduction part that summarizes the review approach and report compilation process, the overview of HIV epidemic in Uganda and, the progress made during the FY 2017/18. The report highlights key challenges and implementation gaps as well as recommendations that could be implemented to improve the national response in the coming years. The report also captures the progress registered against the undertakings of the 2017 Joint AIDS Review (JAR) undertakings.

This report is a result of a highly participatory and consultative process involving the key stakeholders in NSP implementation. The report also utilized secondary quantitative data abstracted from the DHIS2, OVC MIS, MoES MIS and desk review of reports and spectrum estimates and some selected studies carried out during the review period. The data and report were further reviewed and validated by a Joint Thematic Technical Working Group UAC technical staff, UAC Partnership Committee, the 11th Joint AIDS Review (JAR) and 9th Partnership Forum (PF). A content analysis was done on various progress reports from the Sectors, SCEs, CSOs and partners and triangulated for drawing of the necessary conclusions and recommendations of the progress report.

2 STATUS OF THE HIV EPIDEMIC IN UGANDA

Despite numerous efforts and innovations over the past years to combat HIV and AIDS epidemic in Uganda, the epidemic remains firmly established in the general population and HIV prevalence remains significantly high. According to Uganda 2017 HIV and AIDS estimates (UNAIDS, 2017), an estimated 1.3 million people were living with HIV, and an estimated 26,000 Ugandans died of AIDS-related illnesses. Women and young girls in particular are disproportionately affected.

Table 1: Uganda 2017 HIV and AIDS Estimates

General Population	0-14 years	15+ Years	15+ Years	All
Mid 2018 Population	18,014,000	9,400,000	9,041,000	36,454,90
Number of PLHIV	93,676	738,588	492,418	1,324,685
HIV Prevalence	0.5%	7.6%	4.7%	6.2%
Newly Infected	7,863	20,624	18,000	46,487
AIDS related deaths	3,800	8,300	14,000	26,000

Source: *MOH 2018*

According to UPHIA 2016/17 HIV there has been a shift in the trend of the epidemic from younger to older individuals, prevalence peaks at 14.0% among men aged 45 to 49 and 12.9% among women aged 35 to 39. Among young adults, there is a disparity in HIV prevalence by sex. HIV prevalence is almost four times higher among females than males aged 15 to 19 and 20 to 24. HIV prevalence is nearly three times higher in men and women aged 20-24 compared to those aged 15-19. Prevalence among adults aged 15 to 64, depicts demographic disparities across the country as shown in Figure I below;

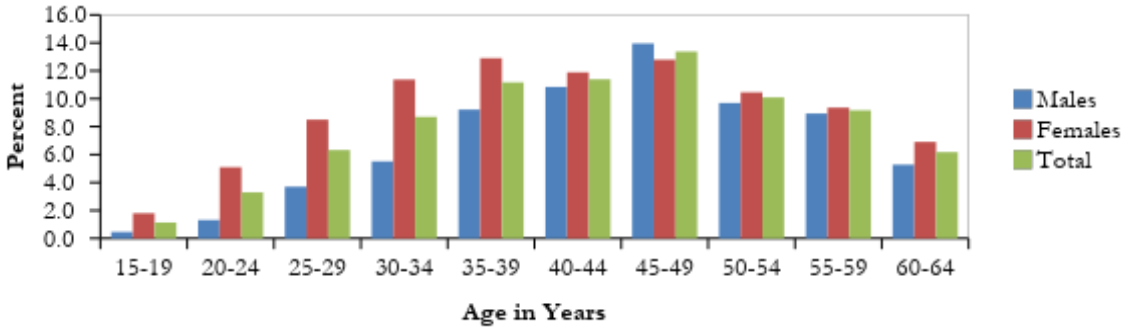
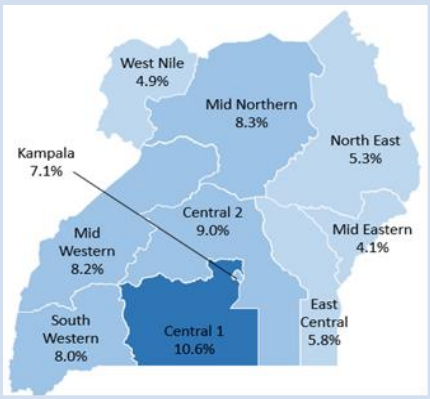
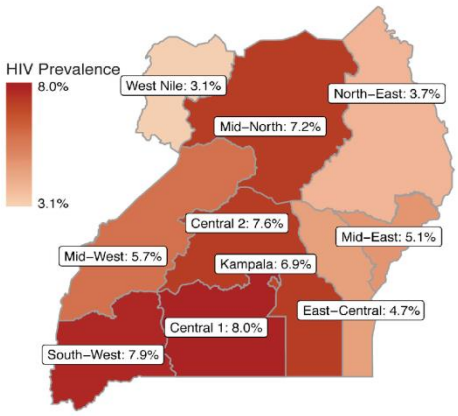


Figure 1: HIV Prevalence by age in years (UPHIA 2016/2017

The general decline in national prevalence masks regional disparities (UPHIA 2016/17), showing highest HIV prevalence Central region at 8.0% and lowest in West Nile region 3.1% (Figure 2). Furthermore, whereas all regions showed decline in prevalence, there was an increase in Mid-Eastern region from 4.1% to 5.1% between 2011 and 2017. Urban areas, especially along the major transport corridor in the country continue to experience a higher prevalence rate 7.5% than rural areas 5.8%. HIV prevalence is higher among women living in urban areas 9.8% than those in rural areas 6.7% (UPHIA, 2016/2017).



UAIS 2011



UPHIA 2016/17

Figure 2: Maps showing Comparison of HIV prevalence by regions in Uganda over the last 5 years (Source: UAIS 2011 and UPHIA 2016/17)

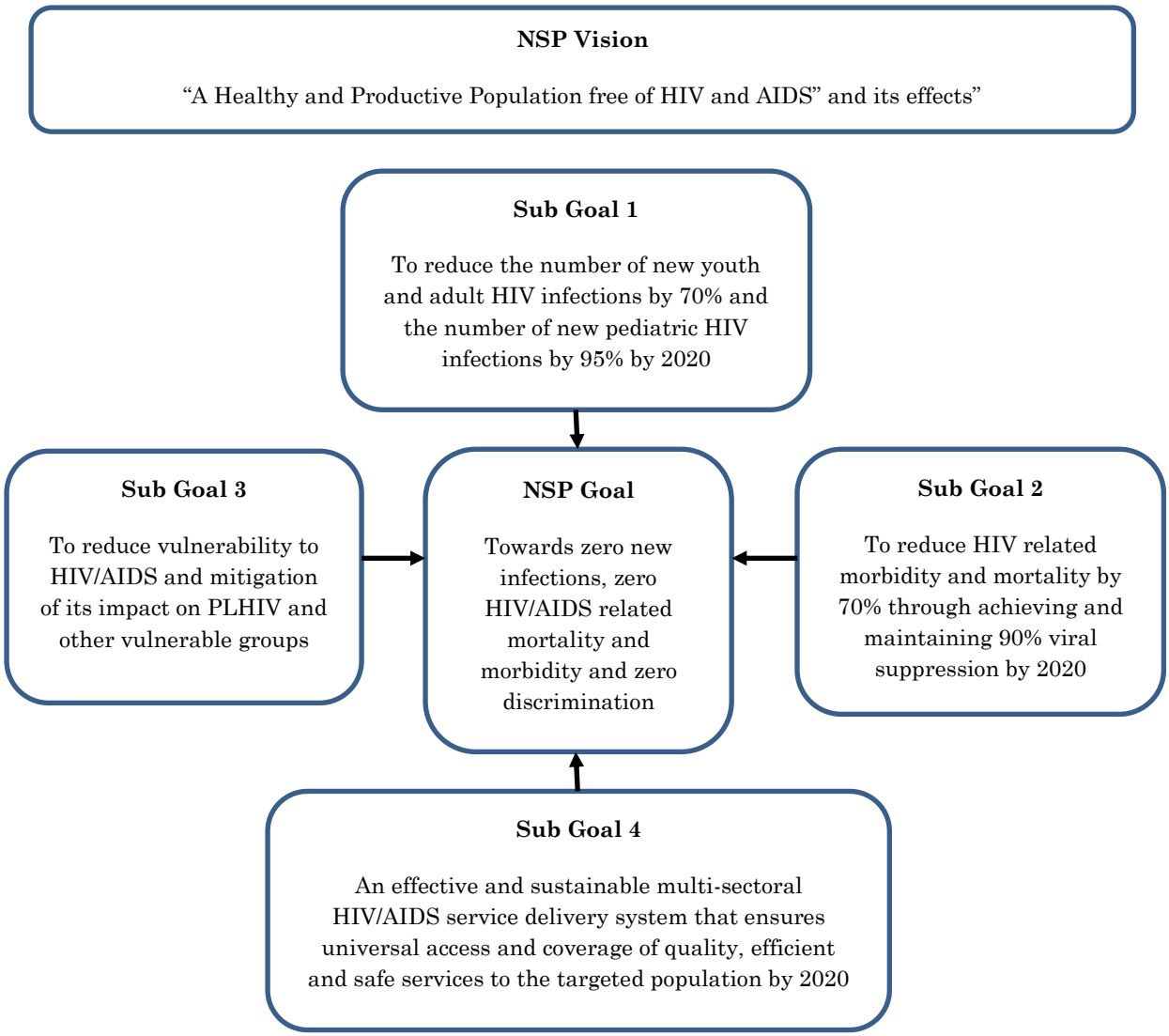
The Most at Risk Populations (MARPs) continue to experience a higher HIV prevalence, particularly, the sex workers estimated at 37% in 2015/16. It is estimated that sex workers and their clients accounted for 18% of new HIV infections in Uganda in 2015/16[1]. A 2017 study among men who have sex with men in Kampala reported high risk behaviors to be common, including 36% of respondents reporting regular unprotected anal sex, 38% selling sex, 54% having multiple steady partners, 64% having multiple casual partners, and 32% injecting drugs[2]. The 2017 study mentioned above found 40% had experienced homophobic abuse and 44.5% had experienced suicidal thoughts. HIV prevalence among Uganda's fishing communities is estimated to be three times higher than the general population. A 2013 study of 46 fishing communities found HIV prevalence to be at 22% with no variation between men and women[3]

[1] Uganda AIDS Commission, (2016) 'The Uganda HIV and AIDS Country Progress Report July 2015-June 2016'

[2] Hladik W et al (2017) 'Men Who Have Sex with Men in Kampala, Uganda: Results from a Bio-Behavioral Respondent Driven Sampling Survey' AIDS Behaviour, 21(5):1478-1490.

[3] Opio, A. et al, (2013) 'HIV Infection in Fishing Communities of Lake Victoria Basin of Uganda – A Cross-Sectional Sero-Behavioral Survey' PLoS

2.1 National Strategic Plan for HIV/AIDS (2015/16- 2019/20) Implementation



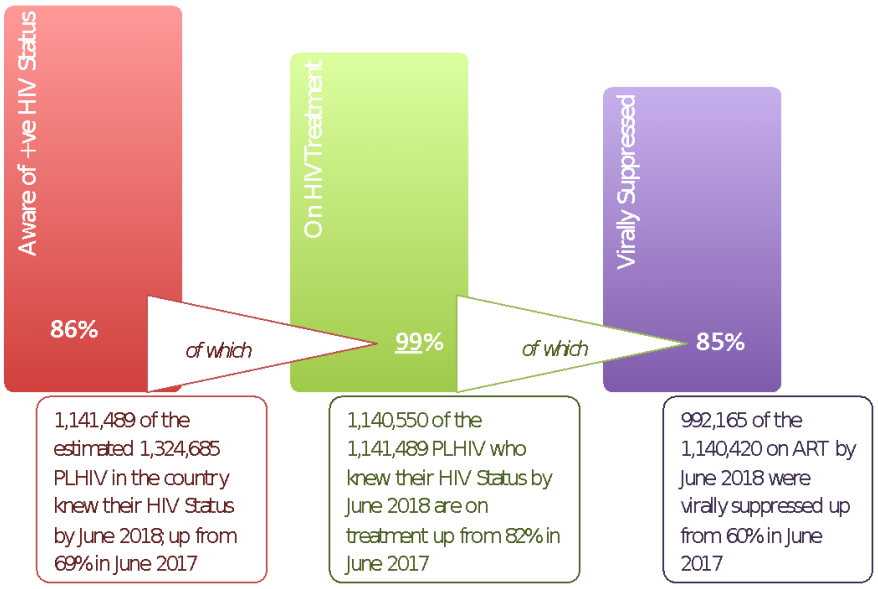
Uganda is currently implementing the fourth cycle of the National HIV and AIDS Strategic Plan (NSP) (2015/16-2019/20) with the Vision "***A Healthy and Productive Population free of HIV and AIDS and its effects"*** and overall goal ***"Towards Zero New Infections, Zero HIV and AIDS related deaths and Zero discrimination".*** The NSP 2015/16—2019/20, is aligned to the second National Development Plan (NDP II) that emphasizes scaling up HIV prevention and integrating HIV and AIDS in all programs and projects. It is also aligned to the global efforts to end the AIDS pandemic in line with the United Nations post- 2015 agenda that commits to ending the AIDS epidemic by 2030. The NSP provides the overall strategic direction for the national response under four broad thematic areas including; (i) prevention, (ii) care and treatment, (iii) social support and protection, and (iv) systems strengthening which includes governance, infrastructure, human resource, financing/resource mobilization, monitoring, evaluation and research.

Limitations of the 2017/18 Annual Review

Since there was no priority action plan for FY 2017/18, there were no targets against which to assess progress attained during the year under review. In view of this, the Consultant benchmarked achievements of 2016/17 as a basis for assessing and reporting progress made during the FY 2017/18 while taking into consideration 2017 JAR undertakings. Based on the reflected changes in the coverage achieved in 2017/18, the Consultant was able to provide explanatory narratives on progress registered (lack of it/decline) over the period of 2017/18 to shed light on what was happening in the national response. A content analysis was done on various progress reports from the Sectors, SCEs, CSOs and partners and triangulated for drawing of the necessary conclusions and recommendations of the progress report.

3 PROGRESS TOWARDS 90 90 90 TARGETS

Uganda is among the first African countries to adopt the 90-90-90 Strategy in its National Strategic Plan for HIV and AIDS Response. In 2014, the MoH adopted the 90-90-90 Strategy through quality improvement approaches, ongoing onsite supervision and mentorship, and strengthening of supply chain systems support to ensure availability of supplies.



Currently, 332,520 PLHIV are not virally suppressed and need to be reached in the next implementation period in addition to the estimated 50,000 annual new infections. 149,385 PLHIV are on ART but not virally suppressed after 12 months of treatment. 183,196 are the HIV infected people who have not yet been tested and will form an annual backlog for 2018/19.

4 STATUS OF NSP IMPLEMENTATION FOR FY 2017/18 PERIOD

Table 2: Status of NSP Implementation for FY 2017/18

Indicators	Baseline	Targets 2019/20	Achievement 2016/17	Achievement 2017/18	Assessment of Progress
Level of achievement of HIV Prevention Outcome Indicators					
Outcome 1: Increased adoption of safer sexual behaviors and reduction in risky behaviors					
% of young women and men 15-24 who correctly identify ways of preventing sexual transmission of HIV and who rejects misconceptions about HIV transmission	M=39.3%	M=70%	45%	45% (UDHS 2016)	Not on course to meet target 33.3% (LQAS 2018)
	F=38.6%	F=70%	46%	46% (UDHS 2016)	Not on course to meet target 29.3% (LQAS 2018)
% of adults aged 15-49 who use a condom at last high risk sex	M=37.9%	M=75%	22%	M= 57% (UDHS 2016)	On course but needs acceleration to meet 2020 target
	F=29.4%	F= 75%	N/A	F= 37% (UDHS 2016)	Not likely to meet 2020 target

% of young women and men 15-24 years who have had sexual intercourse before 15 years	M=11.9%	M=7%	6.4% LQAS 2017	21% (LQAS 2018) Average 13.6% M= 17.3 (UPHIA 2016/17)	Retrogressed, will not meet target
	F=13.1%	F=7%		F= 10.2 (UPHIA 2016)	Reduced but will not meet target 28.1% (LQAS 2018)
% of males and females 15-49 years reporting consistent condom use	M=37.9% (UAIS, 2011)	90%	57%	N/A	
	F=N/A	N/A	F= 37%	N/A	
Outcome 2: Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled up					
% MARPS 15-49 reporting consistent condom use	SW		65%	No special studies	No Data
	Uniformed services	50%	N/A (No MARPS specific studies		No Data
	Fishermen	50%			No Data
	MSM	50%			No Data

	Truckers	50%	done)		No Data
% of men and women who tested for HIV in the last 12 months and know their results	47% 7,800,000 (2013)	80%	53.8% LQAS 2017	M=37.3% (UPHIA 2016/17) 55% (LQAS 2018)	Not on course, Indicator irrelevant following new policy change
				F=48.1% (UPHIA 2016/17)	Not likely to meet 2020 target; Indicator irrelevant following new policy change
% of MARPS who have received an HIV test and know their status	SW 49.2%	N/A	N/A	N/A	No Data
	Uniformed services N/A	N/A	N/A	N/A	No Data
% of HIV+ pregnant women who received ART to reduce MTCT of HIV	75% (2014)	85 %	86% MoH data	89%	2020 target surpassed
% of exposed infants who have received ARV prophylaxis to reduce risk of MTCT of HIV	36.7% (2013)	80%	95%	92%	Surpassed 2020 target
% of infants born to HIV+ women receiving a virological test within 2	1st PCR =44%	1st PCR = 75%	1st PCR = 52%	44% (43,008/ 97,722)	On course to meet the 2020 target

months of birth	2nd PCR=10% (2013)	2nd PCR = 70%	2nd PCR =31%		
% of males 15-49 who are circumcised	25% (2013)	80%	43% (UPHIA 2016/17)	43% (UPHIA 2016/17) 47.6% (LQAS 2018)	Not on course to meet target
% of donated blood units screened for HIV in a quality assured manner and according to national or WHO guidelines	100%	100%	100% UBTS annual report	100% (UBTS annual Report	Target met
Outcome 3: Underlying social-cultural gender and other factors that drive the HIV epidemic mitigated					
% women 15-49 who experience SGBV	27% UDHS 2011	23 %	13% (UDHS 2016)	13% (UDHS 2016) 21% (LQAS 2018)	Surpassed 2020 target
% of adults that believe that a woman is justified to refuse sex or demand condom use if she knows her husband has a STI	M= 90% F= 84% (2010)	M=95% F=90%	N/A	M=91% F=87% (UDHS 2016)	On course to meet the target

Care and Treatment Indicators Performance					
Outcome 1: Increased access in pre-ART care to those eligible to 90% by 2020					
Proportion of adults and children enrolled in HIV care services	70%	80%	67%	87% (1,140,420/1,324,685*)	Improved performance observed mainly in the last quarter
Outcome 2: Increased access to ART and sustained provision of chronic care for patients initiated on ART					
% of adults and children with HIV known to be on treatment 12 months after initiation of ART	83%	90%	86.1%	72.5% (128,153/176,645*)	Reduced performance or High loss to follow up cases in Oct-Dec 17 and Jan-Mar 2018 could explain the decline in the cohort.
Proportion of MARPS with HIV maintained in on ART for 12 months by category	N/A	95%	N/A	N/A	No data
Outcome 3: Improved quality of chronic HIV care and treatment					
% of estimated HIV+ incident TB cases receiving both TB and HIV treatment	60% (2013)	70%	36.2%	57% (*)	Improved performance
% of people with diagnosed HIV infection on Isoniazid Preventive therapy	N/A	80%	97%	For new case 8% (17,493/217,447*)	Prevention therapy course - six months Country needs IPTP

					reprograming in line with test and treat
Outcome 4: Strengthened integration of HIV care and treatment within health care programs					
Unmet need for FP among PLHIV	34% (general population)	PLHIV = 24%	PLHIV =41.2%	WLHIV=32% (FP Study, 2017)	Improved performance
Proportion of HIV positive acutely malnourished clients who received nutrition therapy	N/A	50%	N/A	48% (10,064/21,133*)	Indicates all PLHIV routinely assessed and given therapeutic interventions
Social Support and Protection Indicators Performance					
Outcome 1: To scale up efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups					
Percentage of individuals aged 15-49 years with accepting attitudes towards PLHIV	Overall: 34% Male =34.2% Female =22.2% (UDHS 2011)	70%	19.1% (external stigma experienced by young people in East Central)	Overall = 66.8% Male = 71.3% Female =65.6% (2016)	On track to meet the target.

Outcome 2: To scale up services to meet the needs of PLHIV, OVC and other vulnerable groups in development programs					
Percentage of OVC households that are food secure	45.2% (LQAS 2013)	60%	37.2% (LQAS 2017)	37.2% (LQAS 2017)	Reduced. More effort needed
Percentage of OVC aged 5-17 that have at least three basic needs met	24.8 % (LQAS 2013)	70%	50% OVC MIS	39% (LQAS 2017)	Reduced. More effort needed. There are limited interventions supporting OVC with basic needs
Outcome 3: To develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups					
Percentage of districts with Life skills cycle sensitive comprehensive package of social support and protection	Not Available	100%	Information not available	Information not available	No information available to measure progress
Percentage of vulnerable individuals receiving a life cycle sensitive comprehensive package	Not Available	65%	Information not available	Information not available	No information available to measure progress
Outcome 4: To engender all social support and protection programs to address the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV/AIDS					
Percentage of married women who participate in all the three decisions pertaining to their own health care, major household purchases, and visits to their family or relatives.	38% (UDHS 2011)	70%	Information not available	Overall = 51% 15-19 years = 35.5% 20-24 years =	On course to achieve the target

				43.9% (UDHS 2016)	
Percentage of men and women who believe that wife beating is justified	Overall =55.1% Women= 58.3% Men= 42.8% (UDHS 2011)	20%	Information not available	Overall=47% Women=49% Men =40.1% (UDHS 2016)	Violence against women still high-not on course to achieve the target
Percentage of women who own land alone or jointly with their spouses	38.7% (UDHS 2011)	40%	68%[4]	47.7% (UDHS 2016)	Already surpassed the target
Systems Strengthening Performance Indicators					
Outcome 1.To strengthen the governance and leadership of the multi- sectorial HIV/AIDS response at all levels					
% increase in no. of large workplaces (30 workers and over) with HIV/AIDS work place policies and programs	NA	100%	80%	40/45*100=88.9 %	On course
Outcome 6. To strengthen coordination of the national HIV/AIDS response					
Proportion of functional HIV/AIDS Coordination structures at national and district levels	30%	100%	80%	Districts, 115/121*100=96% MDAs 40/45*100=88.9 %	On course

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

4.1 Progress made In HIV Prevention

4.1.1 Adopting Safer Sexual Behaviors and Reducing Risky Sexual Behaviors

Comprehensive Knowledge about HIV

Whereas, in the recent past there was observed improvement in comprehensive knowledge among adolescents and young people from 2011 to 2015/16, from 39.3% to 45% and from 38.6% to 46% among men and women respectively (UDHS 2011 and 2016), findings from a recent LQAS done in Northern Uganda in April 2018 show that comprehensive knowledge among this age group may be as low as 33.3% and 29.3% among men and women respectively, much lower than the NSP baseline (2013). This is far below the target of 70% awareness to be achieved in the remaining 2 years of NSP. It is therefore unlikely that this target will be achieved by 2020.

Young Women and Men 15-24 years who have had Sexual Intercourse before 15 years

The review shows deterioration in this indicator with more young people initiating sexual intercourse before 15 years. The UPHIA (2016/17) which indicated that 17.3% of boys and 10.2% of girls aged 15-24 had experienced sex before their 15th birthday. This compares with the UDHS (2016) results (17% and 12% for boys and girls respectively). Compared to 2011, more boys are reporting sexual experience at age 15 than girls, perhaps because most prevention programs focused on the girl child leaving out the boys. Indeed, whereas fewer girls had sexual experience in 2016 compared to 2011, it was the reverse for the boys. The 2018 LQAS conducted in northern Uganda also showed that as many as 21% boys and 28.1% girls have sexual debut by age of 15, which is almost twice the NSP baseline (2013) and far from the national target of 7%.

4.1.2 Condoms Programming and Use

The proportion of men and women aged 15 to 49 years engaged in high risk sex using condoms for protection has improved from 37.9% for male and 29.4% for female respectively to 57% and 37% for women (UDHS 2011 and UDHS 2016). The improvement is better among males compared to female indicating that with accelerated implementation the 75% NSP targeted could be achieved while the female counterparts are not likely to meet the target. However, the UPHIA 2016/17 condom use at last high risk sex was 37.6% and 29 % among men and women respectively which is far below the NSP target for both sexes. Furthermore, condom use is very low among the key populations; fisher folks (5.51%), sex workers (17.32%), truck drivers (6.3%) and uniformed persons (6.3%) *(*Uganda Total Market Approach-Case study, 2016*)*

The national need for condoms to protect all sexual acts from HIV infection and unplanned pregnancy (universe of need) for 2017/18 was estimated at 452,851,682 pieces. Approximately 25,246,439 condoms are needed for Family Planning, 217,603,495 for HIV prevention, and 210,001,747 specifically for MARPS). Government of Uganda with support from partners planned to procure 350 million male condoms, but only 142 million male latex condoms (41% of planned) were the actual available in stock over the same period. The Alternative Distribution Mechanism (ADM) where condoms picked from the central (UHMG) and regional warehouses and distribute to pick-up points,

through outreaches and social marketing channels was the main route used, as well as CSOs through donor funded projects. Stock outs were experienced at all levels of the supply chain as reported in the February to June 2018 stock status reports.

Over the same period, 500,000 pieces of female condoms were available in stock, of which only 307,000 were distributed, signifying a persistently low demand and use of the female types of condom despite spirited campaigns to promote its use. Earlier in the year, the country introduced and is promoting the panty condom to empower young women and overcome resistance of condom use by men.

Distribution among Key Populations is through targeted channels such as the 14,528 condom dispensers installed in hotspots in compliance with MoH specifications and provisions/installation guidelines.

Gaps/Challenges

(1) Shortage of both male and female condoms due to occasional delays in procurement processes.

(2) Lack of alternative distribution lines to the Private Sector further limiting access to condoms and family planning.

(3) Promotion skewed towards HIV rather than dual protection which has not translated into desired behavioral change.

(4) Limited capacity of the National Drug Authority (NDA) to expedite post-shipment processes.

4.1.3 Utilization of Biomedical HIV Prevention Interventions for Integrated Healthcare Services

HIV Testing Services

HIV Testing Services (HTS) have been integrated in the different points of care and is expected to be provided in all health facilities in the country. Over the review period, almost 8.9 million people accessed HTS as summarized in the graph below;

Figure 3: HIV Testing Services

Almost 70% of the individuals who received the HIV Testing Services were aged 19-49 years and yet the same age group contributed 84% of the people identified to be HIV positive.

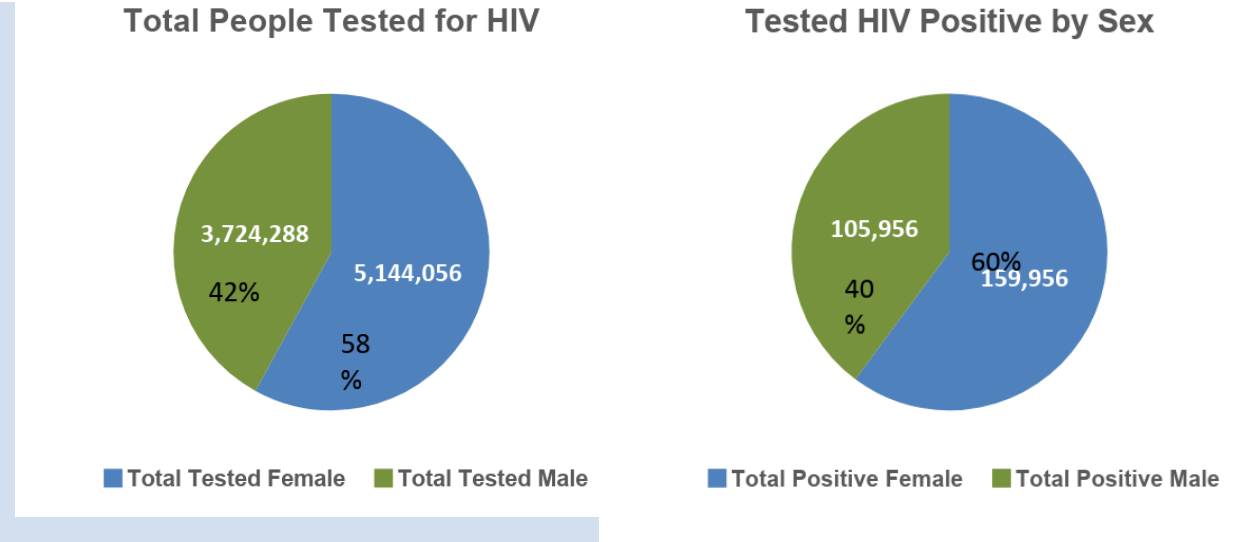


Figure 4: Comparison of persons tested and positivity rate by sex

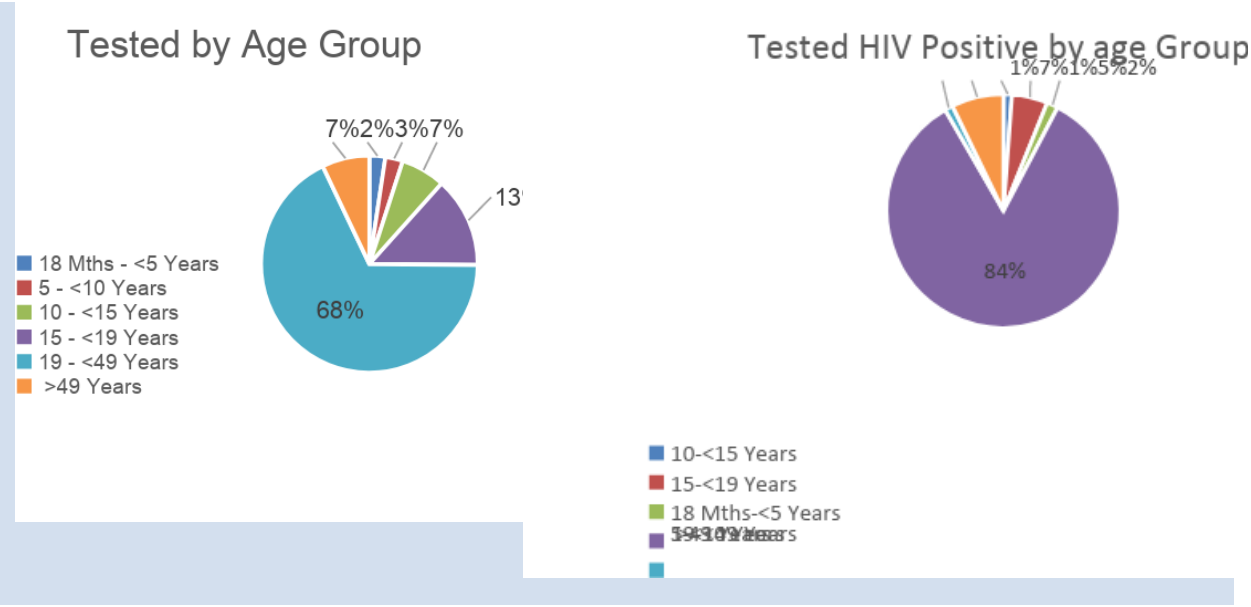


Figure 5: Comparison of percentage of persons tested and Testing positive by age group

The majority of people who accessed HTS were in the sexually active age range; the 19-49 years groups were 68% of total tested, but this proportion increased to 84% among those who tested HIV positive, implying that HTS have been focused on the sexually active. The 15-19 years age group made 13% of people who tested for HIV but only 5% of those who tested HIV positive.

The individuals who tested HIV positive were 265,912 (positivity rate of 3.4%) up from 217,765 that tested positive in 2016/17 (DHIS2 2016/17, and 2017/18). Although there was a reduction in the number of HIV tests conducted, the 2017/18 tests yielded a higher positivity rate compared to the 3% reported in the previous year. First time testers constituted 22% (1,951,040) of total tested, down from the 33% reported last year. This year, 68,150 MARPs accessed HTS with almost 65% of them coming from Kampala and the Central Regions. Both Eastern and Western Uganda reported very few numbers of MARPs receiving HTS (PEPFAR Program reports).

The increased positivity rate could be attributed to a SURGE strategy adopted by Government and partner efforts that included; new innovations like HIV Self-testing (HIVST), Assisted Partner Notification (APN) / HIV-positive index clients; Resolving inconclusive HIV Test Results following a first Inconclusive result; Re-testing for verification and use of SD bioline to replace Unigold as a tie breaker in the testing algorithm. The SURGE strategy, intended to improve testing efficiency in HTS and linkage to care and treatment in a timely manner.

Between July 2017 and June 2018, the number of HTS outlets increased from 5,000 to over 6,282 the surge occurring in the last quarter of 2017/18. Eighty-two percent (82%) (7,207,438) of those tested, were aged 15-49 including 34% (2,866,847) men, whose numbers are beginning to increase this year due to efforts under the Presidential Fast Track Initiative (PFTI) that emphasizes supporting men to access HTS.

The revised guidelines for HTS that were launched in January 2017 have been rolled out to all hospitals, HC IVs and HC III and over 70 % of HC IIs. The guidelines have updated sections on The Test and Treat policy was fully implemented and all persons who test HIV positive are started on ART immediately.

HIV Self-Test (HIVST) prioritized for young people 18 years to 24 years; emancipated minors (<18years if pregnant, have a child, main caregiver for the family); men including partners of pregnant and lactating mothers; and Key Population was piloted in 3 districts.

Linkage to Care

There was an improvement in linkage to care among newly tested HIV positive clients with only 2,463 not linked compared to over 76,000 in 2016/17. The observed difference could be due to the test and treat policy which has now been fully implemented across the country. Figure 6 shows the comparison of identified HIV positives linked to care in the last 2 years;

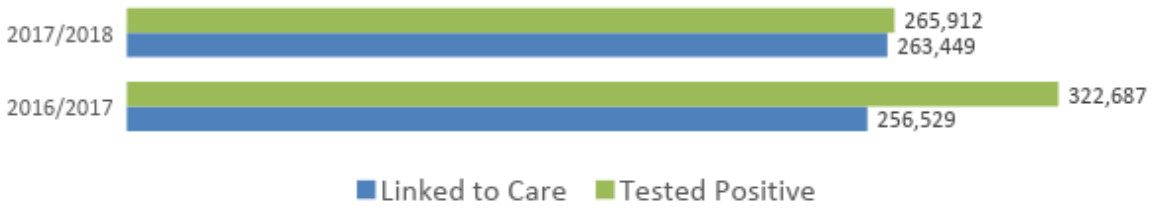


Figure 6: Linked to care

In the districts piloting SURGE, linkage to care has improved from 73% in March to 91% in June 2018 (PEPFAR June Report) leading to a testing efficiency (yield) of 4.3% in the intervention districts compared to non-SURGE districts.

Challenges/Gaps

(1) Men and youths 15-24 years are not being reached with HTS services

(2) There is still poor linkage of the identified HIV positives into HIV care with adult men being the worst affected.

(3) Linkage of individuals from neighboring countries that come for testing services and test positive.

There is need to fast track mapping and segmentation of men's groups and scaling up the piloted effective strategies e.g. HIVST, targeting HTS to KP/PP in their hot spots, and testing men at critical entry points so as to reach the missing HIV positive persons in Uganda who do not know they are infected.

4.1.4 HIV Prevention among the Key Populations

In Uganda, three categories of people are considered among key and vulnerable populations, namely:

a) Existing key population (Sex workers, truckers, MSM, fisher-folk, and uniformed services personnel),

b) Emerging key population (Prisoners, miners, plantation workers, boda-boda riders, taxi-men, brick-layers, and salt-extractors) and

c) Vulnerable key population (Migrant and mobile populations, young women, adolescents, HIV-discordant couples, pregnant women and PWDs).

The Priorities for Local AIDS Control Efforts (PLACE) study conducted in 40 districts of Uganda established that comprehensive knowledge among KPs was as low as 35.6% with the radio as the main source of information reported (PLACE 2018). Out of 22,968 respondents, 30% reported having had more than 1 sexual partner in the previous 4 weeks, and 28% reported having experienced signs of STI in the preceding 12 months. Further to this, 8% of respondents aged 30-34 years tested HIV positive.

The PLACE study estimated the national population for key population as follows; female sex workers, 2.2% - 3.1%; men having sex with men, 0.5%-0.6%; persons who inject drugs; 0.1% - 0.3% and fisher folks 0.1% - 0.3% of the general population.

Under Key Populations programming the following service package is being provided to Key Populations (KPs); social and behavior change communication (SBCC); risk reduction counseling; HTS; ART provision and adherence support; sexual and gender-based violence (SGBV) screening; post care pre-exposure prophylaxis (PrEP), emergency contraception (ECP), alcohol/drug harm reduction; and reproductive health services.

The uniformed personnel, especially the police, prisons and the army have established dedicated clinics and outreaches specifically for MARPs. In order to reach the other categories, MoH & UNFPA supported Kampala, Wakiso, Hoima, Fort portal, Mbarara, Gulu, Mbale districts to develop MARPs SRH/HIV strategic, operational and M&E plans that are currently being implemented. All regional referral hospitals have a KP focal person and a team trained in KP issues and a 3-member coordination committee.

Over the period under review, 25,135 female sex workers were reached with HIV prevention messages and 7,662 tested for HIV and received results; 2,396 MSM were reached with HIV messages and 394 tested received results for HIV and 42 injection drug users were reached with messages and 9 tested for HIV and received results (Source: Program Reports). The country developed and piloted the KP training manual.

Challenges/Gaps

(1) Targeted implementation for KP service packages has remained largely partner led.

(2) The coordination and tracking of the national MARPS Response is still limited in scope and capacity.

(3) The current definition of KPs excludes immigrants, sex workers, charcoal traders, farmers, and people living in camps, construction workers, and youth both in schools and out of school yet PLACE study found them to be equally at risk.

(4) Limited capacity, and attitude of health workers to offer key population friendly services without stigmatization.

(5) Lack of standard training curriculum for health workers and peers providing key population services.

(6) Lack of capacity to diagnose and report on STI leading to under reporting and misdiagnosis of STI among KPs.

In order to improve Key Population services, there is need to streamline and strengthen coordination of their response at national, district and community level. There is also need to undertake a synthesis, triangulation and harmonization of the several key population mapping and population size estimations studies and service delivery data available in the country. The resulting sub-national key population size estimation data will be used to form the basis for a national size estimation exercise, which will be used for KPs programming in the country. The NSP which is currently undergoing revision should incorporate the new and emerging population groups like PWID and LGBTI in order to expand and further strengthen the KPs response in the country. There is need for continuous capacity building for HWs to offer KP friendly services and STI management. The training curriculum for HWs and peers providing KP friendly services should be finalized and rolled out while Legal and enforcement sectors should be continuously engaged as key stakeholders in KPs response in the country.

4.1.5 Reducing the Risk of Mother-to-child Transmission of HIV

Uganda has successfully scaled up Prevention of Mother to Child Transmission of HIV (eMTCT) services to over 3,200 health facilities, of which 2.900 are HC IIIs and HC IIs. The program has been expanded and integrated with Immunization (EPI) and Early Infant Diagnosis services (EID), resulting into the number of EID sites increasing to 2,304. In the period July 2017-June 2018, the performance on key PMTCT cascade indicators was as follows;

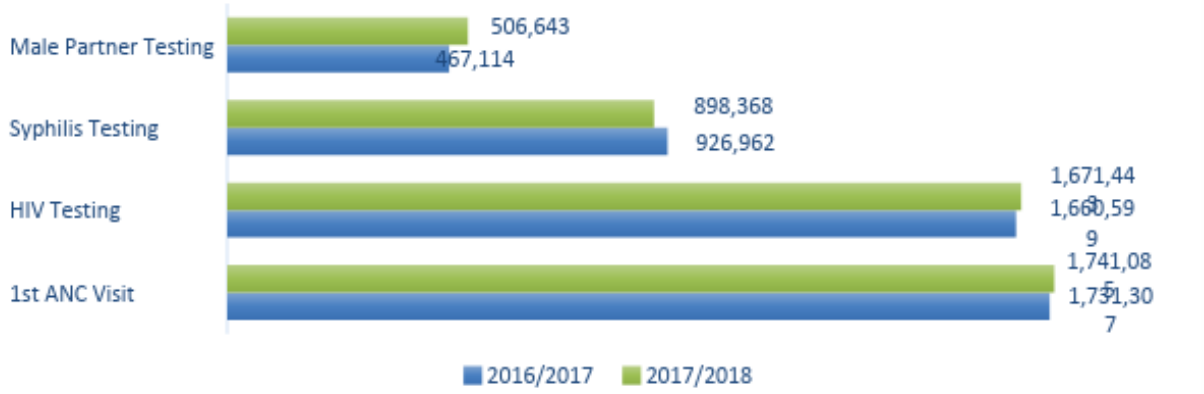


Figure 7: ANC Cascade (Source MoH, 2018)

During the review period, over 96% (1,671,443) of mothers who attended ANC1 (1,741,443), took an HIV test or already had an HIV + status and 97,722 (6%) were identified as HIV positive requiring immediate ART. The HIV positivity rate was highest in the Central 1 region (9.4%) and lowest in North East and West Nile regions (1.4% and 2.1% respectively). Four Regions (Central, Central 2, Kampala and South Western) had HIV positivity rate above average,

ART provision for Pregnant Women was 84% (82,237), which is 2 percentage points lower than that achieved in 2016/17 and 1 percentage point below the 2020 target. The 2016/17 UPHIA reported 95% ART coverage among this group. The HIV positivity rate among the 506,000 spouses that took an HIV test through the PMTCT program was 2%. Male partner testing was highest in North East region (70%) and lowest in Central and Kampala Regions (10% and 12% respectively).

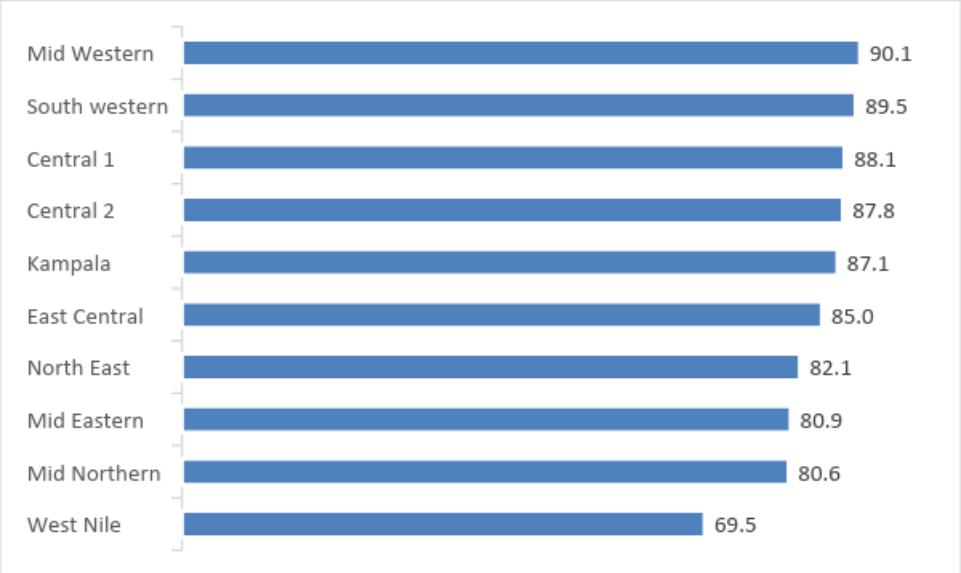


Figure 8: Percentage of HIV Positive Pregnant Women who received ART

Over 30% of HIV positive pregnant women in West Nile region did not receive ART to prevent transmission to their exposed infants.

The country has revised the e-MTCT guidelines to emphasize 6 monthly viral load testing throughout pregnancy and breastfeeding period (till the baby is 18 months) to identify mothers with high viral load and take measures to minimize risk to new infant infections. The updated guidelines also introduced HIV/Syphilis SD Bio-line Duo kit to screen pregnant and breastfeeding mothers for HIV and Syphilis, with Stat-pak used as a confirmatory test. This was implemented in 242 high volume health facilities and once fully adopted will improve syphilis screening within MCH. Other changes introduced include use of AZT/3TC/NVP for high risk infants captured at birth or later and a PCR test at 9 months. Performance on these indicators is set to improve over the next period.

4.1.6 Early Infant Diagnosis (EID)

Uganda is among the countries on track to eliminate MTCT of HIV and is currently undergoing assessment for readiness to attain WHO certification for pre-elimination status.

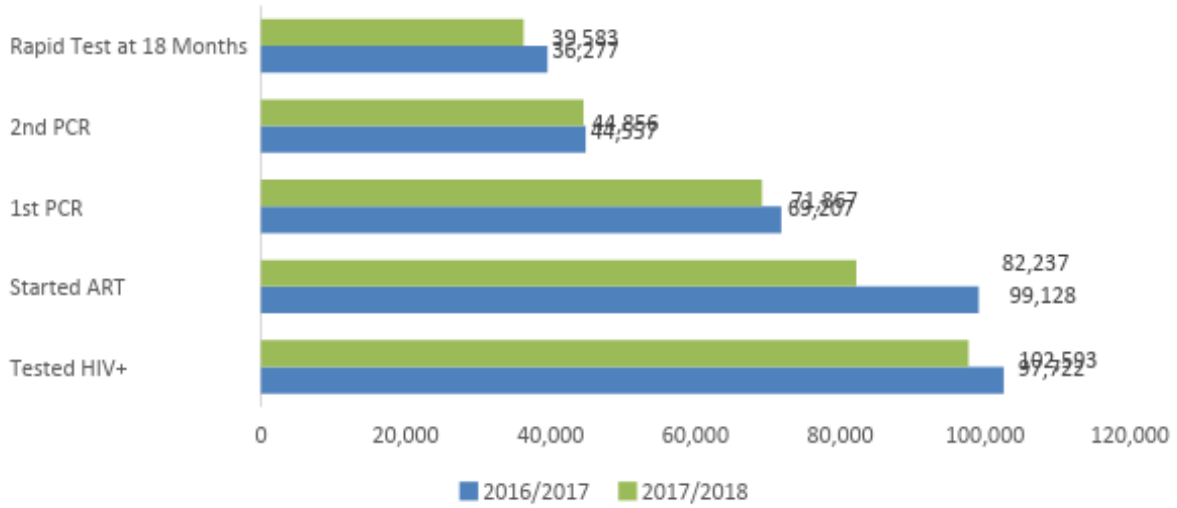


Figure 9: Mother Baby Cascade (MoH, 2018)

The exposed infants who were tested for HIV before 18 months of age were 69,207 representing 70.8% of those expected. However, infants who got their 1st PCR test within 6 weeks were only 44%, implying that we have not made any progress from the baseline levels. This indicator is greatly affected by the very low deliveries in health facilities in Uganda and is yet to respond to the integration efforts made with EPI and other RNMCP services. There were 2,498 babies who tested HIV+ among those receiving a PCR test, with a 1.8% transmission rate at 6 weeks 1st PCR. ARV prophylaxis for HIV exposed infants was at 37% and 42% respectively. Program reports indicated that 90% of the HIV exposed infants who delivered at health facility received ARV prophylaxis. Most children who did not get ARV prophylaxis were in Eastern, Mid-Western and West Nile regions. There was also reported stock out of NVP syrup noted in most PMTCT facilities across the country.

The integration of EPI/EID/PMTCT to ride on the successful EPI program will go a long way to improve identification and follow up of HIV exposed infants, and the provision of antiretroviral therapy (ART) for those identified to be HIV-positive.

Achievements

There has been consistent reduction in the number of new paediatric infections across the 3 years of this strategic period. Uganda is therefore on track to virtual elimination of MTCT. The country achieved an 86% reduction in new HIV infections among children, becoming one of the 7 Global Plan countries in sub-Saharan Africa that reduced new HIV infections among children by 70% by 2015 (UNAIDS, 2017)..

However, the number of HIV Exposed Infants (HEI) who receive ART prophylaxis has stagnated at around 42%, largely due to the very low health facility deliveries observed among mothers in Uganda. There is still need for focused attention to keeping mothers and babies in care so as to improve retention rates for eMTCT mothers from the current 65-75% to the 90% target

The implementation of birth cohort monitoring approaches in all sites has greatly improved the identification, monitoring and reporting for mother and their babies enrolled in HIV care.

Challenges/Gaps

(1) eMTCT achievements have not been fast enough to reach the 2020 targets set by UNAIDS and partners as part of the Super-Fast-Track Framework to end AIDS.

(2) Most MCH staff have not been trained in PMTCT in general and cohort monitoring in particular

(3) Uptake of male partner testing during ANC is still below the set targets

(4) Low Viral Load monitoring among eMTCT mothers (30-45%)

4.1.7 Safe Male Circumcision (SMC)

The country set a target of one million males circumcised each year and this year achieved 75% of the target as presented in the graph below;

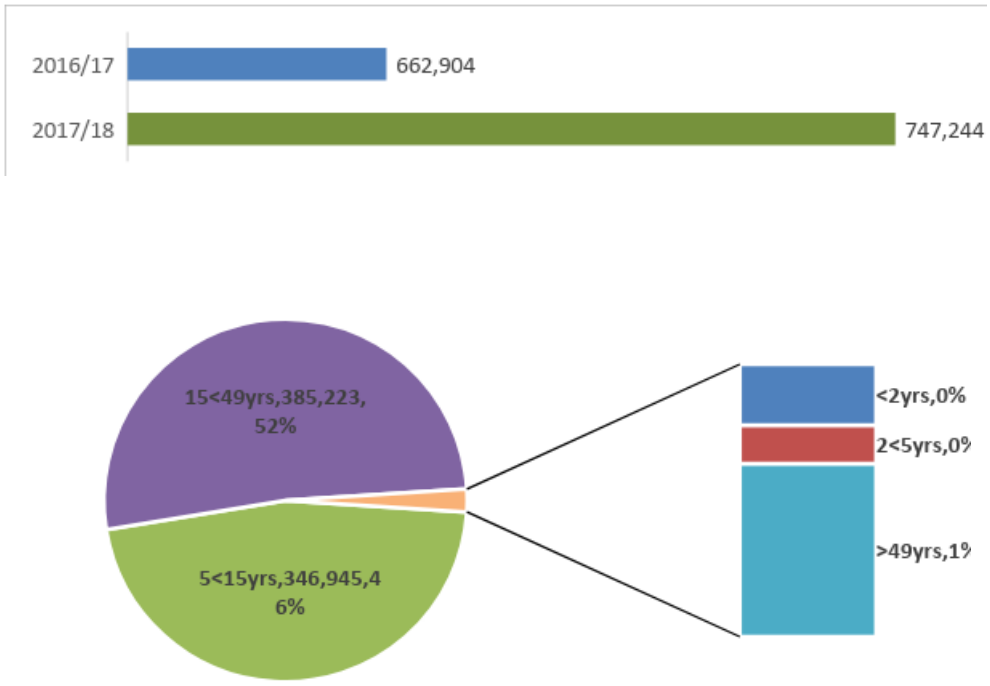


Figure 10: Number of males circumcised

More men (747,244) were circumcised in 2017/18 compared to (662,904) men circumcised in 2016/17. Almost all (99%) (718,747/747,244) of the SMCs were done using surgical techniques and 80% (593,954/747,244) were carried out in outreaches.

During the period under review, the process of facility accreditation for SMC was piloted and implemented in 261 health facilities, with 75% meeting the minimum standards. Most facilities which failed to meet the requirements were found in the Northern and South Western regions. In addition, the training curriculum for national Safe Male Circumcision (SMC)/Early Infant Male Circumcision (EIMC) were developed and piloted. A safety monitoring team was instituted to monitor the magnitude and distribution of adverse events emanating from SMC.

4.1.8 Pre-Exposure Prophylaxis (PrEP)

Uganda adopted PrEP as one of the biomedical prevention interventions. This year PrEP was rolled out in a phased approach. All implementing sites must be accredited and have a signed authorizing letter from the Ministry of Health (Director General of Health Services) before initiating PrEP. Currently there are 35 sites in Kampala and Wakiso district where PrEP can be accessed. As of March 2018, about 8,000 people had been screened for PrEP and over 3,000 received the service.

Technical guidelines, M&E tools and facilitator manuals for PrEP have been completed. The implementation guidelines are in final draft form. However, the following issues are emerging from the experience of rolling out PrEP.

Gaps/Challenges

- *The modeling done indicate that PrEP is more useful for SWs and DC & not MSM*
- *Follow up and adherence are major challenges*
- *Stigma among PrEP clients (resemblance of pills)*
- *Accreditation of sites is on-going but a slow pace*

4.1.9 Infection Prevention and Control (IPC) - PEP

In 2017, it was reported that a total of occupational and non-occupational exposures and 13,829 clients accessed PEP, with only 40.8% completion rates. The PEP service is not provided to all the eligible clients, some clients do not complete treatment. The PEP policy guidelines which were developed in 2013, as well as the M&E tools are now due for review.

4.1.10 Underlying social-cultural gender and other factors that drive the HIV epidemic mitigated

The NSP prioritized to monitor progress on 2 indicators; women 15-49 who experience SGBV; proportion of adult Ugandans that believe that a woman is justified in asking her husband to wear a condom if he has an STI. Based on 2016 UDHS, there is tremendous progress towards achieving 2020 target for SGBV with only 13% of women respondents reporting having experienced it surpassing the NSP target of 23%. However, the April, 2018 LQAS found SGBV experience to be 21%, which is far from the NSP target and shows deterioration in this indicator compared to achievements of 2016. Therefore there is the need to step up SGBV prevention efforts to sustain previous gains and be able to achieve the set target by 2020. Although a number of partners have been supporting SGBV interventions, the NSP Mid Term Review noted that existing services for Sexual and Reproductive Health, GBV and HIV provided by different partners, often not well integrated or coordinated, they are limited in scope and geographical coverage.

Government engaged cultural institutions as part of gender response, to mainstream gender messages into all their events and functions. The Buganda Kingdom continued to implement the "Obuntu Bulamu" campaign championed by the Kabaka and Nnabagereka. Similarly, in Karamoja the kraal leaders were engaged to convey HIV prevention and GBV messages, as were the clan leaders in Busoga, Tooro and Lango sub-regions engaged through their kings. A gender tracking dashboard has been introduced at UAC, which once it is rolled out will provide comprehensive information on GBV with requisite disaggregation.

There has been consistent overwhelming belief that women are justified to refuse sex or demand condom use if she knows her husband has a STI. The 2016 UDHS established that 87% of women and 91% of men concurred with this.

4.2 PROGRESS MADE IN CARE AND TREATMENT

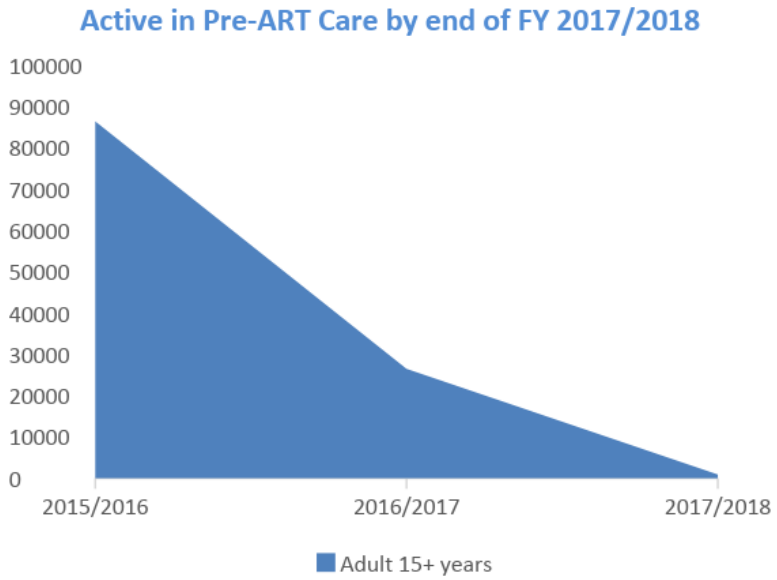
Table 3: Status of Care and Treatment at a glance

	Children <15 years	Adults 15+ years			
Estimated PLHIVs	93,679	1,231,006	492,418	738,588	1,324,685
Active on ART	66,110	1,074,440	371,339	703,101	1,140,550
ART Coverage	70.6%	87.3%	75.4%	95.2%	86.1%

Source MoH, 2018

4.2.1 Access to Pre-Antiretroviral Therapy Care

There was a significant reduction among those active in Pre-ART, from 26,482 in 2016/17 to 882 in 2017/18. Pre-antiretroviral therapy care for those eligible, has been over taken by the "test and treat" rolled out in January 2017 and is now be considered as increasing linkage to ART though DHIS2 data shows that there are still a sizeable number who delay initiating ART.



4.2.2 Access to Antiretroviral Therapy

Annual performance shows that access to ART was better in FY 2017/18 with 7,359 more people testing HIV positive and accessing care in FY 2017/18 (263,449) compared to FY 2016/17 (256,529).

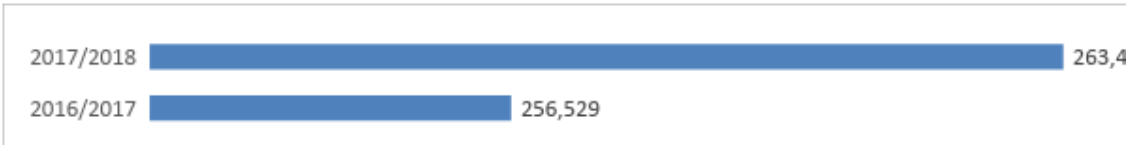
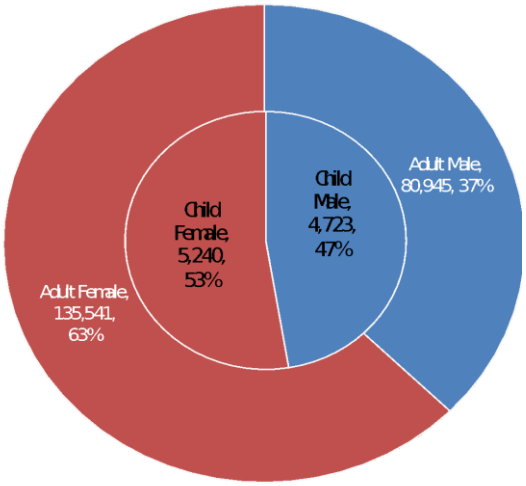


Figure 11: Access to ART

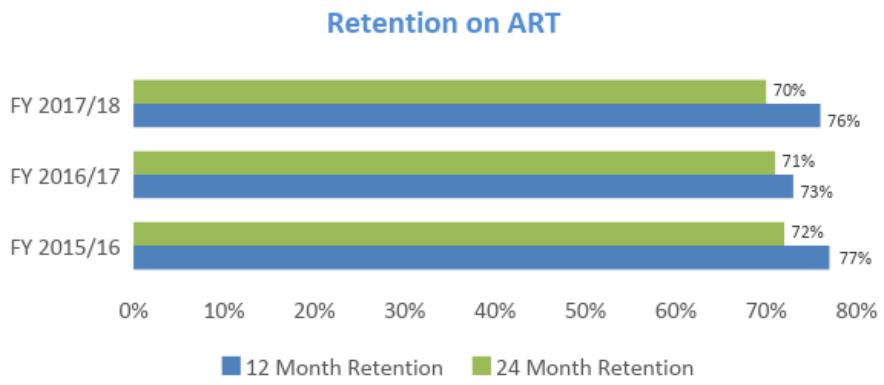
During FY 2017/18, DHIS data shows that an additional 226,449 were newly initiated onto ART, thus increasing the total number of PLWHA on treatment in the country from 1,028,909 by June 2017 to 1,189,811. The June 2018 ART coverage is estimated at 86.1% (1,140,550 / 1,324,685), 70.6% (66,110 / 93,679) among children and 87.3% (1,074,440 / 1,231,006) among adults PLWHA.



Over the FY 2017/18, 87% (229,940/263,449) of people testing HIV positive were linked to care improving from 78% (220,431/256,529) in FY 2016/17. Although by June 2018, 33,948 individuals testing positive over the FY 2017/18 were not started on ART, the annual "Test and Treat" gap generally narrowed by 9 percentage points from previous year. Nevertheless, key linkage gaps for people testing HIV positive still exist

Data also shows that there was a very significant gender difference in ART enrolment among adults above 15 years group, the enrolment of men was almost half (37%) compared to that of women (63%). However, there was no significant gender difference among children below 15 years. Within different age groups, infants and young adolescents had the largest linkage gap of 13% and 16% of those testing positive not linked to care.

There was improved 12 month retention on ART at 76% by June 2017/18 compared to 73% by June 2016/17. However, there was a slight reduction in the 24 month retention on ART from 71% in 2016/17 to 70% in 2017/18.



Gaps/ Challenges

(1) Linkage to treatment remains suboptimal among men and infants and young adolescents.

(2) Cohort Analysis for 12 Months (2017/18) showed that 14% (25,833/176,645) of patients aged 5 Years and above started treatment late (Baseline CD4 count <250).

(3) Undiagnosed HIV positive people still exist and a total of 41,590 HIV positive were not reached.

Despite some challenges and gaps noted in ART, there are some promising practices that need to be scaled up including; promotion of same day linkage to ART; targeted DSDM for adolescents and adolescent friendly services; strengthening young adolescent engagement and; the countrywide "SURGE" strategy for Intensification of Program Efforts to reach those in need of treatment

4.2.3 Paediatric and Adolescent ART

Pediatric ART coverage increased from 62% (59,748/95221) in January-March quarter of 2015, 68% (65,427/95221) in the July-September quarter to 69.4% (66,110/95,221) in the April-June 2018. Paediatric HIV prevalence in Uganda is estimated at 0.5% (UPHIA 2016) with 88,437 children under age 15 are living with HIV. By the end of June 2018, 8,831 extra Children LHIV were enrolled on ART implying an increase from 67% by June 2017 to 76%.

Adolescent friendliness is offered in 59.4% of ART sites an improvement of 2% from that noted in 2016/17. An estimated 88,510 adolescents (10–19 years) are living with HIV. By the end of June 2018, 14,350 extra adolescents were enrolled on ART implying an increase from 58,227 (66%) by June 2017 to 76%. About 68% of young adolescents and 54% of older adolescents accessed a viral load test in 2017, with suppression rates of 73% and 72% respectively. Thus, viral load suppression rates have remained suboptimal.

Viral load coverage for children living with HIV below 15 years of age has almost doubled over the three years from 36.8% in 2015/16 to 69.3% in 2017/8, with a viral suppression rate of 70% over the three years. There are still 29,054 children living with HIV who are not yet in care.

Quality of Chronic HIV Care and Treatment

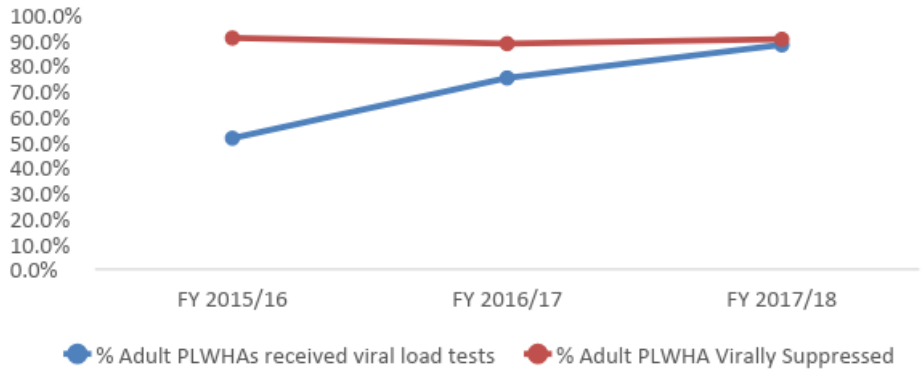
A cohort analysis of DHIS2 data FY 2017/18 showed that 72.5% (128,153/176,645) of people 5 years and older were known to be alive and on treatment 12 months after ART. This implies an annual reduction in treatment retention from 86.1% (126,102/162,282) by June 2017 recorded in the MTR. However, this could be an under reporting due to some loss to follow who are actually self-transferred to other facilities as reported by the study on the outcomes of Patients lost to Follow-up from HIV Care and Treatment at 3 Regional Referral Hospitals in Uganda in 2017.

There is still suboptimal retention with 20% (36,374/176,645) of the cohort lost to follow up and 1.6% (299/176,645) dying. Retention among mothers with the 12 months Cohort of eMTCT Mothers (Pregnant women and Lactating) started on ART showing that only 69% were still on ART. However, there is an improvement from 65.2% (23,464/35,990) in 2017 (MTR).

4.2.4 Treatment Monitoring Using Viral Load

Over the FY 2017/18, a total of 1,045,514 samples were received by CPHL where VL testing is centralized in the country. This represents 86% of the annual target of 1,200,000 viral load tests and an increase from 618,076 samples in 2016/17. **There was improvement for viral load tests for adults 88.2% in 2017/18 compared to 75.2% in 2016/17.**

In addition, there was improved efficiency as seen from the sample rejection rate dropping from 7% in the past three years to 0.3%. Similarly, the viral load results mean turn-around time improved from an average of 4-6 weeks to < 2 weeks due to expansion of electronic results delivery at the 100 laboratory hubs and over 300 HF and frequent sample pick up from the laboratory hubs. The CPHL reports show that viral suppression rate at the national level was 90.4% in 2017/18, showing an improvement from 88.7% in 2016/17.



High HIV prevalence regions in South Western, Rwenzori and Central regions achieved high viral suppression. However, 22 districts (in Mid-Eastern, Karamoja and Lango regions) had sub-optimal viral load coverage of >90%.

Gaps/Challenges

(1) Low VR suppression mainly found in Mid-Eastern (Namayingo and Mayuge high prevalence districts) and North East and West Nile districts

(2) Refugee community in West Nile have low suppression rates

(3) Young men aged 20-24 years have VL suppression of 81% compared to 89% among young women aged 20-24 years

(4) Children and adolescents have much lower VLS rates

4.2.5 HIV Drug Resistance

Due to high HIV pre-treatment drug resistance (PDR) to non-nucleoside reverse transcriptase inhibitors (NNRTIs) of 15.4% in 2016, Uganda revised the treatment guidelines in February 2018 and recommended Dolutegravir, Lamivudine and Tenofovir Disoproxil Fumarate Tablets (TLD) as the preferred adult first-line ARV regimen. TLD more tolerable, with fewer side effects, cheaper and Dolutegravir is less prone to resistance. As per the national plan, TLD transition begun in July 2018.

Over the review period, 5% of people on ART are on 2nd line or higher showing a slight increase from 4% reported for 2016/17. The proportion of resistance among below 15 years is higher than 10% and attributed to low adherence.

Table 4: ART Line regimen by age

	<2 Years	2 - < 5 Years	5 - 14 Years	15 Years and above
1st Line	3,831	10,804	43,509	1,029,133
2nd Line	434	1,382	6,086	44,788
3rd Line or higher	3	2	59	519
Proportion on 2nd line or higher	11%	13%	14%	4%

Source: *DHIS 2 June 2018*

The country continued with bi-monthly 3rd line switch committee meetings, which selected optimum regimen case by case. The 3rd Line ART service delivery was still centralized at RRH and Centers of excellence in Kampala-Wakiso due to low capacity at the lower levels facilities and Care.

Promising Interventions for Scale Up

☞Among the key policy improvements were the development of National implementation guidelines and Service Standards for providing psychosocial care and Support (PSS) for PLHIV in Uganda. The PSS (including counselling and

adherence support) improves Linkage into care, retention, adherence and Viral suppression and mental health.

☞Differentiated service delivery models (currently covering about 16% of ART clients).

☞CDC - METS pilot project using fingerprints (and national IDs) as unique identifier to track PLHIV in care.

☞Expansion of updated the viral load testing algorithm to provide for frequent virological monitoring of pregnant and breastfeeding women, quality indicators, monitoring tools and data visualization platforms (VL dashboard, HIV situation room).

☞The ten-point package developed to address non-suppression along with Quarterly VL Summary Report HMIS 113 being piloted for inclusion in DHIS2 as non-suppressed Register.

4.2.6 Integration of HIV Care and Treatment within Health Care Programs

The massive expansion of the ART programme, older PLWHA treatment increasing and the rising burden of NCDs in Uganda is placing considerable strain on health care services, which presents challenges of maintaining high quality public services. HIV, like other chronic illnesses share common challenges as the country moves towards implementing integrated services. HIV services are being integrated with an array of other health services, including SRH, TB care (which is highly correlated with HIV), adolescent health STIs services and NCDS.

The Consolidated Guidelines for Prevention and Treatment of HIV in Uganda provide the guidance for integration covering Nutrition Care and Support; Prevention, Screening and Management of Co-Infections; Sexual and Reproductive Health Services; Screening and Management of Non-Communicable Diseases; Vaccines for PLWA and Positive Health, Dignity, and Prevention.

HIV/TB Integration Progress

TB/HIV co-infection rate is 41% (ACP), six times more than the HIV prevalence in the general population and thus continues to be priority. The program indicates that 97% (1,108,047 / 1,142,124) of individuals active on ART were assessed for TB over FY 2017/18, indicating improvements in annual performance from 95% in FY 2016/17. Although there was an improvement in initiating PLHIV co-infected with TB on TB treatment (from 30.8% in FY 2016/17 to 57% in FY 2017/18), this is still suboptimal since it implies that 43% of all PLWHA with TB are not started on treatment.

From the TB program, national TB case detection rate was 56% (52,485 / 93,723). Of these 21,306 (41%) were found to be HIV positive and 20,929 (98%) were enrolled on ART while 20,918 (98%) were started in CPT. In FY 2017/18 paediatric TB comprised 11% (5,100 cases) of all incident TB cases up from 9%. The country introduced the new globally recommended paediatric TB friendly formulations in August 2017 and adopted and piloted integrated TB/HIV/ICCM guidelines. Treatment success rate among children diagnosed with TB remained stagnant at 76% compared to the previous year.

Isoniazid (INH) Prophylaxis Therapy (IPT)

IPT prevents the progression of TB infection to active TB disease. All PLHIV with a negative TB symptom screen should be offered IPT for six months according to the national guidelines. Over the FY 2017/18, out of the 206,651 new patients enrolled in HIV care, 17,493 only (8%) clients started on INH Prophylaxis TB preventive therapy. Among the 16,212 under 5 contacts of TB Smear Positive Patients, 2,510 (15%) were started on started on TB Prophylaxis. Isoniazid preventive therapy (for under five contacts) uptake increased from 11% in FY 2016/17 to 16% in FY 2017/18.

The efficiencies and effectiveness of an integrated HIV/TB/SRH prevention has not yet been realized. TB deaths in PLWHA are still reported as responsible for 30% of HIV deaths in the country. Whereas linkage in TB program is performing well, there is suboptimal performance in testing for HIV among TB patients. Efforts to improve performance include improving TB screening tool for use where CD4 machines are absent; rolling out TBLAM[5] (point-of-care tests for TB) to all RRH, GH, and HCIVs and strengthening IPT monitoring.

Gaps/ Challenges

(1) Low IPT completion rates contributed to by insufficient stocks especially of INH 300mgs (paediatric), few health units ordering for isoniazid.

(2) Only 523/1773 health facilities were trained in IPT and only 371 were providing IPT by June 2018,

(3) Stock out of IPT registers or IPT job aides at national level and;

(4) Limited effective referral of contact traced U5s for evaluation for IPT

Cotrimoxazole Preventive Therapy (CPT)

An average of 1,320,000 people active on ART received CPT/Dapsone at their last visit every quarter based on facility reports.

Nutrition Assessment Counselling and Support (NACS)

Nutrition assessment counselling and support (NACS) is an important component of comprehensive care for PLHIV and/or TB/HIV because HIV increases energy requirements; can reduce dietary intake; can cause nutrient malabsorption and nutrient loss. NACS, therefore, is conducted in PLHIV from enrolment and extend throughout the care continuum. By June 2018, 48% (10,064 / 21,133) malnourished cases identified among HIV positive 5-12 years received nutrition supplementary / therapeutic feeds. Kampala (25%), Midwestern (13%) and south-western (11%) recorded half of the malnourished cases identified among HIV positive of 5-12 years in the country. However, the service remains limited in scope and geographical coverage.

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[5] Lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV

Integration with SRH

Uganda has embarked on dual elimination of mother-to-child transmission of HIV and congenital syphilis in PMTCT and successfully piloted the dual test kits. The number of HIV+ Family Planning new users recorded in 2017/18 was 56,436 down from 80,004 in 2017 recorded in DHIS2. Family Planning and Sexual and Reproductive Health population Survey among HIV Infected Individuals in HIV Care in Uganda report released 16th March, 2018 showed that use of modern or tradition FP use among HIV+ women was high at nearly three quarters (72.3%); 58.3% modern-only, 5.5% non-modern only, 8.3% modern and traditional. Among modern FP users, male condoms were the commonest (46.8%) followed by injectable (25.8%) implants (12.5%), Pills (4.4%), tubal ligation (TL) (4%), and female condoms (2.7%). Overall, 32% of HIV+ women who would like to use a modern form of contraception do not have access, well above the national average of 28%. The unmet need is attributed more to limiters (24.5%) than spacers (7.5%).

Uptake of cervical screening (screened at least once) was 30.3%. Of the women PLHIV who had ever had a cervical cancer-screening test, 53% had their last screening in the last 12 months, 31% between 1 to 2 years and 15% in more than 2 years.

Gap/Challenges

(1) The survey findings show a high unmet need for FP, knowledge gaps and uptake of safer conception services, and cervical screening.

(2) Stock out of supplies and commodities for FP

(3) HIV SRH integration at service delivery points is still weak without adequate operational guidance

There is need to further enhance efforts for FP/SRH and HIV service integration at service delivery points in order to increase access to services and bridge the unmet need.

4.3 SOCIAL SUPPORT AND PROTECTION

A number of interventions were implemented under the Social Support and Protection component, with the view to enhance services to improve the quality of life of PLHIV, OVC and other vulnerable groups. Below is a summary of the key achievements realized under this Thematic Area for FY 2017/18.

A summary of Key achievements in Social Support and Protection

- *Efforts enhanced to eliminate stigma and discrimination for PLHIV through various interventions that include the revival of the PIASCY program in schools, coordination of the PLHIV networks, male engagements, and peer to peer counselling initiatives among others.*
- *At least two policies one on OVCs and the other on HIV and AIDS Mainstreaming Policy Guidelines reviewed to enhance HIV and AIDS response to OVCs and mainstreaming in all sectoral plans and budgets. The National Anti HIV and AIDS Stigma and Discrimination Policy is in its final stages of approval.*
- *Increased male engagement in GBV and HIV and AIDS interventions. Over 200 groups of male champions formed so far.*
- *Integrated social support services (education, economic strengthening and psycho social support) provided to some of the vulnerable categories of people mainly OVCs, Adolescent girls and women among others.*
- *Increased cultural and Religious leaders' commitment to implement HIV and AIDS interventions aimed at eliminating GBV and stigma and discrimination at household and community level*
- *Multi sectoral coordination structures and Coordinated HIV Networks are in place to support implementation of HIV interventions at various levels.*

4.3.1 Scaling up efforts to eliminate stigma and discrimination

The Inter Religious Council committed themselves through a Pastoral letter to reduce GBV and stigma and discrimination for PLHIV among other activities. Some of the cultural institutions like Buganda, Busoga kingdom, Inzu Ya Masaba, Bunyoro Kitara, have embraced the drama strategy and conducted weekly radio talk shows with the different kingdom based radio stations to discourage GBV, Stigma and Discrimination. Community support structures like the family support groups, post-test clubs, women's savings groups, Mama Clubs, Male Action groups, Positive Men's Clubs, burial groups, and other forms of CBOs share information on HIV and provide peer counselling for stigma reduction.

Uganda AIDS Commission has worked very closely with UNASO, a network that coordinates activities of CSOs and NAFOPHANU that coordinates 13 PLHIV Networks at National and district level in 112 districts to implement interventions aimed at eliminating stigma and discrimination for PLHIV. NAFOPHANU has conducted tele-counselling to MARPS and other young people through the SALT helpline.[6] The Mbuya Knowledge Room managed by WONETHA, has reached 13,144 MARPS with HIV information, HIV testing and counselling services; (UAC, 2017a). NAFOPHANU has

[6] NSP Midterm review report (2018)

trained 172 expert clients and set up 44 young positives clubs to fight stigma amongst communities in the Karamoja region,[7] while UNASO has coordinated activities of CSOs implementing HIV Response interventions. The MoES has re-invigorated the PIASCY programme with over 100 teachers trained to roll out the PIASCY while schools have been encouraged to form School clubs, Assembly days, Parents days to provide psychosocial support to boys and girls orphaned due to HIV.

The Stigma Index study (2017) conducted in Central Uganda revealed that some PLHIV were still experiencing both the internal and external stigma too. 53% of respondents found it difficult to tell other people about their HIV status; 32% felt guilty that they had HIV, 26% were ashamed to have HIV; while 22% experienced feelings of worthlessness. Some respondents experienced exclusion from social gatherings or activities and others from religious and family activities, while 6.7% were denied employment leading to loss of income as shared by 41% of the respondents.

Key Challenges

From the findings, it is explicit that although efforts to eliminate stigma experienced by PLHIV exist, more needs to be done to eliminate it in all its forms. Majorly, social / external stigma remains a major challenge in communities where PLHIV live and this infringes on their right to association and participation. Relatedly, interventions targeting key populations are still limited in scope with a limited number of CSOs and or partners targeting them, while rights awareness activities for PLHIV are limited as well. Cultural institutions that are often in touch with and are trusted by communities have limited funding and personnel to effectively implement anti-stigma campaigns among communities. It is thus an issue of priority to scale up interventions to eliminate stigma for PLHIV through the use of high impact and wider geographical scope coverage strategies. MARPS and key populations need to be targeted for more anti-stigma interventions.

4.3.2 Mainstreaming the needs of PLHIV, OVC and other vulnerable groups into development programs

Socio-Economic empowerment projects that target women and girls and other vulnerable categories are being implemented in different parts of the country to support them meet their social and economic needs. OVC households that received economic strengthening support increased from a total quarter highest of 58,912 in FY 2015/16, to 113,974 in FY 2016/17 and currently at 84,718 in FY 2017/18 (OVC MIS) as indicated in the figure below;

[7] Ibid

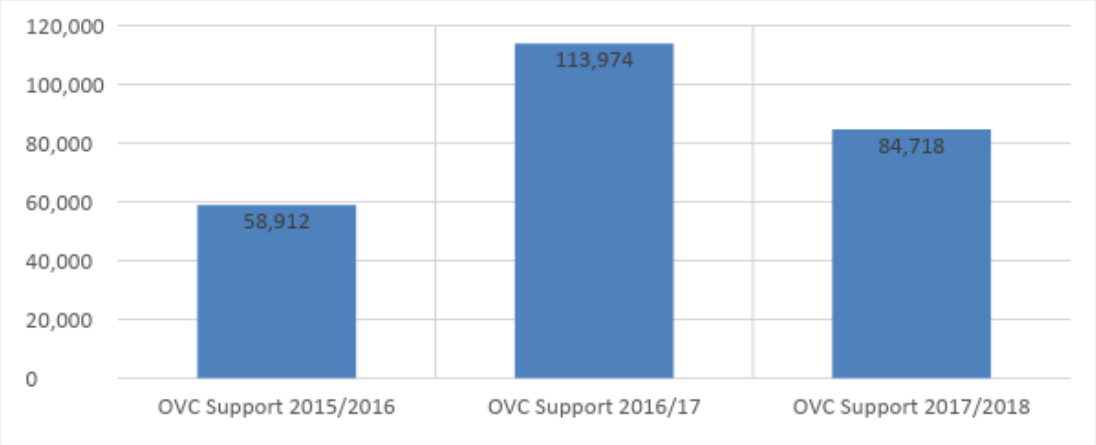

Figure 12: Economic Strengthening support to OVC (Source: OVC MIS, MoGLSD)

In the figure above, the year 2017/18 registered a decline in the OVC support to 84,718 OVCs by August 2018. This is partly attributed to the elapse of some projects for OVC support among the different development actors. Some OVCs have been supported to meet their various basic needs among which include; access to education, food, shelter, and health services as shown in table 4 below;

Table 5: OVC basic needs support FY 2016/17-2017/18

S/N	Basic needs support to OVCs	No. of OVCs; 2016/2017	No. of OVCs (FY 2017/18)[8]
1	Access to education	208,139	263,989
	Provided with food	20,142	18,074
2	Access to safe water	43,736	55,175
3	Food and nutrition support	91,174	117,949
4	Health services	122,755	143,786
6	Access to shelter	4,743	3,742
7	Psychosocial support	374,433	410,314
	Total	**865,122**	**994,955**

Source: OVC MIS (MoGLSD)

Overall, the number of OVCs that received support to their basic needs increased from 865,122 in FY 2016/17 to 994,955 in FY 2017/18, partly attributed to their integration into the development programmes.

[8] OVCMIS Data (August 2018)

By July 2018, a total of 197,728 youths had benefited from the Youth Livelihood Programme (YLP), of which 4,891 representing 2.5% are Youths Living with HIV (YLHIV), 2.8% are Youths with Disabilities (YWD; 11.8% are single parent youths while 34.6% are school dropouts. The females constitute 46% of the beneficiaries; (MGLSD, UYL Project data 2018). The Social Assistance Grant (SAGE) co-funded by DFID/UKAid, Irish Aid, has so far benefited over 123,153 older persons with monthly grants of UGX 25,000 in 35 districts currently (from the year 2010 to present 2018). The program targets un-pensionable older persons (65+), however, there is no disaggregated data available for PLHIV.

By December 2017, the Uganda Women Entrepreneur Programme (UWEP) had supported 2,333 women living with HIV with startup capital, credit extension services and trainings in business management and entrepreneur skills. The number for the same category of women beneficiaries increased to 8,352 by July 2018; representing 10.9% of the total women beneficiaries for the project. Similarly, the AGYW project under the DREAMS[9] Initiative had enrolled 126,524 AGYW by December 2017; 755 of whom were HIV positive; (UAC, 2017a,).[10] The OVCs have further been supported to access livelihood opportunities, vocational skills training and informal education as shown in table 5 below;

Table 6: Livelihood, vocational and other support to OVCs

S/N	*Type of OVC support*	*2016/2017*	*2017/18*
1	Economic strengthening support	113,974	84,718
2	OVCs supported with basic care	52,015	75,316
3	Support to attain vocational/ apprenticeship skills	40,930	24,356
4	OVCs provided with tool kits/start up kits	6,140	5,157
5	OVCs that received agricultural/ farm inputs	33,551	26,164
7	OVCs that received agricultural advisory services	45,489	46,299
8	OVCs re-integrated into their families	3,070	75,316
9	OVCs removed from child Labour	3,932	2,162
10	Child abuse cases handled	10,011	9,231
11	OVCs that received psycho socio-support	374,433	411,932
	TOTAL	**683,545**	**760,651**

[9] **DREAMS** stands for Determined, Resilient, and Empowered AIDS free Mentored and Safe

[10] MoGLSD 2018a, MoGLSD OVC MIS, MoGLSD 2018b).

Source OVC MIS Data bases 2017

As shown in Table 5 above, the number of OVCs that received livelihood, vocational and other support increased to 760,651 in the year 2017/18. Over 5,000 individual OVC and 506,194 OVC households have benefited from the Operation Wealth Creation (OWC) program, through farm input support, economic trainings and smaller IGAs.[11]. HIV+ mothers & other priority populations have been trained in livelihood projects like craft making, farming, saving schemes. The Socio-Economic Empowerment Program (SEEP) through AHF Uganda Cares has provided microfinance services, group lending and loan monitoring to the different vulnerable groups.

Coordination of the social support and protection service providers has improved over the years. The MoGLSD has coordinated all entities that are mandated to deliver on the social support and protection thematic area, while UAC is nationally coordinating all actors implementing HIV interventions through the multi sectoral approach.

Policies have been reviewed to enhance access and support for the vulnerable categories of people like OVCs, PLHIV. In the year 2017/18, the OVC policy was reviewed by the MoGLSD to enhance support for OVCs, while UAC spearheaded the review of the HIV and AIDS Mainstreaming Policy Guidelines to enhance HIV and AIDS mainstreaming in all sectoral plans and budgets. Relatedly, on 11th May 2018, the National Education Sexuality Framework (SEF) was launched by the First Lady and Hon. Minister of MoES to respond to the growing sexual reproductive health problems, including HIV and AIDS. The Gender Unit under the MoES is implementing the National Strategic Plan on Elimination of Violence against Children in Schools (2015/16-2019/20). Partners like Plan Uganda, World Vision and RTI are supporting the implementation of the Child protection component of the project in 34 districts and in 138 schools spread in different parts of the country.

Key Challenges

Although the programmes have fairly benefitted a number of vulnerable categories, the major focus was on economic strengthening at the expense of food security. Secondly, data management for social support and protection service providers as well as their effective coordination remains a challenge for the social support sector.

4.3.3 Implement life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups

The MoGLSD with the help of UNICEF has continued to implement the use of the Uganda Child Help line (UCH) / Sauti (116)-a Toll Free line on which cases of child abuse/ violence are reported to the relevant institutions. By the year 2016/17, the Helpline was functional in 27 districts, while this has been rolled out to over 115 districts currently. A total of 2,878 child abuse cases were reported through the Help Line in the year 2016/17[12]. Of the 2,878 child abuse cases, 1,638 were reported by girls while 1,180 were reported by boys. By 2016/17 only 25% of cases were concluded and

[11] TASO & UAC Gender Assessment report (2018)

[12] Uganda Helpline Annual Report 2016/17

closed up. About 1118 clients benefitted from counselling services through the Helpline. The Helpline has continued to support over 1000 children with similar support in the years 2017/18.

Some CSOs like UGANET trained 451 health workers, 41 prosecutors, 360 police officers and 120 community champions on how to address the needs of PLHIV[13]. From the year 2016/17-2017/18, a total of 6,744 community volunteers and 2,358 MoGLSD staff have been trained in OVC programming aimed at enabling them to fulfill their mandate in social support and protection. Seven hundred (700) religious and cultural leaders were re-oriented on the use of HIV and GBV tools for social protection of their congregations. WONETHA trained 668 sex workers in Natete and Kabalagala to advocate for their rights while the VHTs were trained to offer counselling and testing services to the PLHV, and how to address their stigma and discrimination.

The Uganda Harm Reduction Network (UHRN) through the Drop in Centre (DiC) Service delivery model has supported People Who Use and Inject Drugs (PWUIDs) with harm reduction counsellors that provide psycho-socio support and addiction counselling. They have further been linked to community facilitators, peer educators and paralegal services. By 2018, a total of 1,487 drug users, 427 male and 1,010 female had been targeted with Information, Education and Communication materials (IEC), Sexual Reproductive health services and GBV awareness campaigns; (UHRN, JAR Presentation 2018).

MoGLSD in partnership with UNFPA developed guidelines for providing psycho-social support to GBV survivors. These have been shared with the different partners implementing the GBV interventions to guide in their implementation process. In the year 2016, Ministry of Health (MoH) together with other stakeholders like MoGLSD, UAC and other partners developed policy guidelines for HIV Testing and Counselling. Among the key issues emphasized in the guidelines is the non-stigmatization and non-discrimination of PLHIV in the course of accessing such services.

In July 2016, a GBV technical working group comprising of MoGLSD, UNFPA, UNICEF, UNHCR, and other partners was formed to respond to GBV issues that affect women, girls, children and other vulnerable groups. The available reports indicate a slight reduction in the violence practices against children although a lot needs to be done.

Table 7: Magnitude of child/OVC abuse

OVCs removed from child Labour		**Child abuse and neglect cases**	
FY	OVC figures		
2015/16	6,670	2015/16	11,723
2016/17	6, 257	2016/17	14,084
2017/18	2,156	2017/18	13,044

[13] Gender Assessment report (2018)

Source: OVC MIS Data

The table demonstrates that more effort is needed to eliminate child violence. The Uganda Police Force Annual Crime Report (UPF, 2017), shows that 17,395 defilement cases were reported in the year 2016. These reduced to 14,985 cases in the year 2017 (implies a decrease of 14%). Of these, 4,651 cases were taken to courts of law, 20 cases were acquitted, and 318 cases were dismissed, while 3,704 cases were pending conclusion (UPF, 2018).

In regard to rape, a total of 1,496 rape cases were reported in the year 2016, while in the year 2017, there was a reduction by 10.6% where 1,335 rape cases were reported. According to UPF, some of the major drivers of child violence is poverty and engagement in early sex by mostly the teenage girls. Efforts to fight child abuse are slightly paying off although gaps are still noticeable in case management.

Key Challenges

During this implementation period, it has been noticed that the life cycle sensitive comprehensive package for social support and protection has not been defined clearly in the Indicator Hand Book. There is uncoordinated implementation of the life cycle sensitive comprehensive package for social support and protection by the different actors, while some Key Populations and MARPS (like the fisher folk, boda bodas) are less targeted by the package interventions.

4.3.4 Engender social support and protection programs to address unique structural challenges that promote vulnerability to HIV and AIDS

Most of the national and CSO projects and programmes for social support and protection have been engendered, although men have been less targeted for some interventions. Legal and policy instruments like the Gender in education policy (2018), the National Anti- HIV and AIDS Stigma and discrimination policy (2017-2018) that has been developed in coordination with UAC with support from UNAIDS and the National Gender Based Violence Elimination Policy (NGBVEP) have been developed to enhance men, women, girls and boys access to social support services.

The National Action Plan for Women, Girls, Gender Equality and HIV (2018), the National Gender Based Violence Elimination Action Plan, the National HIV Testing and Counseling Policy (HTC) and the OVC policy; partly aim at removing gender and structural barriers to accessing HIV services. The National Strategy for girls' education has been used as instrument for promoting girls education in the country.

The gender integration strategy has contributed to a number achievements reflected as indicators in the NSP. In the year 2016, married women aged 15-49 years participated in all three specified household decisions, either alone or jointly with their husbands (UDHS 2016). This was above the baseline value (38%) but below the target (70%) set in the NSP 2015/16-2019/20. The achievement is partly attributed to the rights awareness campaigns by actors like the CSOs, PLHIV Networks and other actors at national and district level that are creating awareness about the rights of women. By 2018, TASO had conducted 128 GBV campaigns in their programme areas.

Similarly, findings from the UDHS 2016 show that 48% of women owned land alone or jointly with their spouses which was above the NSP baseline value (38.6%) and

surpassed the target (40%) set in the in the current NSP 2015/16-2019/20. Land ownership was higher in rural (50.6%) than Urban (39.4). This increment is partly attributed to the sensitization, economic empowerment and existence of laws and policies that guarantee women's land and property ownership.

Relatedly, according to (UDHS 2016), the proportion of men and women who believe that wife beating is justified reduced from 55.1% (i.e. 58.3% of women and 42.8% of men) at baseline to 47.01% i.e. 49% women and 41% men. This is still short of achieving the set target of 20%. Reports indicate GBV cases still high. In the year 2016, 7,320 GBV cases were reported by 79 districts, while in the year 2016, there was an increase in GBV cases to 7,722 (reported by 94 districts). This year; by August 2018, 1827 cases had been reported by only 19 districts.[14].

Key Challenges

Reporting of GBV cases is still a challenge in many districts, while the cultural norms in many societies impede efforts by women to own land. Men's awareness of women's rights and their involvement in GBV interventions is limited in scope. Traditional gender stereo types where some women have accepted wife beating as part of life and marriage set ups still presents as a stumbling block to fight GBV. Cultural and religious leaders are under resourced to support GBV interventions as well.

4.4 SYSTEMS STRENGTHENING

As part of systems strengthening a number of strategic interventions were undertaken to ensure that strategic policy frameworks and guidelines were implemented to promote effective stewardship, oversight, coalition building as well as appropriate regulations to support the national AIDS response. Key interventions were carried out in the following key areas; governance, leadership and management, human resource, procurement and distribution of medicines and supplies, financing, strategic information and monitoring and evaluation of NSP. Below is a summary of the key achievements realized under Systems Strengthening Thematic Area for FY 2017/18.

A summary of Key achievements in Systems Strengthening

- *A number of strategic policy frameworks and guidelines have been launched and are now being implemented to provide guidance in implementation of various interventions in the different thematic areas of the NSP.*
- *The PFTI has been rolled out as a strategy to rejuvenate and scale up the national response. Accordingly, All districts and urban authorities have adopted the PFTI and signed the Declaration to implement its strategies and actions; Cultural institutions, private sector, labour groups, faith-based organizations, nongovernmental organizations (NGOs) and other civil society entities, have been mobilized to support the implementation of the PFTI through their structures*

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

- *UAC developed a PFTI Message Handbook which was launched on June 6, 2017 and distributed to 93 districts to guide the local government action plans*
- *The National HIV prevention road map was revised and aligned to the Presidential Fast Track Initiative targets.*
- *Adolescent girl and young women inter-ministerial task force (chaired by H.E the First Lady) has developed a framework under which adolescent and young women issues are being addressed*
- *Appointment of the new UAC Board and Director General thus covering the gap that affected leadership and management of the response in the previous year 2016/17.*
- *The partnership coordination at the national level has been strengthened through reconstitution of the Partnership Committee that meets every quarter.*
- *A National Quantification and Supply Planning System was introduced and a Report for the Public Health facilities in Uganda prepared by the Ministry of Health, April 2017 providing a summary of the procurement planning processes for the coming financial year 2017/18.*
- *Web-based ARV Ordering and Reporting Commodities supply chain management system was developed and launched*
- *NMS is constructing a new 30,000 pallet location warehouse in Kajjansi to increase on holding capacity for supplies*
- *Electronic Patient Monitoring System has been introduced*
- *HIV mainstreaming guidelines were developed and rolled out;*
- *AIDS Trust Fund (ATF), implementation regulations were revised and resubmitted to Parliament for approval. However, there is need for continued advocacy with both Parliament and Ministry of Finance to speed- up both the approval and operationalization of the fund.*
- *Government through the Ministry of Finance Planning and Economic Development directed every MDA to allocate 0.1% of the recurrent funds to HIV programming in FY 2018/19. It is estimated that this will generate at least $ 5million annually.*
- *Uganda was successful in securing a Global grant for the HIV and TB response of HIV had about US $ 292.5 million for the funding period 2017-2020 and new partners have been courted for the Response including the KOICA*
- *UAC with the support of UNAIDS and Irish Aid has introduced a Situation Room to facilitate timely information generation and reporting for decision making.*

4.4.1 Strengthening governance and leadership of multi-sectoral HIV and AIDS response

Leadership and Commitment for the National Response

The HIV response in Uganda has witnessed renewed impetus through the Presidential Fast Track Initiative (PFTI) to end AIDS by 2030. The Initiative was launched by H.E the President on the 6th June 2017 following the 69th United Nations General Assembly declaration to end HIV as a public threat by 2030. The PFTI outlines a 5-point agenda that should guide the country to reach the 2030 targets as indicated below:

1. To engage men in HIV Prevention and close the tap on new infections particularly among adolescent girls and young women
2. To accelerate Implementation of Test and Treat and attainment of the fast track 90-90-90 targets particularly among men and young people
3. To consolidate progress on elimination of mother-to-child transmission of HIV
4. To ensure Financial sustainability for the HIV and AIDS response
5. To ensure institutional effectiveness for a well-coordinated multi-sectoral

The Initiative has been embraced by different leaders and stakeholders at national, regional and sub national level. At national level, activities of the National HIV Prevention Committee (NPC) were reviewed and aligned to the HIV prevention road map to the PFTI. The road map outlines HIV Prevention and Management interventions/strategy and the implementation approaches that Uganda will prioritize to end AIDS by 2030. Regional annual review meetings have been organized to review progress of the action plans implementation by the different stake holders. UAC developed a PFTI Message Handbook which was distributed to 93 districts to guide the local government action plans. The Handbook is in the process of translation into local languages and will be printed for continued dissemination and mobilization of the local communities for enhanced HIV and AIDS response. All districts and urban authorities have adopted the PFTI and signed the Declaration to implement its strategies and actions. World AIDS Day for 1st December 2017 was used as a platform for engaging the public on the PFTI on ending AIDS in Uganda by 2030, under the Theme: "*Reaching men, girls and young women to reduce new HIV infection".*

Cultural institutions, private industry and labour groups, faith-based organizations, nongovernmental organizations (NGOs) and other civil society entities, as well as those representing PLHIV have been mobilized to support the implementation of the PFTI through their structures. In the same vein, religious leaders at the inter-denomination level have endorsed position papers focusing on HIV prevention, male engagement and sexuality education, sexual Gender Based Violence (SGBV) and other social development programs. The Inter-religious Council has also embraced the PFTI and issued a Declaration signed by the respective leaders *"From Commitment to Action" towards Revitalizing the HIV and AIDS Response through Male Involvement*, signed on 17th July 2017. PFTI was also rolled out to MDAs, ADPs and UN Country Team, and the Private Sector for mainstreaming HIV and AIDS in all sectors. Members of the Parliamentary HIV Committee have been actively involved in PFTI activity implementation, and have provided consistent leadership and oversight in advancing the PFTI through monitoring of services delivery and engagement of leaders.

Furthermore, a meeting for Accounting Officers (Permanent Secretaries) was conducted on the PFTI and its mainstreaming Guidelines were also presented;

Uganda through the umbrella of Mayors and local leaders AMICAALL, has maintained a coordination structure for the urban authorities to contribute to the National AIDS response. Mayors and other Urban Leaders have demonstrated the immense potential local governments have to mobilize local resources to support local HIV/AIDS initiatives including the PFTI. The local resource mobilization for PFTI led by Mayors and other urban leaders under their umbrella organisation "AMICAALL" is a promising practice that could be replicated in other local authorities to sustain the PFTI campaign. Urban authorities are home to one-third of HIV infected and affected populations. During the year under review, the focus was on the urban poor living in slums and categorized as "hard-to-reach" who include, among others, transporters (boda boda riders, drivers) market vendors, sex workers, bar attendants, drug users and sellers, MSMs etc.

Key Challenges:

Although the PFTI has been prioritized for its implementation, civil society has not been adequately mobilized to implement it. This is accentuated by absence of guidelines and tools for their involvement, while the limited resources to implement the activities of the PFTI present a challenge. There is also a fear that, PFTI might be projectised and once donor funding runs out it will lose momentum and cease to be a vibrant initiative to mobilise the public and local community as it has done in the recent past.

The Parliamentary HIV Committee and related matters at the Mid-Western PFTI engagement Forum –Feb 2018

4.4.2 Implementation of legal and policy related instruments and guidelines

The country is commended for promotion of a conducive legal and policy environment through formulation of supportive policy and legal instruments, as illustrated by the examples highlighted below.

(i) The National Implementation Guidelines and Service Standards for providing Psychosocial Care and Support (PSS) for PLHIV in Uganda were reviewed and finalized. So far overall, 73% are linked to care and support services;

(ii) The Ministry of Education and Sports launched and disseminated the National Sexuality Education Framework and conducted Health/HIV Technical Working Group Meetings;

(iii) The National Consolidated HIV Prevention and Treatment Guidelines were reviewed, validated and rolled out. These are intended to scale up coverage of prevention, care and support services;

(iv) Parliamentary Standing Committee on HIV and Health was engaged to provide inputs into the Uganda National Laboratory Services Bill, 2016 that was before Parliament;

(v) The National HIV Test and Treat Policy was rolled out and is being implemented by most health facilities. This provides an opportunity to mobilize men for testing and being put on treatment for HIV and AIDS and other related conditions; and

(vi) MoH has operationalized the national policy on PPPH and has finalized its strategy and disseminated its Guidelines for adoption during implementation.

Furthermore, the UN through the MoGLSD supported the development of the Child policy, which now awaits approval of top management and cabinet approval. The policy focuses on comprehensive case management including issues to do with HIV; social protection, and violence against children. The accompanying action plan is currently under review. It is expected that both the policy and action plan will be approved by the Cabinet by end of 2018. UAC in collaboration with the NGO registration Bureau at Ministry of Internal Affairs is developing standards to provide oversight for the assessment for registration and certification of AIDS services organizations to ensure alignment of their operations with the priorities in the NSP and the multi-sectoral AIDS response.

Although the policy and legal framework have been prioritized, most of the laws, policies and guidelines have not been widely distributed, disseminated and popularized among key stakeholders; there are also concerns that the country is still intolerant over key population groups which tend to reverse any gains made over the stigma index; and the stringent rules and regulations on CSOs curtailing their effective contribution to the national response. There is resistance on sexuality education by some few religious institutions while the National Strategic Plan on Violence against Children in Schools (2015-2020) is silent on HIV and AIDS affected children; and this might perpetuate stigma and impact on their learning.

4.4.3 Strengthening UAC capacity and partnership mechanism

Coordination of the multi-sectoral HIV response by UAC has been strengthened by the appointment of the new Board and Director General thus covering this gap that affected leadership and management of the response in the previous year 2016/17. The Board is representative of different constituencies (PLHIV, Media, Young people, academia, Private Sector, Culture, Religion/faith-based, Parliament, Civil society and Public Sector) in the multi-sectoral response. The partnership coordination at the national level has been strengthened and Partnership Committee meets every quarter. The Self-Coordinating entities continue to meet though with variations, some meet more frequently than others. However, reporting of SCEs is still poor, very few are currently reporting. For example, only CSOs (NNGOs) and ADPs have prepared and submitted their annual reports to inform this year's Country AIDS Response Progress Report.

With support from government and development partners, the following achievements were realized during the year; i) UAC supported 14 Local Governments to develop costed HIV and AIDS Strategic Plans and participated in the LG Budget consultative workshop for the FY 2018/19 to guide Local Governments on incorporation of HIV and AIDS in their BFPs ii) A Draft Concept Note on Quality Assurance of HIV activities for major projects and work places were developed iii) UAC supported and linked Operation Wealth Creation (OWC) with HIV service providers to offer free HIV testing and HIV and AIDS sensitization during music festival organized by OWC which attracted over 27,000 participants in the central region.

Key Challenges

Among the challenges observed include; inadequate funding for HIV and AIDS Response that is impacting on UAC capacity to fully execute its mandate. Furthermore, UAC is experiencing staff capacity gaps at the top and mid-management levels that need to be filled. These include, among others: Director Planning and Strategic Information; Documentation Officer (1); Human Resource Officers (2); Zonal Coordinators (2). The observed poor reporting of SCEs to the Partnership Committee and UAC is affecting information sharing and coordination of the multi-sectoral response.

4.4.4 Adequate human resource for delivery of quality HIV and AIDS services

During the year (2017/18) some interventions were undertaken, with support of development partners, to ensure availability of human resources for the delivery of quality HIV and AIDS services. This NSP objective is supposed to be tracked by identifying the percentage facilities with the required staffing levels;

In order to increase availability of human resource, MoH had planned to conduct a review of the Human Resource Policy and Strategy for attraction, motivation and retention of staff delivering HIV and AIDS services in health and non-health and community-based service departments in both public and non-public sector. The Human Resource Policy and Strategy were also supposed to guide deployment of staff delivering HIV and AIDS services covering various aspects mentioned above. However, these activities were not undertaken this year. Nevertheless, available documented evidence indicates that overall the health sector staffing improved slightly in 2016/17[15] to 73% from 71% in 2015/16 above the HSDP target of 70% as shown in Figure 12 below. The HSDP seeks to fill the staffing sector to at least 80% of the staffing norms by 2019/20.,

[15] Ministry of Health is in the process of conducting another Human Resource for Health Audit and advised this team to use the current audit report.

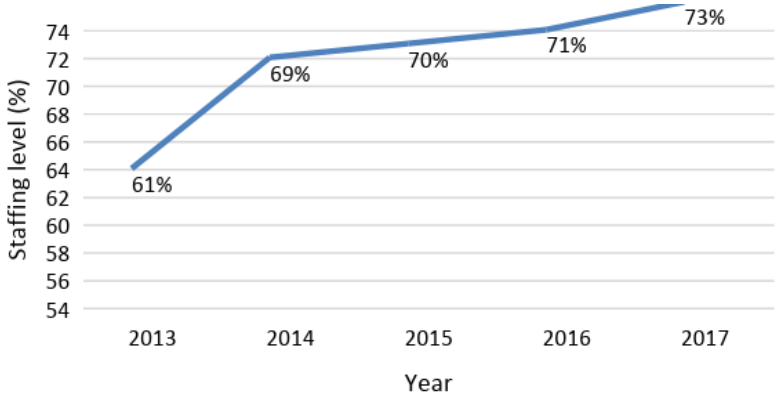

Figure 13: Approved Staffing Level Trends (Source: MoH Bi-Annual HRH report 2017)

The overall staffing level at central-level institutions (national referral hospitals, specialized health institutions and RRHs) increased to 83% (2017) from 69% in 2015. The staffing at health facilities and management offices at the District Local Governments and Municipal Council levels increased to 71% (2017) from 67% in 2015. The staffing for Municipalities increased to 100% (2017) from 63% (2015). Generally, more females (54%) than males (46%) exist in the sector. Without updated human resource audit for 2017/18, it has not been possible to do thorough assessment of the sector performance for the year under review.

Despite the reported progress, the number of health workers per 1,000 population in Uganda is still far below the WHO threshold of 2.3 doctors, nurses and midwives per 1,000 population. In 2016/17 FY, the ratio of doctors, nurses and midwives to the population was 1: 28,202; 1: 2,121 and 1: 6,838 respectively. Overall, staffing has improved though still skewed in favour of specialized health institutions and larger health facilities (NRH 92%; RRH 80%; GH 68%; HC IV 85%; HC III 80%; HC II 53%).

The staffing levels and gaps established are summarized in the short Table 7 below which also shows the number of the health units covered in the Centre and Districts and PNFP.

Table 8: Health Facility staffing levels

No	Cost Centre	No. of Units	Total Norms	Filled	% Filled	% Net Vac Rate
1	Ministry of Health Headquarters	1	821	771	94%	6%
2	Mulago NRH	1	2,335	2,072	89%	11%
3	Butabika NRH	1	429	407	95%	5%
4	Regional Referral Hospital	14	5,430	4,353	80%	20%
	MOH National Institutions:					
5	Uganda Virus Research Inst.	1	227	82	36%	64%
6	Uganda Cancer Institute	1	272	147	54%	46%

7	Uganda Heart Institute	1	190	118	62%	38%
8	Uganda Blood Transfusion Services.	1	246	322	131%	-31%
	Sub-total: Centre Level	21	9,950	8,272	83%	17%
11	General Hospitals	45	8,550	5,816	68%	32%
12	DHOs Offices	116	931	1,012	109%	-9%
13	HC IV	171	8,208	6,896	84%	16%
14	HC III	953	18,107	14,501	80%	20%
15	HC II	1,690	15,210	8,116	53%	47%
16	Municipal Councils	36	216	216	100%	0%
17	Town Councils (Big)	2	14	8	57%	43%
18	Town Councils (Small)	122	610	192	31%	69%
	Sub-total District	3,135	51,846	36,757	71%	29%
	Total National Level	3,156	61,796	45,029	73%	27%
	Private Not For Profit (PNFPs)					
1	UCMB	292	10,233	9,129	89%	11%
2	UPMB	103	4,987	4,040	81%	19%
3	UMMB	50	1,653	788	48%	52%
4	UOMB	6	304	119	39%	61%
	GRAND TOTAL PNFPs	451	17,177	14,076	82%	18%
	COMBINED GRAND TOTAL	**3,607**	**78,973**	**59,105**	**75%**	**25%**

Source: MoH Bi-Annual HRH report 2017

From the above scenario, the Audit Report makes the following conclusions: that in the Public Health Sector 1,329 or 37% health facilities out of 3,156 achieved staffing levels of 75% and above. The same was attained by 176 or 39% units out of 451 in the PFPs. However there is need for action to deal with overstaffing and understaffing highlighted by the Audit Report.

Capacity Building of Service Providers

As part of human resource capacity development, different cadres of staff at the health facilities have been trained in Comprehensive HIV skills, TB-HMIS management, DSD modeling and Case management for the social workers. An additional 1,095 health workers including 154 clinical officers, 58 medical doctors, 177 nurses, 63 pharmacists 202 nursing assistants, 382 lab staff and 59 councillors were trained. In addition, various partners have been supporting some selected districts local governments to

recruit and train staff on various projects and programs. For example, staff were supported through PEPFAR and seconded in public and PNFP facilities in Mubende region. Infectious Diseases Institute (IDI) trained 1,265 health workers. Reach-Out Mbuya had 23 health workers trained in CRAG screening, case management and comprehensive HIV management and held community trainings in GBV case management and reporting. As part of community systems strengthening, UHMG held training and mentorship for 1,106 community health workers in provision of comprehensive health services to communities. 2,222 health workers received training in HIV and AIDS programming.

Key Challenges

In spite of the capacity building efforts for the health staff, some challenges are noted; among which include; the Inadequate staffing at all levels a significant number of posts are not filled and current staffing norms not commensurate with the services provided and workload. There is slow absorption of contract staff recruited through PEPFAR support to enable the country's compliance with Global UNAIDS 90-90-90 targets. The doctor-patient ratio is still very low, especially in the rural areas; this has a negative impact on realization of national targets and there are facilities and districts with either excess or shortage of staff in different categories.

4.4.5 Efficient procurement and supply chain management system for delivery of HIV and AIDS services

A number of measures have been initiated to rectify the procurement and supply chain management system and reduce on stock outs and expired or damaged drugs due to poor storage facilities.

Quantification Planning and Procurement

The Ministry of Health produced a National Quantification Report for the Public Health facilities in Uganda April 2017 providing a summary of the procurement planning processes for the coming financial year 2017/18. The Report makes an evaluation of commodity situation decline in the value of partner support with about 34% (in relation to need) commitment expected in the FY2017/18. Generally, it is noted that over 70% of drugs and medical supplies are funded by external partners. If, therefore, the assumption of a complete absence of partner support holds true, the estimated financial year requirement from the Government of Uganda is in the range of UGX824bn compared to the current overall commitment for these items which amount to UGX142bn.

Table 9: Percentage of annual forecast (FY 2017/18) currently not funded by the GoU

Commodity category	FY 2016/17 Annual forecast (UGX)	FY 2017/18 Annual forecast (UGX)	FY 2016/17 % Not funded by GOU	FY 2017/18 % Not funded by GOU
Essentials Medicines	191,568,068,565	194,515,109,892	52	52
Laboratory(HIV test kits and other requirements)	112,262,460,156	90,813,251,687	96	96

ACTs	71,617,957,179	29,314,647,872	93	93
Artesunate Injections Vials	34,800,747,664	22,653,475,844	100	100
mRDTs	34,692,248,710	22,279,843,983	100	100
ARVs	413,711,495,290	298,279,843,983	77	68
Reproductive Health	84,329,038,698	93,743,889,702	90	91
Anti-TB	33,948,221,011	1,761,011,949	70	0
Immunisation	13,868,772,348	16,032,087,706	35	44
Overall	**1,017,207,421,152**	**824,656,022,172**	**77%**	**72%**

Source: MOH: National Quantification Report for Public Health Facilities in Uganda, April 2017.

Web-based ARV Ordering and Reporting Commodities supply chain management system

The Government in collaboration with its partners has introduced reforms to address challenges relating to stock outs, drug expiry, and other supply issues. These measures include: a National Quantification and Supply Planning system; upgrading of WAOS tools (order and report forms, and dispensing log) which have been institutionalized and is hosted within the District Health Information Software (DHIS2). The tools and processes are expected to be fully implemented this financial year (2018/19). Through WAOS, 92% of essential drugs and supplies were available at Baylor Uganda supported facilities. To further improve on supply chain management, NMS is constructing a new 30,000 pallet location warehouse in Kajjansi to increase on holding capacity for supplies.

A total of 70 health facilities including RRHs will be in position to place an order through NMS and all facilities (PNFP/PFP) supported through JMS and MAUL will also be in position to place their orders. There has been coordinated development & pilot roll of the national Condom Logistics Management Information System (CLMIS) among 7 key condom Implementing Partners; IDI, TASO, UHMG, MSU, AIC, Uganda Cares, Youth Alive & PACE & trained 44 CLMIS users in the system across these IPs.

On the other hand, Civil society has continued to play its advocacy role by engaging with Government and Pharmaceutical Companies for increased access and affordability of drugs and supplies; urging for social accountability and score card; and conducting research on stock outs in the country and using the findings as evidence for advocacy.

Introduction of Electronic Patient Monitoring System

During the year under review, 47 sites had functional electronic patient monitoring systems and 27 new computers were purchased to ensure 27 other sites also have open-Medical Record System (MRS) system. There are 100 district based distributors supported to deliver integrated HIV Prevention, FP, Malaria, Nutrition & WASH products. However, there is need to do more in this area.

Key Challenges

Among the key challenges observed under this review include; stocks outs of commodities at facility level owing to incorrect forecasting, frequent staff transfers which affects stability and utilization of acquired skills in the implementation of the response at the organization/facility level in addition to high staff turnover. Other challenges include; funding gaps for ARVs, Antimalarial and chemistry and hematology laboratory reagents in the public sector and the inadequacy in the maintenance of medical equipment nationwide; inadequate storage and limited warehousing space, etc. This, however, is being rectified by construction of new larger NMS warehouse (at Kajjansi) with Global Fund support as well as US Government & other Partner support towards strengthening of the Supply Chain

4.4.6 Coordination of the response and access to quality HIV and AIDS services

Self-Coordinating Entities (SCEs) continued to collaborate in implementing the national response. Quarterly and bi-annual meetings were held to track progress and address any challenges impeding progress. There have been efforts to prepare the progress reports although participation and reporting is still weak, not all members of the respective SCEs attended or even prepared and submitted their reports. This may be due to the fact that such meetings are not mandatory and do not carry any penalties/sanctions or rewards on the other had.

The country made a number of significant achievements including, among others, the following; (i) draft HIV and AIDS Mainstreaming Guidelines for Sectors and Local Governments were developed by UAC validated and approved by stakeholders. (ii) quarterly HIV and AIDS Committees meetings (DACs, SACs, and VACs) for Local government held in Iganga and Bugiri districts with support from UNYPA; while 8 districts under Baylor in the Rwenzori Region were supported to implement district led programming strategy in the region (iii) The Judiciary established an HIV/AIDS Committee to, among other things, develop an HIV and AIDS Work-based policy and sensitize staff on the HIV and AIDS scourge. The Committee produced the policy which is in process of approval by Top Management; (iv) Two Gender Technical Working Group meetings were held and received reports regarding the plight of Women living with HIV and Progress of SGBV.

Key Challenges

Challenges noted with the coordination of the national response include; pockets of unreached constituencies on mainstreaming HIV and AIDS in their districts and limited level of mainstreaming HIV services in the different sectors. Other challenges include; the limited understanding HIV mainstreaming in development programmes. On the other hand Civil Society Organizations are facing a challenge of weak coordination due to internal and external threats associated with limited resources to support effective representation, coordination and participation in different forums at various levels.

4.4.7 Strengthening infrastructure for scaling-up delivery of quality HIV and AIDS services

Efforts have been made to expand availability and capability of laboratories at different levels of HIV and AIDS delivery facilities. Mildmay Uganda has ensured that all the 114 ART sites have been able to access the Gene Xpert services through the hub system. IDI continued to provide specialised HIV and AIDS diagnostic services through the Makerere University - Johns Hopkins University (MU-JHU) Core Laboratory which provides extensive HIV and AIDS diagnostic services. In the quarter, a total of 20,457 tests were carried out at the lab. 38,924 blood samples were sent for screening. In order to expand services, the Uganda Prisons Service increased accreditation of 14 more facilities to provide ART bringing the total number to 24 compared with 10 in the past year.

4.4.8 Mobilizing resources and streamline management for efficient utilization and accountability

The HIV response has been mainly funded through the following mechanism, On Budget support by the GoU and External partners, direct project support by the Development partners and the Out of Pocket contributions from the individual households.

The key achievements during the period of implementation include among others; AIDS Trust Fund (ATF), regulations were revised and resubmitted to Parliament for approval. However, there is need for continued advocacy with both Parliament and Ministry of Finance to speed- up both the approval and operationalization of the fund. UAC developed the guidelines for mainstreaming HIV and AIDS; captured under the Budget Call Circular. Nonetheless, there is a lot that remains to be done to ensure that the intended objectives are achieved and the responsible institutions allocate 0.1% of their budget allocations to implement HIV and AIDS interventions. Therefore, UAC should request for an output to be used to track the allocation in the budget for FY 2019/20; NASA exercise was rolled out across the country; Capacity was built for at the national level to undertake the National AIDS Spending Assessment (NASA).; Over the period, there has been sustained partnership and support from the Donor community which included the USG, IRISH AID GF, and the UN Family.: Uganda was successful in securing a Global grant for the HIV and TB response of HIV had about US $ 292.5 million for the funding period 2017-2020. New partners have also been courted for the Response including the KOICA, JICA.

While the NSP projected an estimated resource requirements of US 752.4 million for the period 2017/18, the actual resources approved for the response has been estimated at $ 620.4 Million Notable during this period is the fact that GoU contribution to the response has remained constant for the last four years despite increase in program scale up. The funding needs have been met majorly by the external partners and the household out of pocket contributions. Table 11 shows resources in flow for the national response

Table 10: Funds for the HIV Response year 2017/18

Agency	Approved funding 2017/18	Released funding 2017/18	Source
GoU HIV earmarked resources	29.971	29.766	MTEF and budget performance reports 2017/18.

HIV attributed funds.	33.006	32.107	
GoU estimates	**62.977**	**61.873**	
CHAI			
FAO	0.300	-	Uganda JUPSA strategic plan 2016/17-2019/20
Global Fund	115.125	108.154	Global Fund allocations to Uganda
ILO	0.100	-	Uganda JUPSA strategic plan 2016/17-2019/20
IOM	0.300	-	Uganda JUPSA strategic plan 2016/17-2019/20
Ireland	4.558	3.868	Irish AID Annual work plan
UNAIDS	0.700	-	Uganda JUPSA strategic plan 2016/17-2019/20
DFID	-	-	Funding redirected through GFATM since 2016/17
UNICEF	3.842	1.509	Uganda JUPSA strategic plan 2016/17-2019/20
UNIFEM	0.298	0.320	Uganda JUPSA strategic plan 2016/17-2019/20
UNDP	0.400	-	Uganda JUPSA strategic plan 2016/17-2019/20
UNHCR	0.415	-	Uganda JUPSA strategic plan 2016/17-2019/20
UNESCO	0.375	0.209	UNESCO Annual Work plan 2018
UNFPA	7.000	5.581	UNFPA country Plan 2017/18
United States Government	410.000	379.106	PEPFAR country Operational plan 2017
WHO	0.465	-	Uganda JUPSA strategic plan 2016/17-2019/20
Research Agencies	14.260	14.258	
	620.424	**574.878**	

Key Challenges

Funding from GoU has remained at less than 10% of the Response requirements.; Late or non-submission of accountabilities resulting into late replenishments; Delays in operationalizing the ATF and Limited involvement of the Private sector Initiatives in HIV funding

4.5.9 Strengthen national mechanism for generating comprehensive, quality and timely HIV and AIDS information for the National M&E 2017/2018

Information generation, reporting and sharing

Uganda AIDS Commission with the support of UNAIDS and Irish Aid has introduced a Situation Room to facilitate timely information generation and reporting for decision making. The Situation Room is a database/software platform with tools to monitor and analyze the AIDS epidemic through the creation of efficient visualizations. Currently the platform has been installed at UAC and MoH, in the next phase it will be rolled out

to Parliament, President's office and other line ministries. The Situation Room is able to access real time quality data from DHIS2, Spectrum HIV Estimates and CPHL and analyze the data to reflect the HIV Burden and show HIV performance in various areas including; HTS, V L Coverage and Suppression, and the 90-90-90s. A Gender dash board has also been established with support from UN Women to monitor GBV related issues.

As part of continued institutional capacity building, UAC has been supported to participate in the regional and national data cleaning exercises which has seen an improvement in the quality of data generated in DHIS2. In order to improve HIV reporting, a reporting tool template has been developed for Sector reporting while districts have been supported to develop M&E Plans for their HIV Strategic Plans.

A number of NGOs have been involved in information sharing and advocacy. For instance, UNASO organized a meeting for CSOs (including; KPs, PLHIV and FBOs) with the UNAIDS Executive Director to share CSO experience and contribution in the national response, the progress so far, and key areas of concern regarding drug stock outs, human rights abuses at work place (imprisonment of PLHIV-maid) as well as delayed implementation of the national HIV Trust Fund. Baylor Uganda project supported Biostatisticians, HSD in-charges and facility in-charges to review and share monthly and quarterly reports with health facility staff while District Biostatisticians were supported to validate and submit HMIS reports on time.

As part of improving condom programming and monitoring, Condom LMIS pilot was launched in seven districts (Mbarara, Fort Portal/ Kabarole, Mbale, Wakiso, Hoima, Gulu, and Kampala), which once scaled up will resolve the country's gap of condom utilization data.

Research and Development

A number of HIV related researches were conducted to generate information to guide policy formulation and programming. (i) The UN supported a process for conducting a baseline survey on SRH/HIV/GBV linkages and integration at national level in 8 districts drawn from various regions in the country including Amudat in Karamoja. The baseline study findings will be utilized for effective GBV programming among women and young girls; (ii) IDI published over 30 research articles in peer reviewed journals and there are currently 64 research studies that are going on; (iii) In March 2018, Ministry of Health and Makerere University School of Public Health, with funding from the Global Fund and the United Nations Population Fund (UNFPA) conducted a study on Family Planning and Sexual and Reproductive Health Survey among HIV Infected Individuals in HIV Care in Uganda. The aim of this study was to assess the uptake of FP among PLHIV and establish the unmet need for FP among HIV infected women in care to inform the strengthening of SRH and FP services into HIV care and treatment services.

Capacity Building for M&E

Civil Society Organizations were trained to improve M&E systems in the districts; Mildmay Uganda supported CSOs in improving quality reporting in West Nile region and 7 District Health management teams trained in governance and management and all districts were rated using the GGM scorecard. This support has improved reporting, 92% ART sites consistently submitting timely (monthly & quarterly) HMIS reports to MoH DHIS2 and 77% eMTCT sites consistently submitting timely Option B+ weekly

reports while 74 sites implementing the Uganda Electronic Medical Record (EMR) of data. There has been coordinated development & pilot roll of the National Condom Logistics Management Information System (CLMIS) among 7 key condom Implementing Partners; IDI, TASO, UHMG, MSU, AIC, Uganda Cares, Youth Alive & PACE & trained 44 CLMIS users in the system across these IPs.

Whereas, human resource capacity for M&E has been improved in UAC by the recruitment of some additional permanent staff and hiring of temporal staff with the support of Development Partners like UN-Women and UNAIDS, human resource capacity for M&E remains inadequate to cope with the current demands. Equally, most NGOs have limited M&E capacity due limited funding to support M&E in their ongoing projects and programs.

Key Challenges and Gaps

(1) The situation room is still being hosted outside the country thus limiting its control and maximum use; it has limited scope for data capture, leaving out other important health and social indicators to be monitored. There is also limited skilled staff to manage the situation room at UAC.

(2) Implementation of laws and policies remains inadequate at all levels as most of the laws, policies and guidelines have not yet been widely distributed, disseminated and popularized among key stakeholders

(3) Poor information documentation, analysis and reporting mainly associated with lack of appropriate data collection tools especially, for no-biomedical data at sectoral and community levels

(4) Although a lot of useful data/information is generated by different IPs, it is not widely shared, hence limited use for decision making and programming by health workers and policy makers. A lot of research findings generated especially through the academia are not being disseminated and therefore not utilized in decision making and HIV programming. For instance, Makerere School of Public Health has published a number of HIV related researches during the year under review which were not disseminated and are not registered in UAC's inventory "National Documentation and Information Centre (NADIC)" for ease of access and use by NSP Implementing Partners. Furthermore, there is poor coordination of HIV and AIDS Research, there is no Research Agenda to guide and prioritize research needs for the country.

(5) Human resource capacity for M&E remains inadequate for UAC and CSOs as well as MDAs.

(6) Research findings and recommendations were not disseminated and the relevant publications not registered with the

5 LESSONS LEARNED

- Leadership and commitment is the main stay for accelerating the national AIDS response. Meaningful engagement of political, cultural and religious leaders at all levels has the potential to fast track the response in the country and end the epidemic

- Local Governments have great potential to mobilize local resources to support local HIV/AIDS initiatives including the PFTI. The local resource mobilization drive for PFTI initiated and led by Mayors and other urban leaders under their umbrella organisation "AMICAALL" is a promising practice that could be replicated in other local authorities to sustain PFTI campaign

- Creating Leadership mentors at facility and community levels leads to good clinical outcome and high efficiency

- Lack of a research Repository at UAC has denied an opportunity to utilize research findings for HIV/AIDS strategic planning, decision making and programming in the country.

- The poor coordination of the development actors and stakeholders implementing HIV response interventions affects information sharing, effective networking, and inefficient use of scarce resources and contributes to duplication and inequitable distribution of programmes.

- The social support and protection component is broader in scope and therefore requires multi-sectoral implementation and enhanced resourcing to deliver holistic intervention to meet diverse needs of PLHIV, MARPS, KPs and other vulnerable groups.

- Meaningful Cultural and religious institutions can be effective strategies in delivering GBV and anti-stigma interventions as these are often in touch with communities and families where stigma attitudes and practices are deeply entrenched. They however need resource mobilization and capacity development support.

- Without an organized, well managed and consolidated data base that includes non-biomedical data, it is difficult to objectively assess HIV and AIDS delivery progress in the country, especially on the social support component

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

This annual review has shown that the country has made some significant progress in implementing the National Strategic Plan for HIV and AIDS during its third year. The report highlights specific achievements in all the different NSP Thematic areas and related sub-themes. One of the most significant achievements was the launch of the Presidential Fast Track Initiative to ending HIV by 2030, and the re-commitment of

leaders at all levels including MDAs, Local Governments, Cultural Institutions, Faith-based organizations, etc. Besides, several reforms have been introduced to streamline and enhance testing and treatment, addressing stigma and supporting OVCs and quantification and procurement of supplies especially ARVs, the launch and operationalization of the Situation Room, among others.

This, notwithstanding, several daunting challenges exist and call for concerted efforts of stakeholders and partners to find and support practical solutions if the country is to realize the set targets of the Plan. Challenges identified include, financial resources in the context of low public sector contribution against declining external support by development partners, low absorption of resources, especially of the Global Fund among others. The country needs to institutionalize the NASA, the 0.1% Output budget line for HIV, operationalization of the AIDS Trust Fund, and encourage the private sector contribution of "One-Dollar". Further, there is need to address issues related to staffing by particularly streamlining overstaffing vis-à-vis understaffing across the public sector health facilities and strengthening the linkage between public, private and community systems in service delivery for HIV and AIDS.

Finally, UAC should play an effective coordination role including information and knowledge management. There is need to strengthen the capacity of NADIC as a credible resource center on all matters related to HIV and AIDS through improved staffing, technical support and provision of necessary equipment. In addition, UAC should develop enough capacity to coordinate and track these initiatives to be able to understand the volume of resources being spent on HIV and AIDS through a robust web-based monitoring and evaluation system/framework.

6.2 Recommendations

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

6.2.1 Thematic level Recommendations

Prevention

- ☞ Roll out Test and Treat Policy using "new" approaches such as self-testing, assisted partner identification and testing based on an index case as a strategy to improve efficiency yield and linkage to care as well as promoting cost-cutting.

- ☞ Promote use of social media, design youth friendly platforms and Apps to deliver targeted SRH/HIV prevention messages to adolescents and young people

- ☞ Mobilize and empower young people as champions for promoting behavioral change targeting adolescents and the young people.

- ☞ Support Men's organizations and initiatives to reach more men in the different men's sub-groups with appropriate messages and activities/campaigns that promote better health seeking behavior

- ☞ Adopt innovative service delivery models e.g. Drop in Centres and provide targeted prevention packages for MARPs based on their sub population profiles in order to increase access and expand services

Care and Treatment

- ☞ From the analysis of 90 90 90 progress, the country should consider stepping up the target to 95 95 95 by end of 2020 and sustain it, while enhancing care retention and adherence

- ☞ Though there is adequate guidance for integrating HIV within health care programs, implementation still remains largely vertical. There is thus need to support facilities and community systems to offer integrated care especially for chronic illnesses, child illnesses and SRH.

- ☞ There are a number of innovations and clinical guidelines in care and treatment but implementation starts at different times, in different populations, different pace and scope. There is thus need to establish a clear mechanism or pipeline to not only to harmonize biomedical but and other innovations and move promising interventions to scale and sustainability.

- ☞ Build the capacity of schools to support young people living with HIV to adhere to treatment and to promote an environment free from stigma and discrimination

- ☞ Strengthen community structures and systems to expand the provision of home based and community based care for psychosocial support, adherence and retention in care for HIV and TB treatment as well follow up of mother baby pairs.

- ☞ As more and more PWHIV get on treatment, live longer and achieve viral suppression, there is need to review the clinical need for blanket Cotrimoxazole prophylaxis

Social Support and Protection

- ☞ Improve the coordination of partners implementing the Social support component and institute mechanisms for consolidated data management to

facilitate improvements in reporting and programming for the sector as well as alignment of programs to NSP priority areas

☞Provide technical and financial support to cultural institutions to implement GBV and anti-stigma interventions and other commitments assented to in the PFTI.

☞Scale up Legal support services to enhance the rights of PLHIV, KPs and other vulnerable categories.

☞Support implementation of the food security activities to contribute to progress towards achieving the food security especially among the vulnerable groups.

☞Increase funding for the Social Support Sector to mainstream HIV and AIDS in all its programs in order to respond to the diverse needs of the various vulnerable groups supported by the sector

☞Promote meaningful and more involvement of men in HIV response and GBV elimination interventions.

Systems Strengthening

☞ Strengthen health facility based leadership capacity building initiative such as developing tools for regular performance measurement and tracking (e.g. score card method)

☞ Operationalize HIV integration in other health services at facility, stand-alone sites and community levels in order to empower the frontline health workers to implement the strategy. This will require capacity building for the key actors and stakeholders at all levels.

☞ Re-invigorate and strengthen decentralized HIV and AIDS coordination structures, especially at the lower levels (sub-county, parish and village levels) to be able to deliver on their mandate.

☞ Promote and strengthen linkages and partnership between public sector and civil society for effective delivery of HIV and AIDS services

☞ GoU and ADPs should prioritize urban 'hard-to-reach' populations with tailored response programmes. They should work with "AMICAALL" an umbrella organisation for Mayors and Urban Leaders to support the urban health and HIV initiatives and leverage local resources to support the national response

☞ Conduct National Mapping and Size Estimation of KPs and revive and support functionality of the relevant coordination structures to ensue MARPs prioritization at all levels

- ☞ Strengthen district level monitoring and evaluation through supporting district M&E plans and integration of HIV support supervision into other district based activities.

- ☞ Expand JAR and PF to ensure participation of all relevant stakeholders and strategic partners in the national AIDS response and host post JAR meeting for operationalization of JAR recommendations.

- ☞ Provide technical support to UAC to strengthen coordination of the relevant sectors (MoH, MoGLSD, MoES, MoJCA (JILOS), UPDF, Prisons, and Police MAAIF etc.) and build their capacities for effective coordination and monitoring of the national response. However, there in need to review the role of the UAC and the Partnership Structure as the country heads into the pre elimination phase.

6.2.2 General Recommendations

(1) Institutionalize the High-Level Regional Monitoring Accountability Forum for the Presidential Fast Track Initiative as an annual event in order to track progress. Clear indicators adopted from the NSP should be developed to track progress.

(2) Improve the functionality and management of the Situation Room at UAC; the facility should be hosted in country and capacity built for operationalization and roll out at national and sub-national level. More data sources to cover entire health sector and social indicators including OVC MIS and MIS as well linkage to mobile phones to make it more accessible to the users.

(3) Institute systems and procedures for revising National HIV and AIDS clinical guidelines and protocols at preplanned intervals, unless in emergencies to avoid frequent and rapid changes which leave service providers in suspense with no clear guidance regarding some new programs and interventions.

(4) Define the delivery elements under the life cycle sensitive comprehensive package for social support and protection and develop implementation guidelines to facilitate its effective implementation by the different actors.

(5) Recruitment and training of HWs should be continued to fill the existing vacancies of critical cadres to address human resource gaps. Annual recruitment plans should be prepared and PFPs should be covered sufficiently in the HRH audit data collection, analysis and reporting for a better understanding of the human resources for health status and needs in the country.

(6) Map out HIV funding support and investments by various partners including Government of Uganda, the Global Fund and other in-country financing mechanisms by Partners for better alignment of grants and avoid duplication

(7) Fast track operationalization of the AIDS Trust Fund to increase domestic funding and bridge the current HIV funding gap.

(8) Promote institutionalization NASA and broaden its scope to include resource mobilization and expenditure by the Private Sector. NASA should be

conducted routinely to guide decision making and programming rather post audit which does serve future reprograming purposes.

(9) Strengthen the multi-sectoral data management systems and revive the National Documentation and Information Center (NADIC) as the central HIV and AIDS Information and Knowledge Management Centre. The system should include a Community Health Information Management System that integrates non-biomedical data to improve national health information management, planning, monitoring, reporting and service delivery at the community level.

(10) Streamline coordination of HIV and AIDS research and ensure utilization of findings for decision making and programming. Prioritize annual research agenda in line with NSP priorities to guide partners, sectors and academia and establish a "Pipeline" to move promising innovations to implementation and scale up.

(11) Build capacity of the National Drug Authority (NDA) and equip it to expedite post-shipment processes for quality assurance of condoms and other health commodities.

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Annex I: List of Stakeholders Consulted

I. Key Informants Consulted of Key Informants Consultations

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Annex 2: Progress on Implementation of Joint AIDS Review Undertaking for 2017/2018

PLANNED ACTION	PROGRESS OR ACHIEVEMENT	COMMENTS/REMARKS
HIV PREVENTION		
1. Promote comprehensive HIV prevention packages targeting most at risk and vulnerable e.g. utilizing the DREAMS Model		
Define and map out MARPS and vulnerable population to be targeted e. g adolescents, out of school girls, Sex Workers	Size estimation has been conducted through studies such as Crane and PLACE in selected districts	Funds have been secured from UNAIDS to support undertaking a national size estimation
Define a comprehensive package for the MARPS and vulnerable population	A MARPS Training curriculum and manual have been developed. A package was also developed by IOM but targeting mobile population.	There is need to harmonize the two guidelines and any other
Map out IPs with programs providing this targeted comprehensive package	E-mapping exercise by UAC is ongoing and so far covered 62 districts.	This should be continued in the year 2018/19
Roll out implementation of the programs in districts where they do exist	The MARPS framework has been rolled out. It's being implemented in districts where the MARPS are mapped. Roll out of DREAMS project scaled up from 7 to 15 districts with PEPFAR support	There is need to review the framework as per the MTR of the NSP
2. Scale up targeted quality HTS and improve linkage to care and treatment services		
Roll out the training and implementation of HTS guidelines to all health	These have been rolled out to all health facilities and implementation is ongoing.	There is need for support supervision and mentorship to ensure compliance

facilities in the country		
Conduct targeted HTS services in populations with high yield	This has been done through strategies such as SURGE, HIVST, APN etc	Routine testing strategies should continue to enable other non-high risk to continue accessing the service
Build capacity of health workers for counseling	On-Site mentorship is ongoing	Make it continuous
3. Scale up involvement of religious, cultural and opinion, political leaders in promoting male involvement and addressing issues affecting adolescent girls, boys and young people		
Engage Political, Cultural and Religious leaders in advocacy and implementation of SBCC for the different categories	An HIV Communications Tool kit has been developed for the Parliamentarians. A BCC tool on HIV and AIDS has been developed for Cultural leaders and disseminated to 93 districts	Should be disseminated to the remaining districts and monitor its implementation. Make a popular version and translate it into local languages
Organize different fora for Cultural and Religious leaders e.g the Kings' Forum to make commitments targeting Men and Adolescents	The Cultural leaders and institutions have been engaged during the PFTI roll out during the routine cultural days and accountability for a for the PFTI	Roll out PFTI commitments to the remaining regions
Engage national youth Structures e,g Young Positives, National Youth Council and Young People SCE to reach out to their peers with messages	Engaged University leadership in HIV advocacy through the University Guilds in UCU and Kyambogo	Lessons learnt should inform the scale up to other institutions of higher learning

Implement the Protect the Goal approach to engage youth in and out of school	The Protect the GOAL campaign has been rolled out in West Nile and Karamoja with support from UNESCO and UNFPA through MoES	Should be integrated and harmonized with the PFTI
Engagement of established community structures to deliver services to adolescents and young people out of school	Funds have been allocated to functionalize the CHEWS	Fast track the establishment of CHEWs structure
4. Scale up HIV and AIDS services in Emergency settings (refugee situations, IDPs, migratory communities etc.)		
Engage political, Religious and cultural leaders in Emergency settings and advocate for HIV and AIDS services	UAC in collaboration with UNHCR engaged cultural and political leaders in the HIV and AIDS response specifically in West Nile. Leaders have been mentored as change agents in the refugee settlements and communities	Scale up the engagement to other refugee settlement areas
Quantify the needs (Medical supplies)	Capacity has been built to quantify supplies to mitigate stock outs. PEPFAR is supporting UNHCR in the process	Further support needed to meet the increased demand for supplies and commodities
Build capacity of Health workers to respond to the emergency situations	We are using modules to train health workers in refugee settlements for both government aided facilities and UNHCR specific facilities in the camps and settlements	Continued supervision and monitoring to ensure compliance
5.Conduct a comprehensive national wide mapping of MARPS and priority populations in Uganda		
Identify partners for engagement(for funding and data collection) at different levels	Partners have been identified through MARPS Network and individual organizations	Need to build capacity for coordination and data collection

Develop a concept paper with detailed ToRs to guide the MARPs Programming process	The concept paper on strengthening MARPS programing has been developed	Approval, dissemination and roll out of the concept
Procure TA to conduct the mapping exercise and compile a detailed report	TA for the size estimation has not yet been procured	Should be undertaken in 2018/19
Update the National MARPs programming framework with a Road map to guide IPs	The Framework is being updated based on the concept note	The updated framework should be disseminated to guide IPs
CARE AND TREATMENT		
6. Scale up Differentiated Services Delivery Models		
Finalise and disseminate Guidelines for the Differentiated Service Delivery model	Finalized and rolled out to all ART sites	Monitor implementation to ensure compliance
Strengthen the community structures for implementation of the DSDM	The strategy focusing on strengthening community structures has been finalized	Fast track implementation
Build capacity of health workers and community health support workers to implement the DSDM	This has been done in all the ART sites	Monitor implementation to ensure compliance

Engage Mentor Mothers, expert clients and peer groups both at health facilities and communities	Capacity building is ongoing and continuous	Scale up to cover all participating health facilities
7. Scale up the coverage of Viral Load monitoring services.		
Procure Equipment for Viral Load testing	Not done	Hub system has been strengthened to cover the whole country and this has increased coverage in VL testing.
Strengthen the sample transportation system	Hub system has been rolled out and strengthened throughout the country	Monitor implementation to ensure efficiency
SOCIAL SUPPORT AND PROTECTION		
8. Provide economic empowerment and incentives for especially young girls and adolescents		
Identify incentives for empowerment targeting adolescents and girls in and out of schools	Several incentives were identified such as UWEP, OWC, NAADS, DREAMS, Youth Livelihood and Empowerment Project among others	Monitor implementation to ascertain coverage and impact
Disseminate the refined tool to the implementers to set a standard for implementation	The tool is being finalized after getting guidelines.	Strengthen monitoring and reporting
9. Roll out PIASCY including the Sexuality Education Framework and address stigma in schools		
Finalize and disseminate Sexuality Education guidelines	The guidelines are ready but not yet disseminated widely	Work with all stakeholders to disseminate and roll out the revised guidelines to schools and institutions of learning

Review and disseminate PIASCY guidelines	The guidelines have been reviewed	Disseminate and roll out the revised guidelines
Implement and monitor implementation of PIASCY and Sexuality Education programs in schools	This is dependent on the dissemination plan	Implementation should be expedited
10. Address Stigma in the community and schools		
Fast track the development of the National anti-Stigma and Discrimination Policy	The policy has been developed and is awaiting approval from the Solicitor General's office	Engage SG's office to fast track approval process
Disseminate the National Anti-Stigma Policy	Not yet disseminated	Fast track approval from SG's office
Conduct regular Stigma Index studies in Schools and Community	Stigma index study was done in the community	Need to conduct studies in schools and share findings
Build Capacity of teachers in Counseling and addressing stigma in Schools	This shall be done with revised guidelines	Scale up to the remaining schools and monitor the counseling exercise
SYSTEM SRENGTHENING		
11. Increase investment and improve efficiencies including tracking of the resources		
Hold Development Partners Dialogue on sustainable financing options for HIV and AIDS response	Meetings have been convened with ADPs and concepts discussed and funded	This should be a continuous process to ensure sustained domestic resource mobilization
Presentation of ATF legislations to Parliament	ATF Regulations are yet to be tabled in Parliament	Fast track approval of ATF by Parliament

Implement the ATF	Pending passing of the ATF to law	Engage Parliament
Fast track the NASA	Draft report was presented to stakeholders and is being reviewed and to be ready by end of August.	Plan for dissemination of the report immediately after completion
Institutionalize NASA to enable regular tracking of resources for the HIV and AIDs response	UAC staff were part of the NASA Core team and participated in the NASA exercise	Make recommendations on building national capacity as a process of institutionalizing NASA
12. Review staffing norms to match the required services		
Review the current staffing structures against the services provided	The structure was reviewed and submitted to HSC.	Follow up with HSC to expedite the process of approval
Fill the vacant positions to 100%	Recruitment awaiting approval of the new structure	Expedite approval of structure
Build capacity of the Health workers based on the services available	This is ongoing with support from partners	Develop a training database
13. Operationalize the situation room and the gender dashboard to facilitate information		
Constitute the Situation Room Committee	A Technical Working Group for the Situation Room has been constituted as well as a Core Team	The Situation Room to be scaled up in the first and second quarters of 2018
Harmonize the sector databases to enable linkage to the Situation Room	A process for selecting priority indicators for various sectors and programs is ongoing.	Fast track the process for selecting priority indicators
Build capacity of the M&E TWG and National Data management teams in application/management of the Situation room	40 technical personnel were oriented and trained. Members from the Core Team have also attended workshops on the same	Continued capacity building and knowledge transfer to ensure sustained use, and promote it among the users

Roll out and popularize the Gender indicator tracking dashboard	The dash board has been established with selected indicators. An MoU has been signed between UAC and UN Women on the implementation	A work plan and budget in place for the implementation and popularization
14.Conduct Quarterly national and regional performance review and data quality/validation meetings		
Convene National Data review meetings	4 quarterly regional (nation- wide) data validation meetings were convened and 4 at national level	Develop a mechanism for ease of access to Data use
Convene Regional performance review meetings	This has been convened by some of the IPs in their respective regions	The regional review meetings should be centrally coordinated by UAC to ensure wider stakeholder participation and buy in
Convene regular thematic TWGs to validate data before reporting	Most of the TWGs have met quarterly	Develop a schedule for the TWGs meetings Generate follow up actions
Generate quarterly and annual reports	UAC has compiled 4 quarterly and one annual report for this period	Strengthen contribution and participation in the quarterly and annual reporting by sectors
Conduct AIDS reviews	The MTR and NPAP final reports are under review Technical Assistance to compile JAR/GARPR has been hired	Set deadlines for submission of the final reports and dissemination plans

Annex 3: Planned Joint AIDS Review Undertaking for 2018/2019

The 2018/19 JAR Undertakings constitute the key outcomes of the 2017/18 Joint Annual AIDS Review. UAC will lead and ensure effective implementation and monitoring of the JAR undertakings through an annualized multi – sectoral Action plan. The Undertakings will be widely disseminated among partners for comments and consensus building and ownership. The multi – sectoral Action plan will include clearly defined performance indicators and timelines as well responsible parties for implementing the different components of the undertakings based on their comparative advantage. In order to track progress and ensure compliance among partners, a high-level National Monitoring and Accountability Forum will be constituted biannually to review status of implementation. Multi-sectoral reporting tools will be developed to facilitate tracking of the progress. The progress of implementation of 2018/19 JAR undertakings will feed into the national and global reporting process of 2019/20 to be undertaken by UAC. Annex 3: summarizes the 2018/19 JAR undertakings.

UNDERTAKING	OUTPUT	LEAD INSTITUTION
Objective 1: Engage men in HIV Prevention and close the tap on new infections particularly among adolescent girls and young women		
1.1 Empower community structures including cultural/traditional/Religious institutions, CBOs and CHEWs among others to champion targeted SBCC interventions segmented for young people, women, men, PWDs and the elderly	Young people, women, men, PWDs and elderly reached through community structures	Ministry of Gender; MoH, UAC
1.2 Provide technical guidance for KPs Mapping and Size Estimation **1.3** Review and roll out MARPS framework to include MARPs service delivery models including Drop in Centers, Strengthen capacities and empower MARPs and PLHIV in Human rights so they understand, exercise and claim their rights	Guidelines for KPs Mapping and size estimation developed and disseminated to the relevant IPs and stakeholders MARPS Programming scaled up and strengthened in all identified areas with MARPS	UAC, MoH, IPs
1.4 Integration of HIV, SRH and GBV services in facilities based on recommended framework and tools	Facilities providing integrated comprehensive services	MoH
Objective 2: Accelerate Implementation of Test and Treat and attainment of the fast track 90-90-90 targets particularly among men and young people		
2.1 Strengthen ART services in infants, children and adolescents;	Increased uptake of ART among men and young people	MoH

• Treatment and adherence support • Address barriers to treatment		
2.2 Strengthen target testing models and approaches	Reduced Test and Treat gap	MoH
Objective 3: Consolidate progress on elimination of mother-to-child-transmission of HIV		
3.1 Strengthen community structures to facilitate follow up of mother – Baby pairs	Increased retention among mother-baby pairs	MoH; UAC, Ministry of Gender,
3.2 Targeted interventions and best practices to increase retention of exposed infants in care	Increased retention among HEIs	MoH
Objective 4: Ensure financial sustainability for the HIV and AIDS response		
4.1 Establish mechanisms for increasing domestic funding for the HIV Response	One dollar Initiative operational AIDS Trust Fund operational	UAC; Private Sector, Parliament
4.2 Map out HIV funding support and investments by various partners including Government of Uganda, the Global Fund and other in-country financing mechanisms by Partners for better alignment of grants and avoid duplication	Better alignment and prioritization to guide HIV resource allocation	UAC, ADPSs, Private Sector,
4.3 Fast track NASA institutionalization and broaden its scope to include resource mobilization and expenditure by the Private Sector	NASA Institutionalized	UAC; MAKsPH, UBOS
4.4 Establish a vote output - Monitor to ensure compliance of the 0.1% enshrined in the national mainstreaming strategy	Sectors reporting on HIV Mainstreaming	UAC; MoFPED
Objective 5: Ensure institutional effectiveness for a well-coordinated multi-sectoral response		
5.1 Strengthen the multisectoral data and information management system that includes a Community Health Information Management System and integrates non-biomedical data. **5.2** Improve the functionality and management of the Situation Room, built UAC capacity for operationalization and rolls out at national and sub-national level and include more indicators to cover entire health sector and social indicators	Functional NADIC serving as a national HIV Information and Knowledge Management Centre Community Health Information Management System and that integrates non-biomedical data developed Situation Room rolled out to District level	UAC, MoH

including OVC MIS		
5.3 Ensure effective coordination of research and use of findings for decision making and programming	Annual National AIDS Research Agenda developed National HIV and AIDS Conference convened Functional DACs and SACS	UAC; MoH, Academia, MoLG