The Republic Of Uganda

ANNUAL JOINT AIDS REVIEW REPORT

FY 2021/22

Uganda AIDS Commission

November, 2022

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LIST OF ACRONYMS

ADPS	**AIDS DEVELOPMENT PARTNERS**
AGYW	Adolescent girls and young women
AHD	Advanced HIV Disease
AIDS	Acquired Immune Deficiency Syndrome
APN	Assisted Partner Notification
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
AYP	Adolescent and Young People
CABLA	Long Acting Injectable Cabotegravir
CCLAD	Community Client Led ART Distribution
CCM	Country Coordinating Mechanism
CD4	Advanced HIV Disease
CDC	Centre for Diseases Control and Prevention
CDD	Community Demand-driven Development
CDDP	Community Drug Distribution Point
CERUDEB	Centenary Rural Development Bank
CHAG	Christian Health Association of Ghana
CHAI	Clinton Health Access Initiative
CHD	Community Health Department
CHDS	Community Health Departments
CNET	Condom needs estimation tool
COVID	Corona Virus Disease
CPHL	Central Public Health Laboratories
CQI	Continuous Quality Improvement
CRAG	Cryptococcal Antigen
CRPDDP	Community Retail Pharmacy Drug Distribution Points
CSOS	Civil Society Organization
CSSA	Civil Society Strengthening activity
CTE	Committee of Technical Experts
DANIDA	Danish International Development Agency
DATIM	Data for Accountability, Transparency, and Impact Monitoring
DHIS2	District Health Information System
DHO	District Health Officer
DHT	District Health Team
DIC	Drop-in centre
DQA	Data Quality Assessment
DSD	Differentiated Service Delivery
DREAMS	Determined Resilient Empowered, AIDS-free, Mentored and Safe
DSDM	Differentiated Service Delivery Model
DTU	Diagnostic and Treatment Unit
DVR	Dapivirine Vaginal Ring
EARS	East Africa Radio Services Limited
EDA	Enterprise Development Assistance
EID	Early Infant Diagnosis
EMIS	Education Information Management System
eMTCT	Elimination of Mother-To-Child Transmission
EOC	Equal Opportunities Commission
EPI	Expanded Program for Immunization
ERP	Enterprise Resource Planning
FBIM	Facility Based Individual model
FBO	Faith-Based Organization
FTDR	Fast Track Drug Refill
FSW	Female sex worker
FY	Financial Year
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIS	Geographic Information System
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMU	Grant Management Unit
GOU	Government of Uganda
HC	Health Centre
HCW	Health Care Waste
HF	Health Facility
HIVDR	HIV Drug Resistant
HIVPCA	HIV Prevention and Control Act of 2014
HIVST	HIV self-testing
HLM	High level meeting (UN)
HMIS	Health Management Information System
3HP	Isoniazid and Rifapentine (TB treatment)
HRAPF	Human Rights Awareness for Promotion Forum
HRH	Human Resources for Health
HTS	HIV Testing Services
ICWEA	International Community of Women Living with HIV in East Africa
IDI	Infectious Disease Institute
IDLO	**International Development Law Organization**
IDU	Injecting Drug User
IHRIS	integrated Human Resource Information System
ILO	International Labour Organization
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IP	Implementing Partner
ISO	International organization for Standardization
JAR	Joint Annual Report
JMS	Joint Medical Stores
KP	Key Population
LACJ	Legal Aid and Community Justice
LAM	Lipoarabinomannan
LEA	Legal-Policy Environment Assessment
LG	Local Government
LIM	Less Intensive Models
LQAS	Lot Quality Assurance Sampling
LTFU	Lost-to-follow-up
M&E	Monitoring and Evaluation
MARPS	Most at Risk Populations
MAT	Medically Assisted Therapy
MDAS	Ministries, Departments and Agencies
METS	Monitoring and Evaluation Technical Support (Program)
MIS	Management Information System
MMD	Multi-month dispensing
MOES	Ministry of Education and Sports
MOFPED	Ministry of Finance Planning and Economic Development

MGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MSM	Men who have sex with men
NAFOPHANU	National Forum of People living with HIV Network in Uganda
NASA	National AIDS Spending Assessments
NCCPS	National Comprehensive Condom Programming Strategy
NCDC	National Curriculum Development Centre
NCDS	Non-Communicable Diseases
NDP	National Development Plan
NITA	National Information Technology Authority
NMS	National Medical Stores
NPA	National Planning Authority
NSP	National HIV and AIDS Strategic Plan
NSPP	National Social Protection Policy
NSR	National Single Registry
NTLP	National TB and Leprosy Program
ODPP	The Office of Director of Public Prosecution
ODI	One Dollar Initiative
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
OVCMIS	Orphans and Vulnerable Children Management Information System
PDM	Parish Development Model
PEPFAR	Presidential Emergency Plan for AIDS Relief
PFTI	Presidential Fast Track Initiative
PITC	Provider initiated testing
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PoC	Point of Care
PP	Priority Population
PrEP	Pre-Exposure Prophylaxis
PSI	Population Services International
PSP	Public Service Providers
PWD	Persons with Disabilities
PWID	People who Inject Drugs
QI	Quality Improvement
RASP	Research, Academia, Science and Professional (entities)
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RRH	Regional Referral Hospitals
RSSH	Resilient Systems Strengthening for Health
RTRI	Rapid Testing for HIV Recent Infection
RTSU	Regional Technical Support Unit
SAGE	Social Assistance Grants for Employment
SBCC	Social Behaviour Change Communication
SCE	Self-Coordinating Entity
SCG	Senior Citizens Grant
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SITES	Strategic Information Technical Support (Activity)
SMC	Safe Male Circumcision
SMS	Short message service
SNS	Social Network Strategy
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
SW	Sex worker
TASO	The AIDS Support Organization
TB	Tuberculosis
TB LAM	Tuberculosis Lipoarabinomannan
TMA	Total Market Approach
TPT	TB preventive therapy
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UCC	Uganda Communications Commission
UDHS	Uganda Demographic Health Survey
UGANET	Uganda Network on Law Ethics and HIV/AIDS
UHRN	Uganda Harm Reduction Network
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNESCO	United Nations Education, Scientific and Cultural Organization
UNHLS	Uganda National Health Laboratory Services
UNYPA	Uganda Network of Young People Living with HIV
UPHIA	Uganda Population-Based HIV Impact Assessment
USAID	United States Agency for International Development
US$	United States Dollar
UVRI	Uganda Virus Research Institute
UWEP	Uganda Women Entrepreneurship Programme
VAC	Violence Against Children
VAW	Violence Against Women
VHT	Village Health Team
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WLHIV	Women Living with HIV
YAPS	Young Adolescent Peer Supporters
YLP	Youth Livelihood Program

FOREWORD

Uganda has made tremendous progress in combating the HIV and AIDS epidemic over the past 10 years. By end of 2021, Uganda had an estimated 1.4 million people living with HIV, AIDS-related deaths had declined by 67% from 51,000 in 2010 to 17,000 and new HIV infections had declined by 39% from 88,000 in 2010 to 54,000 (Uganda 2022 HIV Epidemiological Estimates).

This progress is attributable to the multi-sectoral response that is guided by strategic plans developed by the Uganda AIDS Commission in collaboration with key stakeholders. The current National HIV/AIDS Strategic Plan (NSP) 2020/21–2024/25 provides the overall strategic direction for the response based on four broad thematic areas, namely HIV Prevention, Care and Treatment, Social Support, and Protection, and Systems Strengthening. It is aligned to the Third National Development Plan (NDP III) 2020/21-2024/25, and aims to address Sustainable Development Goal (SDG) 3 by addressing the key drivers of the epidemic.

This annual Joint AIDS Review (JAR) 2022, documents the progress made during the second year of implementation of the NSP 2020/21–2024/25. During this period, the COVID-19 pandemic, which in Uganda, began in March 2020, impacted HIV-related services, the health system, as well as the wider socioeconomic context of the country, and threatened Uganda's achievement of the goals set in the NSP, the NDP III, and SDGs. The pandemic created demands on the overall health system and highlighted the need for a multi-sectoral response and integration of the services in order to ensure both COVID-19 and HIV and AIDS are prioritized. However, the results of this second year of the NSP implementation indicate that the country is still on track to attain set targets towards ending AIDS as a public health problem by 2030.

The report also documents key undertakings of the JAR Aide Memoire for FY 2021/22 with action plans for FY 2022/23. The journey towards the 2030 aspirations is possible if we take collective responsibility and do not leave anyone behind. I urge all stakeholders internalize the report and contribute to a sustainable national response by ensuring that HIV and AIDS is integrated into your plans.

For God and my country.

Dr. Eddie Mukooyo Sefuluya

CHAIRMAN, UGANDA AIDS COMMISSION

ACKNOWLEDGEMENTS

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

Uganda AIDS Commission leads the multisectoral response and during this past year, ensured that all review processes for the JAR 2021/22 were highly participatory, involving all key stakeholders at national and sub-national levels, including interest groups like communities of PLHIV. This year's JAR report used a different approach for its compilation process—a team from key institutions including Ministry of Health, UNAIDS, Monitoring and Evaluation Technical Support (METS) Program, Strategic Information Technical Support (SITES) Activity, Ministry of Gender, Labour and Social Development (MoGLSD), Uganda Network of AIDS Service Organisations (UNASO), the National Forum of People Living with HIV/AIDS in Uganda (NAFOPHANU) led by Uganda AIDS Commission, was convened in a retreat to review relevant documents/data and compile a report. This draft report was validated by the respective thematic Technical Working Groups and a final report produced.

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

On behalf of Uganda AIDS Commission and my own behalf, I also take this opportunity to thank all of you who participated in the 2022 Joint AIDS Review. I would like to thank the ADPs and implementing partners, and in a special way acknowledge UNAIDS for the financial support provided to this exercise especially the report writing retreat hosted in Jinja.

I congratulate all those who are implementing the National HIV and AIDS Strategic Plan and the National Priority Action Plan (NPAP). Your efforts and actions toward implementation in the second year are appreciated. I look forward to your relentless and continuous contribution to the fight against HIV and AIDS. Together we shall end AIDS as a public health problem by 2030.

Dr. Nelson Musoba

DIRECTOR GENERAL

EXECUTIVE SUMMARY

This report presents the progress in the second year of implementing Uganda's NSP (2020/21 - 2024/25) and the 7th year of reporting against the UNAIDS 95-95-95 targets for attaining epidemic control. The report is divided into three sections: i) Section 1 gives context to the report, outlines the goals, and objectives of the report, methodology of compilation, as well as an overview of the HIV and AIDS epidemic in Uganda; ii) Section 2 describes the achievements and interventions responsible for the achievements under the key thematic areas and their strategic objectives as per the NSP 2020/21 – 2024/25; iii) Section 3 summarizes achievements against the PFTI objectives. Within each section, the report highlights key challenges and implementation gaps as well as recommendations that could be implemented to improve the national response.

Goal and Objectives

The report aims to review the NSP implementation progress for the period July 2021 to June 2022, with a focus on how the COVID-19 pandemic affected the response.

Methodology

A multi-sectoral team from self-coordinating entities (SCE) including ministries departments and agencies (MDAs), was constituted by UAC to write the different sections based on available quantitative and qualitative data, under specific Terms of Reference. A facilitator was engaged to compile the different sections into one coherent report. The draft report was validated by the thematic technical working groups of the Uganda AIDS Commission and then finalized by the facilitator.

HIV and AIDS Situation

Based on the Epi-data country estimates for FY 2021/22, HIV prevalence among adults is 5.2% a decrease from 6.2% in the UPHIA 2016/17. Incidence among adults is at 0.24%. Close to two-thirds (65%) of new HIV infections among adults in 2021 were among women compared to their male counterparts (35%). Further, young people (10-24 years) are more vulnerable to HIV infection with 43% of the cases occurring in this age group. Among young people, adolescent girls and young women (AGYW) are even more vulnerable to HIV infection; four in five (79%) of new HIV infections in young people occur in adolescent girls and young women aged 10-24 years. Regional variations in HIV prevalence show improvements in all regions except for the Mid North and South Central.

There were an estimated 1.4 million people living with HIV (PLHIV) in FY 2021/22, 54,000 new infections, and 17,000 AIDS-related deaths. Overall, the trends in new infections and AIDS-related deaths are on a decline, but more efforts are needed to reach epidemic control.

Against the UNAIDS 95-95-95 targets for epidemic control by 2025, Uganda achieved 89-92-95 per Epi-data estimates and with children below 10 years having the lowest values for the first (68%) and third target (89%). Results from UPHIA 2020 also show a decline in the first target (81-96-92), indicating that Uganda has to intensify efforts to achieve the targets.

Prevention Program Achievements

SBCC Campaigns. During the year, UAC launched the National HIV and AIDS Communication Strategy which will guide social behaviour change communication (SBCC) component of the response. The major SBCC campaigns that run during the year include the "Time Up HIV Campaign" that encouraged prevention options and adherence to ART. Other SBCC activities through which HIV prevention messages were disseminated include annual HIV and AIDS events such as the World AIDS Day, the Candle Light Memorial and the Scientific Conference that incorporated the JAR 2020/21 dissemination and the Philly Lutaaya memorial lecture.

Adolescent Girls and Young Women (AGYW). Given the importance of addressing the reasons AGYW are more vulnerable to getting HIV infection, the National Strategy for AGYW outlines a package of interventions for HIV prevention among AGYW. Initiatives like the Determined, Resilient, Empowered AIDS-free, Mentored and Safe (DREAMS) and Young Adolescent Peer Supporters (YAPS) provide components of this package that include life skills, social and economic empowerment options, family planning commodities and legal literacy, to AGYW. A cross-cutting theme in all the programs for AGYW is HIV prevention messaging and HIV testing and counselling.

A total of 347,525 AGYW were reached with prevention services in 44 districts through the DREAMS initiative, while the YAPS program provided health education to 570,689 adolescent and young people (AYPs); screened 394,543, for HTS; and identified 254,222 eligible for testing. Of those identified, 226,360 received the HIV test and 8,087 adolescents and young people (AYP) tested positive (a 3.6% yield of positive cases among those tested).

Another key platform for reaching adolescents and young people is the school environment; keeping girls in school empowers them to make good life choices. During the report period the Ministry of Education and Sports (MoES) through the district education offices and other local government structures, distributed subsidies in the form of tuition fees for primary and secondary schools targeting 20,000 most vulnerable adolescent girls in the 20 districts of Nakaseke, Nakasongola, Kiboga, Hoima, Buliisa, Kyankwanzi, Tororo, Mbale, Bukwo, Dokolo, Kitgum, Pader, Mayuge, Buikwe, Jinja, Iganga, Buyende, Kaliro, Buvuma and Busia. The Hon. Minister of Education and Sports launched the Education Plus Initiative, which is a high-profile, high-level political advocacy drive to accelerate actions and investments towards making AGYW and boys as agents of change to prevent HIV, reduce teenage pregnancy, early marriages and gender-based violence. This is in addition to the Sexuality Education Framework that she launched earlier. During the reporting period, 962 teachers were trained in delivering the New Lower Secondary Curriculum that incorporates sexuality education. one hundred (100) teachers living with HIV and AIDS under the Teacher Anti-AIDS Group (TAAG) were also trained as trainers on standardised information to enhance understanding and positive living in schools, increase uptake of HIV and AIDS prevention, care and treatment related service, strengthen referrals, linkages. Altogether, A total of 65,069 students (25,726 males; 39,343 females) from 844 primary schools and 253 secondary schools were reached through school programs.

Although these AGYW interventions are promising in terms of their effect on reversing trends in new infections among this population, the coverage of interventions is still very low given their estimated population of 7.5 million. There is therefore need to fast-track the scale up of these interventions to all districts of the country for a bigger and quicker impact on HIV prevention.

Condom Distribution. Uganda with support from GFATM through UNAIDS and UNFPA launched a 3-year strategic initiative on condom stewardship which aims to catalyse improvements in the quality of condom programmes by making them more differentiated, equitable, people-centred and data driven. The MoH also revised the Condom Distribution Guidelines and adopted the Last Mile Distribution Initiative and distributed 1,138 condom dispensers to geo-mapped drop-in-centres (DICs). About 192 million condoms were distributed during the year with 73% of them available at no cost (free-to-use).

Key Populations (KP) and Priority Populations (PP) remain an important target group for prevention interventions since HIV prevalence is high among them (between 11-34%). In Uganda, KP include men who have sex with men (MSM), sex workers and their clients, transgender people, people who inject drugs (PWID), and prisoners and other incarcerated people, while PPs include uniformed personnel, fisherfolk and long-distance truck drivers. During the reporting period, a Legal Policy Environment Assessment was conducted to identify and document the laws that affect human rights of PLHIVs in general and KPs specifically. Interventions specific to KPs included peer support groups who provide psychosocial support and encourage prevention service acceptance and linkage to care; support to about 75 drop-in-centres (DICs) across the country including four in Kampala and Wakiso; support to

persons who inject drugs (PWID) at the medically assisted therapy (MAT) clinic at Butabika; and PrEP services at 702 sites across the country. Overall, there was a 3% yield of HIV positive individuals from the various interventions.

Differentiated HIV Testing Service models are mechanisms for reaching as many PLHIV as possible with appropriate HIV prevention, care and treatment services. They include HTS, index testing, assisted partner notification (APN), social network strategy, HIV self-testing, and rapid testing for recent infection (RTRI). Altogether, 7,325,790 individuals were tested for HIV during the year, and of these, 2.6% were identified as HIV positive, and 91% of them were linked to care.

eMTCT. Under the eMTCT Programme, 1,909,456 women attended antenatal care (ANC), 36% of these in the first trimester. Of all the women who attended ANC, 98% knew their HIV status, while 84% were tested for syphilis (a reduction from 88% last year), and 22% were tested for Hepatitis B (an increase from 17% last year). A total of 84,748 women were identified as HIV positive, 72% of these were already HIV positive before the pregnancy while 28% were newly identified as HIV positive. All the HIV positive (100%) received ART. Of those that attended their first antenatal visit with an already known HIV status, only 59% had a viral load done and of these 91%were suppressed. Those newly found to be HIV positive are a concern for the programme because they need to be reached with prevention messages before they get pregnant and/or with PrEP In the case of risky sexual behaviour.

Follow up of mother-baby pairs is still a big challenge in the PMTCT program with only 83% of women who start ART retained in care at 12 months and 10% of mothers non-suppressed after the first 12 months post-partum. Ninety two percent (92%) of the HEI in need were provided with ART prophylaxis, and 92% got a first DNA/PCR test within 2 months. Also, 95% HEI were enrolled into the HIV exposed infant cohort for care. Overall, infant testing yielded a positivity rate of 3%.

PrEP. During the year, the use of the Dapivirine Vaginal Ring (DVR) and Long Acting Injectable Cabotegravir (CABLA) as prevention options was approved, and service guidelines updated appropriately. Of the 296,783 individuals assessed for eligibility in the 473 facilities offering PrEP across the country, 199,405 (67%) were found eligible and of these, 179,081 (90%) were initiated on PrEP, the highest category of beneficiaries being sex workers and their clients.

VMMC: A total of 490,655 circumcisions were conducted during the reporting period with 77% of them during outreaches. Severe adverse effects were reported in 0.02% of the clients.

Integration of SRHR, Maternal, Neonatal, Child Health and Nutrition with HIV Prevention Programming. Due to the intrinsic relationship between HIV, SRHR and gender-based violence (GBV), the MoH and stakeholders are working towards integration of these services. Uganda has progressed from 57% in 2016 to 66% in 2019 and 70.8% in 2020 in the SRHR and HIV Linkages Index indicating good progress, but there are still gaps that need to be addressed.

HIV and AIDS Care and Treatment

According to the Epi-data estimates, the lowest performance is for the first -95 target (PLHIV who know their status) and more so for children (68%) and men (88%). These low achievements highlight the challenges in mobilizing the population especially priority populations and mother-baby pairs. Overall HTS services need to be intensified using the different approaches to improve the first '95' target.

As of June 2022, 1,348,517 clients were active in care, with 1,334,885 (99%) categorized under a DSD approach. During the reporting period, roll out of multi-month dispensing (3-6 monthly) ARV drug refills continued across the country and 83 pharmacies were linked to 56 health facilities through the Community Retail Pharmacy Drug Distribution Points (CRPDDP approach. Seventy-three (74%) of the adult clients and children below 10 years were retained after 12 months of initiating treatment

compared to 63% for adolescents 10-19 years. Ninety-six (96%) of adults, 89% children 0-14 years and were virally suppressed.

Integration of HIV and AIDS with TB and other diseases. Since December 2021, the country adopted 3HP (Isoniazid and Rifapentine) as one of the WHO-recommended short regimens for TB prophylaxis among PLHIV and this regimen has been rolled out in phases to regional referral hospitals, district hospitals, centres of excellence, and military and prison facilities. In FY 2021/22, 92 % of PLHIV in care were screened for TB, while 99% of TB patients were screened for HIV and by June 2022, there was 89% coverage of TPT among the eligible PLHIV in care.

Seventy-three (73) facilities in the Kampala Metropolitan area and Ankole Region, and an additional 35 including 8 RRHs, are piloting the integration of HIV and NCDs in preparation for national roll out.

Social Support and Protection

***Awareness Creation on Stigma and Discrimination*.** Several policies were developed, disseminated and their roll out started during the reporting period. Key among these are the National Policy Guidelines for Ending Stigma and Discrimination against PLHIV. The implementation of this policy was through anti-stigma/discrimination interventions carried out by MDAs and SCEs and CSOs such as dialogue meetings, training sessions, and anti-stigma messaging through print and radio/TV media. Other awareness creation activities include the annual World AIDS Day, Philly Lutaaya memorial lecture and the Kabaka's run. These activities mobilized more than 25 million people to fight against HIV and AIDS.

Socioeconomic Interventions. Economic support helps empower vulnerable PLHIV and their families to access and sustain treatment, and to secure much needed basics such as food and welfare for children. During the period continuing government programs such as the Senior Citizen's Grant (307,145 beneficiaries), the Youth Livelihood Programme (21,280 youth group beneficiaries), Uganda Women's Entrepreneurship Programme (17,852 women group beneficiaries) as well as CSO interventions such as the GFATM-funded TASO project (13,000 AGYW beneficiaries) mobilized and supported vulnerable people to get gainfully employed and choose better options in life. Through PEPFAR support, 403,589 orphans and vulnerable children (OVC) received social support services. Of these, 354,786 (87.9%) received a package of comprehensive services addressing their health, safety, schooling and stability needs, 98% of those 0-17 years knew their HIV status, and 18.7% were HIV positive.

Psychosocial Support was provided to the relevant vulnerable populations through individual or group counselling sessions during service delivery (HTS/socioeconomic interventions), and through Helplines such as *Safe Pal*, and the GBV and Children's Helplines hosted by the Ministry of Gender, Labour and Social Development (MoGLSD).

GBV/VAC Interventions. A total of 12,811 incident GBV cases were reported by community champions trained mainly by CSOs, and 17,533 domestic violence cases reported to the police posts. Relatedly, 20 VAC centres were functionalized to address VAC cases. However, out of the domestic violence cases reported to the police, only 9% of these cases were followed through to court and 2.7% ended with a conviction, indicating a big gap in enforcement of the existing laws against GBV.

Systems Strengthening

UAC Oversight. Under this thematic area, UAC continued to improve its oversight and coordination role on the overall HIV and response in the country. UAC with input from stakeholders reviewed the UAC Communication Strategy, incorporating high level priorities. The National Equity Steering Committee was established and under this committee's guidance, a National Equity Plan was costed and resources secured from the GFATM to support its implementation. Relatedly, an Equity Coordinator was recruited under UAC to coordinate equity interventions.

During the year, regulations that operationalise the UAC Act (1992) mandate were approved and gazetted for public awareness. UAC also supported the National Planning Authority (NPA) to embed HIV mainstreaming into the national cross-cutting issues planning guidelines and held dialogue meetings with the Ministry of Local Government (MoLG) to explore mechanisms of leveraging the Parish Development Model (PDM) for furthering the HIV and AIDS response. Further, 100 districts were supported to develop their strategic plans for HIV and AIDS plans. The SCEs functionality improved compared to the previous year as evidenced by their quarterly meetings and reports. In an effort to better coordinate partners UAC with partners, developed a directory of key development partners supporting HIV and AIDS. It is hoped it will inform the planning for partner and resource distribution resources across the country.

Health Systems Strengthening. To improve availability of logistics for HIV prevention, a logistics management plan for the HIV self-testing commodities under PEPFAR and the GFATM was developed and the stocks and targets FY 2021/22 harmonized; telemedicine was utilized for delivering continuous professional education to facility staff; and two incinerators installed to support waste management across the country.

Resource Mobilisation. During the year a total of US$ 659 million was mobilized to fight HIV and AIDS in the country. The response is still heavily donor-dependent with 85.9% of the funds from donors and 13.8% from government. The major donors are PEPFAR (64.3% contribution) and GFATM (15.2% contribution). The HIV mainstreamed funds contributed 1.5% of all expenditure for the year. Overall, 58% of the funds were utilized for ARV procurement.

Impact of COVID-19 and other Shocks on HIV and AIDS Services. According to program data from MoH, COVID-19 led to a reduction of 30% in the use of HIV testing services in communities and health facilities. Further, the initiation of antiretroviral therapy decreased by 31% between April and June 2020 alone; and between December 2019 and June 2020, viral load coverage for PLHIV decreased from 96% to 85%, and CD4 access decreased from 31% to 22%. The recovery of some of these services was slow and the resultant effect on health and outcome indicators cannot be under-rated. The findings confirm the moderate to severe disruptions of HIV services by the mitigation measures for the COVID 19 pandemic in Uganda and exposed the lack of disaster preparedness in the country, which needs to be remedied with the development of a Disaster Management Plan for HIV and AIDS.

Monitoring and Evaluation

During the reporting period, UAC developed the national HIV and AIDS Research Agenda 2020-2025, disseminated the NSP M&E Plan and supported MDAs to develop their own M&E frameworks. Other studies include the Legal Policy Environment Assessment and LQAS studies in the Lango Acholi, West, East Central and Karamoja Regions. Preliminary results for UPHIA 2020 were also discussed at a stakeholder meeting and the Epi-data estimates for 2021/22 disseminated.

The key challenges and recommendations for the year are captured below:

Prevention

Challenges*:*

- Only 44 out of the 62 high incidence priority districts have been covered with comprehensive AGYW interventions and further, coverage of AGYW is not yet at 100% nor has a package of services for non-high incidence districts been determined.
- Weak M&E system for AGYW interventions with inadequate referral tracking in the AGYW programme.
- There has been a waning of HIV prevention SBCC interventions; and “Time Up” campaign did not cover all districts.
- The M&E system for the condom programme is weak with limited data, management and use of evidence for condom programme decision making.
- 11% of PLHIV do not know their status as per the Epi-data estimates, recency testing is only available in 64% of ART sites; Sub-optimal linkage to confirmation testing for HIVST is still low (67%).
- MTCT is increasing as evidenced by increase in positivity rate of HEI

Recommendations:

- Scale up of AGYW interventions to remaining 18 high incidence districts and strengthen referral monitoring of the AGYW programme.
- Scale up the "Time Up" campaign to all districts in the country; develop tailored messages for priority populations; develop a condom SBCC campaign to increase demand.
- Fast-track the HIV MOT study to inform better planning for KPs.
- Implement selected recommendations of the Legal Environment Assessment.
- Develop and establish a condom tracking system that will better inform quantification and planning for condom distribution.
- Revise the HTS optimisation plan to include new guidance from the new HTS policy June 2022
- Intensify mother-baby pair follow up through peer support groups.

Care & Treatment

Challenges*:*

- ART coverage among children and adolescents continues to be a challenge.
- TB treatment has not yet been integrated into the DSD models.
- There is limited facility coverage of YAPS with a few high-volume facilities implementing the intervention in the supported districts.

Recommendations:

1. Review of DSD guidelines together with the Consolidated Guidelines for Prevention and Treatment of HIV and TB in Uganda as per the WHO guidance for patient-centred care, to allow clients to choose their preferred approaches for care.
2. Scale up the YAPS program to the remaining 34 districts.
3. Roll out guidelines for NCD integration into HIV care to more facilities

Social Support & Protection

Challenges*:*

- Stigma and discrimination against PLHIV persist in the community especially for KPs.
- Gap between number of GBV/VAC events and perpetuators followed up for meting justice is wide.

Recommendations*:*

1. Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels.
2. Scale up comprehensive AGYW socioeconomic intervention to remaining 18 high incidence districts.
3. Conduct a bottleneck analysis on the GBV/VAC cascade from event to conviction of perpetuators.
4. Invest in media relations to create favourable conditions for increased strategic reporting on HIV related cases.

Systems Strengthening

Challenges*:*

- Inadequate resources to effect new service delivery models that factor in epidemic control measures.
- Inadequate HIV and AIDS mainstreaming across MDAs and LGs.
- Disruptions in supply chain management for ART due to overall health system challenges during the epidemic.
- Lack of a disaster management plan to counteract disruptions in HIV and AIDS service delivery

Recommendations*:*

1. Complete district HIV/AIDS strategic plans
2. Fast-track implementation of the Resource Mobilization Strategy.
3. Fast-track and complete the roll out of HIV and AIDS mainstreaming across MDAs and LGs.
4. Roll out the Resource tracking Tool
5. Develop a HIV and AIDS Disaster Management Plan for the response, which can be activated when required.

Monitoring & Evaluation

Challenges:

- Lack of data for behavioural indicators
- Inadequate coordination of ongoing HIV related research studies.

Recommendations:

1. Determine behavioural indicators for routine monitoring.

2. Strengthen coordination of HIV and AIDS research efforts that are passed by different IRBs, to ensure use in improving programming and more efficient use of resources.

1.0 INTRODUCTION

1.1 BACKGROUND AND RATIONALE

The National HIV and AIDS Strategic Plan (NSP) 2020/21-2024/25 is now in its second year of implementation. To fulfil its mandate of strategic information management and reporting both nationally and internationally, UAC in collaboration with stakeholders conducts Joint Annual AIDS Reviews (JARs) to track the progress of implementation of the NSP.

The 2022 JAR marks the 7th year of reporting on the Sustainable Development Goals (SDG), in particular, SDG 3: *Good health and well-being: Ensure healthy lives and promote well-being for all at all ages;* and its target to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030, and SDG 5: *Gender equality: Achieve gender equality and empower all women and girls.* This JAR will also mark the fifth year of implementation of the (Uganda) Presidential Fast Track Initiative to end AIDS by 2030 (PFTI).

In accordance with UN General Assembly Resolution 75/260, a high-level meeting of member countries convened from June 8-10, 2021 to renew their commitment to ending AIDS by 2030. The meeting undertook a comprehensive review of the progress on the commitments made in the 2016 Political Declaration toward ending the AIDS epidemic by 2030, and how the response, in its social, economic, and political dimensions, continues to contribute to progress on the 2030 Agenda for Sustainable Development and the global health goal. The meeting passed the 2021-2026 Global AIDS Strategy, with renewed commitment and engagement of leaders, countries, communities, and partners to accelerate and implement a comprehensive universal and integrated response to HIV/AIDS and accelerate actions to end the AIDS epidemic by 2030.

Uganda has made great progress in combating the HIV and AIDS epidemic and its effects with a significant reduction in new infections, HIV prevalence, and AIDS-related mortality over the past 10 years. By end of 2020, Uganda had an estimated 1.4 million PLHIV, AIDS-related deaths had declined by 67% from 51,000 in 2010 to 17,000 in 2020 and new HIV infections had declined by 60% from 88,000 to 54,000 in 2021 The progress was however affected by the COVID-19 pandemic which threatened to negate the gains made in the national response. During the pandemic, for example, HIV testing was reduced by 41% and referrals for diagnosis by 37% (MoH, 2021). As we end the first year of the global AIDS strategy 2021-2026, Uganda's HIV epidemic remains generalized, and heterogeneous across geographical, socio-economic, and demographic population subgroups, and calls for review and reorganization of the response to achieve the NSP targets.

This JAR report, therefore, reflects on the NSP implementation successes and challenges with a view of strengthening the response and achieving both national and global targets.

1.2 GOAL AND OBJECTIVES

Goal:

To review the NSP implementation progress for the period July 2021 to June 2022, and agree on key undertakings for 2023.

Specific Objectives:

- To review performance during the second year of the NSP 2020/21 – 2024/25.
- Review and disseminate progress on implementation of undertakings of the Aide Memoire, 2021.
- To review and provide highlights on the progress of the Presidential Fast Track Initiative (PFTI).
- To review the impact of COVID-19 on the National HIV response.
- Agree on undertakings for implementation in FY 2022/23.

1.3 METHODOLOGY

A multi-sectoral team was constituted based on the different NSP thematic areas and mandated to write the different sections under specific Terms of Reference. Each team had membership from UAC, who ensured data collection and timely completion of the respective thematic reports.

Self-Coordinating Entities (SCE) including Ministries Departments and Agencies (MDAs) were supported to compile their respective reports with emphasis on the JAR 2021 undertakings. A facilitator was engaged Put together the different sections and ensure coherence.

Document Review: Several documents were reviewed by the TWGs, facilitator, and stakeholders. These included policies, plans, and program reports related to HIV and AIDS programming in the country and globally.

Secondary data analysis: Data from different databases across various MDAs including the Ministry of Health (MoH)'s Health Management Information System (HMIS), PEPFAR's Data for Accountability and Transparency Information (DATIM) and HIBRID, and dashboards for gender-based violence (GBV), COVID-19, early infant diagnosis (EID), and HIV Viral Load.

Key Informant interviews and stakeholder consultations: TWGs held interviews at national and subnational levels, with personnel from government MDAs, AIDS Development Partners (ADPs,) civil society organizations (CSOs), HIV and AIDS focal persons from selected districts, and implementing partners (IPs) such as Infectious Diseases Institutes (IDI), Baylor College of Medicine, and beneficiaries of services including PLHIV, youth, key and priority populations.

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

1.4 HIV AND AIDS SITUATION ANALYSIS

Box 1: Key Data on HIV and AIDS Epidemic in Uganda

Prevalence among adults (15-49 years)	5.2%
HIV Incidence (adults)	0.24%
HIV Incidence (adolescent girls)	0.35%
New HIV infections (all ages)	54,000
New infection 0-14 years	6,000
New infections women 15+	31,000
PLHIV	1,400,000
PLHIV 0-14 years	88,000
PLHIV 15-24 years	170,000
AIDS related deaths	17,000

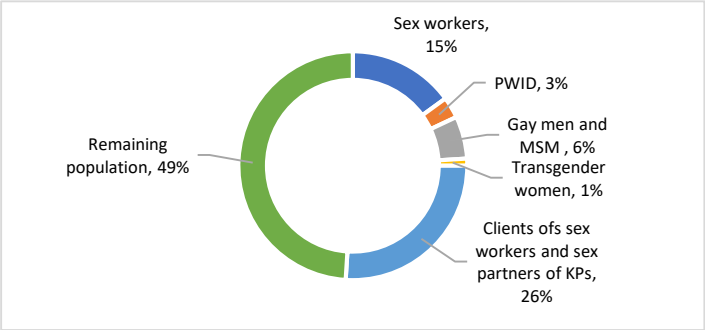
Source: Epi-data (SPECTRUM) country estimates, 2021

The HIV burden has been on a gradual decline since the 1990s, when it was estimated at 18%, to 5.5% in 2020 (UPHIA 2020); and according to the Uganda 2022 HIV Epi-data estimates, this has reduced further to 5.2% among the adult population 15-49 years (MoH, 2022). Both new HIV infections and AIDS-related deaths declined during the decade (2010-2021), but the magnitude of new HIV infections is still very high. Ugandan epi-data estimates for 2022 show that although new HIV infections have declined by 39% since 2010, 54,000 new infections were registered in 2021. AIDS-related deaths were estimated at 17,000 in 2021 (down 67% from 51,000 in 2010).

Despite these gains, the fight to end AIDS is far from over considering the eight years left to achieve the 2030 goal of ending AIDS as a public health threat. Across the globe, in the Sub-Saharan Africa Region and Uganda, there are key and priority populations that continue to record high incidences of HIV and high AIDS-related deaths. According to studies, the epidemic remains concentrated among the KPs with FSW at 31%, people who inject drugs (PWID) between 11% and 34% and MSMs at 12%[1].

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

Figure 1: Population groups that drive the HIV epidemic across Sub-Saharan Africa

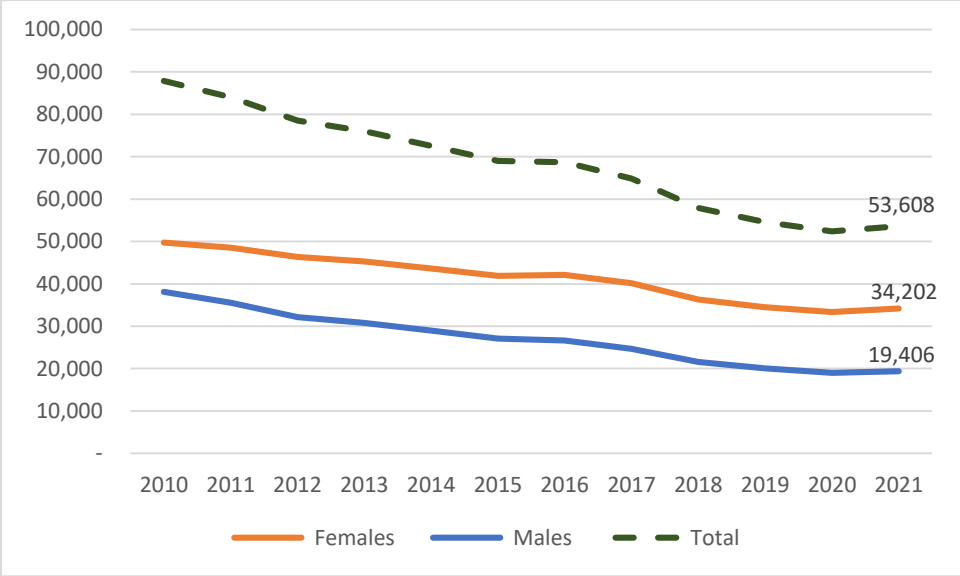


Source: UNAIDS, special analysis 2022

An analysis of new HIV infections in the Sub-Sahara Africa region shows that about half (49%) occur within the general population, close to a third (26%) occur among clients of sex workers and sex partners of the key population, and 15% among sex workers (Figure 1). This pattern is similar to that of Uganda where studies have shown high HIV prevalence among sex workers (up to 37%) and men who have sex with men (13.7%).[2]

Overall, Uganda continues to observe a decreasing trend in new infections (Figure 2). Close to two-thirds (65%) of new HIV infections among adults in 2021 were among women compared to their male counterparts (35%). Further, young people (10-24 years) are more vulnerable to HIV infection with 43% of the cases occurring in this age group. Among young people, adolescent girls and young women are even more vulnerable to HIV infection; four in five (79%) of new HIV infections in young people occur in adolescent girls and young women aged 10-24 years. New infections still occur among children despite the science and tools at hand for preventing mother-to-child transmission (PMTCT) of HIV. Uganda is undertaking a Modes of Transmission Study to establish exactly where new infections occur to inform the prioritization of the prevention response.

Figure 2: Trends in new HIV infections 2010-2021, by sex



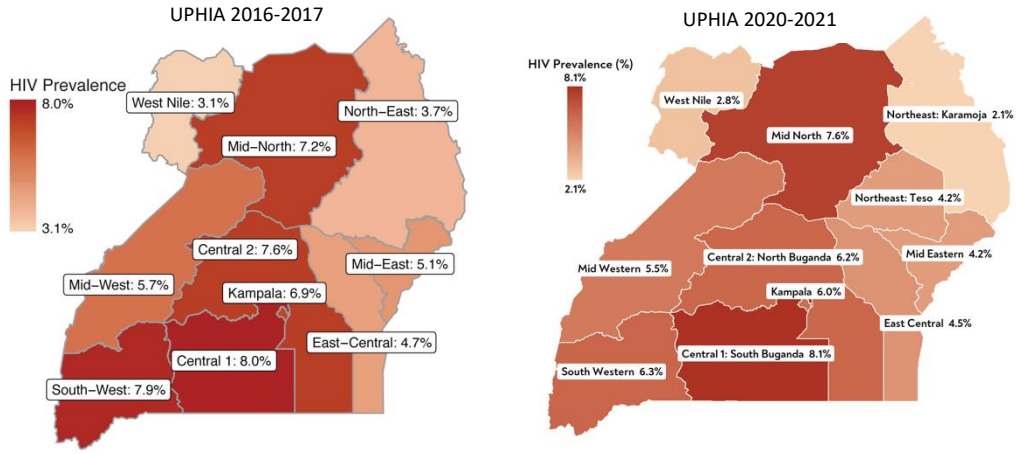
Source: Uganda Epi-data country estimates, 2021

[2] Uganda AIDS Commission (2020). National HIV and AIDS Strategic Plan: Ending HIV and AIDS: Communities at the Forefront.

According to the Epi-data estimates, at regional level Kampala, South Central, Acholi, Lango, North Central and Ankole have the highest incidence per 1,000 population of HIV, while Karamoja, West Nile, Bugisu, Bukedi and Busoga have the least. Thirty-one (31) out of 146 districts contributed 60% of new HIV infections with Wakiso, Kampala, Lira, Mukono, Buikwe, Kabarole, Mbarara, Kyenjonjo, Gulu, Luwero, Mubende, Masaka, Tororo, Kyotera, Jinja and Mbale registering the highest numbers. UPHIA 2020 data also reflects the regional variations of HIV prevalence although the order of the highest incidence is different (Figure 3)

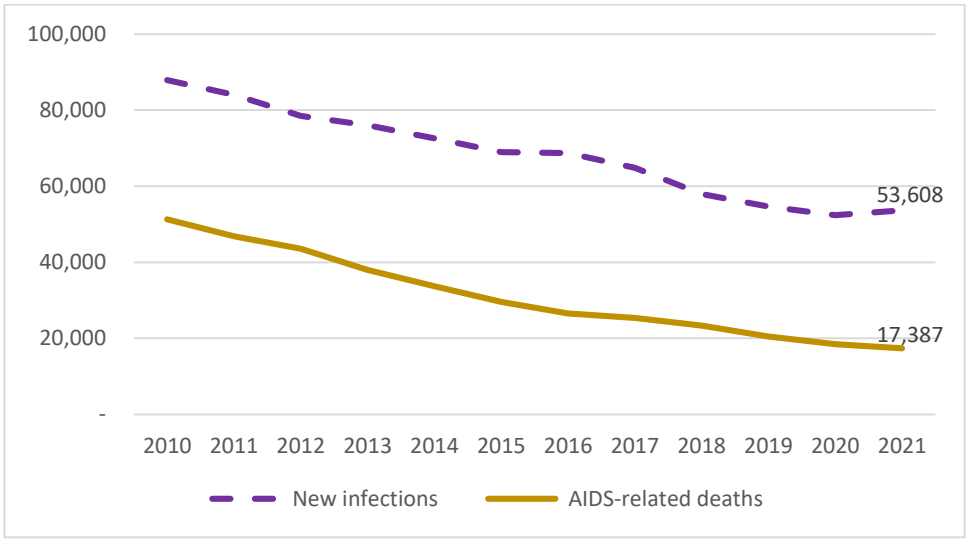
Whereas all regions show improvements, in HIV prevalence, the Mid North and Central South show a worsening, from 7.2% to 7.6% (Mid North) and from 8.0% to 8.1% (Central South).

Figure 3: Regional HIV prevalence, 2016/17 and 2020/21



In Uganda, AIDS related deaths have declined by 67% between 2010 and 2021 with the SPECTRUM modelled data estimating about 17,000 deaths in FY 2021/22 (Figure 4). Overall, about 400,000 AIDS-related deaths have been averted by the successful ART program in the country since 2016. However, c Compared to the AIDS-related death, new infections are still high, signifying the country is still far from epidemic control.

Figure 4: Trends in new infections and AIDS-related deaths, 2010-2021

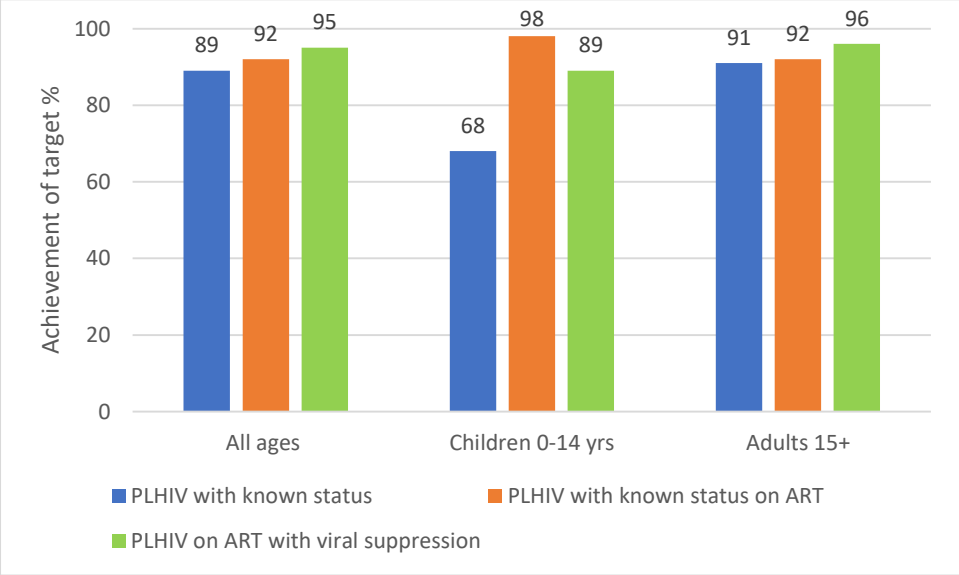


Source: Uganda Epi-data country estimates, 2021

1.5 PERFORMANCE AGAINST GLOBAL TARGETS

According to the Epi-data (SPECTRUM) country estimates, 89% of the estimated 1.4 million PLHIV in the country knew their HIV status in FY 2021/22, 92% were on ART and 95 % have viral suppression—an achievement of 89-92-95 against the UNAIDS 95-95-95 targets by 2025 (Figure 5). This indicates a decline from 94:98:91 in the previous year. There is a decline in the first and second targets, which is attributed to disruption in service delivery during the lockdown period at the peak of the COVID-19 pandemic. The COVID-19 shock shows that the gains in the epidemic response remain fragile and must be protected. With the implementation of innovative HIV testing approaches such as index testing, recency testing and APN, to find HIV-infected persons, there is hope that the first target will be attained or even surpassed. Achievements against the first target are particularly poor for children below 14 years (68%) and among men (88%) with the identification of infected children (first target) being the biggest program bottleneck. Achievement of the third target is also weak for children, possibly due to poor treatment retention and adherence as well as the higher prevalence of HIV drug resistance in children compared to adults. Overall however, the country is still on course to attain the 95-95-95 targets by 2025. ART coverage in pregnant women has reached 95% but Uganda still registered 6,000 cases of vertical transmission, despite the tools available and science. The reasons for this stagnation need focused attention.

Figure 5: Clinical cascade achievements against 95-95-95 targets



Source: Uganda Epi-data country estimates, 2021

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

The NSP 202 0/21-2024/25 provides overall strategic direction for the national response under four thematic areas namely: i) HIV Prevention; ii) Care and Treatment; iii) Social Support and Protection, and iv) Systems Strengthening, monitoring and evaluation (M&E) and research. The cross-cutting issues of gender and human rights are integrated across all of the thematic areas. The achievements under each thematic area are discussed in the subsequent sections.

2.1 HIV PREVENTION PROGRAMME

2.1.1 NSP Aspirations for HIV Prevention

Box 2: HIV Prevention Achievements against NSP Targets

Indicator	Baseline	NSP Target	FY 2021/22 Achievement	Gap
HIV Incidence (15-49 years)	0.3%	0.20%	0.24%	(0.04%)
New infections among youth & adults (15+ years)	46,000	18,200	48,000	(29,800)

Source: Uganda Country Epi-data estimates, 2021

The goal of the HIV prevention thematic area of the National HIV and AIDS Strategic Plan (NSP) is to reduce the number of new youth and adult HIV infections by 65% and the number of new paediatric HIV infections by 95% by 2025. According to Epi-data estimates for FY 2021/22, although the HIV incidence is on the decline, the number of new infections increased slightly in FY 2021/22, mainly due to an increase in adolescent/young people infections (Box 2). Annex II provides an update of achievements against NSP Prevention indicators.

To achieve the set targets, the NSP 2020/21-2024/25 prioritizes implementation of behavioural, biomedical and structural HIV prevention interventions to respond to the multiple determinants of HIV infection. Further, the NSP re-emphasizes implementation of primary HIV prevention interventions that target HIV negative persons, in addition to re-invigorating decentralised HIV prevention programming.

The HIV prevention targets in the NSP were aligned to the Uganda HIV Prevention Road Map (2018-2030) and they draw on the aspirational targets for ending the epidemic by 2030 as outlined in the revised Uganda HIV Investment Case (2020-2030). As part of the PFTI, key HIV prevention focus areas include; accelerating steps to decrease the spread of new HIV infections, particularly among adolescent girls and young women (AGYW); consolidating progress on elimination of Mother-To-Child Transmission of HIV (eMTCT) by expanding coverage and uptake of services along the four eMTCT prongs (emphasizing the triple elimination of HIV, syphilis and hepatitis; closing emerging gaps in the uptake of ART uptake, retention and adherence; monitoring mother–baby pairs; and increasing testing and care of HIV-exposed infants); and accelerating implementation of the first 95 target by ensuring that 95% of all PLHIV are diagnosed.

This section of the annual report shares progress and achievements of the HIV Prevention thematic area at the end of the second year of the NSP. The key interventions in this thematic area fall under three main strategic objectives:

1. Increase adoption of safer sexual behaviours and reduction in risky behaviours among key populations (KPs), priority population (PP) groups and the general population.

2. Expand coverage and uptake of quality biomedical priority HIV interventions to optimal levels.
3. Address underlying sociocultural, gender and other structural factors that drive the HIV epidemic.

Box 3: Key HIV Prevention Interventions 2021/22

- Developed the National HIV and AIDS Communications Strategy
- Launched and rolled out the "Time Up HIV" campaign, reachig more than 17 million people with key messages on HIV prevention and control
- Launched the National HIV and AIDS Action Plan for the Faith Sector in Uganda 2021/22-2024/25
- Resumed school-based HIV prevention activites when schools were re-opened to learners after a two year COVID-19 lockdown
- The Hon. Minister of Education and Sports launched the Education Plus Initiative
- Reached 20,000 learners with education subsidies to keep them in schools
- Long acting PrEP options, Dapivirine Vaginal Ring (DVR) and Long Acting Injectable Cabotegravir (CABLA), were approved as prevention options

2.1.2 Increase Adoption of Safer Sexual Behaviours and Reduction in Risky Behaviours

The National HIV and AIDS Communications Strategy. During the reporting period, a National HIV and AIDS Communication Strategy was developed and launched. It articulates the HIV and AIDS communication priorities for the period 2020/21-2024/25, and streamlines coordination of HIV and AIDS communication efforts among stakeholders. Under this strategy, various SBCC interventions were implemented at national, regional and local levels.

The "Time up HIV" campaign. One such intervention was the launch and roll out of the "Time Up HIV" campaign, which is an integrated social and behaviour change (SBC) campaign supporting the country's effort to avert new HIV infections and increase the proportion of PLHIV adhering to HIV treatment guidelines to prevent HIV/AIDS-related deaths.

L-R: Dr. Daniel Byamukama of Uganda AIDS Commission (UAC), leaders of the Inter-Religious Council of Uganda (IRCU) and Dr. Joshua Musinguzi of AIDS Control Programme during the breakfast meeting with religious leaders at Serena Hotel Kampala on 4th March, 2022.

The campaign promotes the uptake of key HIV prevention and control services, including HIV Testing Services (HTS), Safe Male Circumcision (SMC), Pre-Exposure Prophylaxis (PrEP), HIV prevention among Adolescent Girls and Young Women (AGYW), Prevention of Gender Based Violence (GBV), elimination of Mother to Child Transmission (eMTCT), HIV Care and Treatment and Cervical Cancer screening. The campaign also addresses other crosscutting issues like drugs and alcohol abuse, stigma and discrimination, and management of co-morbidities.

As part of the campaign roll out, the MoH oriented and commissioned implementing partners (IPs) and CSOs to implement the campaign in their catchment areas/regions. They are estimated to have reached more than 17 million persons with HIV/AIDS messages on the different mass media platforms, including print, television and radio. The messages continue to be disseminated on buses, community halls, health facilities, supermarkets and in public arenas. To ensure privacy and personalised responses, the campaign leverages digital media including social media pages (Obulamu), Hotline (0800-211-046), SMS short code (8080), artificial intelligence chatbots, and apps to supplement traditional media on HIV prevention—over 83,735 contacts (males 68%) have been exposed to HIV prevention content through the hotline and SMS platforms alone.

HIV Prevention among Adolescent Girls and Young Women (AGYW)

The NSP prioritizes adolescent girls and young women (AGYW) for the HIV prevention response because of their exceptional vulnerability and high HIV burden. Preliminary results from UPHIA 2020/21 show that AGYW (15-24 years) had the highest HIV incidence rate at 0.62% compared to all other age groups—0.0% for young men of the same age and 0.29% for adults 15+ years (UPHIA 2020). To guide the response to addressing AGYW, the AGYW HIV Prevention Strategy, implementation guidelines and monitoring and evaluation framework, define age-specific prevention packages to be provided using a multisectoral approach. The different programs such as Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) and Young Adolescent Peer Support (YAPS) focus on empowering adolescent girls and young women economically, promoting safer sexual behaviours, keeping girls in school, and providing psycho-social support when needed.

The AGYW HIV Prevention response in the country is led by the central and local governments and supported by development partners, implementing partners, CSOs, and private partners. They include biomedical, structural and behavioural HIV prevention interventions at health facility, school and community settings. At the health facility, interventions include youth friendly services, HIV/STI risk assessment, HIV risk reduction counselling and testing, active provider-initiated condom distribution and promotion, PrEP and PEP, and other sexual and reproductive health (SRH) services. At the school level, interventions include comprehensive sexuality education, training for menstrual hygiene management, ending GBV, providing sanitary pads for needy AGYW, cash transfers and other school subsidies, and strengthened access to comprehensive HIV information and life skills. Community interventions aim to improve access to existing social protection and social assistance programs, improve nutrition and household food safety, strengthen parenting/caregiving skills, change cultural norms, prevent violence, strengthen access to comprehensive HIV information and life skills, and introduce structured interpersonal communication skills (using methodologies as Stepping Stones and SASA!).

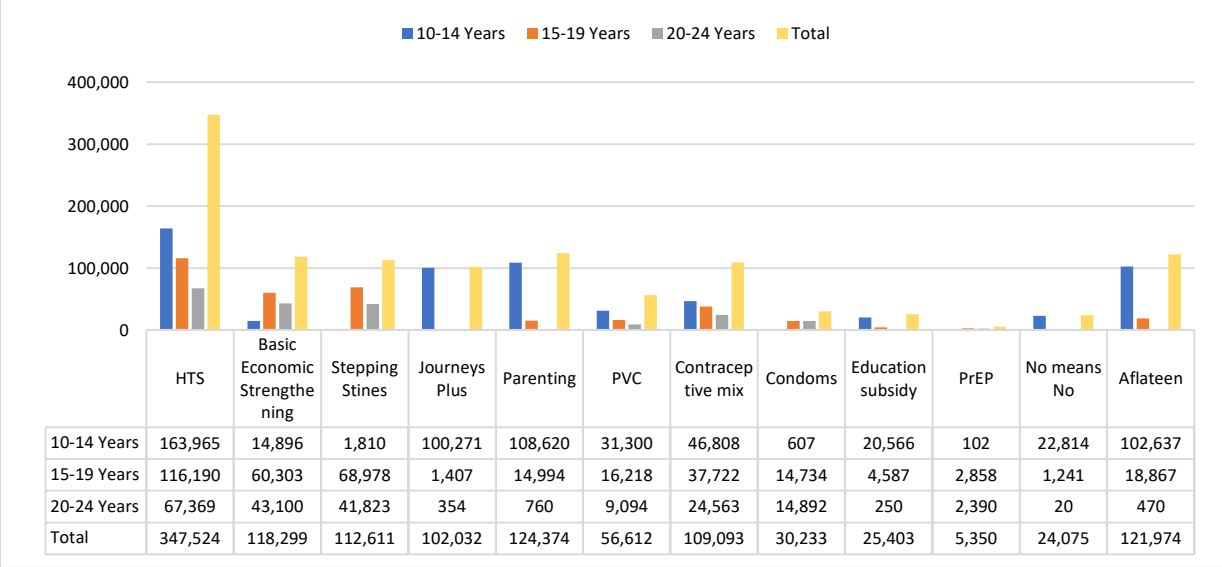
Details of some of these initiatives addressing AGYW needs are described below.

YAPS initiative. The YAPS program is a differentiated, multi-sectoral and multi-level intervention that addresses the three global 95-95-95 targets. HIV prevention activities under the YAPS package include HTS, linkage to treatment, distribution of self-test kits, and support to Index Client testing as well as peer counselling, tracking missed appointments, screening for vulnerabilities and referral to wrap-around services for children and adolescents. During the year, an additional 442 YAPS were trained and attached, bringing the total number of YAPS to 1,156. They provided health education to 570,689 adolescent and young people (AYPs); screened 394,543, for HTS; identified 254,222 eligible for testing. Of those identified, 226,360 received the HIV test and 8,087 AYPs tested positive (3.6% yield) and 91% of the positives were linked to care.

DREAMS. Based on modelling data from Spectrum, 62 districts with a high HIV incidence (0.4% or more) among AGYW were identified and prioritized for targeted AGYW interventions, adapted from the USAID-funded *Determined, Resilient, Empowered, AIDS-free, Mentored and Safe* (DREAMS) initiative. Under this initiative, AGYWs receive a primary package of interventions consisting of HTS, Basic Economic Strengthening (including financial literacy), 'Stepping Stones' (SBCC methodology),

'Journeys Plus', life skills. During the reporting period, only 44 (71%) of the 62 districts received comprehensive package of interventions for AGYW. There has been an increase in the number of AGYW being reached out from 171,445 in 2020/21 to 347,525 in 2021/22, however, compared to the population of AGYW in the country (approximately 7.5 million), the efforts are still very inadequate. There was also an increment among young girls who completed a full primary package plus relevant secondary service from 80% in 2020/21 to 90% in 2021/22. Figure 6 depicts the target groups for the different interventions, while Figure 7 shows the districts with DREAMS interventions.

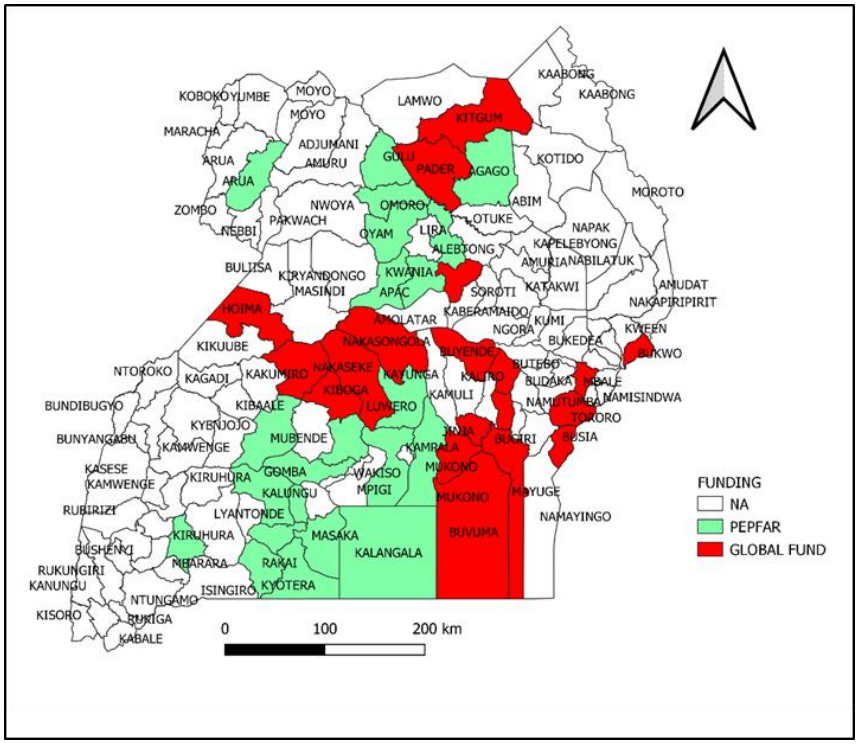
Figure 6: AGYW served under DREAMS Programme



	HTS	Basic Economic Strengthening	Stepping Stines	Journeys Plus	Parenting	PVC	Contraceptive mix	Condoms	Education subsidy	PrEP	No means No	Aflateen
10-14 Years	163,965	14,896	1,810	100,271	108,620	31,300	46,808	607	20,566	102	22,814	102,637
15-19 Years	116,190	60,303	68,978	1,407	14,994	16,218	37,722	14,734	4,587	2,858	1,241	18,867
20-24 Years	67,369	43,100	41,823	354	760	9,094	24,563	14,892	250	2,390	20	470
Total	347,524	118,299	112,611	102,032	124,374	56,612	109,093	30,233	25,403	5,350	24,075	121,974

Source: DREAMS Program data, 2022

Figure 7: Districts with DREAMS interventions



Keeping Girls in School

The primary school dropout rate in 2020 was estimated at 38.5% and it is worse for girls,[3] and the COVID-19 lockdown restriction worsened the situation. Keeping girls in school indirectly prevents HIV infection as they get more empowered to make better choices for their lives, therefore the school platform is also one of the powerful ones for disseminating health and HIV prevention messages. During the year, the MoES also revised the HIV/AIDS Workplace Policy and developed an HIV information pack to support capacity building of teachers and leaners living with HIV and AIDS. A total of 100 teachers living with HIV and AIDS under the Teacher Anti-AIDS Group (TAAG) were trained as trainers on standardised information to enhance understanding and positive living in schools, increase uptake of HIV and AIDS prevention, care and treatment related service, strengthen referrals, linkages and partnerships for comprehensive HIV prevention, support and treatment services. They were also oriented as champions for workplace programs that target the wellbeing of learners and educators living with HIV and AIDS. The training covered 20 districts including Mayuge, Namayingo, Mbale, Butaleja, Busia, Kibuku, Jinja, Iganga, Namutumba, Kaliro, Luuka, Nwoya, Gulu, Kitgum, Amuru, Omoro, Lamwo and Pader. The TAAG members will cascade this to fellow teachers as well as learners living with HIV and thus contribute to reducing HIV related stigma and discrimination in schools.

Further, the Hon. Minister of Education and Sports launched the Education Plus Initiative, which is a high-profile, high-level political advocacy drive to accelerate actions and investments towards making AGYW and boys as agents of change to prevent HIV, reduce teenage pregnancy, early marriages and gender-based violence. The entry point for the program is ensuring access to secondary school education. Many stakeholders participated in the launch of this initiative by the Hon. Minister of Education and Sports at Mengo, including officials from MoES, Ministry of Gender, Labour and Social Development (MoGLSD) Ministry of Health (MoH), UNAIDS, UNICEF, UNFPA, UNESCO, UN WOMEN, UAC, and religious leaders, parents, teachers and a number of adolescents and young people.

Hon Minister of Education and Sports, launching the Education Plus

The MoES jointly with the National Curriculum Development Centre (NCDC) trained 962 teachers on the New Lower Secondary Curriculum which integrates Sexuality Education (SE), in line with the National Sexuality Education Framework which was launched by the Hon. Minister Ministry of Education and Sports. The trainee teachers were selected from the Acholi, South Western, Eastern and West Nile districts of Amuru, Nwoya, Pader, Agago, Kitgum, Lamwo Arua, Amudat, Kasese, Kitgum, Kyegegwa and Tororo. During the training, the teachers generated action plans to cascade the knowledge and skills to their schools. Since the programme has just begun, there is need to establish a system to monitor and evaluate its progress and impact closely in order to adjust the intervention if necessary.

[3] National Planning Authority, 2020. Third national Development Plan (NDPIII) 2020/21 – 2024/25.

One key intervention targeted at keeping the most vulnerable adolescent girls in school is the provision of the education subsidies. During the report period the MoES through the district education offices and other local government structures, distributed subsidies for primary and secondary schools targeting 20,000 most vulnerable adolescent girls in the 20 districts of Nakaseke, Nakasongola, Kiboga, Hoima, Buliisa, Kyankwanzi, Tororo, Mbale, Bukwo, Dokolo, Kitgum, Pader, Mayuge, Buikwe, Jinja, Iganga, Buyende, Kaliro, Buvuma and Busia—this translates to approximately 1,000 students between the ages of 10-19 in each district.

Effect of COVID-19 on AGYW. The COVID-19 pandemic and government's containment measures during the peak period between 2020 and 2021 affected AGYW in several ways. Due to closure of schools and the major economic and social crisis caused by the pandemic, AGYW had increased their vulnerability to various forms of violence, early marriages and unwanted pregnancy. This resulted in many of them resuming the traditional roles of providing homecare and at the time of reopening of schools, many AGYW remained stuck in these realities and faced challenges with re-engaging with school. It is estimated that teenage pregnancies increased by 17% between March 2020 and June 20214 and the National Planning Authority (NPA) projections indicate that 30 percent of learners (about 4.5 million) were unlikely to get back to school due to teenage pregnancies, early marriages or child labour at the time of schools re-opening. To overcome some of these challenges the Ministry of Education and Sports (MoES) issued Revised Guidelines for the Prevention and Management of Teenage Pregnancy in Schools, which among other things, directs all schools to prioritize the admission of pregnant and breastfeeding girls. The guidelines also guide on how to tackle stigma, discrimination, and violence against learners who are pregnant or are parents.

Despite all these gains, the coverage of AGYW interventions remains far below what is required to reverse the increasing trend in new infections among the estimated population of 7.5 million AGYW. There is therefore need to fast-track the scale up of these interventions to all districts of the country for a bigger and quicker impact on HIV prevention

Other Social Behaviour Change Communication (SBCC) Interventions

In November 2021, the UAC held a Scientific Conference under the theme. *"HIV and COVID-19: Reflecting on our Vulnerabilities and Resilience"*. The conference was a platform for several SBCC activities including the dissemination of the JAR 202/21 report and the Philly Lutaaya memorial lecture that was delivered by the King of Tooro, who also launched the Zero-MTCT for his kingdom.

The annual Candlelight Memorial Day, which is a platform for increasing awareness about HIV and AIDS issues as well as mobilize communities to respond to the epidemic, took place on May 2022. More than 10 million people were reached with HIV and COVID-19 messages through various activities by stakeholders during the memorial.

During the report period, UAC also ran spot messages on HIV prevention, HIV testing, treatment, stigma and discrimination including specific messages for young people and men by the President. The messages were aired on 12 stations and one TV station and reached a total of 21,706,464 people through adverts, mentions, and talk shows on radio and TV.

Challenges

- Only 44 out of the 62 high incidence priority districts have been covered with comprehensive AGYW interventions and further, a package of services for non-high incidence districts has not yet been determined.
- Inadequate referral tracking in the AGYW programme.
- There has been a waning of HIV prevention SBCC interventions and Inadequate focus of campaigns on vulnerable groups e.g. PWD.

[4] https://www.unicef.org/uganda/media/13811/file/UNICEF%20Uganda%202021%20Annual%20Report.pdf

- "Time Up HIV" campaign did not cover all districts and there was HIV and AIDS messaging gets overshadowed by emerging epidemics.
- Unmet demand for cancer screening and other services as evidenced during the "Time-Up" campaign.

Recommendations

1. Scale up AGYW interventions to remaining high incidence districts and strengthen referral monitoring of the AGYW programme and conduct a country wide survey to determine the impact of AGYW programming high teenage pregnancy on should be carried out.
2. Scale up the "Time Up HIV" campaign to all districts. This requires adoption of the campaign into planned and ongoing activities of implementing partners in their regions and districts.
3. Develop and disseminate tailored messages for PP such as PWD.
4. Integrate HIV messaging into other disease campaigns as a component of continuation of essential health services.
5. Strengthen health worker skills and logistic supplies for cancer screening in health facilities to ensure availability of these services when integrated with other disease programmes.
6. Use local radio stations, which appeal to local communities to increase the reach of the radio messages.

Comprehensive Condom Programming

Condom programming in Uganda is guided by National Comprehensive Condom Programming Strategy and Implementation Plan 2020-2025. The strategy seeks to achieve triple protection against HIV, STIs and unintended pregnancies through four major objectives; a) establish functional capacity for condom program management, b) increase condom use at last high-risk sex, c) increase condoms access through commercial sector and d) increase domestic funding to condom programming to 30% of resource needs by 2025.

Strengthening functional capacity for condom program management. Following an inception assessment of major gaps in condom programming, and a prioritisation process, Uganda with support from GFATM through UNAIDS and UNFPA launched a 3-year strategic initiative on condom stewardship which aims to catalyse improvements in the quality of condom programmes by making them more differentiated, equitable, people-centred and data driven. Funds were mobilised to support distribution of condoms and demand creation, and facilitated an enabling environment for commercial players. To facilitate this mode of distribution, condom distribution guidelines were finalised, with a strong emphasis on accountability for condoms. MoH conducted biannual support supervision and capacity building to districts for condom programming and as a result, 43 districts developed and followed up action plans to improve condom coordination and programming. The MoH in collaboration with partners, also supported the training of 154 trainers for female condoms (FC2) service providers in six regions including Kampala. Family Health International (FHI-360) supported this training with female condom demonstration tools.

During the implementation period, the MoH revised the Condom Distribution Guidelines and Joint Medical Store (JMS) with support from USAID and UNFPA, implemented "The Last Mile Distribution Initiative." Through this initiative, nation-wide geo-mapping (using GIS) of community hotspots revealed that only 3,499 (28.7%) hotspots had condom dispensers. Over 1,138 dispensers were distributed to the identified hotspots and direct distribution of the condoms to the hotspots was carried out to complement the traditional outlets at public health facilities. The mapping also enabled geo-spatial tracking of distributed stock, and ensured continued availability of stocks at community level. During the first phase of the initiative (July-December 2021, a total of 26.37 million male condoms were distributed to the 14,175 hot spots in 90% of the districts, mainly in Kampala City and Wakiso District. This resulted in a 30% increase the number of male condoms distributed in the first six months (July to December 2021).

Increase condoms access through commercial sector. For the reporting period FY 2021/2022, a total of 192,077,257 male condoms were distributed compared to 181,574,979 in the previous year (Figure 8). This is against the universal quantified need of 282,887,601 for those who need condoms for HIV

and other STI preventions as well as pregnancy prevention. Out of the 192,077,257 condoms distributed, 73.8% were distributed through public channels (free of charge) while 17.2% was through commercial sector. Of the commercially distributed condoms, 38,600,902 were distributed through socially marketed brands (Table 1). The quantified need for female condoms was estimated to be 1,437,481 pieces, but only 4,680 (0.3%) pieces of free female condoms were distributed through the alternate distribution system (ADS), by implementing partners, during the reporting period. This is largely due to the 2-year stock out of female condoms resulting from a fire outbreak at JMS warehouse, but also the inadequate demand creation as well as bottlenecks in distribution arrangements by CSOs.

Figure 8: Estimated condom needs and pieces distributed

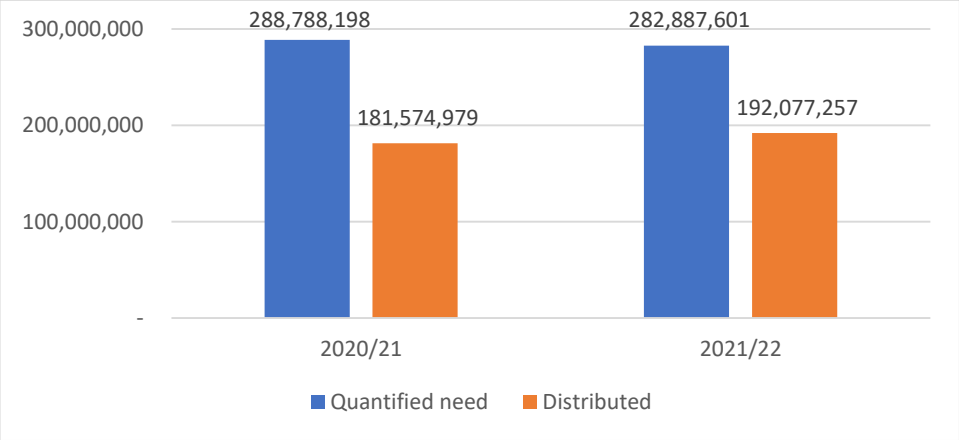


Table 1: Branded condoms distributed by the private sector through social marketing programs

Condom sales data from social marketing programs in Uganda (July 2021 to June 2022)		
Organisation	**Condom Brands**	**Sales**
PSI	Trust Condoms	2,576,520
MSI	Life Guard Condoms (Classic and Chocolate)	6,262,760
UHMG	O condom	1,460,448
AHF (Uganda Cares)	Love Condom, ICON Gold	3,510,780
DKT	Kiss Condoms	7,690,464
PACE - PSI	Free Condoms	17,099,930
Total		**38,600,902**

Increase condom use at last high-risk sex. Condom demand creation promotion and activities remained limited during the period mainly due to lack of funding with only traces of integration into family planning and small-scale campaigns by youth serving organisations. Coupled with the supply chain challenges, failure to meet quantified need is therefore two-pronged (both supply and demand-sided). The Uganda Network of Young People Living with HIV (UNYPA), with support from UNFPA, held a mini campaign to break condom social stigma. The campaign used multiple channels including peer to peer messaging through champions, virtual platforms, and mass media reaching 14,421,278 people with condom behavioural change messages. It is believed this messaging translated to the achievements for the year. Population-based condom use will be reported in the upcoming national demographic surveys and the final UPHIA report.

Challenges

- Meeting the demand for condoms is a two-pronged challenge; i) there is a lack of national condom demand creation/SBCC program and campaigns, yet there is a high level of social, cultural and political condom stigma amidst increasing new infections and high pregnancy rate especially for adolescents and young

people, and ii) funding for last mile condom delivery is inadequate, inconsistent and largely from external sources, leading to condom stock outs at user points.
- The M&E system for the condom programme is weak with limited data, management and use of evidence for condom programme decision making.
- Limited engagement of the private sector in condom distribution.

Recommendations

1. MoH and partners should avail invest in, and implement a condom SBCC//demand creation programme linked to condom distribution and with a strong monitoring component at national, district, health facility and community levels.
2. Cost the Condom Distribution Plan and develop an Implementation Plan for it.
3. Revise the in-country procurement and supply chain management costs to include last mile distribution for condoms and update the costs according to regularly mapped user points, in order to ensure availability and access to condoms at user points. Relatedly, all organisations procuring condoms should include last mile distribution costs during planning.
4. Develop and establish a condom tracking system that will better inform quantification and planning for condom distribution.

Prevention Programming for Key Populations (KP) and Priority Populations (PP)

The NSP identifies Key Populations and Priority Populations as key drivers of the epidemic and as such outlines strategies and interventions targeting KPs and PPs in the response. The NSP categorises these groups as key populations: men who have sex with men (MSM), sex workers and their clients, transgender people, people who inject drugs (PWID), and prisoners and other incarcerated people, while PPs include uniformed personnel, fisherfolk and long-distance truck drivers. The epidemic remains concentrated among the KPs with prevalence among female sex workers (FSW) at 31%, PWID between 11% and 34% and MSM at 12%[5]. During the report period, the Uganda AIDS Commission (UAC) in collaboration with the MoH and partners developed a National Key and Priority Populations Programming Framework (2021–2025) and Action Plan (2021–2023). The framework is meant to provide guidance to all stakeholders in the national HIV response to address gaps and enable rapid scale-up of sustainable key and priority populations programmes. Further, the Programme harmonized KP/PP data collection and reporting tools, and the storage of data into one data base—the KP Tracker.

With support from partners, USAID/Civil Society Strengthening activity (CSSA), the country conducted a national Legal-Policy Environment Assessment (LEA) and published a report which was launched by the acting Minister of Justice and Constitutional Affairs on May 27, 2022. The LEA articulates some of the prevailing policy challenges that sabotage the national KP programme. UAC and stakeholders are currently working with Ministry of Justice and Constitutional Affairs (MoJCA) to ensure the recommendations of the LEA are acted upon.

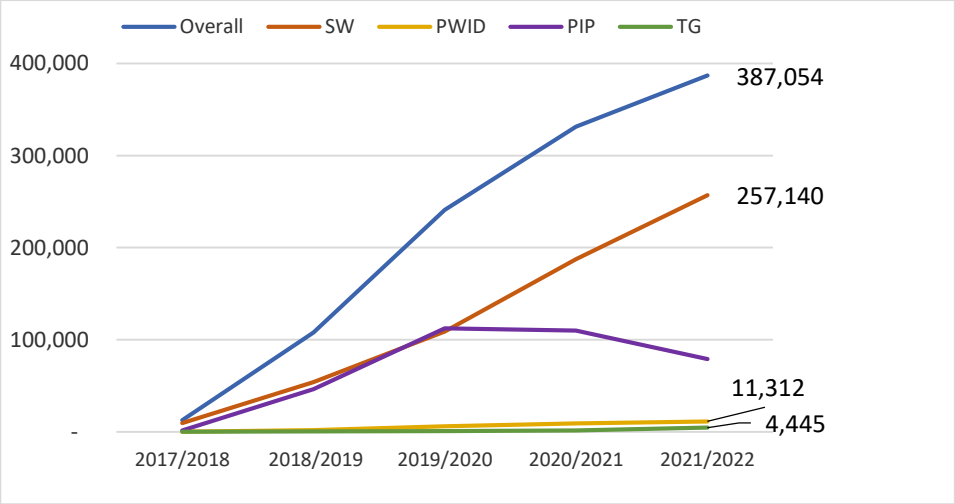
HIV Prevention Interventions for KP. The NSP recommends a comprehensive package of evidence-based interventions to prevent HIV transmission among KP, including both health sector interventions such as medication assisted treatment (MAT), ART, voluntary medical male circumcision (VMMC]) and non-health sector interventions such as community empowerment, and violence and stigma reduction. The NSP also presents a scale-up plan for the recommended program services coverage from 8% for PWIDs, 35% for MSM, and 77% for SWs to 90% by 2025.

[5] Doshi RH, Apodaca K, Ogwal M, Bain R, Amene E, Kiyingi H, Aluzimbi G, Musinguzi G, Serwadda D, McIntyre AF, Hladik W. Estimating the Size of Key Populations in Kampala, Uganda: 3-Source Capture-Recapture Study. JMIR Public Health Surveill. 2019 Aug 12;5(3):e12118. doi: 10.2196/12118. Erratum in: JMIR Public Health Surveill. 2020 May 12;6(2):e19893. PMID: 31407673; PMCID: PMC6771531.

A National Steering Committee for the key populations programme, with its secretariat at UAC, is responsible for the overall coordination of the multi-sectoral KP programme. The national multisectoral stakeholders also established an Equity Plan Steering Committee to provide a mechanism for shared leadership, monitoring and accountability in removing equity barriers across the national HIV, TB and malaria responses. Within MoH, a technical working group (TWG) coordinates the health sector interventions under the leadership of a designated KP program officer. At decentralised levels, district health offices (DHOs) and health facilities are responsible for coordination of the health sector program interventions within their areas of jurisdiction. However, several CSOs also implement prevention and care activities for KPs using the differentiated service delivery models that increase access to services for all KP groups, while maintaining confidentiality. Those testing positive for HIV were referred and linked to HIV treatment and viral load testing services.

A total of 387,054 KPs were reached with HIV prevention services during the reporting period indicating and increasing trend in service coverage over the years (Figure 9).

Figure 9: Trends in number of KP reached with HIV prevention services, by KP group



Source: KP Tracker

The main activities for FY 2021/22 are described below.

- With support from the GFATM (NF3) the Uganda Harm Reduction Network (UHRN) supported four drop-in centres (three in Kampala and one in Wakiso District) and the Most-at Risk Population Initiative (MARPI) clinic in Mulago. These sites implement the Needle Exchange and Syringe Programme for PWID.
- All KP groups continued to have access to available reproductive health services including family planning, VMMC and free public condoms from safe spaces in approximately 75 community drop-in centres (DICs), stationed at hotspots areas. These DICs provide a platform for community mobilisation, training and organising initiatives, sharing of information on events, activities and services relevant to the community, provision of psychosocial services and support, and condoms and lubricants distribution. Of the DICs, 23 are based at public health facilities.
- The Medically Assisted Therapy (MAT) program for PWID that started at Butabika National Referral Hospital in 2020 continued to expand its operations through the reporting period. However, services remained only available to PWIDs admitted at the facility. Notably, there was no provision for PWIDs who got arrested or are already incarcerated to initiate or continue opioid substitution treatment (OST) due to challenges with the legal policy environment. Plans for community distribution and outreach are being developed.

- National standards for HIV Testing Services (HTS) were implemented using differentiated service delivery models that increase access for all KP groups. All testing was voluntary and confidential (informed consent obtained) with immediate referral and facilitated linkage to HIV treatment services for those testing positive and viral load tests were accessible for key populations living with HIV.
- A total of 702 out of 1,500 ART sites provided services to KP across the country with 90 out of 136 districts providing oral pre-exposure prophylaxis (PrEP) for key populations groups. However, none of the community DICs across the country offered PrEP during the period.

Programme Outcomes

Data from the KP Tracker indicates that the proportion of KPs eligible for testing who declined to be tested decreased from 0.69% in FY 2020/21 to 0.25% in 2021/22. Data from DATIM also shows a 3% yield of HIV positive KPs and 93% of those currently on treatment are virally suppressed (Figure 10). The highest number of KPs reached were sex workers (Figure 11).

Figure 10: KP treatment cascade achievements 2021/2022

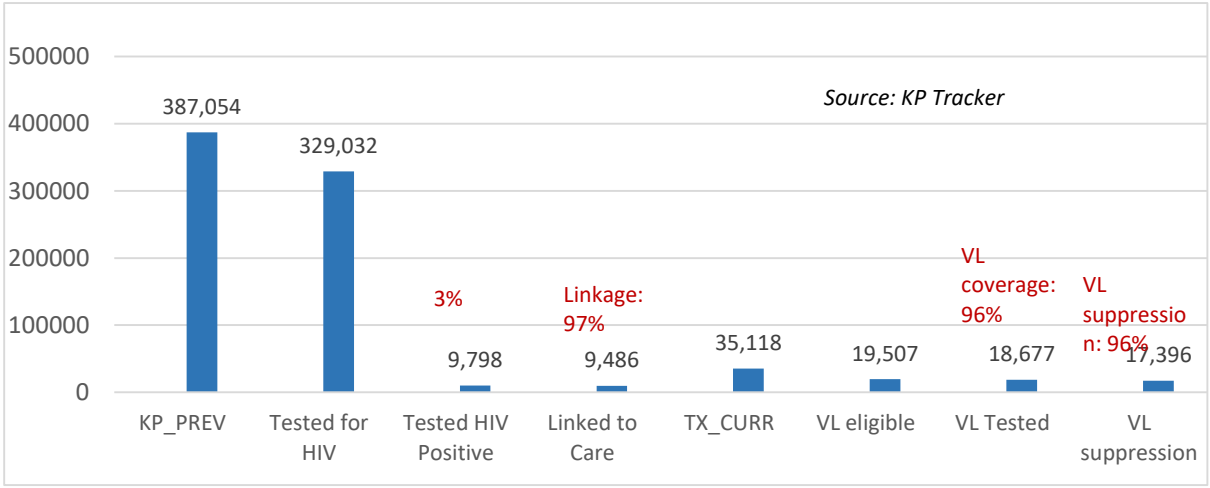
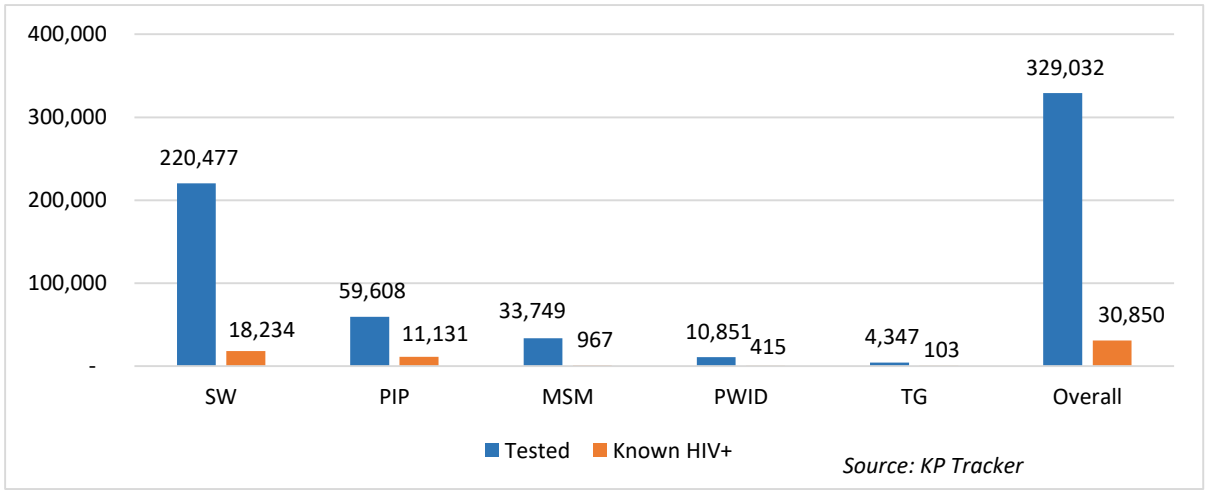


Figure 11: KP tested and known HIV positive, by category, FY 2021/22



Challenges	***Recommendations***
• Stigma against KP both in communities and health care settings is still widespread and human rights abuses, such as arrests by law enforcement agencies.	1. Implement selected recommendations* of the Legal Environment Assessment to revise laws that are discriminative against KP and hinder access to integrated package of services 1. 1.

Challenges	*Recommendations*
• Inadequate skills and training of health workers on how to handle KPs. • Programs to address violence against key populations, including PWIDs, are implemented on a limited scale, mainly with support from civil society and KP-led organizations. • Although MoH and partners developed tools for capturing service delivery data (KP Tracker), they were not adequately disseminated resulting in under-use. • Inadequate mental health service across the country and more so for KPs. • Low uptake of the MAT and needle and syringe services. • Although KPs issues are outlined in the HIV and AIDS Communication Strategy, and SBCC activities are included in the national KP Programme, their implementation remains at suboptimal scale. • The last modes of transmission (MOT) survey is outdated (2014)	1. including harm reduction policies in the context of HIV prevention. 2. All stakeholders should endeavour to increase awareness on stigma against KP/PP and its impact, through tailored SBCC interventions. 3. Training of health workers and law enforcement agencies should be scaled up and sustained to ensure that there is no reversal of achievements. 4. The newly revised HMIS tools that incorporate KP data capture and reporting should be systematically disseminated across the country. 5. Ensure integration of mental health issues that pertain to KPs into routine mental health services and scale up services across the country. 6. Develop innovative interventions to mitigate challenges of current MAT services and scale them up to all regions of the country e.g. use of peer outreach educators. 7. Scale up interventions on awareness creation about injection safety; DICs; paralegal and linkages to legal support; and training of enforcement officers. 8. Fast-track the HIV MOT study to inform better planning for KPs. **see undertakings in Annex II*

2.1.3 Expanding Coverage and Uptake of Priority/Quality Biomedical HIV Interventions

Scaling up Coverage of Differentiated HIV Testing Services to High-risk Groups

The NSP guides stakeholders to implement interventions that break the HIV transmission cycle through targeted and differentiated HIV testing and counselling, focusing on populations likely to be HIV-positive and enrolling them into treatment. Since 2018, the program has been implementing an HTS optimisation plan that prioritizes individuals at high risk to increase the test yields with approaches such as targeted initiated-testing (PITC), assisted partner notification (APN), HIV self-testing (HIVST), and social network testing strategy. These more efficient testing approaches has resulted in a decrease in the number of tests carried out, from over 10 million in previous years to between 7-8 million over the last three years. This plan has provided the framework for increased efficiencies despite the negative effects of COVID 19 on programming.

During this reporting period, program data shows that 3.0% of 4,440,868 individuals tested were identified as HIV positive and 93% of them were linked to care. The 2022 Epi-data estimates suggest that Uganda has identified only 89% of the estimated PLHIV and 92% of these have been started on treatment indicting the need to continue implementing the 10-point package for linkage and further enhance linkage and initiation of care for all individuals testing positive as the indicators both fall short of the first two global 95-95-95 targets. Program data indicates that men aged 25 and above had the highest positivity rate of about 3.8% compared to other groups. The lowest positivity (1.0%) was recorded among adolescent males and young men (15-24 years) although this same age group had the lowest linkage to care services at 88%. AGYW with a positivity of 1.5% and the best linkage rates at 94.5% followed by women over 25 years at 93%.

Index Testing/Assisted Partner Notification (APN)

MoH has revised the HTS policy and implementation guidelines to integrate re-engagement of clients into care, providing clear implementation guidance for the social network strategy, HIVST and screening for eligibility without stigma and discrimination. During the reporting period index testing of contacts of PLHIV including assisted partner notification (APN), contributed 58% of all HIV positives identified. Of the partners identified as HIV positive, 26% were already in care testing.

The proportion of individuals identified as HIV positive through the different approaches were 11% (social network strategy), 2.3% (PITC).

HIV Self-testing (HIVST)

The MoH developed an HIVST scale up plan for Uganda following the award of a catalytic fund from the GFATM in the New Funding Model (NFM 3). To optimise this approach, MoH has approved HIVST for adolescents (15-17) and care giver assisted oral screening for exposed children 2-14 years. The country was stocked with HIVST kits during the reporting period however, distribution was delayed due to late deliveries by the manufacturers arising from COVID 19 limitations, but by May 2022, the National Medical Stores (NMS) had delivered the kits delivered to all facilities listed for HIVST. In the next year, focus will be on monitoring the HIVST outputs through DHIS2 reporting and community mechanisms. Currently, the positivity from HIVST users is 2% with 67% linkage to confirmatory testing and 90% linkage to care.

Rapid Testing for HIV Recent Infection (RTRI)

Recent infection testing, which began in October 2019 aims to identify geographic locations associated with recent infections and to monitor trends in the prevalence of recent infections among all newly-diagnosed PLHIV. By July 2022, RTRI had been rolled out in 875 (64%) of the 1,366 ART accredited sites with functional electronic medical records (EMR) in all regions of Uganda. From these facilities 20,000 samples were tested for recent infection using RTRI kits, their viral loads, and recent infection determined using a Recent Infection Testing Algorithm (RITA). Results from the tests show that 3.5 % of the samples from newly identified HIV positive clients were confirmed to have recent infection (within the 12 months prior to testing). Further epidemiological analysis of these samples will be used to inform prioritization and refocusing HIV prevention interventions.

External Quality Assurance (EQA) for HIV Testing

The program with support from UVRI implements a quality assurance program for HIV testing. During the reporting period, 97.2% of the HIV testers passed the proficiency testing evaluation. For the last two years, MoH has also been monitoring the quality of HIV index testing through an accreditation program. During this period, 90% of the sites implementing index testing were assessed and 94% of these passed and were accredited for index testing. The others are undergoing remediation.

Challenges

- 11% gap of PLHIV who do not know their status as per the Epi-data estimates
- Sub-optimal linkage to confirmation testing for HIVST is still low (67%).
- Data quality as evidenced by discrepancies in DHIS2 reported data. The degree varies from region to region.
- High prices of HIVST kits in the private sector hinders access and exerts a high demand on the public sector commodities for prioritised populations

Recommendations

1. Scale up and performance monitoring of HIVST to optimise case identification and linkage to both prevention and care.
2. Focused Community Testing—utilizing community networks for demand creation and linkage to care and integrating into social network strategy.
3. Integrate HIVST into all HTS strategies including into community pharmacies, HIVST and DICs to support the rollout of effective delivery models.
4. Roll out of HTS module in EMR to ensure real time capture of HTS data and improve data quality.
5. Continued scale up of RTRI and use of data and geo-mapped locations of recent infections to deploy appropriate prevention strategies to interrupt transmission of HIV.

Revitalize Elimination eMTCT Approach and Optimize eMTCT Services

The program for prevention of mother to child HIV transmission (PMTCT) has continued to implement intervention along the four prongs that is: a) primary prevention, b) prevention of unwanted pregnancies among HIV positive women, c) PMTCT and d) care, treatment and support for HIV positive women, their partners and children as guided by the Elimination Plan II. Interventions are fully integrated into maternal and child health (MCH) care services and have been fully expanded to include syphilis and hepatitis B in line with the triple elimination agenda. However, the COVID-19 pandemic and measures to mitigate it affected service implementation and have contributed to regression in achievements. And this has seen the new infections among children increase from 5,300 in 2019/20, to 5,955 in 2021/22 (Table 2). Most (44%) of new paediatrics infections were due to mothers who started on ART but defaulted from the programme, and mothers newly infected during breastfeeding and pregnancy (40%). The program therefore needs to strengthen interventions to improve adherence and retention through approaches such as using peer mothers, use of family support groups, mother and baby campaigns as well improving the tracking of mother-infant pairs.

Table 2: New child infections by source of infection, FY 2021/22

Status of Mother	New Child Infections	
	Sub-total	Total
Started ART before the pregnancy: child infected during pregnancy	165	2,480
Started ART during the pregnancy: child infected during pregnancy	240	
Dropped off ART during pregnancy: child infected during pregnancy	1,318	
Started ART late in the pregnancy: child infected during pregnancy	95	
Mother infected during pregnancy	662	
Started ART before pregnancy: child infected during breastfeeding	188	3,475
Started ART during pregnancy: child infected during breastfeeding	238	
Dropped off ART: child infected during breastfeeding	1,302	
Started ART late in pregnancy: child infected during breastfeeding	27	
Mother infected during breastfeeding	1,720	
	5,955	

Source: DHIS2

Additionally, the programme should provide PrEP to women who have risky sexual encounters before they get pregnant including forced sex by intimate partners. Programme data shows that 13.1% mothers had experienced some form of violence, out of whom 4.6% had experienced sexual gender-based violence (SGBV) and 85% of the perpetrators were reported to be intimate partners suggesting some reasons for infections during pregnancy. However, of those who reported sexual violence, only

31.8% reported getting any services from a health facility, underscoring the need for differentiated models of service delivery within communities, for such mothers.

In FY 2021/22, 1,909,456 women attended antenatal care (ANC), 36% of these in the first trimester. Of all the women who attended ANC, 98% knew their HIV status, while 84% were tested for syphilis (a reduction from 88% last year), and 22% were tested for Hepatitis B (an increase from 17% last year). A total of 84,748 women were identified as HIV positive, 72% of these were already HIV positive before the pregnancy while 28% were newly identified as HIV positive. All the HIV positive (100%) received ART. Of those that attended their first antenatal visit with an already known HIV status, only 59% had a viral load done and of these 91%were suppressed. Those newly found to be HIV positive are a concern for the programme because they need to be reached with prevention messages before they get pregnant and/or with PrEP In the case of risky sexual behaviour.

Follow up of mother-baby pairs is still a big problem with only 83% of women who start ART retained in care at 12 months and 10% of mothers non-suppressed during the first 12 months post-partum. Relatedly, about half (56.2%) of women living with HIV (WLHIV) on ART had a viral load test during pregnancy, but access to viral load testing was only 23.2% for AGYW aged 15-19 years and 42.1% for those aged 20-24 years in districts implementing DREAMS interventions.

HIV Exposed Infants

During the 2021/22 FY, 95% of HEI were enrolled in HIV exposed infant cohort for care, 82% of them received Nevirapine Prophylaxis within 6 weeks of birth. The same proportion had a 1st DNA/PCR test within 2 months while 81% were initiated on Cotrimoxazole prophylaxis within 2 months. Nearly all (99%) had a documented Final Outcome reported with a 3% HIV positivity rate in the birth cohort (similar to what was reported in the PMTCT Impact Evaluation. Lifelong ART was initiated for about 8/10 HIV positive infants reported.

The recent PMTCT Impact Evaluation[6] determined an MTCT rate of 2.8% at 18 months. This is already below the national target of 5%, suggesting that Uganda is on the trajectory to eliminate new paediatric HIV infections. However, it is on an increasing trend since 2019/20 when it was 1.7%. The study further showed a cumulative maternal incidence of HIV infection of 4.3 per 1,000 during the 18-month postpartum period. The proportion of mothers aged 15-24 years with HIV-infected infants was higher at 3.7% compared to 1.4% among mothers 25 years and older. This higher infection rate among AGYW coupled with increased teenage pregnancy rates experienced during and after the COVID-19 lockdown suggests the need to strengthen interventions for pregnant and breastfeeding adolescent and young women. The Program is working together with the Reproductive Health Division to develop and scale up strategies to increase early ANC attendance, especially for young mothers.

HEI indicators including testing below 2 months, those receiving the second and third test as well as those retained in care until 18 months are still performing poorly. The programme is therefore working on strategies to improve early infant care and testing including scaling up point of care testing to over 256 facilities countrywide.

These findings suggest the national eMTCT program should focus on increasing awareness about MTCT among women, increasing ANC attendance, enhancing ART enrolment of HIV-infected pregnant women, achieving viral suppression, and enhancing uptake of infant Nevirapine prophylaxis. The social determinants that increase HIV infection such as GBV should also be addressed more comprehensively.

Further, program data shows that about half (46%) of mother-infant pairs attend services for MCH/PMTCT at Health Centre (HC) IIs, which by policy, are not mandated to provide a comprehensive package of services. However, with the challenges in the referral system and long distances that they

[6] MoH, 2022. MoH PMTCT Impact Evaluation Study 2017-2019

have to travel to access services, the program is now focusing on supporting over 500 HC IIs to provide comprehensive PMTCT services to mother-infant pairs.

Challenges	*Recommendations*
• HEI indicators are still low indicating poor follow up of mother-infant pairs • MTCT increasing as evidenced by increase in positivity rate of HEI • Low VL testing among HIV+ pregnant women (56%) and AGYW (23%)	1. Intensify mother-baby pair follow up through peer support groups. 2. Focus on social determinants that hinder service uptake including GBV; service infrastructure.

Pre-Exposure Prophylaxis (PrEP)

Pre-Exposure Prophylaxis (PrEP) is recognized and prioritized as a key HIV prevention tool in both the NSP 2020/21-2024/25 and the National HIV Prevention Roadmap. The country initiated the Oral Pre-Exposure Prophylaxis (PrEP) program as one of the Biomedical HIV prevention tools in December 2016 and is rolling it out in a phased manner across the country.

During the reporting period, there were scientific advances in PrEP options, including the use of the Dapivirine Vaginal Ring (DVR) and Long Acting Injectable Cabotegravir (CABLA), which necessitated updates to relevant national strategies and guidelines. These included the Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda (2022), Technical Guidance on Pre-Exposure Prophylaxis (PrEP) for persons at High Risk of HIV in Uganda (2022), and the National PrEP Communication Plan (updated 2022). Funding support for the PrEP program including the drugs, HIV/laboratory tests, human resources, communication strategy, M&E system, is mainly provided by PEPFAR and the GFATM. However, the non-oral PrEP options are not yet available for client use due to funding constraints.

Currently, in Uganda PrEP is recommended for a) people who have multiple sexual partners of unknown HIV status, b) those who engage in transactional sex, including sex workers, c) those who use or abuse injectable drugs and alcohol, d) those who have had more than one episode of an STI within the last twelve months, e) HIV negative partners in a discordant relationship if the HIV positive partner is not on ART or when his/her viral load has not been suppressed, f) recurrent users of PEP, g) individuals who engage in anal sex, h) AGYW who are at substantial risk of HIV, i) pregnant women and breastfeeding mothers at substantial risk of HIV, j) and KP who are unable and unwilling to use condoms consistently. These risk factors are likely to be more prevalent in key and priority populations such as sex workers, fisher folk, long distance truck drivers, MSM, uniformed forces and adolescents and young women engaging in transactional sex.

PrEP is offered in 473 health facilities in 86 out of the 135 districts in the country, spread across all regions except Karamoja. Although there was no increase in the number of districts offering PrEP from the previous year, the number of health facilities increased by 24%. Several modes of PrEP service delivery are utilized in the country, including health facility, DICs, and outreach/mobile services. However, there is limited integration of PrEP within HIV and other reproductive, maternal, neonatal, child and adolescent health (RMNCAH) programs.

The MoH with support from development and implementing partners conducts on-job training for PrEP services providers, and ongoing mentorship and support supervision, across the country. However, PrEP is not yet incorporated into the core pre-service training package for health workers.

Program Outcomes

By end of June 2022, the cumulative number of people ever assessed for eligibility for oral PrEP since the start of the program in Uganda was 815,885 (Table 3). Of those ever assessed for eligibility, a cumulative total of 450,356 individuals were found eligible and of these, 352,219 were initiated on

PrEP. The number assessed for eligibility during the reporting period were 296,783. Of those assessed for eligibility, 199,405 (67%) were found eligible and of these, 179,081 (90%) were initiated on PrEP.

Table 3: Number of new and cumulative individuals assessed and initiated on PrEP

Category	Screened		Eligible		Initiated on PrEP	
	New	Cumulative	New	Cumulative	New	Cumulative
AGYW	27,543	41,692	21,595	30,360	19,250	26,744
Pregnant women	2,874	9,749	2,315	5,766	1,993	3,487
Breastfeeding women	2,592	4,498	2,087	3,664	1,942	3,289
CSW (Clients of SWs)	50,287	102,864	35,380	68,165	32,237	53,963
Discordant couples	9,877	29,773	9,601	26,948	9,499	26,024
Displaced persons	142	1,489	127	1,341	97	149
Fishing communities	15,574	66,281	8,071	19,984	7,822	15,741
MSM	16,861	35,997	11,750	24,631	8,554	17,243
Mobile populations	15,820	56,409	9,857	22,802	8,334	15,741
NIDU	7,122	15,348	3,754	9,709	3,360	6,893
other	9,487	69,477	8,489	23,425	8,069	16,928
PIP	1	13,006	0	456	0	179
PWID	6,948	18,975	4,543	12,128	4,014	8,525
Sex Workers	120,173	312,039	75,460	183,745	68,474	145,581
Transgender	1,472	2,860	976	1,692	928	1,537
Truckers	6,464	20,287	3,569	9,541	2,987	6,506
Military and Uniformed Services (MUS)	3,546	15,141	1,831	5,999	1,521	3,689
Overall	**296,783**	**815,885**	**199,405**	**450,356**	**179,081**	**352,219**

Source: KP Tracker

Challenges

- Up to 10% of individuals who were screened and found eligible for PrEP were not initiated on PrEP during the report period.
- Inadequate health worker skills in the provision of PrEP.
- No PrEP provisions in prison settings mainly due to the prevailing policy-legal environment.

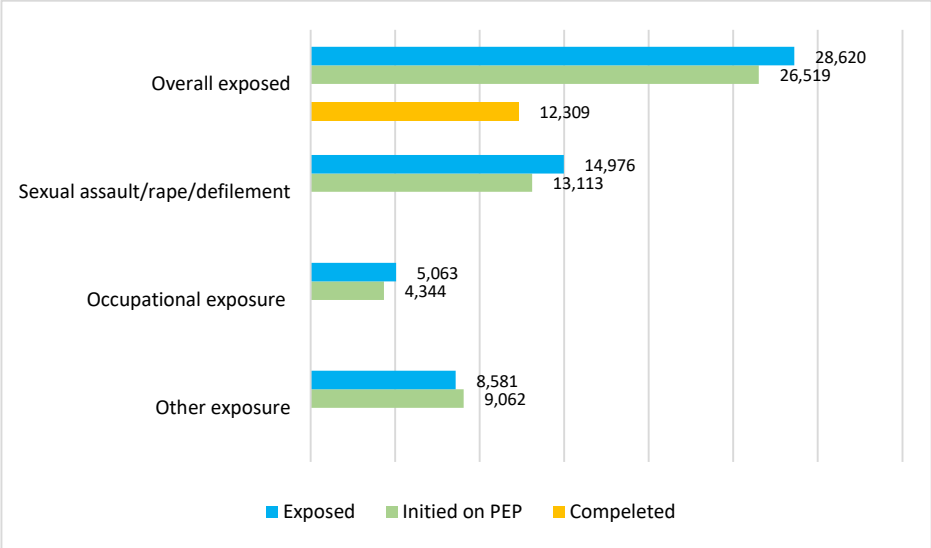
Recommendations

1. Explore mechanisms of integrating PrEP into the routine health system.
2. In order to scale up service provision, there is need to dialogue with health training institutions to include PrEP training as part of the core pre-service training package.
3. Explore ways to integrate PrEP services into routine services for incarcerated populations.

Post-Exposure Prophylaxis (PEP)

During the reporting period, PEP was provided to a total of 26,519 out of 28,620 (92%) exposed individuals. Of the exposed individuals, 13,113 (49%) were individuals who had been raped or defiled, while 4,344 (16%) were health workers who had been exposed at their work place. Only 46% of those initiated on PEP completed their ART course, underscoring the need for close follow up of these individuals. Among those followed up, 1% sero-converted.

Figure 12: PEP service uptake, FY 2021/22



Source: DHIS2

Coverage and Access to Quality Voluntary Medical Male Circumcision (VMMC)

Safe circumcision of male adults is one of the interventions identified in the NSP for HIV epidemic control in Uganda ever since scientific evidence affirmed its impact in reducing new HIV infections. Uganda prioritizes young men 15-29 years in regions with high HIV prevalence and high unmet need for the intervention. The Program target is to circumcise one million young men annually till 80% coverage of safe male circumcision (SMC) is attained for this age group.

A cumulative total of 6 million men have been circumcised since 2010. During the report period, 490,655 circumcisions were conducted, with 376,649 (77%) of them conducted during community outreaches (Table 4). Overall, 471,293 (96%) males were followed up within 48 hours following circumcision and out of these, 77 severe adverse events following circumcision were reported. The majority (40) of the sever adverse events occurred after facility-based circumcisions. A total of 470,528 tetanus toxoid (TT) doses were administered.

To improve uptake and efficiency of the service, the Programme is diversifying the VMMC approach by promoting the use of the *Shang ring* non-surgical device to complement surgical approaches in the country. This shift follows a pilot that demonstrated its safety and cost-effectiveness. The pilot demonstrated that the ring had high acceptability among the different target population groups especially among men and was also cost-effective.

Table 4: VMMC outputs FY 2021/2022

SMC Service	Number circumcised
Facility services	114,006
Outreach services	376,649
Follow-up visit within 48 hours - Facility	106,335
Follow-up visit within 48 hours - Outreach	364,958
Adverse Effect - Facility - Severe	40
Adverse Effect - Outreach - Severe	37
TT - 1st Dose (TT1)	470,528
TT - 2nd Dose (TT2)	10,404

Source: DHIS2

To improve the quality of service delivery, MoH conducted continuous quality improvement (CQI) training at national and regional levels. Further, RRHs were assessed for capacity building needs in order to tailor technical support towards establishing them as centres of excellence for management of severe adverse events. It is anticipated that this will reduce the cost of SAE management and also provide local support to SMC implementers in the catchment area of RRHs.

2.1.5 Address Underlying Sociocultural, Gender & Structural Factors Driving the HIV Epidemic

Strategic Engagement of the Media, CSOs, and Religious, Cultural, and Political Institutions in the HIV Prevention Effort

Recognizing the key role that cultural leaders have in shaping their subjects' behaviours and mobilizing resources towards fighting HIV and AIDS, UAC has developed working relations with cultural leaders in Uganda. During the year, the cultural leaders were engaged in several activities to both increase awareness about HIV and AIDS as well as mobilise resources and their subjects to support the fight against HIV and AIDS.

King Oyo hand over a Plaque to King of the Mic, aka Edwin Katamba, a PLHIV, during the Philly Lutaaya

Participants of the Kabaka's Birthday Run, 2022

Tooro Kingdom. Uganda AIDS Commission joined the Kingdom of Tooro to celebrate their king's birthday by supporting and coordinating an HIV Symposium. The HIV symposium was held on 12th April at the Mucwa Parliamentary Chambers in Fort Portal. The symposium was held as a precursor to the king's birthday and was aimed at rallying cultural and religious leaders, and youth to refocus their role in fighting HIV especially in Tooro Kingdom, one of the regions with highest prevalence in the country. The symposium was graced by His Highness King Oyo Kabamba Iguru Nyimba Rukidi IV who is also a UNAIDS Goodwill Ambassador for Youth in Sub-Saharan Africa. The event mobilised over 120 cultural, religious, government and political leaders, youth leaders and UN Women representing development partners to contribute to the HIV and AIDS response. The UAC team was led by Dr. Eddie Mukooyo, the Board Chairman, who signed a memorandum of understanding (MOU) with Tooro kingdom to spearhead implementation of the PFTI targets, mobilize the communities to fight HIV/AIDS, and conduct periodic monitoring and support supervision of HIV and AIDS activities implemented by Tooro Kingdom. In addition, the MOU is meant to mobilize and guide technical support for HIV and AIDS activities and acknowledge the contributions of Tooro Kingdom to the HIV and AIDS response through their 25-year Strategic Plan, which aims at ensuring no child is born with HIV while engaging men to close the tap of new infections.

Later that day the King of Tooro launched the 'Back to School' Campaign which was coordinated by UAC. The campaign is a partnership between UAC and the Tooro Kingdom to take 150 vulnerable AGYW back to school. It is supported by UN Women and aims at curbing teenage pregnancies and reducing chances of AGYW catching HIV in the region. Over 300,000 people in the region were reached

through the media with prevention messages during the event. King Oyo also grace the Philly Lutaaya Memorial event in Kampala.

Buganda Kingdom. The Kingdom of Buganda organized several events aimed at curbing the HIV and AIDS epidemic.

- An interactive campfire event for adolescent boys and young men in secondary schools and universities to sensitise them on prevention of further spread of new HIV/AIDS infections, discourage stigma and discrimination of PLHIV and gather their ideas on how to end HIV and AIDS as a public health threat by 2030, and ensure zero AIDS related deaths.
- Sports tournaments which attract 20,000 to 30,000 fans, with the theme *Men against HIV/AIDS to Save the Girl Child*, including the Bika Cup, and Masaza Cup tournaments.
- The Women's Convention, which discussed social and structural drivers of HIV such as harmful gender norms, gender-based violence, stigma and discrimination and empowered women to confidently stand against bad socio-cultural practices that lead to acquisition of HIV.
- The Kabaka Birthday Run 2022 with the theme *Men should take lead in the fight against HIV/AIDS to save the girlchild*, this popular run attracted 80,000 runners from across the country greatly advocated for individual responsibility to prevent HIV in the long run contributes to reduction of fear surrounding the disease.
- HIV/AIDS prevention, awareness and advocacy campaign in the islands in particular Kalangala District, which were led by the Minister for Presidency and the Katikkiro of Buganda. The campaigns run health camps that offered free medical services to the people including HIV Counselling and testing Services. The Katikkiro discouraged the negative social practices and behaviour among the fisherfolk that lead to disregard of HIV prevention practices.
- Sharing of IEC materials with HIV prevention and anti-stigma/discrimination messages through social media platforms, kingdom-owned media stations and places of worship.
- Distribution of condoms to boda-boda cyclists, at market places and slums, to prevent further spread of HIV/AIDS through unprotected sex.
- Interactive engagements on HIV and AIDS across the Kingdom counties spear headed by the youth leaders and attended by young people under their umbrella organization, *Baganda Nkobazambogo*. Also, savings groups under the Project to Empower Women through Savings and Loan Associations (PEWOSA), enhanced dissemination of HIV/AIDS prevention messages to the people in their communities.

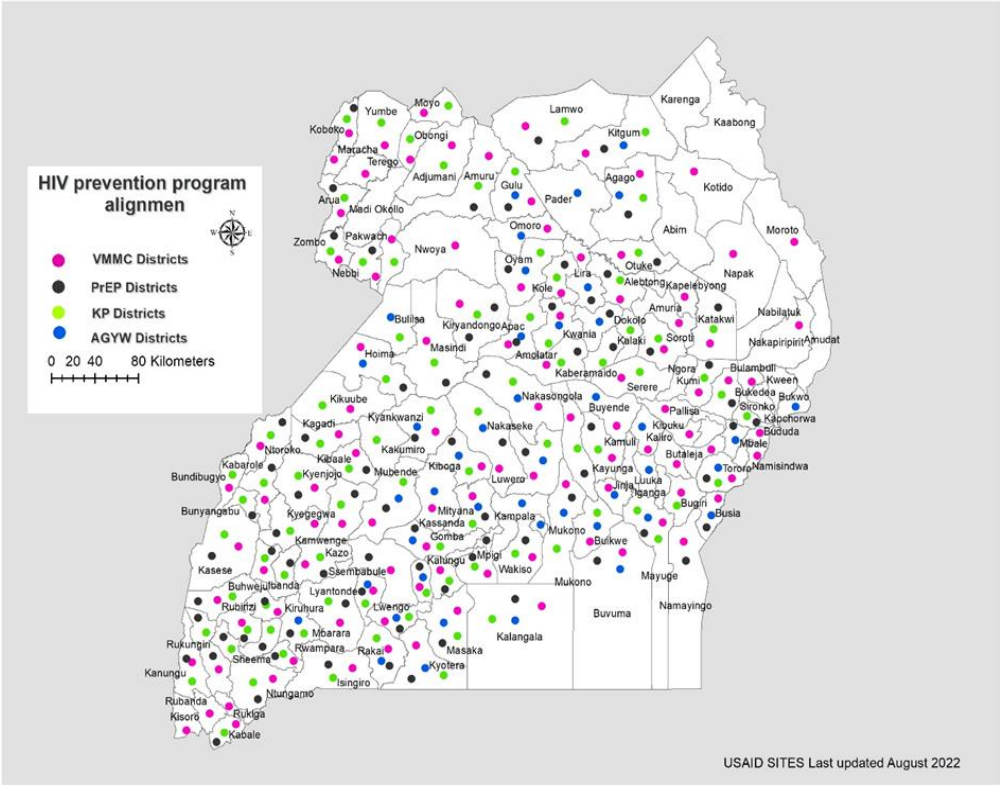
Other cultural institutions including Inzu ya Masaaba, Ker Kwaro Alur, Ker Kwaro Acholi, Tieng Adhola, and Ikumbania Bwa Bugwere undertook activities to create awareness about negative cultural practices and norms such as GBV that contribute towards HIV prevalence. They used their cultural events to disseminate HIV prevention messages and provide services such as HIV testing. Others worked through PLHIV to disseminate HIV prevention messages.

UAC continued to engage the Media SCE, through press briefings and oriented journalists in four regions of Uganda (Ankole, Busoga, Bugisu and Bunyoro) on HIV/AIDS and COVID 19 in a move aimed at integrating reporting of both pandemics. The engagement opened the space for discussion on HIV/AIDS prevention and also acted as a springboard for renewed interest and reporting on HIV/AIDS on television, radio, newspapers and social media.

During the reporting period, UAC in collaboration with stakeholders, completed and launched the National HIV and AIDS Action Plan for the Faith Sector in Uganda 2021/22-2024/25. UAC also oriented comedians working with Comedy Store, on how to ably disseminate HIV and AIDS messages in line with the Presidential Fast Track Initiative pillars. UAC also collaborated with the Patriotism Secretariat, Kampala Capital City Authority, to impart HIV prevention skills, patriotism and mindset change to 200 youths at Kaazi Camp site. The focus of the training was on ''HIV and AIDS Prevention, Patriotism and Mindset Change''.

Figure 15 depicts the coverage of the HIV prevention services discussed above across the country. The map shows a general paucity of interventions in the Karamoja and Mid-West Regions and further, inadequate coverage on PrEP and AGYW interventions across some regions.

Figure 13: Map showing coverage of key HIV prevention services



Addressing Legal, Policy and Institutional Barriers to HIV Prevention among Key and Priority Populations

The NSP recognizes the need to emphasize holistic and inclusive HIV and AIDS interventions hence the prioritization of HIV prevention programmes targeted at populations not adequately covered, such as KPs and in particular, sex workers, men who have sex with men, transgender persons, persons who inject drugs and prisoners. In addition, the strategic plan recognizes that psychosocial, economic, legal and protection services are social enablers for HIV prevention and the uptake of care and treatment services, especially among KP. Conversely, legal and social protection services can promote stigma and discrimination against KPs, and other vulnerable groups. During this reporting period therefore, two legal-policy environment assessment (LEA) were conducted by MakSPH with support from USAID and CDC. The assessment reports articulate the major legal hindrances to health, legal and human rights of PLHIV in general and for KPs.

Support Implementation of High-quality Research in HIV Prevention Interventions

During the report period, UAC and partners finalized the development of the National HIV and AIDS Research Agenda for the period 2021-2025. The agenda serves as a guide to the implementation of research at both national and sub-national levels. It outlines a robust research agenda in prevention, treatment, social support and protection, and health systems strengthening, to enable achievement of the goals of the NSP and PFTI.

During the report period the UAC in collaboration with MoH and the Research, Academia and Professionals Self Coordinating Entity (SCE) held the National HIV and AIDS scientific meeting which

provided a forum for a broad spectrum of HIV professionals to share their expertise and research findings, in addition to an opportunity to identify remaining gaps in knowledge.

Integrate Sexual and Reproductive Health and Rights (SRHR), Maternal, Neonatal, Child Health and Nutrition (MNCHN), and TB Services with HIV Prevention Programming

The intrinsic relationship between HIV, SRHR and gender-based violence (GBV) are well-established. HIV is predominantly sexually transmitted and associated with pregnancy, childbirth and breastfeeding. Similarly, sexually transmitted infections (STIs) can increase the risk of HIV acquisition and transmission. GBV, especially sexual and gender-based violence (SGBV) is a documented contributor to HIV infection[7] and reproductive ill-health as well a common consequence of both; all these are still major health concerns in Uganda. Gender inequality and GBV constitute significant barriers to individuals especially women to exercise their SRHR including practicing preventive behaviours and accessing timely and quality services.

The inter-connectivity of programmes addressing these health areas requires integrated approaches to policy and programming in order to empower beneficiaries and provide them with comprehensive integrated services, while harnessing system efficiencies for universal coverage. Integration provides an opportunity for HIV services to act as an effective entry point for key SRHR and GBV services such as: family planning, cervical cancer screening and management of GBV. Similarly, SRHR services help to reach the beneficiaries with HIV prevention, treatment and care. One such initiative is the 2gether 4SRHR project, a regional (East and Southern Africa) project that was funded jointly by UNAIDS/UNICEF/UNFPA/WHO to improve SRHR with a focus on adolescents and young people from 2016-2021. The project developed a service delivery package (including condom use, prostate cancer screening, alcoholic anonymous, safe male medical circumcision, STI screening and management, infertility screening management, anger management, counselling, vasectomy) for male involvement for health facilities and built the capacity of 120 health workers at 27 project supported health care facilities across the country in RMNCAH-N GBV/VAC, SRH including HIV/TB as well as data collection and use for improving services. Additional funds to continue project interventions in three out of the eight districts of project implementation were secured.

There is increasing focus on integration of strategic and operational planning and implementation frameworks. Various sectors, major resource mobilization/funding streams e.g. GFATM, PEPFAR, and health system MDAs are working together to ensure integrated systems are established. Examples include the shift from single strand commodity specific logistics management information systems (LMIS) to the integrated eLMIS, and the health management information system (HMIS) which now captures and reports on integrated service delivery to enable efficiencies in program planning and implementation. Overall, there is increasing appreciation and programming for structural factors that hinder choice and access to services.

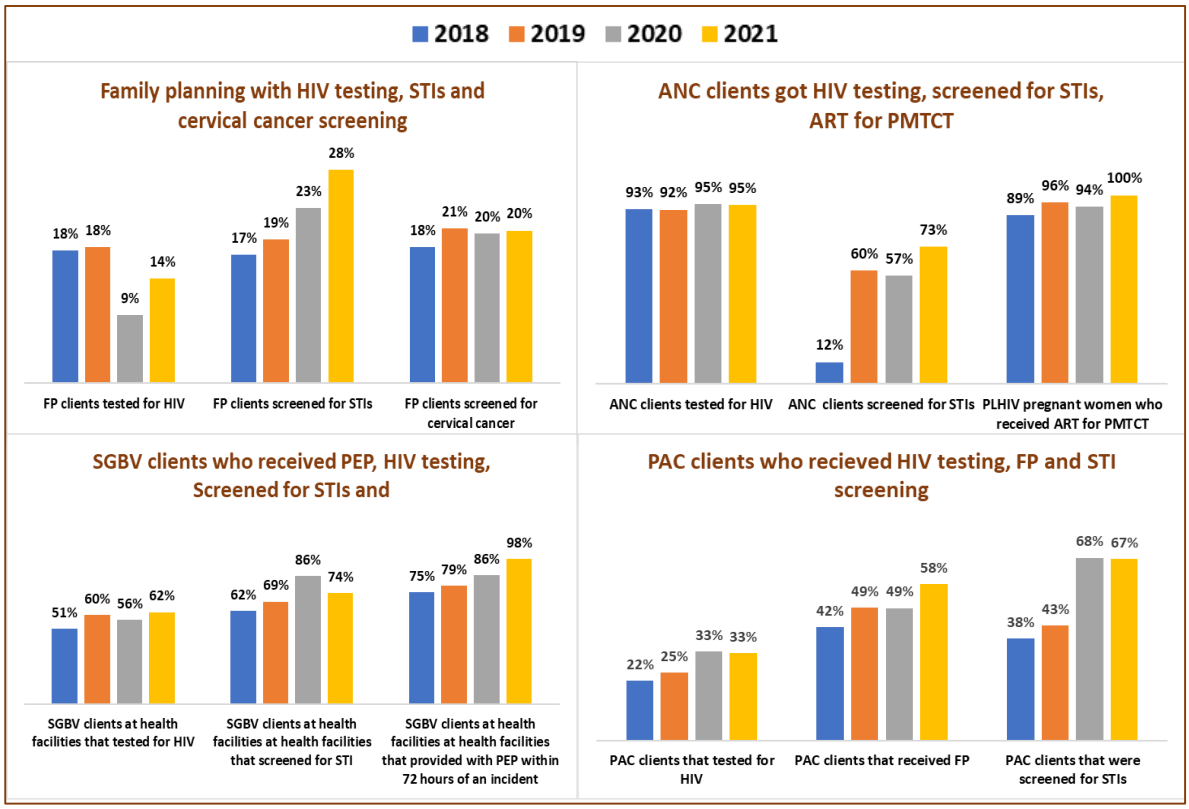
Increased leadership commitment and ownership. Government at national and district local government (DLG) levels, CSOs, faith-based and cultural institutions. The MoH has instituted a policy level Steering Committee that meets annually to provide guidance on both policy and technical areas for integration among government MDAs and development partners. In addition, quarterly sub-committee meetings focus on integration and feed into the MCH Cluster, as well as development partners' and other coordination and accountability platforms.

Increasing investment in human resource capacity development for the integration agenda. HW capacity for SRH/HIV/GBV friendly services especially for AYP and KPs and Expanding critical mass of policy makers, programme managers championing integration.

[7] Igulot, Patrick. 2022. Sexual and Gender-Based Violence and Vulnerability to HIV Infection in Uganda: Evidence from Multilevel Modelling of Population-Level HIV/AIDS Data. Social Sciences 11: 301. https://doi.org/10.3390/socsci11070301

As a result of the various initiatives to integrate services, Uganda has progressed from 57% in 2016 to 66% in 2019 and 70.8% in 2020 in the SRHR and HIV Linkages Index[8]. Key highlights of achievements in integration during FY 2021/22 are described below and Figure 14 depicts some of the integrated service outcomes.

Figure 14: Trends in key SRHR/HIV/GBV integration service delivery indicators



Data source: Assessment in 32 sampled facilities from 8 districts where UN-JOINT program on integration was implemented; Kampala, Namayingo, Isingiro, Yumbe, Gulu, Katakwi, Bududa, Amudat.

Challenge

- Gaps still exist in the integration efforts as highlighted in the Figure 13 and SRHR and HIV Linkages Index (57%)

Recommendations:

1. Health Sector to prioritise advocacy for, dissemination, and implementation of the integrated SRH/HIV/TB/GBV/Nutrition strategy and guidelines.
2. MoH should consider providing specific in-service training in SRH, HIV and GBV service integration to enable scale up of these services.
3. Improve commodity stock availability at facilities for the integrated package of services.
4. Strengthen and institutionalise the national capacity for monitoring integration by including SRHR/HIV and SGBV indicators in management information systems. Further, the M&E systems and logistics systems for SRHR, HIV and SGBV should be interlinked for better implementation of integrated services and tracking of achievements.
5. MDAs, development partners and stakeholders should review the gaps in achievement of the SRHR and HIV Linkages Index and plan for closing those gaps through continuous quality improvement interventions.

[8] The SRHR and HIV Linkages Index is a composite global index that is computed using 30 indicators across the three domains; a) enabling environment, b) health systems that support SRHR and HIV integration, and c) integrated services to increase access to and utilization of SRHR and HIV services.

2.2 HIV Care and Treatment

NSP Aspirations

The overall goal of the HIV Care and Treatment thematic area is to reduce AIDS morbidity and mortality by at least 50% by 2025. The strategic objectives under this goal are to a) increase the number of diagnosed HIV-positive persons who start antiretroviral therapy to 95% by 2025; b) increase HIV-diagnosed individuals started on antiretroviral therapy who adhere to regimes and are retained on treatment to 95% by 2025; and c) Achieve and maintain 95% viral suppression among those on ART.

Box 4: Care & treatment Achievements against NSP Targets

Indicator	Baseline	NSP Target	FY 2021/22 Achievement	Gap
Annual AIDS-related deaths*	21,000	10,800	17,000	7,800
Proportion of diagnosed HIV-positive persons on ART*	-	95%	92%	2.2%
Proportion of diagnosed HIV-positive KP who start ART within one month	-	95%	94%	1%
Proportion of PLHIV retained on ART at 12 months after initiation	88%	95%	73.3%	22.3%
Adult women (15-49 years)	94%	95%	74%	21%
Adult men (15-49 years)	79%	95%		
Children (0-14 years)	68%	95%	74%	21%
Adolescents (15-19 years)	-	95%	62.8%	32.2%
Proportion of PLHIV with viral load suppression*	75%	95%	95%	-

*Source: DHIS2; *from Epi-data country estimates 2022*

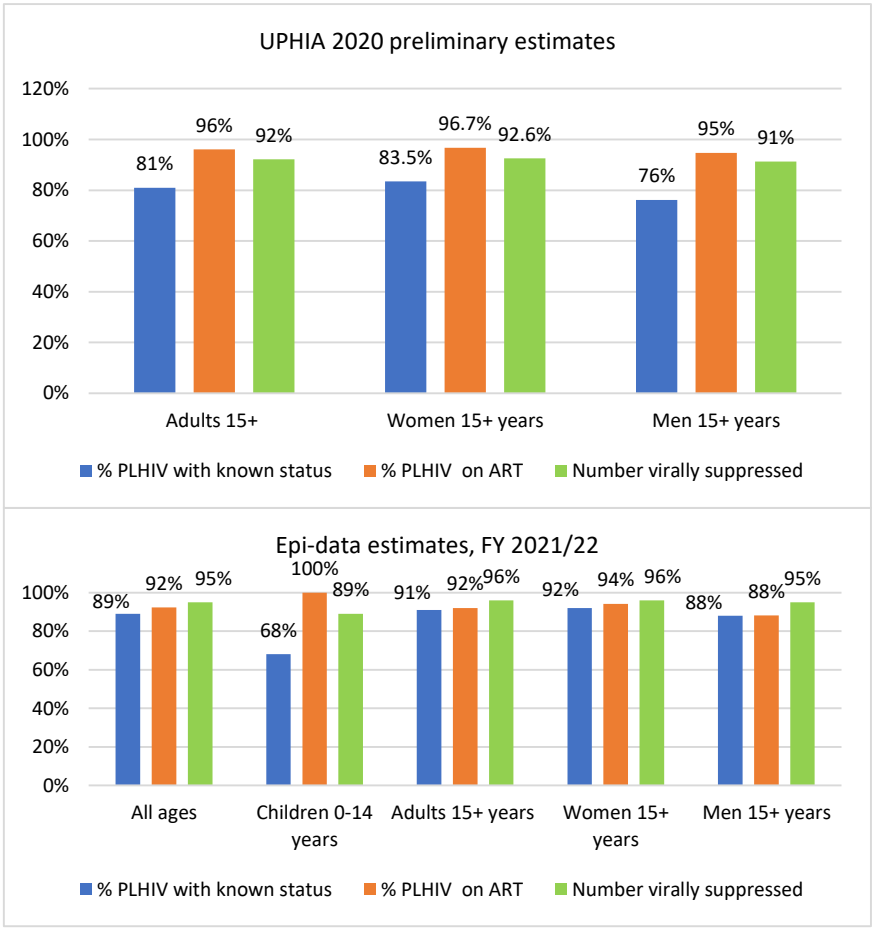
According to the Epi-data estimates, Uganda has only achieved the third 95-target with 95% PLHIV on ART having viral suppression (Box 4). The global 95-95-95 targets provide the cornerstone for further reduction of HIV infection and AIDS-related deaths by 2025, with deliberate programmatic emphasis on achieving (above 90%) coverage among sex workers and other KP. Additionally, adequate community ART coverage and viral load suppression will reduce HIV transmission and prevent new infections. Progress and interventions under each of the strategic objectives is described in this section. A summary of achievements for all Care and Treatment indicators is provided in Annex III.

Box 5: Key Care and Treatment Interventions 2021/22

- 99% of active clients served through Differentiated Service Delivery Models (DSDM)
  - 64% on Less Intensive Models
  - 36 on More Intensive Models
  - 83 pharmacies linked to 56 health facilities as Community Retail Pharmacy Drug Distribution Points (CRPDDP).
- 95 districts implementing YAPS model as a means of reaching the youth
- 236,572 women PLHIV screened for cancer of cervix;
  - 6% screened positive; 75% linked to care
- Provision of supplemental foods to 20% of malnourished PLHIV
- 73 facilities implementing NCD integration into HIV & AIDS care

Under the *Test and Treat* or *Test and Start* national policy, ART is provided at accredited facilities countrywide to all target population groups. According to the Epi-data estimates, the lowest performance for the first and third targets was among children 0-14 years at 68% and 89% respectively. These low achievements highlight the challenges in following up mother-baby pairs and ensuring the babies are enrolled and adhere to care. Figure 16 shows both Epi-data and UPHIA estimates for the treatment cascade, key indicators for the 95-95-95 targets.

Figure 15: HIV and AIDS treatment cascade by source, June 2022



Comparing the data from the two sources, the Epi-data over-estimates those with known HIV status and those who are virally suppressed; and under-estimates those on ART. Both sources depict a decline in the adults who are virally suppressed from 94% in the previous year to 92% indicating a need for intensifying support services for adherence and retention, especially among men. There is a need to understand the program dynamics better in order to adjust the modelling data and narrow the gap in estimates between the two sources.

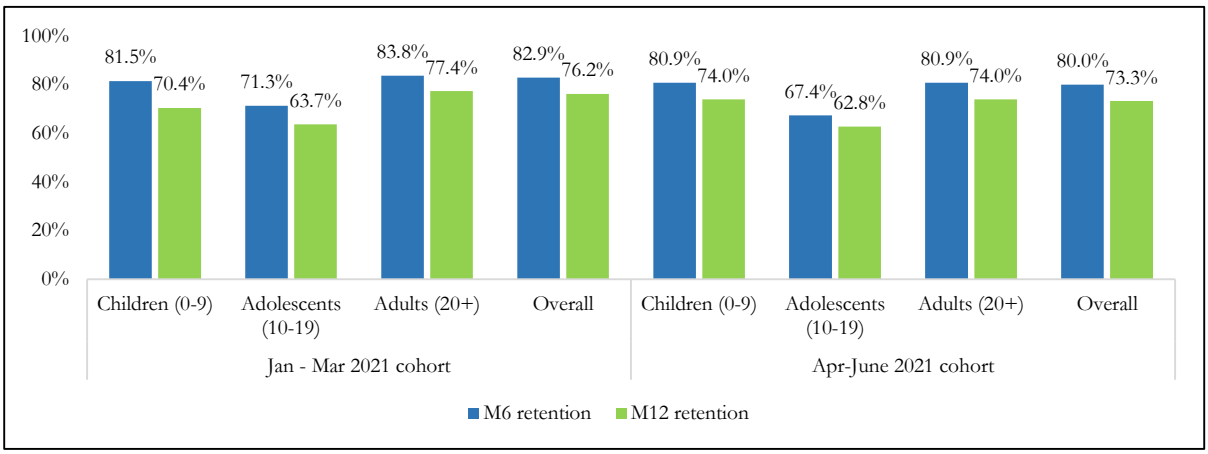
ART coverage among KPs remains at 96%, an improvement from 65% in 2019 with 94.6% on 1st line regimens, 5.3% on 2nd line, and 0.1% on 3rd line. The routine viral load testing and availability of HIVDR testing has led to an increase in the number of those on 3rd-line regimen.

2.1.3 Increase Retention and Adherence to ART to 95% by 2025

ART Adherence and Retention

There was a slight increase in the proportion of PLHIV retained on ART at 12 months after initiation from 71.5%% in 2020/21 to 73.3%, which is still way below the 95% target (Figure 16). Retention at month 12 was lower than that at month 6 (80%) highlighting the need to focus retention efforts on individuals newly initiating treatment. The lowest retention rates were registered amongst adolescents 10-19 years at 67.4% and 62.8% in the 6th and 12th month respectively underscoring the need for intensifying programmes addressing psychosocial support as well as stigma and discrimination among adolescents.

Figure 16: Retention on ART at 6 months and 12 months



Source: DHIS 2

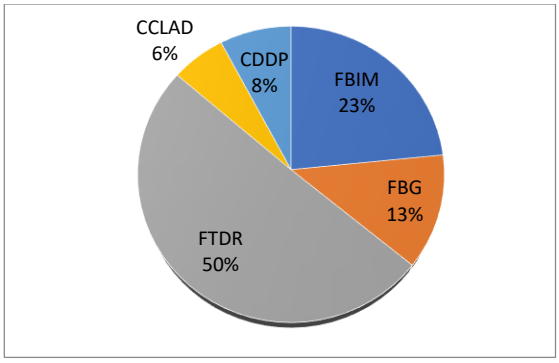
Addressing HIV drug resistance and ART toxicity. HIV drugs are a leading cause of adverse effects to drugs in the country and third line treatment option are provided to manage such cases. Active and passive pharmacovigilance implementation is carried out at all levels of the health system resulting in improved facility reporting of adverse events to HIV/TB drugs. During the year, an additional 400 PLHIVs were enrolled on third line ARV options as a result of improved screening, identification, management, and commodity security, bring the total number of clients on these options to 1,691 PLHIVs.

Differentiated Service Delivery Models (DSDM): As of June 2022, 1,348,517 clients were regularly receiving care and treatment services with 1,334,885 (99%) categorized under a DSD approach. Of these, 64.1% of categorized clients, were on Less Intensive Models (LIM), 35.9%, on More Intensive Models (MIM). During the reporting period, roll out of multi-month dispensing (3-6 monthly) ARV drug refills continued across the country for the LIM.

There were increments from 46% to 50.4% of all clients on the Fast Track Drug Refill (FTDR) model; 8% in the Community Drug Distribution Point (CDDP) model, while the Community Client Led ART

Distribution (CCLAD) model clients remained at 6% (Figure 17). There were drops in those receiving treatment through MIM, from 40% to 35.9%, those utilizing the Facility Based Individual model (FBIM) from 28% to 23.4 %, and Facility Based Groups stagnated at 12.5%. Facility-based models address individuals requiring special care such as pregnant or breast-feeding clients; patients with concurrent opportunistic infections, or those not virally suppressed. The increase in the proportion of clients on CDDP is attributed to the implementation of Community Retail Pharmacy Drug Distribution Points (CRPDDP). By June 2022, 83 pharmacies were linked to 56 health facilities through this approach and 26,197 clients (25%) of the CDDP enrolments are from CRPDDP.

Figure 17: Proportion of clients by DSD model models, June 2022



Source: DHIS2

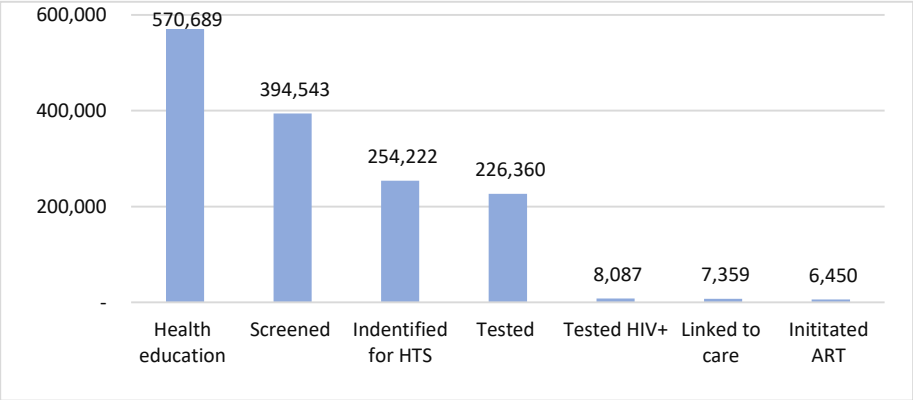
DSD for KPs: This is being implemented as per the DSD guidelines in the different approaches as seen above. With the development and dissemination of the DIC guidelines, and the development of a DSD tool kit, KPs are now receiving services under DSD approaches they qualify for both at the facility and in the community and the programme focus can shift to address the key issues of retention and adherence among KPs.

Peer-to-Peer Initiatives in Care and Treatment

***Young People and Adolescent Peer Supporters (YAPS) model*:** The Young People and Adolescents Peer Support (YAPS) model was rolled out as a novel peer support intervention for Adolescents and Young People (AYP) living with HIV to improve clinical outcomes. In 2021/22, the program continued to scale up the YAPS program to an additional 26 districts bringing the total number to 95 districts implementing the YAPS program (from 72 in 2020/21), and 430 facilities.

The YAPS program addresses the three global 95-95-95 targets; focusing on HTS and linkage to treatment; peer counselling; tracking missed appointments; screening for vulnerabilities and referral to wrap-around services for children and adolescents. In the review period, an additional 442 YAPS were trained, bringing the total number of YAPS to 1,156. They provided health education to 570,689 adolescent and young people (AYPs); screened 394,543, for HTS; identified 254,222 eligible for testing (Figure 18). Of those identified, 226,360 received the HIV test and 8,087 AYPs tested positive (3.6% yield). Of those who tested positive, 91% were linked to care and treatment, however, only 88% (6,450) were initiated and started on ART, highlighting the need to examine the reasons for failure to start treatment for the 12% who were not initiated, and intensify their follow up. The YAPS model has sustained and improved retention with 95% return to treatment. It has also improved viral load coverage to 94.5% and viral load suppression to 94% in the YAPS districts compared to 91% in non-YAPS districts.

Figure 18: YAPS Program achievements, FY 2021/22



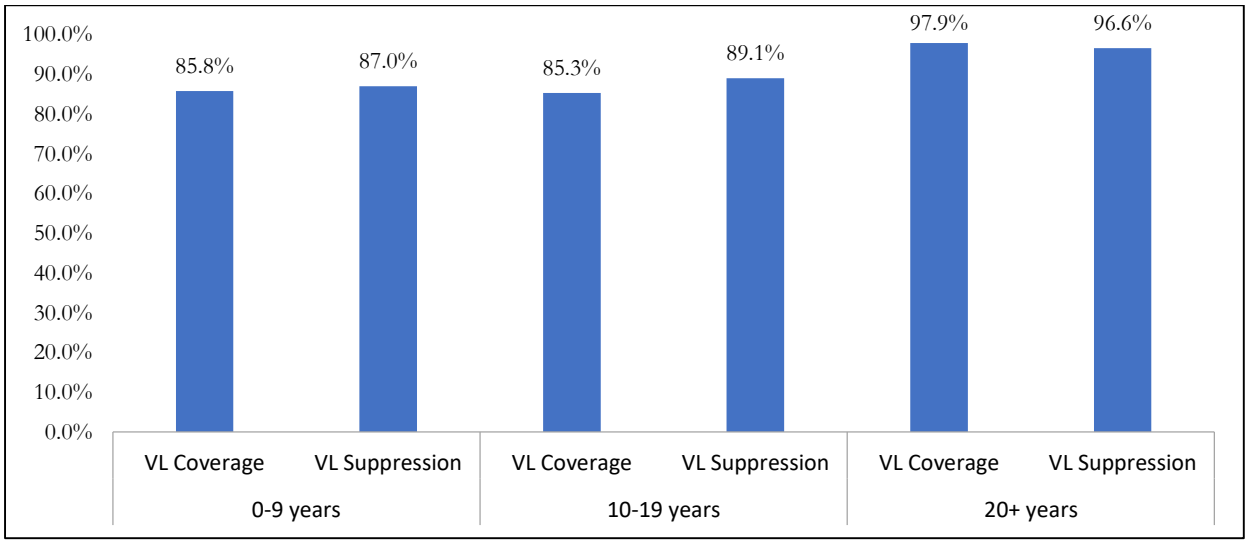
Source: Program data

2.2.2 Achieving and Maintaining 95% Viral Suppression among those on ART

Viral load testing coverage and viral load suppression (VLS): Overall, program data shows that viral load testing coverage dropped slightly to 96% as of June 2022, compared to 97.5% in June 2021 (Figure 19). It also dropped from 98.7% to 97.9% among adults 20+ years. Among adolescents 10-19 years, there was an increase in testing from 82.5% in 2020/21 to 85.3% in 2021/22. Similarly, there was an increase in testing for children 0-9 years from 81.4% in 2020/21 to 85.8%.

By end of June 2022, among those who accessed viral load testing, the proportion virally suppressed was 96.1% (1,243,573/1,294,058), an improvement from 94% in June 2021. Adults had the highest viral suppression rates at 96.6% followed by adolescents (89.1%) and lastly children (87%). The improvement is largely attributed to the implementation of ART regimen optimization which started in 2019 and the DSD model.

Figure 19: Viral load testing coverage and suppression by age group, June 2022



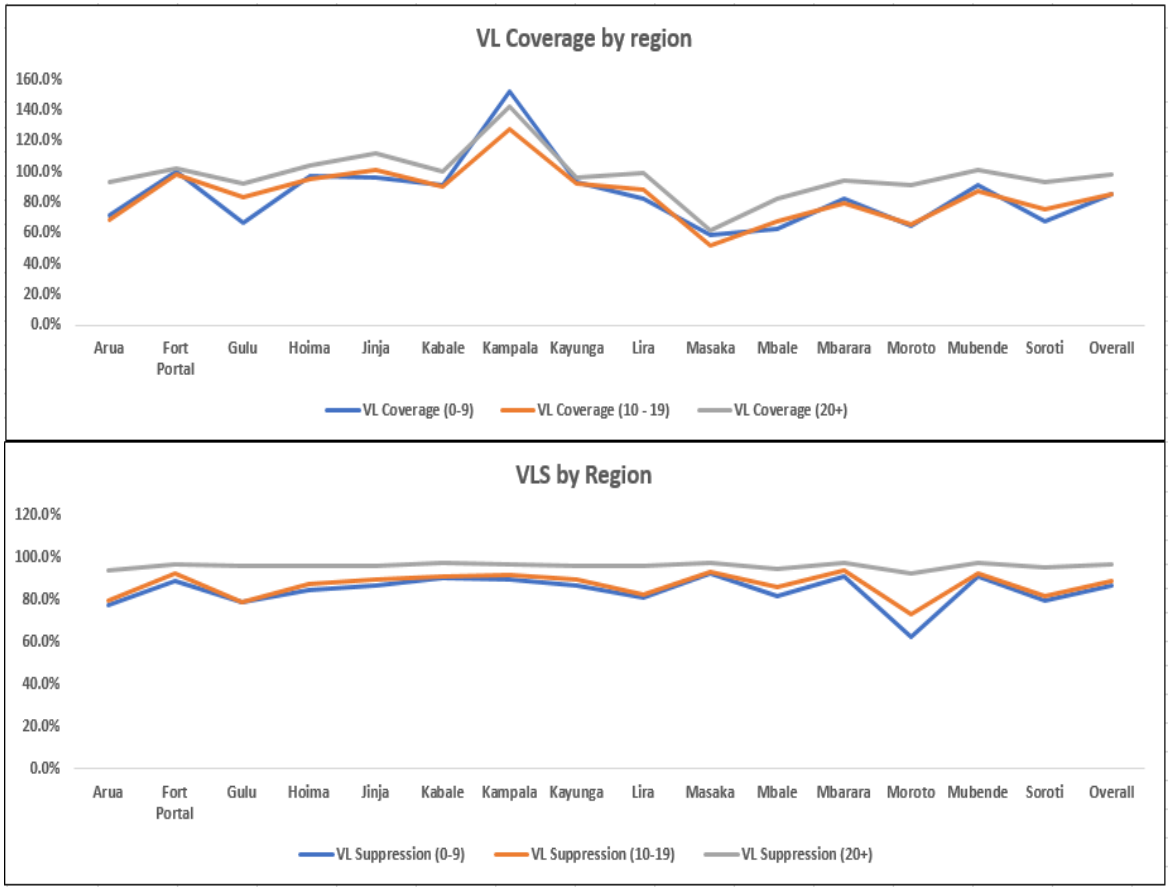
Source: CPHL Database

Across the different populations, VLS is still lower among children (87%) than adults (96.6%) as it was in previous years, because of continued adherence challenges— dependence on adults for care; higher levels of HIV drug resistance (due to previous PMTCT exposure); and lower coverage for ART regimen optimization. However, this performance improved from 81.4% recorded in 2020/2021. Among adolescents 10-19 years, VLS improved from 86.2% to 89.1%, but coverage, adherence and

retention challenges persist in this population. The improvement is attributed to use of better ART regimens plus implementation of retention initiatives such as YAPs as part of DSDM.

Viral load coverage is lower in the regions of Masaka, Moroto, Arua, Gulu, and Soroti, while VLS is lower in the regions Moroto, Arua, Gulu, Mbale and Soroti (Figure 20). The variations indicate the need for intensifying follow up services to PLHIV in these districts and quality assurance of testing services. The 100%+ coverage in Kampala can be explained by the cross-district clientele who self-refer to the urban facilities nearer to their residences for testing.

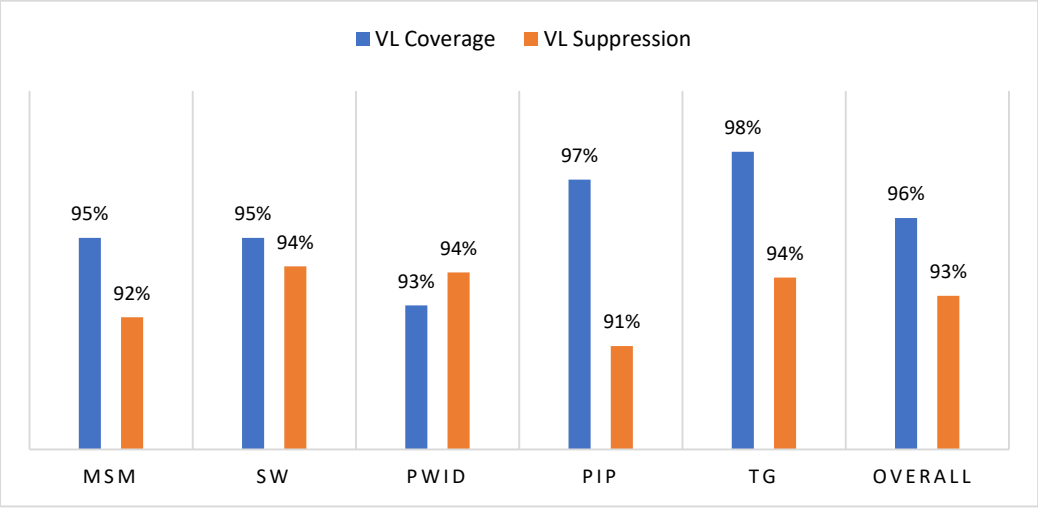
Figure 20: Viral load testing coverage by region, June 2022



Source: CPHL Database

Linkage to services and VLS among KPs and PPs: A total of 329,032 KPs were tested for HIV and 9,798 were found to be positive and of these 9,486 were linked to care support services. Based on KP Tracker data, the viral load suppression among KPs is 93% (Figure 21).

Figure 21: Viral load testing coverage and VLS for KPs, 2021/22

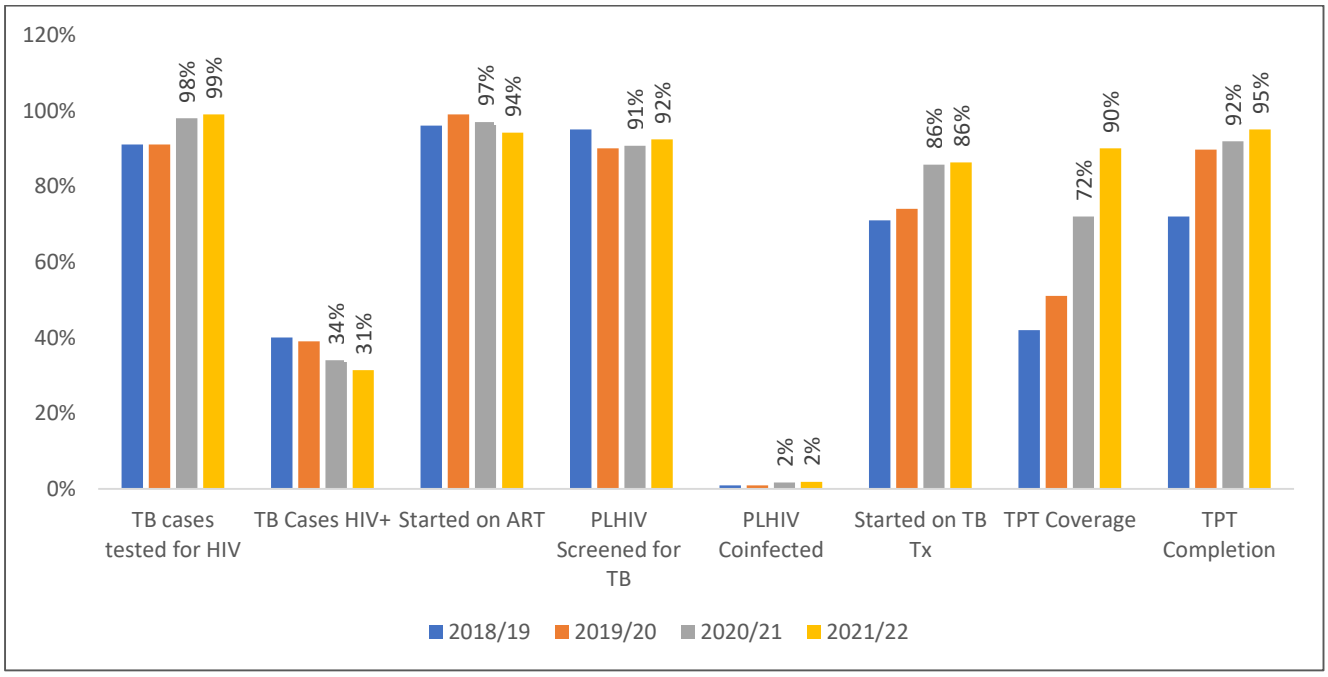


Data source: KP Tracker

2.2.3 Integration of HIV Care and Treatment across Programs

TB/HIV integration: TB/HIV services are well integrated. In FY 2021/22, 92% of PLHIV in care were screened for TB, 1% were confirmed to have active TB, and 86% of those found to have TB were initiated TB treatment. In the TB care setting, 99% of patients were tested for HIV, 31% of these were found HIV-infected, and 94% were initiated on ART. An estimated 90% of PLHIV have received TB preventive therapy (TPT) with a 95% completion rate among those who initiated TPT in the previous reporting period. This is an improvement from the previous year's TPT coverage of 72% and a completion rate of 92%.

Figure 22: TB/HIV collaborative service coverage 2018/19-2021/22



Source: DHIS2

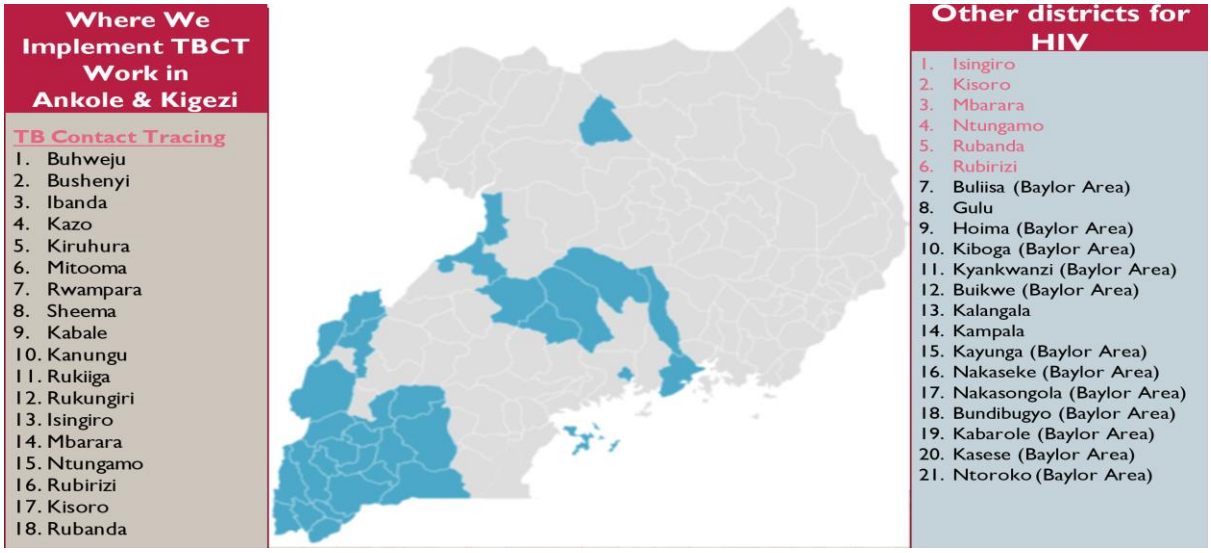
During the period July 2021 to June 2022, a total of 1,348,517 PLHIV were active in care, of these a total of 192,805 eligible PLHIV were initiated on TPT resulting in a cumulative number of 1,197,532

PLHIV in care who have ever completed TPT or 89% national TPT coverage. In line with the 2021 UN high level meeting targets for TPT, the national target for TPT is 90% therefore the unmet need for TPT by June 2021 was 1% translating into 53,188 individuals pending enrolment in TPT.

Since December 2021, the country adopted 3HP (Isoniazid and Rifapentine) as one of the WHO-recommended short regimens for PLHIV and this regimen has been rolled out in phases to regional referral hospitals, district hospitals, centres of excellence, and military and prison facilities. The next phase of the 3HP rollout will be the HC IIIs.

Over the year, the International Community of Women Living with HIV in East Africa ICWEA continued to promote the Resilient Systems Strengthening for Health (RSSH) programme to improve access to HIV/TB services including addressing violence services in 21 districts as per Figure 23 below.

Figure 23: Geographical scope of ICWEA's RSSH Programme



The RSSH programme focuses on strengthening i) coordination and management of national disease control programs; ii) community systems through improved community-based monitoring of TB, HIV and malaria services including GBV, community-led advocacy and research and social mobilization; iii) capacities of 35 local CBOs/Networks through training and tooling of 498 peer leaders and expert clients to create stronger and more resilient community support structures. ICWEA has also contributed to increased TB case finding, increased TB treatment uptake in Kigezi and Ankole; strengthened capacity of 176 health workers from 167 diagnostic testing units (DTUs) in 16 districts of Ankole and Kigezi regions in TPT implementation, contact investigations, use of TB counselling and testing tools and tracking the lost to follow up; investigated contacts of 669 indexes.

Cervical cancer screening: The NSP targets screening 50% of WLHIV for cancer of the cervix by 2025. Program implementation of the National Cervical Cancer Screening and Management Strategy (2021) commenced in January 2021 and this year an additional 1,200 sites were added. By June 2022, 236,572 (56% of the target) had been screened, of which 14,159 (6%) screened positive and 10,555 (75%) were successfully linked to treatment. Screening positivity was slightly lower in the 30yrs+ age group while linkage for the 15-19-year-olds was lower (64%) than the others (Table 5).

Table 5: Cervical cancer screening outputs, 2021/22

Indicator	Age Group				
	All	15-19 years	20-24 years	25-29 years	30+ years
No Screened	236,572	1,260	11,809	48,011	175,492
No Positive	14,159	78	730	3,124	10,227
Positivity Rate %	6.0%	6.2%	6.2%	6.5%	5.8%
No Treated	10,555	50	530	2,418	7,557
Linkage Rate %	74.5%	64.1%	72.6%	77.4%	73.9%

Source: Program data

Advanced HIV Disease (AHD) Management: About 53.4% of patients newly initiating ART had a baseline CD4 performed. Among the 27.8% that had CD4 count below 200 cells/ml (with AHD), 60.5% received a TB-LAM test while 60.1% had a serum CrAg test. Of the 17.8% with a positive TB LAM, 95% were linked to TB treatment. Among the 10.5% with positive serum CrAg, 83.3% were initiated on prophylactic Fluconazole.

Cotrimoxazole Prophylaxis: Of the 1,348,517 PLHIVs active on ART by the end of June 2022, 282,637 (21%) were eligible for Cotrimoxazole prophylaxis, and 79% (222,631) received it. However, this is a decline from 82% registered in the year ending June 2021.

Nutrition: In the year under review, 83% (1,120,665/1,348,517) of PLHIV in care had nutritional assessment at their latest clinic visit. Of these, 6.2% (70,029/1,120,665) were found to have malnutrition but only 19.5% (13,643/70,029) accessed supplemental foods. Moroto Region had the highest malnutrition prevalence at 4.8%.

Non-Communicable Diseases (NCDs): Seventy-three (73) facilities in three regions (Kampala, Wakiso and Mukono, and Ankole) are currently implementing the program on the integration of NCDs and mental health into HIV Care. With support from GFATM, staff in an additional 35 facilities including eight RRHs were trained during the pre-testing of the developed guidelines and training curriculum. Roll-out to the rest of the country will commence in September 2022 in a phased manner.

Impact of COVID-19 on Care and Treatment Services: Although the effect of the COVID-19 epidemic is discussed under the Systems Strengthening section of this report, it is important to note that the two-year interruption in HIV and AIDS prevention, care and treatment services as a result of the pandemic caused severe interruptions in service delivery, including inadequacies in supply chain management of the required commodities and resultant stock outs of ARVs at service delivery level. Additionally, the strict lockdown measures hindered access to refills for the PLHIV and forced some to disclose to enforcement officers in order to be allowed to move. Others went of their regimen due to scarcity of food. To mitigate these challenges, PLHIV networks mobilized resources and promoted the use of differentiated service models to access services. An example is NAFOPHANU that was supported by UNAIDS and Aga Khan Foundation and the Embassy of Ireland to provide psychosocial support to PLHIV; distribute ARVs by consolidating orders from several PLHIV and using MMD; distribute food.

Challenges	***Recommendations***
• ART coverage among children and adolescents continues to be a challenge with the main constraints being finding infected children, linking them to treatment, as well as suboptimal retention in this age group.	1. Review of DSD guidelines together with the Consolidated Guidelines for Prevention and Treatment of HIV and TB in Uganda as per the WHO guidance for patient-centred care, to allow clients to choose their preferred approaches for care.

Challenges	*Recommendations*
• Screening for TB among PLHIV falls short of the expected target by 8%. • TB treatment has not yet not yet been integrated into the DSD models. • There is limited facility coverage of YAPS with a few high-volume facilities implementing the intervention in the supported districts • CD4 access for the non-suppressed PLHIV is still low across the country. • The referral system for linking those found positive to care is still weak. • NCD integration is in a limited number of facilities/districts	2. Strengthen TB screening and improve documentation especially for MMD 3. Scale up CRPDDP across the country to cover more facilities and pharmacies; additionally, integrate more services into this approach like PrEP and NCD treatment. 4. Scale up the YAPS program to the remaining 34 districts 5. Strengthen CD4 testing services including TAT for samples taken from lower facilities. 6. Roll out the HIV/NCD integration Guidelines

2.3 SOCIAL SUPPORT AND SOCIAL PROTECTION

2.3.1 NSP Aspirations

The Government of Uganda through the Third National Development Plan (NDP III) and Vision 2040 recognizes that social protection is an essential strategy for promoting human capital development, inclusive growth and social cohesion in the country. Government has therefore put in place different structures to address social support and protection for vulnerable populations. These efforts are supported by various partners with whom progress has been made under each of the six strategic objectives of the Social Support and Social Protection thematic area of the NSP:

1. Scale up of interventions aimed at eliminating stigma and discrimination.
2. Expand socioeconomic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups.
3. Scale up psychosocial support for people living with HIV, people with a disability, key and priority populations, and other vulnerable people.
4. Strengthen prevention and response to sexual and gender-based discrimination and violence.
5. Strengthen prevention and the response to child protection issues and violence against children.
6. Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all people living with HIV, people with a disability, key and priority populations, and other vulnerable groups.

Key indicators measuring achievements in this thematic area are listed in Annex IV. Most indicators in this thematic area are derived from population-based surveys which for this reporting period are outdated. The Stigma Index Survey being conducted by MakSPH will address many of the indicators.

Box 6: Key Social Support & Protection Interventions

FY 2021/22

- Rolled out stigma policy reaching over 11,701,802 in 135 districts
- Reached 25 million people during advocacy days such as WAD, Cl commemoration and Women's Day to reduce stigma and discrimination
- Developed of the National Policy on HIV and AIDS at the World of Work 2022 by Ministry of Gender, Labour and Social Development
- Developed the HIV Workplace Policies in MDAs, Private Sector and LGs
- GoU launched Parish Development Model
- Reached 307,145 beneficiaries under the SAGE Programme; 21,280 youth projects through YLP; 202,539 women groups through UWEP
- Launched National Single Registry for Social protection
- Developed the Disability Information Management System
- GBV and VAC training for leaders, law enforcement officers

2.3.2 Strengthen the Legal and Policy Framework on HIV and AIDS

To mitigate underlying socio-cultural, gender, and other societal or structural factors, there is need to review existing laws and policies that drive the epidemic and constitute barriers to implementation of an effective HIV and AIDS response as outlined in the NSP 2020/21–2024/25. Uganda has an extensive legal system; Ugandan laws, particularly primary laws such as the Constitution of the Republic of Uganda and the HIV Prevention and Control Act of 2014, are largely positive and enabling in scope, assuring non-discriminatory and equal provision, and access to services for all. However, clauses in some laws contain punitive or restrictive clauses that have the effect of discriminating against certain categories of vulnerable and/or at-risk population groups, thus creating barriers to access services. Both laws and policies generally respect patient privacy and confidentiality in service delivery settings. However, clauses such as HIVPCA Section 18(2) permit health care workers to disclose HIV test results to a third party, eroding patients' rights to privacy and confidentiality. Controversies also remain around the Sexuality Education Framework as well as the Sexual Offences Bill (2019) and the HIV and AIDS Prevention and Control Act (2014).

During the reporting period, a number of critical policies, frameworks and guidelines were finalized thus contributing to an enabling environment for inclusive delivery of HIV services and their utilization. The assessment of the legal and policy environment led by Makerere School of Public Health (MakSPH) was completed and the draft report shared for validation[9]. The study will promote a comprehensive, safe legal environment on HIV and AIDS. This will greatly improve the uptake of legal services for PLHIV KPs, increase access to legal services for these groups, and create a more accepting environment for them among stakeholders at different levels. Preliminary results from the study show that the overall availability, accessibility, acceptability, and quality of services for HIV and AIDS in Uganda has improved over the last five to ten years. Service coverage has expanded generally, and particularly for key and vulnerable populations (KVPs). MakSPH with GFATM funding, is also conducting a national stigma index assessment. This is meant to provide a more comprehensive measurement no HIV-related stigma and will cover the gaps in the stigma assessments conducted by NAFOPHANU.

Other policies supporting inclusiveness of PLHIV across life experiences that were developed during the reporting period include the National Policy on HIV and AIDS at the World of Work 2022 (MoGLSD) and HIV Workplace Policies for MDAs, Private Sector and LGs. The key population programming framework was revised and finalised in the reporting period and implementation of the framework is being guided by the KP Steering Committee.

During the reporting period, the MoGLSD also built the capacity of state and non-state actors in rolling out key policy guidelines, including adoption of the National Social Protection Policy (NSPP). Other policies and institutional frameworks from various MDAs that were advanced during the year include:

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

[9] MakSPH, 2022. Uganda HIV & AIDS Legal Environment Assessment for Key populations

- Development of the Disability Information Management System to enhance social protection targeting among Persons with disabilities.

These policies, guidelines and frameworks were used by various MDAs and SCEs to roll out interventions that empower vulnerable people socially and economically.

There are several interventions (and others are ongoing) to promote the rights of PLHIV in their diversity. These have included specific stigma reduction activities, such as community sensitisation, stakeholder dialogue and training sessions championed by government MDAs, as well as CSOs, religious and cultural institutions and are described below

Improving legal literacy and processes for redress. There is still limited awareness among PLHIV regarding their rights and the existing support mechanisms available to them. This constrains individuals' ability to seek redress when their rights are violated. There are efforts to improve legal literacy, human rights awareness, and access to legal to the general community, PLHIV, and diverse key and vulnerable groups such as widows, orphans, sex workers, and persons with disabilities. However, these are also dependent on donor support, with resulting limits in coverage. Existing best practices in contributing to a better legal and policy environment in Uganda include:

- Meaningful inclusion of PLHIV, key populations and vulnerable populations;
- Engagement with duty bearers, service providers, and other key stakeholders;
- Assisting with access to legal and justice support services;
- Working with and/or through community-based volunteer workers;
- Equipping health workers to integrate rights-based approaches; and
- Integration of medical, legal and psychosocial services.

Many advocacy engagements with duty bearers, stakeholders and communities on legal and human rights issues has taken place, many with the involvement of CSOs affiliated to the CSO Coalition on HIV and the Law, as well as PLHIV-led and KP-led CSOs, including those participating in the Community Led Monitoring Initiative against HIV/TB. These advocacy efforts have focused on the need for legal reform, but also aspects of law enforcement, respect for human rights and stigma reduction. The push for legal reform has in particular focused on: i) Clauses in the HIV Prevention and Control Act (2015) which create the crime of attempted transmission of HIV (Sec.41), and ii) the crime of wilful and intentional transmission of HIV (Sec.43), with the possibility of increasing silence and stigma, discouraging PLHIV from testing to know their HIV status and taking up treatment, and disproportionately affecting women.

For the general population, there has been an increase in the awareness of human rights as a result of training of paralegals and conducting community outreaches by the Human Rights Awareness and Promotion Forum (HRAPF) including. For the KPs, services provision has improved due to having trained health care workers that are sensitive to the needs of the KPs. Access to legal services for KPs improved through the training and engagement of the police and legal fraternity in sensitivity towards sexual minorities. UAC also trained staff of the ODPP on similar issues. As a result, human rights violations by police such as kicking, beating up KPs was not as evident in the media. However, there is need for more engagement of rural based minority groups as opposed to only the Kampala and urban areas in order to have representation of all sexual minority groups. There is also need to increase awareness on KP issues by orienting DHOs, disseminating the MARPs Priority Action Plan; and integrating STI care in the services provided.

TASO with support of the GFATM implemented interventions aimed at reducing human rights-related barriers to HIV/TB services for KPs, adolescent girls and young women. Activities included; development of scorecard as an accountability tool for monitoring the utilization and impact of all relevant law, regulations, policies and guidelines, training of paralegals, developing, rolling out and maintaining community-level reporting tools and processes for documenting rights violations; community sensitization events through mass media and mobile legal aid camps. These activities help

to address violations of their rights, curb GBV and build confidence to undertake HIV prevention and treatment services. While implementation of these community-based activities was affected by the COVID-19 pandemic, in the second half of the year, 59/25 (mobile legal aid camps were conducted reaching out to 3,016 beneficiaries.

UGANET is working with Human Rights Awareness and Promotion Forum (HRAPF) and the International Community of Women Living with HIV in East Africa (ICWEA), to implement the GFATM RSSH and Human Rights component of the GFATM country priority areas for the year 2021 – 2023, that aim to reduce human rights-related barriers to HIV/TB and malaria services. The joint implementation of activities in the performance framework ensures a comprehensive achievement of targets and reporting to the GFATM. During the year, UGANET implemented legal aid and community justice interventions by creating safe spaces for under privileged community groups and individuals, facilitating them to access legal justice and promoting social protection. UGANET also reached communities through outreaches in five regions that delivered awareness messages on justice and rights and provided of legal aid (court representation and mediation). In ensuring access to justice by the communities through mobile legal aid camps, the Legal Aid and Community Justice Departments (LACJ) team members have positively impacted the lives of the communities restoring rights, resolving disputes, and challenging crimes, abuses or human rights violations. In addition, 1,215 persons were trained and 1,366 individuals met during the dialogues.

One key achievement in this reporting period was to successfully hold the 3rd National Dialogue on HIV and the Law in December 2021. Every 10th of December (International Human Rights Day). UGANET and partners hold a national conference that brings together actors/partners from government institutions, policy makers, academia, CSOs, media, community members among other to dialogue on the national issues around legal environment that affect people living with HIV, KP and TB. In 2021, the focus was on the role of the Judiciary in the HIV and AIDS response, and to this effect, a judicial handbook on HIV and the law was launched to give guidance in adjudicating HIV related cases.

Justice Sekaana Musa launches the Judicial Handbook on HIV, Human Rights and the Law, Protea Hotel, December 2021

In November, 2021, the Uganda Network on Law, Ethics & HIV/AIDS (UNAGET) and other Civil Society Organizations (CSOs), with support from the Uganda AIDS Commission successfully hosted the 2021 Philly Lutaaya Awards at Onomo Hotel in Kampala. These awards honour Philly Lutaaya, a Ugandan musician who is remembered as the first prominent Ugandan to give a human face to HIV/AIDS; he became a national hero because he was the first Ugandan to declare that he was HIV positive in 1988. This event and awards are meant to highlight people who over the years have been fighting to see the end of HIV stigma and related discrimination and is well covered by the media as an advocacy tool.

Over the last one year, UGANET has seen an improvement on reporting HIV related cases in the bigger media houses as a result of engaging with these media houses. In NFM2 UGANET trained media personalities / journalist on reporting HIV and TB related cases. From 2019 the trained team of 25 senior journalists has constituently reported about HIV related issues with a focus on stigma and human rights. In NFM3 UGANET continued to engage the team of 25 journalists trained to report on HIV and AIDS issues previously, and 5 of them emerged as the best in HIV related case reporting in the HIV Media Award.

During FY 2021/22, UGANET led the development and rollout of a Human Rights Violations Reporting Tool. It was validated and endorsed by CSO partners, rights holders, representatives of PLHIV Women, KPs, AGYW, and PWDs and 23 DLGs. This tool aims at availing real time data on human rights violations across districts to inform programming, targeted response and hence strengthen a coordinated approach in addressing human rights violations. So far, the tool has been rolled out in 25 districts where district human rights committees have been established.

Participants at the validation workshop for the Human Rights Violation Reporting Tool, Hotel Africana, December 2021

The UGANET team also engaged a total of 2,264 women and AGYW in community dialogue meetings on GBV in the context of COVID-19 in 13 high GBV high-burden districts (Kween, Tororo, Katakwi, Kampala, Kasese, Lira, Gulu, Kiryandongo, Nebbi, Namutumba, Mubende, Jinja and Wakiso). During the meetings, women who needed legal aid support were identified and linked to the LACJ Departments. An example is the land grabbing case in Buvuma whereby a stepfather tried to grab land belonging to the children after their mother died of HIV/AIDs related causes. The advocacy issues raised during the discussions with the stakeholders by concerned women have been captured in a *UGANET Issue paper, Volume 4: 2021* and presented in different forum at national and district level dialogues and through social media.

UGANET further conducted 6 mobile camps on a smaller scale at health centres, key sub-counties and villages identified between April and September 2021. The Mobile Camp Strategy is an opportunity to ensure the services are taken closer to the vulnerable and marginalized in their respective communities. During these camps, the legal team conducted human rights awareness sessions and provided free legal aid services to persons living with and affected by HIV/AIDS, adolescent girls and young women and victims of Gender-Based Violence.

2.3.3 Scale up Interventions Aimed at Eliminating Stigma and Discrimination

Stigma and discrimination against PHIV, KPs and vulnerable groups remains one of the persistent barriers to an effective HIV response in Uganda and is one of the structural game changers prioritized in the NSP. The roll out of the National Equity Plan (full name: “Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda”) was revitalized

following a lull of activities due to the COVID-19 epidemic restrictions. To implement the national Equity Plan, Uganda received US$ 4.4 million in matching funds for programs to reduce human rights-related barriers under GFATM NFM2 and has fully matched this with the total investment amounting to US$ 8.78 million. Under GTATM NFM3, the investment increased to US$ 9.27 million.

The plan, which has nine (9) pillars, aims to address stigma and discrimination in communities and health care settings; GBV; punitive practices; policies and laws that hinder access to services; poverty and other forms of social marginalisation that negatively affect health. During the reporting period, a National Equity Plan Steering Committee was established with representation from relevant stakeholders and its secretariat at UAC. An Equity Coordinator was recruited to lead the implementation of the plan, which is implemented by the different SCEs. Interventions related to legal barriers to access to services are being addressed by partners such as Uganda Network on Law, Ethics and HIV/AIDS (UGANET), Human Rights Awareness and Promotion Forum (HRAPF) and Women Probono Initiative; while the community response is being addressed by the International Community of Women Living with HIV – East Africa (ICWEA), National Forum for People Living with HIV/AIDS in Uganda (NAFOPHANU), the Uganda Stop TB Partnership, the Uganda Action Against Malaria among others. The Office of the Directorate of Pubic Prosecution (ODPP) continues to advocate for PLHIV and persons infected by tuberculosis who have committed minor crimes to be given lesser sentences and supported to complete and adhere to medication.

During the year, the Minister in-charge of the Presidency launched the National Policy Guidelines on Ending HIV Stigma and Discrimination (NPGESD). With support from the GFATM, UAC coordinated stakeholders to disseminate the guidelines to all districts through multisectoral teams that were constituted for this purpose. The dissemination reached all the 135 districts and 41 urban authorities, reaching over 3,500 individuals; district and urban AIDS Coordination Committees, local government leaders, representatives of PLHIV, CSOs, religious and cultural leaders, among others. Further, the dissemination was also carried out with the fraternity of people with disabilities led by POWED. The guidelines were further disseminated to all the PLHIV coordinators during the annual general meeting of National Forum of People Living with HIV/AIDS in Uganda (NAFOPHANU) and this reached 140 PLHIV leaders. The policy is being translated to address concerns of people with disabilities (PWD) in collaboration with the Uganda National Association for the Blind and the Uganda National Association for the Deaf. To oversee interventions in this area, UAC constituted a multisectoral national TWG on HIV and AIDS Stigma and Discrimination.

Interventions to Address Stigma and Discrimination

Various stakeholders including MDAs, were engaged in different interventions in the promotion of the policy on ending stigma and discrimination. the Judiciary disseminated the NPGESD and messages on HIV and AIDS for their officers. Members of the PLHIV constituency and CSOs engaged in media campaigns towards ending stigma and discrimination and continued to hold dialogue meetings at national and sub-national levels on HIV, TB and the Law. The events were useful in promoting champions to deliver messages in the fight against stigma and discrimination. The Media SCE mobilised 140 journalists from three regions—Tooro, Kigezi and Ankole Regions—oriented them on the policy guidelines and tasked them to use their platforms to disseminate HIV prevention and anti-stigma messages to the grassroot people. UAC reached 11,701,802 people countrywide through a media campaign that used radio and TV talk shows to disseminate messages through 84 radio and six TV stations.

UAC contracted Paradigm Group Limited to coordinate the dissemination of radio and TV spot messages on HIV stigma and discrimination through 12 radio stations and one TV station across seven of the 10 regions of Uganda. The dissemination effort reached a total of 10,004,662 listeners and viewers (7,649,418 via radio and 2,355,044 via TV). UAC also contracted East Africa Radio Services Limited (EARS), to coordinate radio and TV talk shows on HIV stigma and discrimination covering 10 regions of Uganda. In total UAC conducted 82 radio talk shows on 41 stations and 6 TV talk shows on

six stations reaching 11, 701,802 people. Another activity was the engagement of the city-based *Comedy Store*, well-known comedians who have a large following through their comedy shows and on social media. They were oriented on HIV and AIDS messaging in line with the PFTI pillars and empowered to disseminate these messages to their fans. The comedians made commitments on what they would do first, in their individual capacity, but also at the corporate level. UAC and the Private sector SCE will follow up these commitments.

The Uganda People's Defence Forces (UPDF) disseminated the *Commanders' Talking Tools* towards the creation of friendly spaces for stigma and discrimination-free services among their personnel.

Other interventions such as awareness, referrals to address stigma and discrimination were conducted through dissemination of pastoral letters, national level dissemination of the Faith Based Action Plan, and community outreaches. The World AIDS Day and the related Candle Light Memorial events focused on ending stigma and discrimination and reached over 25 million people countrywide. In addition, 18 cultural institutions, which are powerful channels for reaching the grassroots, engaged communities with HIV prevention messages addressing stigma and discrimination across the country. In Buganda and Tooro, the kings dedicated their birthdays to sensitizing the communities on HIV and AIDS.

CSOs, especially those of PLHIV play an important role in the reduction of HIV and AID stigma and discrimination. NAFOPHANU conducted facility-based sessions to create awareness of HIV stigma and COVID across the country. The sessions were attended by over 1,602 PLHIV and the engagement enhanced information sharing among PLHIV on adherence, disclosure, TB prevention and management, human rights, and treatment literacy including viral load suppression.

The Kabaka of Buganda flags off thousands of participants for his birthday run under the theme: Ending AIDS, Bulange-Mengo, November 2021

On a limited scale, civil society partners implement a comprehensive legal literacy training for all KP, but a very limited number of KP have benefited from the trainings and are aware of the laws and their rights, and are therefore able to advocate for their needs using non-standardised materials. Nonetheless, the training has been associated with positive impact on KP.

The Global HIV Prevention Coalition (GPC)/ South-South Learning Network (SSLN) with relevant stakeholders, developed a comprehensive training manual for civil society partners to be used in sensitising law makers and law enforcement officers on KP programming issues. This tool is currently under review, but once approved will go a long way in addressing the challenges of all KP groups.

At a low scale, using non-standardised materials, trainings of health workers on human rights and medical ethics related to HIV is ongoing to minimize health worker's negative attitudes towards KP.

2.3.4 Expand Socioeconomic Interventions to Reduce Social and Economic Vulnerability for PLHIV and Other Vulnerable Groups

Social economic strengthening interventions are crucial for the success of HIV prevention and control programs. Economic support helps empower vulnerable PLHIV and their families to access and sustain treatment, and to secure much needed basics such as food and welfare for children. It also empowers vulnerable groups such as AGYW to negotiate for safer sex and thus protect themselves from HIV infection. The NSP therefore places emphasis on socio-economic interventions that help to reduce economic vulnerability of the general population including PLHIV. These take different forms such as social protection and social assistance programs, start-up capital, nutrition, and formal and non-formal education for children as described below for FY 2021/22.

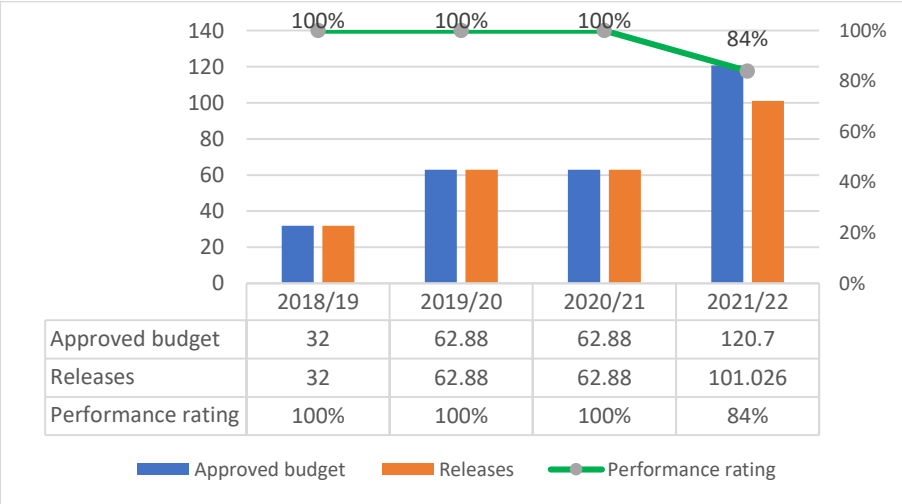
During the year, the Government of Uganda (GoU) launched the Parish Development Model adding to several other economic empowerment programs that are ongoing such as the Uganda Youth Livelihood (UYL) programme, the Uganda Women's Empowerment Program (UWEP), Emyoga and the Social Assistance Grant for Empowerment (SAGE)/Senior Citizen's Grant (SCG). UAC held dialogue meetings with MoLG to discuss mechanisms of integrating HIV and AIDS into the PDM and to this effect, developed indicators for integration into the PDM program. The key interventions across these programmes are described below.

SAGE Programme

During the reporting period 2021/22, GoU supported 307,145 beneficiaries under the SAGE Programme that were enrolled on the Centenary Bank (CERUDEB) payment system and 185,652 (60%) female and 121,493(40%) male beneficiaries on the Public Service Providers (PSP) system; 15,721 beneficiaries are pending migration to the current PSP system through Post Bank Uganda. These primarily include the sick who require home-based enrolment, those who lost their national ID, and those who did not register for a national ID at all. A total of UGX 101 million was released for the reporting period (Figure 24).

All beneficiary payments are currently being financed by GoU as well as development partners, who finance some programme operational activities. However, donor funding is scheduled to end in June 2022 and the plan is to transition all costs to government. A detailed breakdown of the financing for the SAGE programme over the past four years is presented below.

Figure 24: Trends in financing (UGX million) for SAGE programme, 2018/19-2021/22



	2018/19	2019/20	2020/21	2021/22
Approved budget	32	62.88	62.88	120.7
Releases	32	62.88	62.88	101.026
Performance rating	100%	100%	100%	84%

Program reports indicate SAGE interventions have proved to be valuable safety nets and social protection mechanisms for the elderly, helping beneficiaries to sustain livelihoods and have access to basic needs in life for themselves and their dependants, many of whom are orphans and vulnerable children. Going forward, it will be important to know how many of the beneficiaries are PLHIV, in order

to help them age well with HIV. The bulk of the beneficiaries indicated that they use the grant to buy food (88.9%), medical care (57.8%) and hygiene and buying livestock, both at (27%). However, despite literature showing that beneficiaries spend the Grant on education, very few respondents (16.8%) indicated spending on education. This can be attributed to the closure of the schools during the COVID-19 lockdown.

The Youth Livelihood Programme (YLP)

The YLP provides interest free revolving funds to unemployed and poor youth (aged 18-30 years) including but not limited to; school drop-outs, youth living in slums, youth with no formal education, single parents, youth with disabilities, and those living with HIV/AIDS among others. As of June 2022, GoU had released a cumulative total of UGX 168 billion for the YLP Programme, of which Phase I (2015/16-2019/20) received UGX 107 billion, constituting 71.6% of the total budget allocation for this phase. In the ongoing Phase II of the programme a total of UGX 61 billion has been released (Table 6). A detailed breakdown of the amount appropriated and actual releases is presented in the Table 6.

Cumulatively, funds disbursement stands at UGX. 169.4 billion that financed a total of 21,280 youth groups/projects. This has benefited/served 251,679 youth with 46% female. However, program reports indicate challenges in following the guidelines by some implementors and recovery of the revolving funds from beneficiaries.

Table 6: GoU YLP allocations and releases 2015/16-2021/22

Phase I Implementation			
Financial Year	Budget (UGX)	Release (UGX)	Performance rating
2015/16	3,000,000,000	2,150,767,438	71.7%
2016/17	43,000,000,001	24,339,347,328	56.6%
2017/18	37,365,533,505	30,762,375,495	82.3%
2018/19	35,716,456,000	33,220,925,668	93.0%
2019/20	30,267,970,422	16,534,830,176	54.6%
TOTAL PHASE I	**149,349,959,928**	**107,008,246,105**	**71.60%**
Phase II Implementation			
Financial Year	Budget (UGX)	Release (UGX)	Performance rating
2020/21	29,049,000,002	29,049,000,002	100.0%
2021/22	32,000,000,000	32,000,000,000	100.0%
TOTAL PHASE II	**61,049,000,002**	**61,049,000,002**	**100.0%**
Total since inception	**210,398,959,930**	**168,057,246,107**	**79.90%**

The Uganda Women Entrepreneurship Programme (UWEP)

In February, 2016, Cabinet approved the establishment of the UWEP as an affirmative action initiative providing a revolving fund meant to address the socioeconomic challenges facing vulnerable women across the country. Key socioeconomic challenges being addressed by the programme include; limited access to affordable credit from formal financial institutions, limited technical knowledge and skills for business development, limited access to markets as well as information regarding business opportunities.

Implementation of the programme is mainstreamed into government structures at both national and district local government (DLG) levels. DLGs are responsible for mobilisation and sensitisation of the community on the programme, beneficiary selection, facilitating the preparation, appraisal and

approval of projects, monitoring, technical support supervision and recovery of funds. At the national level, the MoGLSD is responsible for providing technical guidelines, capacity building, financing, and overall coordination of the programme.

The design and implementation of the programme is based on the Community Demand-driven Development (CDD) model that provides women with interest free loans (revolving funds) of up to UGX. 12.5 million depending on the nature of the enterprise. These are provided to women groups of 5-15 persons. The terms of the financing are flexible and among others, do not require presentation of any form of collaterals, are interest free for all repayments made within the first 12 months and only 5% per annum charged for repayments exceeding 1 year, and provides for flexible repayment periods based on the project maturity period, business plan. Table 7 summarises financing and beneficiaries of the UWEP for the year.

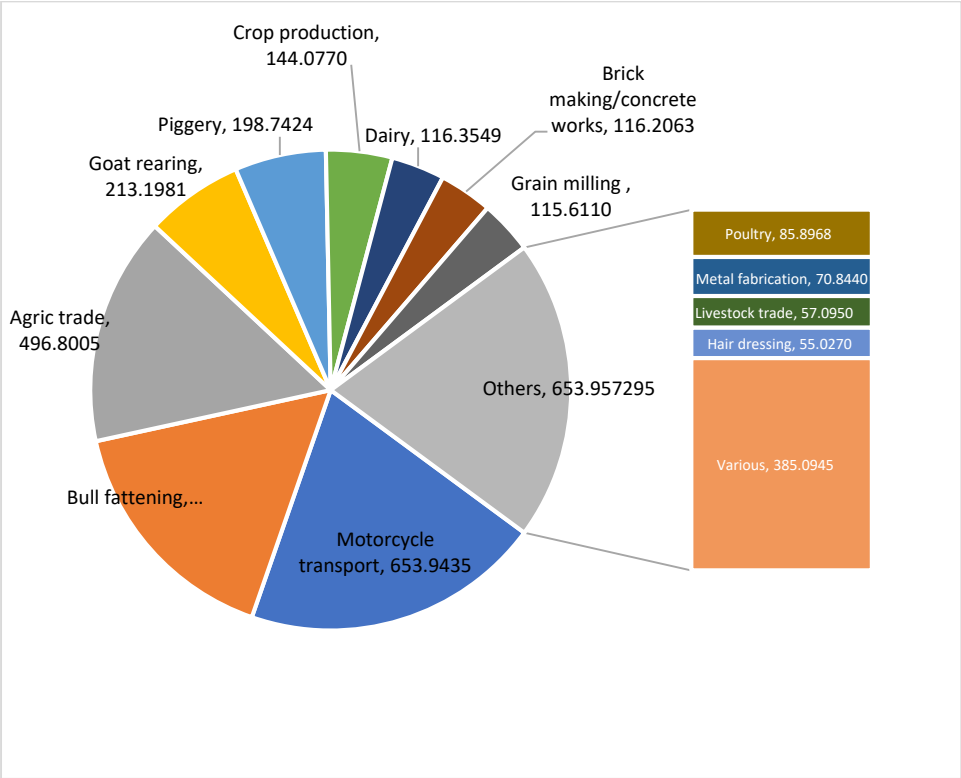
A women's group receiving funds to support their enterprises, Wakiso District

Table 7: Summary of UWEP financing and beneficiaries, June 2022

Number of projects financed	**17,852**
Number of beneficiaries	202,539
Amount of women enterprise funds (start-up capital)	114,288,661,522
Institutional support funds	53,768,584,585
Gross release from MFPED	168,057,246,107

Over 80% of the funding was spent on the agriculture, trade, and service sectors (Figure 25). Although there is no wide gender disparity in engagement of the youth, more women than men are employed in the creative industry (51%). Other sectors that engage a considerable number of women youths are vocational skills (49%), health care (47%), trade (46%) and agroforestry (46%).

Figure 25: Expenditure of UWEP funding by category of enterprise



TASO

With GFATM funding, TASO reached 7,219 (77%) out of 9,378 AGYW between the ages of 10-24 with socioeconomic support. The interventions included vocational skills, enterprise development assistance and a cross-cutting theme of SRHR implemented through empowerment clubs, SRH camps. The funding was channelled through implementing partners and covered 18 districts (Table 8).

Table 8: AGYW beneficiaries by implementing partner and intervention, FY 2021/22

INTERVENTION	BAYLOR	UDHA	PACE	TOTAL
Vocational Skilling training	887	1,615	300	**2,802**
Enterprise Development Assistance (EDA)	268	0	29	**297**
Sexual Reproductive Health and Rights Groups like empowerment clubs, SRH camps	1,888	1,829	403	**4,120**
TOTAL	**3,043**	**3,444**	**732**	**7,219**
	Hoima, Buikwe, Buliisa, Kiboga, Nakaseke, Kyankwanzi, Nakasongola	Jinja, Iganga, Kaliro, Buyende, Mayuge, Buvuma, Tororo, Busia	Mbale, Dokolo, Kitgum	

2.3.5 Psychosocial Support for PLHIV, PWDs, and Priority Populations & Vulnerable Groups

Psychosocial support for PLHIV is provided through various avenues: as part of routine counselling and in the provision of HTS; through peer support groups; during socioeconomic empowerment interventions, through telephone help lines; and through linkage to professional help. The PEPFAR OVC programme provides psychosocial support to OVC and their caregivers through various packages of services.

OVC Programme

OVC are from households which are infected or affected by HIV and therefore a vulnerable population to HIV infection making it an important target group for the HIV and AIDS response. During the 2021/22 reporting period, a total of 403,589 OVC received social support services. Of these, 354,786 (87.9%) received a package of comprehensive services addressing their health, safety, schooling and stability needs, while 48,002 (11.9%) received curriculum-based HIV prevention services in the form of parenting skills for caregivers or life skills for adolescents. Among OVC 0-17 years, 98% of them knew their HIV status and 18.7% were HIV positive.

Peer support groups. Peers have been used across all service areas to augment the counselling support provided by health workers. They include peer mothers, expert clients, KPs, and AGYWs and actively support HIV service delivery through counselling, conducting health talks during ART clinic days, supporting counselling, ART drug refills, follow up of clients through home visits ART home deliveries, referrals and linkages for appropriate care at the facility or in the community. They also conduct group meetings, community dialogues, and deliver ARVs, condoms and other services.

Help lines. During the reporting period, UN Women established a toll-free helpline (0800-199195) in the Uganda Police Force to quicken the response to GBV cases. The Children's Helpline instituted into MoGLSD continued to function and Safe Pal, AGYW helpline was integrated into it during the year. Also active were GBV/VAC Helplines at MoGLSD and the Police Force.

Through DREAMS interventions across the country, 124,374 AGYWs were provided with parenting skills, 24,075 were taught how to be assertive through the "No Means No" intervention, and 56,612 were provided with post-violence care.

2.3.6 Strengthen Prevention and Response to GBV Discrimination

Gender-based violence (GBV) and discrimination continues to negatively affect health and HIV and AIDS outcomes which were further affected by the COVID 19 epidemic. A total of 12,811 incident GBV cases were reported by the GBV champions and community activists, who work with the existing local structures (local councils, police, district community development office, among others) to appropriately manage the cases.

According to police records, in 2021, 17,533 domestic violence cases were reported[10], a reduction of 0.74% from the previous year. Of these, with more 12,877 were adult females and 3,103 adult males, while the rest were juveniles (871 males, 702 females). A total of 1,486 rape cases were registered (a decrease of 2.2% from the previous year), while 14,436 defilement cases were reported (an increase of 2.1%). Of concern is the limited number of cases that are followed through to convictions of the perpetrators of the crimes. Only 1,640 (9.4%) of the domestic violence cases, 6,191 (42.9%) of the defilement cases, and 44.9% of the rape cases were followed through to court and of these 2.7%, 6.5% and 1.7% ended with convictions respectively.

To address gaps in enforcement and judicial processes, several partners provided the police and judiciary with capacity building support. The International Development Law Organization (IDLO) supported training of police officers, probation officers and medical officers on prevention and

[10] Uganda Police Force. 2021. Annual Crime Report, 2021.

response to GBV, violence against children (VAC) in the Albertine, Greater Masaka, North Kyoga and Mt Elgon regions. Barracks Action Teams in the Rwenzori West, Rwenzori East and Albertine Regions were activated to follow up GBV cases and report them to head office on a monthly basis. The Justice, Law and Order Sector (JLOS) also trained 413 police officers including unit commanders, supervisors and investigators on Diversion Guidelines in 17 districts. With support from UN Women, the Child and family protection Department conducted positive masculinity dialogues in the police barracks of Arua, Kitgum, Kasese, Kyegegwa and Bundibugyo. UN Women further established a toll-free helpline (0800-199195) in the Uganda Police Force.

The reporting of VAC and GBV was enhanced with the updating and integration of *SafePal* a digital software application through which young people can confidentially report SGBV and get help, into the Children's Helpline. Capacity was built for frontline service providers and equipment (80 computers) was procured and supplied to the districts to enable functionality of the application. Many community members are now able to report cases and get help on time.

To improve quality of GBV and VAC services the MoH carried out quarterly mentorship to health workers, using the sessions to provide information on updated guidelines, protocols, and standard operating procedures related to GBV and VAC.

2.3.7 Strengthen Interventions to Prevent Violence against Children and Response to Child Protection Issues

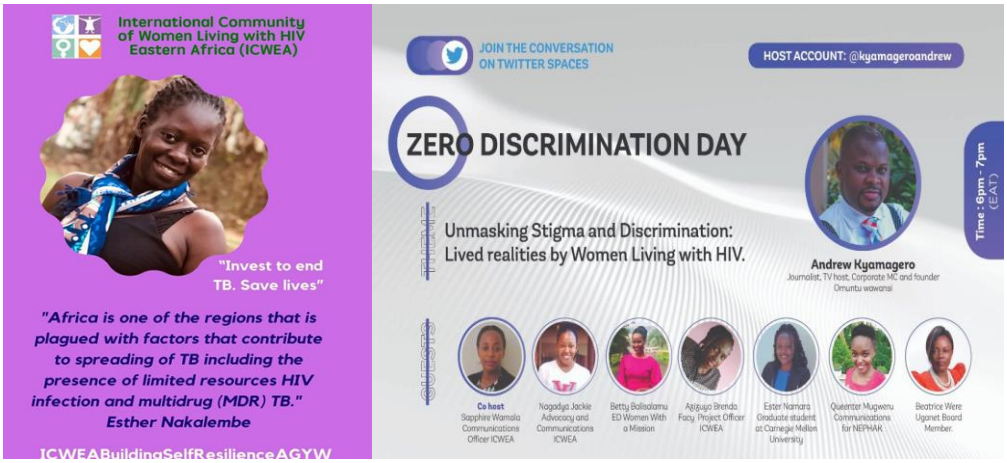
One of the most pervasive, and devastating violations of human rights in the world today is violence against women (VAW) and violence against children (VAC) (Shawar and Shiffman, 2021). In Uganda, both these vices are rampant. The prevalence of physical violence against children is 71%[11], while childhood sexual abuse in Uganda is 59% for girls 10-14 years.[12] Other studies show that 36% of children report emotional abuse, while 59 % of girls and 68 % of boys report physical abuse, and 35 % of girls and 17% of boys report sexual abuse (UBOS, 2018). It is further noted that one in every three girls in Uganda under the age of 15 (33%) had their first sexual encounter forced upon them (Kyegombe et al., 2020). This is consistent with the UBOS (2021) statistics that the younger a woman's age at first sex, the more likely her sexual initiation was forced. One in three girls (35%) and one in six boys (17%) in Uganda's 18-24 age group reported experiencing sexual violence as children (Stamatakis et al., 2021, Ministry of Gender, 2018). The COVID19 pandemic increased the prevalence of VAC and VAW, highlighting the critical need to address these vices (Peterman et al., 2020). Lockdowns and other movement restrictions forced women and children to stay at home with their abusers (Miller et al., 2022, Peterman et al., 2020). MoGLSD has made efforts to strengthen violence prevention and response interventions with a special focus on reducing teenage pregnancy. UNICEF studies on child marriage and female genital mutilation indicate an increase in both vices during the 2-year pandemic restrictions[13] as well as defilements and other forms of SGBV, thus increasing the vulnerabilities to HIV infection. Further, the high school dropout rate, and un-documented mental health challenges experienced by the young mothers and parents continue to be prevalent even after the pandemic declined. According to the Annual Police Crime Report, 2021, aggravated defilement increased by 1.6%, defilement increased by 2.1%, and child neglect increased by 3.7% in 2021. A multisectoral approach is needed to address the underlying factors contributing to these worrying statistics.

To address these vices, the MoH strengthened the functionality of 20 VAC centres in 20 districts. Working with CSOs and AIDS development partners (ADPs), the MoH also built capacity of health workers, developed promotional SBCC messages, held webinars, national and regional dialogues and campaigns aimed at mitigating the effects of teenage pregnancies. The MoES also developed guidelines aimed at keeping pregnant and breast-feeding adolescents at school.

[11] UBOS. 2021. 5th Annual Gender Statistics Forum.
[12] UBOS. 2021. National Survey on Violence in Uganda. Module 1: Violence against Women and Girls
[13] UNICEF. 2022 The Impact of COVID-19 on Child Marriage and FGM. Research Report. February 2022.

AGYW. The MoH has developed an overarching strategy to address the needs of AGYW, however, the roll out of these service through interventions such as DREAMS are not yet countrywide. These interventions are often donor dependent, raising concerns about sustainability of services given current low levels of domestic financing. The programmes also need a strong linkage component as protection and law enforcement services are usually beyond the scope of project implementers.

During FY 2021/22, the International Community of Women Living with HIV in East Africa (ICWEA) continued to support women and girls living with HIV and enhance their representation and participation in the HIV response. The organisation's interventions are premised on the fact that a) self-stigma among PLHIV is a global public health threat because it hampers use of healthcare services, as well as uptake of, and adherence to, life-saving ART. b) adolescent girls, face multiple vulnerabilities, they are severely and unevenly at risk of HIV infection – two thirds of all new HIV infections are contracted by adolescent girls Life is harsh for many, an c) poverty, HIV and AIDS, early marriage, teenage pregnancy, gender-based violence and low participation in secondary education make it difficult for young people to fulfil their potential. The organisation introduced the "Building Self-Resilience among AGYW Living with HIV to Fight Self-Stigma" project and the use of anti-self-stigma champions to health workers to increase health care seeking practices, and improve the participation of AGYW living with HIV in in activism, advocacy, life coping skills.



ICWEA: Putting AGYW at the forefront in implementation of the project. Clockwise from top left: 1. ICWEA AGYW advocacy poster. 2. Social media mobilization poster for Zero-Discrimination Day 2022.

Challenges

- Stigma and discrimination against PLHIV persist in the community especially for KPs.
- Changing donor priorities. The current donor leaning is towards KPs compared PLHIV leading to reduction or stagnation of resources targeting women living with HIV.
- The limited domestic funding for programs may also pose challenges for sustainability and institutionalisation of programs to remove rights-related barriers.
- Gap between number of GBV/VAC events and perpetuators followed up for meting justice is wide.
- Ownership of program by district leaders is still limited.
- PDM roll out has just begun; integration of HIV and AIDS not yet clear.

Recommendations

1. Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels.
2. Strengthen collaborations and partnerships with vulnerable communities.
3. Promote implementation of CSO interventions through consortium arrangements to create synergies and enhanced and timely achievement of results.

4. Scale up psychosocial support for PLHIV, PWDs, KPs, PPs, and other vulnerable groups
5. Strengthen prevention and response to gender-based violence / discrimination.
6. Ensure tracking and reporting of HIV and AIDS PDM indicators.
7. Invest in media relations to create favourable conditions for increased strategic reporting on HIV related cases.
8. Ensure collaboration with DLG offices for ownership of project interventions in the respective districts

2.4 System Strengthening

2.4.1 NSP Aspirations

The system for the delivery of the NSP covers six components namely governance and leadership, infrastructure, human resources, financing/resource mobilization and management, monitoring and evaluation (M&E) and research with the following strategic objectives:

1. Strengthening the governance and leadership of the multisectoral HIV/AIDS response at all levels
2. Enhancing the availability of adequate and appropriate human resources for the delivery of quality HIV/AIDS Services groups
3. Strengthening health systems for infrastructure supply chain and HIV program management for optimal services delivery
4. Strengthening community systems to support population groups including PLHIV and members of KPs for HIV services uptake HIV/AIDS Services
5. Mobilizing resources and streamlining management for efficient utilization & accountability

As part of the Presidential Fast Track Initiative (PFTI), key HIV focus areas for system strengthening include: guaranteeing financial sustainability for HIV and AIDS programs; and reinforcing institutional effectiveness for a multisectoral response. Achievements against key indicators are listed in Box 8 and Annex V.

Box 7: Systems Strengthening Achievements against NSP Targets

Indicator	Baseline	NSP Target	FY 2021/22 Achievement	Gap
Percentage of districts with functional DACs	50%	100%	80%	20%
Percentage of districts with functional PLHIV Networks	95%	100%	91%	9%
Percentage of SCEs with functional HIV and AIDS committees	80%	100%	92%	8%
Percentage of sectors mainstreaming HIV and AIDS	-	100%	74%	26%
Percentage of HC IIIs accredited and offering HTS, ART and EMTCT	-	100%	79%	21%
Percentage of the HIV and AIDS funding from the Government of Uganda	12%	40%	13.8%*	36.2%

**excludes infrastructure, HRH expenditures*

Box 8: Key Systems Strengthening Interventions 2021/22

- The NSP has been disseminated to all key stakeholders
- With support from Global Fund, UAC and partners supported all districts AIDS Committees to convene stakeholders and develop action plans
- 91% PLHIV networks are fully functional and convened annual general meetings to elect new leadership
- There was excellent improvement in the functionality of SCEs compared to last year, with almost 90% of the expected reports being submitted,
- Developed and disseminated policy guidance on resource mobilization and M&E

2.4.2 Strengthening the Governance and Leadership of the Multisectoral HIV/AIDS Response

In FY 2021/22, multiple interventions were undertaken to strengthen governance and leadership of the multi-sectoral HIV response. Below is a summary of the key interventions that have seen the country improve coordination of the HIV and AIDS response for the current reporting period and beyond.

Within UAC, the committee and sub-committees achieved several milestones. The Committee of Technical Experts (CTE) convened an induction meeting where three sub-committees were formed. The Structure Sub-committee drafted an action plan with high level interventions aimed at addressing structural issues for the national response. These include positioning UAC as a fit for purpose organisation and incorporating linkages to the Parish Development Model (PDM) in order to strengthen community mobilisation and engagement for the HIV and AIDS response, and mainstream HIV and AIDS interventions into government MDAs. The National Equity Steering Committee was established and under this committee's guidance, an Equity Plan was costed and resources secured from the GFATM to support its implementation. Relatedly, an Equity Coordinator was recruited under UAC to coordinate equity interventions, hence the secretariat is now fully operational. The Resource Mobilization Sub-committee is also finalizing the UAC Resource Mobilization Strategy that will inform the action plan for mobilizing additional resources for the response.

During the year, regulations that articulate UAC's mandate were approved and gazetted. The online tool to engage the districts HIV/AIDS strategic plans was also completed, with 74% (100/135) district having at least a draft awaiting approval by their respective councils. Further, as part of strengthening HIV mainstreaming in government programs, UAC supported the National Planning Authority (NPA) to embed HIV mainstreaming into the national cross-cutting issues planning guidelines. These will be rolled out in September 2022 during MoFPED regional budgeting conferences in preparation for FY 2023/24 planning cycle.

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

MOH assessed the capacity of 8 RRHs (under CDC funding) using a systems progression tool. A business assessment was also conducted in 9 RRHs. Significant capacity gaps were identified in the areas of governance, supply chain, health information systems, human resources for health, and health financing. Subsequently, MoH developed and is implementing a capacity building plan to address the gaps identified. This includes technical support supervision and onsite mentorship to RRH teams in various technical areas under the health systems strengthening building blocks (governance, human resources [HR], finance, strategic information, service delivery, and supply chain management).

UAC recognises 12 self-coordinating entities (SCEs) or clusters of stakeholders that partner to address specific aspects of the national HIV and AIDS response. Their functionality is monitored through the quarterly performance reports that they submit to UAC. There was an improvement in overall SCE performance, from 50% in the previous year to 89.6% (Table 9). Eight SCEs submitted all the four quarterly reports, compared to only three last year; there was demonstrable consistent improvement across the quarters, from 75% in Q2, to 100% in Q4. Only 4 SCEs (Cultural, media, decentralized response and UNASO had one or two quarterly reports missing.

Table 9: SCE functionality as measured by quarterly reporting, 2021/22

SN	SCE	Q1	Q2	Q3	Q4	Annual performance Score %
1	CCM					100
2	IRCU					100
3	NAFOPHANU					100
4	Private Sector					100
5	ADP					100
6	Cultural Institutions					75
7	Parliament					100
8	Line Ministries					100
9	Media					75
10	Decentralized Response					50
11	UNASO					75
12	Research, Academia, Science and Professional					100
	Percentage reporting per quarter	**83**	**75**	**92**	**100**	**89.6**

- The percentage of facilities having over 95% avail ability of a basket of commodities was 43% in 2020/21 a decrease from 53% in 2019/20 against the annual target of 75%.[14]
- **MoES:** following the wide dissemination of the Sexuality Education Framework, the MoES embarked on capacity building of teachers; over 900 teachers were trained to enhance their knowledge and decision-making skills in addressing cases of child marriage, GBV, SRHR and HIV. MoES also supported school management teams across 12 districts of Northern Uganda to generate work plans for the implementation of Sexuality Education.
- A total of 80 tutors and clinical instructors were trained on management of GBV
- **ODPP:** The Office of Directorate of Public Prosecution reviewed several health policies and guidelines, which are at the stage of institutional approval. Uganda Prisons Service developed a policy for improvement of the prisoner's health as well as guidelines in management of suspects/prisoners infected or affected by HIV, TB and malaria.
- **MoH:** During the reporting period, MoH in collaboration with other sector stakeholders developed and reviewed several policies and guidelines outlined below.
    - The HIV testing Services Policy was reviewed with technical and financial assistance from WHO, CHAI, and GFATM. The policy review led by the MakSPH, considered the ethics of testing all individuals and evaluation of testing services.
    - The PMTCT program worked with the Uganda National Health Laboratory and Diagnostic Services (UNHLS) to develop implementation guidance for Point of Care (POC) viral load testing in the country in readiness for rolling out POC viral load testing starting with pregnant and breastfeeding mothers.

[14] MoH. 2021. Annual Health Sector Performance Report 2020/21

2.4.3 Enhancing the Availability of Adequate and Appropriate HR for the Delivery of Quality HIV/AIDS Services

The NSP acknowledges the importance of strengthening human resource capacity in MDAs and local governments for optimal delivery of HIV/AIDS service. The following strategies were prioritized; building the capacity of health facility staff and health workers and strengthening performance management of human resources for health at the national, regional, district and community levels for the delivery of gender-responsive, quality HIV-related services.

In FY 2021/22, the overall staffing level in the public health facilities stood at 71%, with the RRHs having the lowest staffing at 70%. Government and partners made significant HRH investment in 8 RRHs, to strengthen their oversight mandate to lower health facilities, by secondment of 32 staff to strengthen the Community Health Departments (CHDs) of Arua, Fort Portal, Masaka, Soroti, Hoima, Mubende, Entebbe and Naguru RRHs. The seconded staff included biostatisticians, epidemiologists, infection prevention and control officers, continuous quality improvement officers and grants management officers who support the HIV and AIDS/TB programme as well as the overall health system at that level. An Equity Adviser has also been recruited with GFATM resources to support Uganda AIDS Commission's coordination of equity, human rights and gender equality issues.

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

Challenges	*Recommendations*
• Inadequate human resources for health at all levels which creates work overload for the existing staff. • Operationalisation of the integrated Human Resource Information System (iHRIS) at district level is still a big challenge due to limited capacity to manage the system, and high attrition rates among the trained staff.	1. Lobby for filling of staff positions and additional staff at local government level. 2. Scale up training of health workers on iHRIS system management.

2.4.4 Strengthening Health Systems for Infrastructure, Supply Chain and HIV Program Management for Optimal Services Delivery

Laboratory Infrastructure and Systems

The national lab systems for HIV/TB continued to be strengthened with improved efficiency and a greatly improved hub system turnaround time (TAT) for results. In addition to strengthening the transport system for the delivery of lab specimens from sample collection points to the central testing labs at CPHL and UVRI, the server capacity at CPHL was expanded from 68 TB to 100 TB, which has greatly improved turnaround time. During the year, 33 laboratories were accredited to ISO 15189 standards, thus strengthening the National Quality Improvement System. The capacity of the national equipment calibration centre to support national, regional and district hospital laboratories was also strengthened through renovations and installation of new equipment.

Supply Chain Management

The Emergency Logistics Management System targeting district level support for emergency facility orders is functional, linking facilities, district, MoH, and the National Medical Stores (NMS). Health

facilities have continued to implement the multi-month dispensing (MMD) strategy in order to reduce clinic visits for stable ART clients.

A logistics management plan for the HIV self-testing commodities under PEPFAR and the GFATM was developed and the stocks and targets FY 2021/22 harmonized. The generated distribution list will facilitate NMS in shipment of kits to health facilities country wide. Stocks for 1st and 2nd line ART, HTS and RH supplies have been relatively stable over the review period. However, by June 2022 some 3rd line items were nearing stock out status.

Telemedicine

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

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

Waste Management

The GFATM supported procurement and instalment of two incinerators to support waste management in the country. The disposal of GeneXpert cartridges requires higher temperature incineration to minimize risk of environmental pollution. The gap in waste management is huge currently as medical waste has to be transported from all health facilities countrywide to a few incinerators. These additional regional incinerators will reduce the transport burden.

Capacity Building in Provision of KP Services

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

2.4.5 Strengthening Community Systems to Support Population Groups Including PLHIV and Members of KPs for HIV Services Uptake

The implementation of this intervention continued thus enabling patients to pick ARV medicines from the community drug distribution points post COVID-19 mobility restrictions. For KPs, apart from expansion in service coverage of DICs from 39 to 75, multi-sectoral coordination meetings were held in the districts of Mbarara, Mbale and Gulu with law enforcement, technical and political leaders to create an enabling environment for KP service delivery. In the fishing communities, a new community-led initiative—the CHAG model—was introduced. By June 2021, there were 45 groups of 50 people each in 20 districts providing services though this model implementation of the community-led monitoring of health service delivery for HIV/TB was started.

The MoH conducted DSD coaching in regions with low performance in community DSD. The 6 regions selected for support were Karamoja, Mbale, Ankole, Lango, Busoga and Rwenzori.

2.4.6 Mobilizing and Streamlining Management of Resources for Efficient Utilization and Accountability

Funding for HIV and AIDS Interventions

In FY 2021/22, the GoU and development partners committed significant financial resources to the fight against HIV. While the country realized an increase in the resources mobilized from US$ 655 million in FY 2020/21 to US$ 659 million in FY 2021/22, the resource gap continued to be high at approximately US$ 120 million (not including household financing sources) up from the US$ 77 million funding gap in FY 2020/21. As donor funding stagnates with a call to transition from donor-led to government led HIV and AIDS financing, the GoU invested a larger part of FY 2021/22 in identifying long-term, sustainable approaches and sources of domestic HIV funding to maintain and build upon the successes achieved.

Notably, the HIV and AIDS mainstreaming initiative was intensified. Under this initiative, all government entities have been instructed by the MoFPED to allocate at least 0.1% of their annual budgets (excluding pension, gratuity and transfers) to HIV and AIDS-related interventions. Other notable domestic resource mobilization approaches in the reporting period included the progressive increase of government direct budget allocation from US$ 79.5 million in 2020/21 to US$ 81.2 million in 2021/22 (excluding HIV mainstreaming contribution); the private “One Dollar Initiative.” UAC is also exploring budget allocations by large capital infrastructure projects towards HIV and AIDS interventions e.g. road construction projects.

Significant scale up of HIV services during 2021/22 was largely supported by high levels of donor funding at 85.9% of total HIV and AIDS spending, while government funding (direct budget allocations and through HIV mainstreaming) accounted for13.8%. This is a slight increase from in 12% in 2020/21. PEPFAR funding continued to be the largest contribution with 74% of the total external spending followed by the GFATM at 18%. Additionally, during the year, the total value of PEPFAR resources increased from US$ 408 million in 2020/2021 to US$ 418 million in 2021/2022.

However, contributions from the GFATM fluctuated slightly from US$ 106 to US$ 100 in the same period. Generally, funds from external sources, including bilateral and multilateral donors, international foundations, and corporations, largely remained constant with a slight increase in funding by 0.4% from 2020/21 to 2021/22. In absolute terms, funds from the GoU increased by 2.1% from FY 2020/21 to FY 2021/22 (Table 10).

The performance analysis of resources for the response in FY 2021/22 shows significant funding to HIV related interventions coming from development partners that are not primarily involved in HIV and AIDS programming but whose interventions contribute to HIV control in the country. These partners include; DANIDA, the Royal Embassy of Netherlands and the Embassy of Sweden. Moving forward, closer partnership with these partners may address the current financing gap synergistically, particularly in prevention interventions (BCC, HTS and treatment adherence promotion).

Similar to the previous financial years, the largest amount—US$ 328 million (58%)— of the HIV budget in 2021/22 was allocated for the procurement and supply of ARVs. Program enablers (including wages for health workers, health system strengthening and Program management) were the second largest component at US$ 112 million (17%), followed by prevention interventions at US$ 65 million (10%). Prevention interventions targeted those aged 25+, adolescent girls and young women, adolescent boys and young men, and KPs. Other cost components included HIV testing (6%), social protection (4%), social enablers (stigma reduction, violence prevention, OVC (2.8%, and research (2.2%).

Table 10: Financial resources mobilized for HIV and AIDS intervention, FY 2021/22

Funding source	Funding US$		Interventions
	2020/2021	2021/2022	
A. GoU			
GoU (Direction budget allocations)	79,512,159	81,189,593	HIV Prevention, Care and Treatment, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
GoU (Through HIV Mainstreaming)	9,938,082	9,938,082	HIV Prevention, social support, Systems Strengthening and Capacity Building, Policy Development
B. Bilateral organisations			
DANIDA	2,169,483	1,714,438	SRHR, GBV information and services, and socio-economic empowerment
Embassy of Ireland	2,911,458	1,544,855	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
The Royal Embassy of Netherlands	9,505,352	9,855,452	SBCC, Gender transformative interventions, Prevention and response to gender-based violence/discrimination, Access to HIV counselling and testing services, Strengthening access to condoms through both public and private sector
Embassy of Sweden	5,300,000	3,900,000	Prevention of GBV, integrating SRHR
PEPFAR	408,950,000	418,425,000	Comprehensive HIV Prevention (social and biomedical prevention interventions), Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
GIZ		2,376,700	resilient and equitable health financing, community-based health services
CHAI	1,500,000	1,500,000	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
C. Multilaterals			
GFATM	106,383,344	100,536,279	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
ILO	60,000	80,000	HIV Prevention focusing on HCT at work campaigns among economic enterprises/sectors, systems strengthening and capacity building, domestic health financing strategies through private sector organizations, coordination and monitoring, policy development
IOM	300,000	300,000	HIV prevention targeting migrants in the hotspots - fishing communities, cross border and the transport corridors, social behaviour change and communication, and advocacy
UNAIDS	1,350,000	1,350,000	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation

Funding source	Funding US$		Interventions
	2020/2021	2021/2022	
UNESCO	250,000	200,000	HIV Prevention, Systems Strengthening and Capacity Building, and Policy Development
UNFPA	10,000,000	10,000,000	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
UNHCR	11,312,927	10,812,034	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation - through the implementing partners Medical Teams International (MTI) and International Rescue Committee (IRC)
UNICEF	2,500,000	2,400,000	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation - focusing adolescents and young women
WHO	250,000	250,000	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
UN Women	1,540,072	1,540,072	HIV Prevention, Care and Treatment, Social Support and Protection, Systems Strengthening and Capacity Building, Policy Development, Monitoring and Evaluation
D. Private (non-OOP) expenditure at 0.3% of total HIV and AIDS spending	1,961,199	1,973,738	Care and treatment
Total resources mobilized and spent	**655,694,076**	**659,886,243**	
Target (budgeted)	**732,534,000**	**780,314,000**	
Funding gap	**76,839,924**	**120,427,757**	

**The most recent NASA put the private (non-OOP) expenditure on HIV as a proportion to total spending at 0.3%. This has been calculated as a constant assumption for the FY 2021/22.*

Domestic Resource Mobilisation

Government HIV and AIDS funding (excluding HIV mainstreaming) in FY 2021/22 stood at US$ 81,189,593 (12.3% of total HIV and AIDS funding). While the overall domestic government contribution increased by 2.1% from 2020/21, it is still low as a proportion of total resources for HIV. With the global financial stress following the COVID-19 pandemic, and with competing global issues, positioning the government as the leader in HIV financing will be critical to the continuation of the scale up of the HIV and response, and for promoting the sustainability of funding in the long-term.

The majority of public HIV and AIDS spending (excluding funding from HIV mainstreaming) went on care and treatment at US$ 45 million (56%), Programme enablers and health systems strengthening accounted for US$ 20 million (25%) of public HIV and AIDS spending, followed by prevention with US$ 14 million (14%), and HIV testing and counselling for 3.8% (US$ 3 million). A proportion of MDAs (78%) and DLGs (74%) had up-date costed strategic plans and budgets by the end of FY 2021/22.

HIV and AIDS mainstreamed expenditure. US$ 9,938,082 (1.5%) was funding from HIV and AIDS mainstreaming in MDA budgets and plans, for FY 2021/22. HIV&AIDS is considered a crosscutting issue affecting each of the programs and a vote output code for HIV mainstreaming was created by MoFPED for use across all programs. Previously, a total of 75 mid-term expenditure framework (MTEF) codes

were used, but under the NDP III and beginning FY 2021/22, the single budget output code (000013) for HIV and AIDS mainstreaming was created. This development has several advantages:

- It is a more user-friendly process, because planners and implementers can easily remember one code instead of 75.
- One code used across all sectors is easier to roll out.
- The new HIV and AIDS mainstreaming code is already integrated in the new IFMIS for the next financial year.
- With one code and the new IFMIS, it is now easy to know the source of funds in government for HIV and AIDS, implementing sector/entity, spending data, geographical location of an activity by entity, and to determine regional distribution/allocation of HIV resources.

As part of operationalizing the NDP III, the NPA developed integrated guidelines to facilitate the mainstreaming of crosscutting issues in development plans, and budgeting and reporting frameworks of all government entities. Accordingly, the NDP III integration guidelines were reviewed to capture HIV mainstreaming, and to facilitate a harmonized and synergistic integration/mainstreaming of HIV/AIDS into DLG development plans, and MDAs' strategic plans, budgets and reporting frameworks.

HIV mainstreaming reporting result framework. Speared by the UAC, the country developed a national results framework for mainstreaming HIV and AIDS in each of the NDP III program, which would then serve as the baseline and annual targets for HIV mainstreaming per program. The framework also highlights simple, clear and actionable indicators which were included in the Equal Opportunities Commission (EOC)'s equity assessment tool for cross cutting issues.

Private (non-out-of-pocket) expenditure on HIV and AIDS, 2021/22 was US$ 1,973,738 (0.3%). The GoU recognises the importance of the private sector in sustainable financing and provision of HIV and AIDS services in the NSP. Although the country still lacks a central system to assess the direct contribution of the private sector to HIV services, based on the latest National AIDS Spending Assessment (NASA) estimates, the proportion of private sector (excluding household payment) was approximately 0.3%. This rate has been benchmarked to obtain estimates on the private sector contribution towards the response. Accordingly, the funding of US$ 1,973,738 is composed of HIV services covered through private health insurance and direct costs associated with implementing workforce health programs.

Private Health Insurance. To ensure a healthy workforce, large enterprises in Uganda have opted to provide direct treatment services through workplace programs. While a handful of employers offer both workplace programs and health insurance, these are limited to those located in urban areas, where health services outside of the company property are easily accessible. Rural businesses, such as tea and sugarcane farms, have found it more economical and accessible to operate their own clinics to serve not only their employees, but also the employees' dependents and the local community. These workplace programs range from single-day health campaigns for raising awareness or providing voluntary counselling and testing services for HIV, to long-term engagements that assist private corporations to develop workplace health and HIV program strategies and train trainers.

Further, the private sector continued to provide in-kind contributions to HIV programs. For example, major hotel operators provide venues free of charge for health-related events. In 2021/2022, this contribution is valued at approximately US$ 123,288 (UGX 450 million).

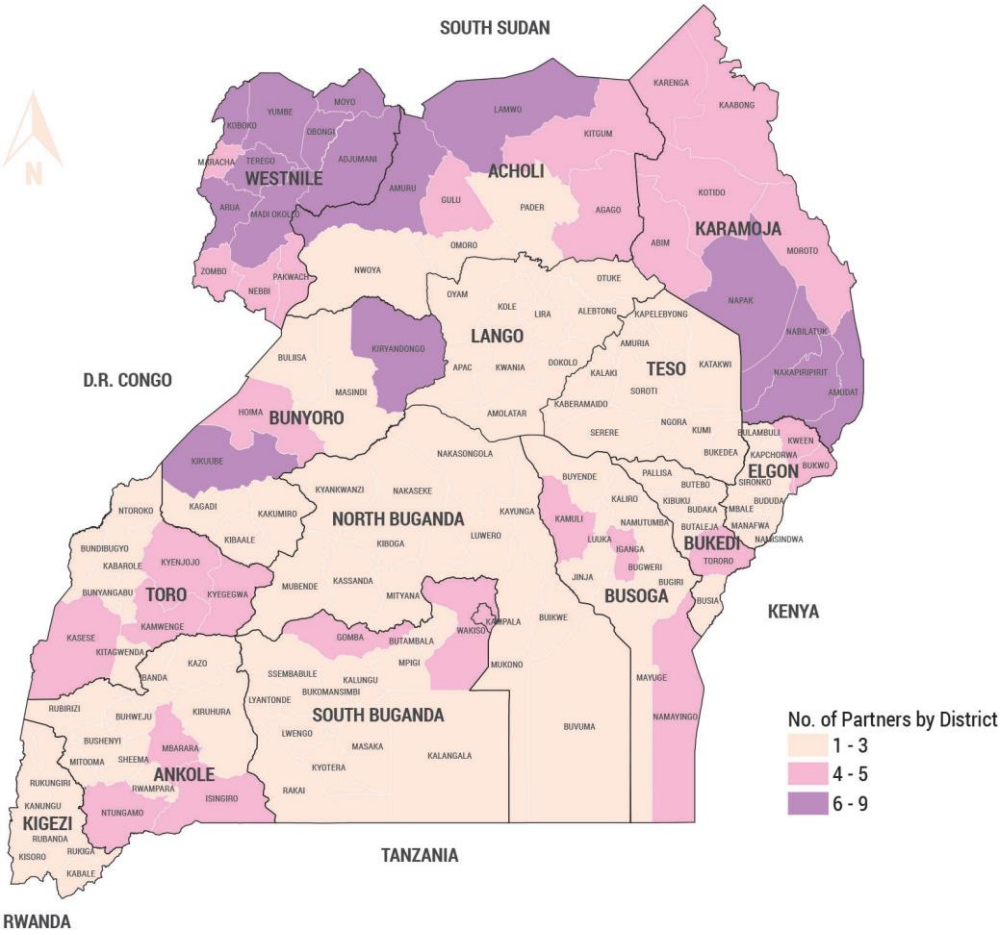
The One Dollar Initiative (ODI) is another important innovative avenue being pursued in Uganda for domestic resource mobilization to complement and sustain government and development partners' response to HIV and AIDS in the country. The ODI appeals to and encourages the public to make a minimum voluntary contribution of one dollar (equivalent to UGX 4,000/=) per person per year or per month towards this noble cause. Other higher contributions are encouraged periodically from the corporate sector, organizations, private individuals, business entities, private sector associations such as Rotary and Lions clubs, professional associations, NGOs/CSOs, religious institutions, Ugandans in

the diaspora and other well-wishers. In financial year 2021/2022, a total of US$ 32,877 (UGX 120,000,000) was mobilized as a contribution from the private sector towards the HIV response.

2.4.7 Efficiency and Harmonization of HIV and AIDS Funding and Allocation

In 2021/22, the country developed a directory of key development partners supporting HIV and AIDS interventions in Uganda with the aim of facilitating greater collaboration, knowledge sharing, interaction and transparency among stakeholders. Furthermore, the directory will enhance effective harmonization of development support for HIV and AIDS services and contribute to reducing duplication of effort thus promoting efficient use of available resources for the national HIV response. The directory shows the number of development partners per district for greater collaboration (Figure 26). All of these goals are in line with the Paris Declaration on Aid Effectiveness (2005), the Accra Agenda for Action (2008), and the Uganda AIDS Commission (UAC) Regulations (2020). However, the actual amounts of resources deployed by the partners has not yet been incorporated into the mapping and needs to be considered for the next year.

Figure 26: Distribution of development partners by district, FY 2021/22



In FY 2021/22 more engagements were undertaken to facilitate national harmonization and alignment of the major funding streams in the country including; the GFATM, PEPFAR, and GoU. These engagements provided a platform for information sharing, strengthens collaboration, mitigate possible duplication and promotion of efficiency in program implementation. The engagements further facilitated gap analysis to inform the priorities for the country's grant funding

requests/application to the GFATM. Moving forward, stakeholders have proposed these strategies for improving harmonization, coordination and efficiency:

- Assess and facilitate coordination among partners at regional and district level and review progress of achievement of results.
- Go beyond partner contributions to also consider harmonising program implementation including that for Community-led Monitoring by aligning of data collection methods used by the different reporting systems.
- A futuristic distribution of partners should also be considered for planning purposes.
- Analysis of reasons for unequal distribution of partners (some districts have more than others) with a view of informing the GoU which should then provide guidance to the contracting and commissioning of partners in different districts.

Similar to the previous years, social protection (social enablers) and HIV prevention interventions continue to receive the least investments (Table 11), because low investment in these areas has significant implications on reversing the prevention gains in the country. To achieve epidemic control, the GoU and its partners should continue to invest in interventions with high impact—that is, those that target populations most-at-risk and those likely to significantly decrease the number of new HIV infections. Overall, the country mobilized substantial resources (at 85% of the need) from a range of sources for the HIV&AIDS national response.

Table 11: HIV and AIDS financing gap analysis, 2021/22

	2021/22 Target (US$ million)	2021/22 Actuals (% total budget)	Funding level based on target (%)
Testing	18.352	39.593 (6%)	215%
Treatment	328.961	382.734 (58%)	116%
Total Prevention:	**155.808**	**65.988 (10%)**	**42%**
Prevention (aged 25+)	53.836	na	na
Prevention (adolescent girls and young women)	26.001	na	na
Prevention (adolescent boys and young men)	72.578	na	na
Key populations	3.393	na	na
Social enablers:	**52.82**	**18.476 (2.8%)**	**35%**
Stigma reduction	8.377	na	na
Violence prevention	12.443	na	na
Orphans and other vulnerable children	32.000	na	na
Total Program enablers:	**186.828**	**112.180 (17%)**	**60%**
Human resources	126.210	na	na
Health system strengthening	22.380	na	na
Programme management	38.238	na	na
Social protection	**30.430**	**26.395(4%)**	**87%**
Research and innovation	**7.114**	**14.517(2.2%)**	**204%**
Totals	**780.314**	**659.883**	**85%**

Projected costs. An additional investment of US$ 43.077 million in HIV prevention is needed to increase the HIV Prevention budget from 42% to 70%. At a unit cost US$ 5.11 per combination of behavioural prevention services attained, 8,430,059 people would be reached with HIV prevention interventions entailing a combination of interventions computed with the following assumptions:

1. Behaviour change: Cost per person per year of behaviour change campaigns to reduce partner concurrency;
2. Community mobilization: Cost per person for attendance of IEC activities; and
3. Condom provision: Cost per male condom sold through social marketing.

At a cost of US$ 885 per HIV infection averted, the above investment would avert 48,675 new HIV infections in Uganda in a year.

2.4.8 Gender and Human Rights in the HIV and AIDS Response

The NSP is aligned to several global, regional and national policies and commitments that seek to ensure that gender is mainstreamed in the response. To this effect the strategy outlines interventions that address both sexes as well as vulnerable populations and stresses reporting of the outputs, processes and outcomes of these interventions. Despite the clear strategy however, there remain gaps across thematic areas of the NSP that need to be addressed in order to achieve better and more sustainable gains in the HIV and AIDS response. Tables 12 and 13 highlight the main issues that need to be addressed in order to fully mainstream gender and human rights issues in the roll out of the NSP.

Table 12: Mainstreaming gender issues in the HIV and AIDS response

Interventions	Response	Examples	Issues
Know your epidemic	Data disaggregated by gender and qualitative analysis of key issues therein	All key indicators are well disaggregated	Data collection and reporting systems do not have some of the elements for the indicators
Prevention	Age, gender and population categories e.g. KP/PP addressed by national response	Target: HEI, PMTCT, Men, AGYW, KPs Service delivery: DSDM; DREAMS; Men Involvement/Engagement	Coverage of AGYW and some DSDM services is not yet countrywide.
Care & Treatment	Age, gender and population categories e.g. KP/PP addressed by national response	Target: HEI, PMTCT, Men, AGYW, KPs Service delivery: DSDM; DREAMS; Men Involvement/Engagement, KPs	Care for the elderly and NCDs need be integrate more into HIV and AIDS programming
Social Support	Age and gender population categories addressed	UWEP (women), SAGE (elderly), YLP (46% females) DREAMS (AGYW)	Continue addressing issues: • Cultural beliefs and practices • Politics • Economic Inequalities • Education

Interventions	Response	Examples	Issues
Systems Strengthening	Policies: Plethora of policies/guidelines exist to address gender issues. Governance/Leadership. Equity Steering Committee established/ Action Plan launched	Child marriage, equity, poverty, prisoners' health management	Implementation/enforcement of policies lagging; Prisoners' concerns both in detention centres and prison need to be catered for Review M&E systems to ensure indicators on issues of concern
	M&E: Reporting is gender aggregated;	Gender Dashboard. Situation Room, HMIS, OVCMIS, GBV Dashboard	Updating of database slow; and use of databases limited Mainstream PWD indicators into M&E system & disseminate existing policies to stakeholders

Table 13: Human rights issues in the HIV and AIDS response

Interventions	Response	Examples	Issues
Know your epidemic	Some quantitative/qualitative data on human rights issues exist	Police reports; CSO survey reports	Data on human rights is not readily available.
Prevention	Age, gender and population categories e.g. KP/PP addressed by national response	Target: HEI, PMTCT, Men, AGYW, KPs Service delivery: DSDM; DREAMS; Men Involvement/Engagement; KP programming	
Care & Treatment	Age, gender and population categories e.g. KP/PP addressed by national response	Target: HEI, PMTCT, Men, AGYW Service delivery: DSDM; DREAMS; Men Involvement/Engagement; KP programming	
Social Support	Age and gender population categories addressed	UWEP (women), SAGE (elderly), YLP (46% females) DREAMS (AGYW)	Sustainability of interventions in the long term
Systems Strengthening	Policies address Human Rights issues	Policies on child marriage, equity, poverty, prisoners' health management Equity Steering Committee established/Action Plan launched; Regulation for mainstreaming HIV & AIDS into MDAs' plans and budgets	Good policies and guidelines exist, but enforcement still has gaps; Some laws have discriminatory clauses that need to be addressed; Prisoners' concerns both in detention centres and prison need to be catered for

Interventions	Response	Examples	Issues
	M&E: Monitoring of human rights implemented by few entities	Human rights organizations	M&E: Monitoring of human rights implemented by few entities; and indicators for routine monitoring not institutionalized.

2.4.9 Analysis of Impact of COVID-19 on the HIV and AIDS Response

In the past few years, Uganda has undergone several shocks in the form of natural disasters and epidemics, some affecting the whole country and others some regions or districts only. Examples include:

- Drought and famine especially in the Karamoja region a
- Refugee crisis and response on HIV and AIDS
- Impact of recent floods on HIV and AIDS response
- The global dynamics – Ukraine and Russia crisis, the shifting global priorities to climate change
- The COVID-19 epidemic

The COVID-19 pandemic is discussed here to highlight the need for building a resilient system for the HIV and AIDS response in the country.

The COVID-19 pandemic shifted prioritization, programming, and health services delivery, especially during the peak period of the pandemic when lockdown restrictions were imposed on the population and service sectors.

The reorganization of the health system that the country underwent during the COVID-19 pandemic increasing need for resources, innovations for implementing services during the lock-down, including SOPs to limit spread of the pandemic, while trying to maintain HIV and AIDS service delivery to the population.

According to MoH, COVID-19 led to a reduction of 30% in the use of HIV testing services in communities and health facilities; the initiation of antiretroviral therapy has decreased by 31% between April and June 2020 alone; between December 2019 and June 2020, viral load coverage decreased from 96% to 85%, and CD4 access decreased from 31% to 22%.

The uptake of virtually all HIV prevention and treatment services dropped to varying levels during the first three months of the hard population lockdown in April – June 2020 followed by a slow recovery in the next quarter, although it did not return to pre-pandemic levels for most services. In most cases, the recovery was short-lived and thereafter continued to gradually drop during the rest of the pandemic period especially at the peak of the first wave during November – December 2020.

However, the total ART enrolment throughout the pandemic period did not drop below pre-pandemic levels. Some services also suffered a shorter and less drastic drop during the second population lockdown in May – July 2020. Although viral load testing declined by 50% during the first population lockdown, it recovered quickly thereafter. The viral load suppression (VLS) among those tested remained level and thereafter increased by 5 – 10% of pre-pandemic levels.

The HIV tests, especially community testing and other community-level services dropped significantly during the period of the hard population lockdown. ART retention during the pandemic period dropped by up to 15% relative to the pre-pandemic level, and client attrition through LTFU increased by up to 300% for some cohorts and particular times. Patient movement between facilities (Transfer in and Transfer outs) also increased substantially during the pandemic period.

There appears to have been a two–three-fold increase in cohort mortality during the pandemic period. The findings were corroborated by reported clinic closures, reduced services, cessation of outreach services, overstretching of health care workforce, and laboratory infrastructure that affected a significant proportion of facilities especially HC IVs and HC IIIs based on provider interviews. There was also significant adoption of recommended measures to ensure continuity of services such as multi-month dispensing of ARVs, community delivery of ARVs, etc in several facilities.

The effect of all the disruptions was modest excess new HIV infections of 2.1% (806) in 2020, 8% (426) in vertical Infections, and 6% (1,352) in AIDS-related mortality in 2020 compared to a scenario where no such disruptions were assumed to have taken place. The cumulative excess numbers for 2020 were 25, arising from the disruptions in 2020 alone are estimated to be approximately 1,382 excess new HIV infections, 718 excess vertical infections, and 3,788 excess AIDS-related mortality.

The post-COVID-19 period, therefore, needs deliberate efforts to increase targeted HTS services, identification of those lost to follow-up, linkage to service delivery points, and generally integration of COVID-19 and HIV&AIDS interventions. Capacity building for mainstreaming of COVID-19 and HIV services is key at all levels for the sustainability of the response.

These findings confirm the moderate to severe disruptions of HIV services by the mitigation measures for the COVID 19 pandemic in Uganda. The uptake of measures recommended for continuity of services ensured a quick recovery of these services in the short run and may have averted significant new infections and mortality but the measures were short-lived. It is necessary for the catch-up measures implemented for several services shortly after the lockdowns to be reinstated and should not be short lived. Secondly, additional measures for continuity of services such as MMD should also be re-invigorated and strengthened. The measures are also necessary at the peak of pandemic waves when health facilities are likely overstretched, and the population apprehensive of potential exposure to COVID 19 infection in health facilities.

Challenges

- Inadequate resources to effect new service delivery models that factors in the epidemic control measures.
- Inadequate HIV and AIDS mainstreaming across MDAs and LGs.
- Disruptions in supply chain management for ART due to overall health system challenges during the epidemic.
- Lack of a disaster management plan to counteract disruptions in HIV and AIDS service delivery.

Recommendations

- Complete district HIV/AIDS strategic plans using the online tool
- Fast-track implementation of the Resource Mobilization Strategy.
- Fast-track and complete the roll out of HIV and AIDS mainstreaming across MDAs and LGs.
- Develop a HIV and AIDS Disaster Management Plan for the response, which can be activated when required.

2.5 MONITORING AND EVALUATION

2.5.1 NSP Aspirations

The Monitoring and Evaluation (M&E) Plan for the HIV and AIDS response aims at ensuring quality and timely collection of HIV/AIDS information to track progress towards attaining the national and global targets. The plan provides a framework for generating strategic information to guide evidence-based decision making on programming policy making for the HIV response. The National HIV and AIDS M&E Plan builds on the NSP as a core part of the global Three One's Principle for strengthening a country's national HIV and AIDS response (one coordinating body, one strategic plan and one M&E framework). The strategic objectives for HI and AIDS M&E are:

1. Strengthening the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring and evaluation of the NSP.
2. Promoting information sharing and utilization among producers and users of HIV and AIDS data and information at all levels

Key achievements under this thematic area are listed in Box 10 and others can be found in Annex VI.

Box 9: M&E Achievements against NSP Targets

Indicator	Baseline*	NSP Target	FY 2021/22 Achievement	Gap
Percentage of sectors and districts with up-to date costed HIV and AIDS M&E work plans	Sectors: 100% Districts: 50%	100%	Sectors: 100% Districts: 74.1%	25.9%
Percentage of sectors submitting timely and complete reports to UAC	25%	100%	81%	19%
Percentage SCEs submitting quality reports	50%	100%	92%	8%

Box 10: Key M&E Interventions 2021/22

- Developed the National HIV and AIDS research agenda 2020-2025
- Disseminated the NSP M&E plan and supported MDAs to develop M&E frameworks
- Conducted Data Quality Assessments (DQAs) covering HTS, Care and treatment, VL testing, TPT, KP, and Health Information Systems
- Conducted several special studies:
    - The 3rd NASA covering 2017/18 and 2018/19.
    - Uganda Population-Based HIV Impact Assessment (UPHIA)
    - Uganda National Household survey (UNHS) 2019/20
- Conducted other research studies:
    - Assessment of the functionality of national and sub-national HIV coordination structures
    - An assessment of the performance of multi-sectoral HIV/AIDS mainstreaming
    - LQAS on HIV services completed in districts of Lango, Acholi, South West, East East-Central, and Karamoja.

2.5.2 Strengthening the National Mechanism for Generating Comprehensive, Quality and Timely HIV and AIDS Information for Monitoring and Evaluation of the NSP

Results framework for mainstreaming. A national results framework for mainstreaming HIV and AIDS into the NDP III program was developed. This provides baseline and targets against which the level of mainstreaming among the MDAs and local governments will be measured. The framework was validated and presented to the Equal Opportunities Commission for guidance.

Development of HIV and AIDS strategic plans. Following the development and dissemination of the NSP 2020/21–2024/25, there was need to support the MDAs and DLGs to develop their respective HIV and AIDS strategic plans and M&E frameworks aligned to the NSP. A total of 100 districts (74.1%) were supported and the plans are under implementation.

Leveraging the PDM. There is need to tap into the PDM planning and implementation frameworks ensure the HIV and AIDS response concerns are incorporated. To track progress of implementation of the HIV interventions, three (3) indicators were developed, discussed and submitted to the PDM secretariat for incorporation into the program M&E results framework.

Education indicators. There is deliberate effort by the MoES to revitalize the Education Information Management System (EMIS). The HIV and AIDs education-related indicators were developed and presented to the HIV and AIDS committee of the MDA and were approved for application. Data will be collected and reported on routinely for decision making.

Quarterly reporting. Quarterly progress reporting for the UAC secretariat, SCEs including MDAs was institutionalized. Reporting improved from 60% in 2021 to 80%.

NDP reporting. The Office of the Prime Minister (OPM) developed a web-based reporting database for NDP III. This was aimed to improving completeness, timeliness and streamlining reporting on all the indicators. The OPM built capacity for MDAs including MoH and UAC for this exercise.

Data collection for stigma and discrimination. Following the dissemination of the recently developed NGESD, data collection tools for stigma and discrimination interventions were developed, piloted and adjustments made. The tools are now being used for routine monitoring of stigma and discrimination.

2.5.3 Promoting information sharing and utilization among producers and users of HIV and AIDS data and information at all levels

UPHIA 2020 Preliminary Report

In 2020 the MoH led the process of conducting the Uganda Population HIV Impact Assessment (UPHIA 2020). The survey provides data and information on the country's HIV epidemic status based on selected indicators that include among others, HIV incidence, prevalence, treatment, and viral load suppression. The survey was conducted between February and March 2020 and resumed in October 2020 to February 2021 after the COVID-19 containment restrictions. The preliminary report for the UPHIA 2020 was released in February 2022 by the Minister of Health. The findings of the report show a reduction in HIV prevalence among adults to 5.8% from 6.2% in the previous UPHIA of 2016-2017 and demonstrate that Uganda is well positioned to achieve the UNAIDS goal to end the HIV epidemic as a public health threat by 2030. Three-quarters (75.4%) of PLHIV had suppressed viral load, meaning that treatment programs are reaching the majority of the population living with HIV. The detailed report showing more results, including those of HIV incidence tests (rates of new HIV infections) and other program coverage and behavioural indicators, will be released in due course.

Dissemination of National and Subnational HIV and AIDS Estimates

The UAC together with the MoH AIDS Control Program led the process of developing the Country's annual national and sub-national epidemiologically modelled HIV estimates for 2021. The estimates are based on program data, and are generated using SPECTRUM software accredited by UNAIDS. The national and sub-national estimates including district estimates for 2021 were released in May 2022.

They show a continuing decline in HIV prevalence relatively close to the UPHIA findings. However, they indicate an increase in new HIV infections for the country (from 52,000 in 2020/21 to 54,000 in 2021/22). The country estimates were shared with the Minister for Presidency and will be shared with cabinet. They are used for generating the country's HIV Fact Sheet that can be accessed on the UAC and UNAIDS websites.

Enterprise Data Warehouse

The UAC initiated the process of developing an Enterprise Data Warehouse. The Data Warehouse is expected provides a one stop platform for HIV multi-sectoral data and information for the country. The Data Warehouse shall be linked to a number of data sources and systems including the DHIS2, EMIS, OVCMIS, GBV Dashboard, UAC Gender Dashboard, KP Tracker among others. The Data Warehouse shall be backed by the NITA National Data Hub that shall also be linked to all national reporting systems. A prototype of the Data Warehouse is in place for piloting before its validated and officially launched for operations.

Resource Tracking Tool

The UAC has been leading the process of tracking utilization of HIV resources in the country through the National AIDS Spending Assessments (NASA). As part of the process of institutionalizing the tracking of HIV resources, UAC developed a resource tracking tool in collaboration with the MakSPH. The tool captures and generates real time data on HIV expenditures by selected stakeholders. The tool has been validated by key stakeholders and recommended for national roll out to guide and inform on key funding priorities for the response.

Presidential Fast Track Initiative

The fourth edition of the PFTI report has been produced and is ready for printing. The report highlights the progress made in achieving the PFTI goal of on ending AIDS as a public health threat by 2030 and performance against the five pillars of the PFTI for the FY 2020/21 to FY 2021/22.

Roll out of KP Tools

KP data is very essential in determining estimates for HIV due to the high prevalence rates and disease burden among KP and during the year, KP data collection tools were developed and piloted with support from GFATM. The tools have been rolled out to specific service points to track provision of KP services.

Challenges

- Lack of data for behavioural indicators
- Poor utilization of data at sub-national level
- Poor quality of program data
- Inadequate coordination of ongoing HIV related research studies.

Recommendations

1. Determine behavioural indicators for routine monitoring.
2. Roll out LQAS to all regions of the country.
3. Popularize performance reviews at sub-national level to create and improve data quality, as well as improve programming of the HIV and AIDS response.

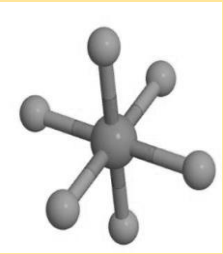
3.0 THE PRESIDENTIAL FAST TRACK INITIATIVE (PFTI)

The PFTI was launched on the premise that the high-profile leadership in the form of the President of Uganda would be a strong advocate for fast tracking the achievements of the NSP and global targets with a focus on the key drivers of the epidemic. Table 14 summarises performance against the pillars of the PFTI and related interventions.

Table 14: Summary of performance against PFTI indicators

	Pillar	Progress 2021/22

	Revitalize HIV Prevention (and close the tap on new HIV infections, particularly among AGYW)	- *192 million condoms distributed*
		- *AGYW strategy developed; with age-specific service package; services expanded to 44 from 23 districts*
		- *Overall, 347,525 AGYW served;*
		  ○ *HTS: 347,525*
		  ○ *Violence Prevention: 120,736*
		  ○ *Economic strengthening:112,611*
		  ○ *School subsidy for 25,403 vulnerable girls*
		- *The sexuality education framework rolled out*

	Consolidate progress on eliminating Mother-To-Child transmission of HIV	- *100% of HIV infected mothers received ART from 96% in previous year;* - *Decline in breast-feeding mothers virally suppressed from 100% to 91%* - *Among HIV-Exposed Infants, 92% received prophylaxis to reduce MTCT; sero-positivity within 8 weeks at 3%*
	Accelerate Implementation of 'Test and treat' and attain the 90-90-90 targets	*Overall- 89% of PLHIV know their status; of these, 92% are on ART; of which 95% are virally suppressed (Overall: 89-92-95)* - *Adults: 91-92-96* - *Children 0-14 years: 68-98-89*
	Address financing sustainability for the HIV response	- *Government contribution 13.8% of total HIV budget* - *HIV mainstreaming in MDAs strengthened; 38.8 billion mobilized in FY 2021/22; Budget vote output for 0.1% operationalized* - *One Dollar Initiative active*
	Ensure Institutional effectiveness for a well-coordinated multi - sectoral response	- *Committee of technical experts (CTE) constituted to replace Partnership Committee* - *NSP 2020/21-2024/25 and M&E framework disseminated* - *MDAs supported to mainstream HIV/AIDS; establish HIV/AIDS committees, develop strategic plans, workplans* - *Coordination structures revitalized at district level, within MDAs, and at sub county*

4.0 KEY CHALLENGES AND RECOMMENDATIONS

FY 2021/22 continued to register overall recovery of the national HIV and AIDS response after the disruptions of services occasioned by the COVID-19 epidemic. The Epi-data estimates show that against the UNAIDS 95-95-95 targets for epidemic control by 2025, Uganda achieved 89-92-95 with children below 10 years having the lowest values for the first (68%) and third target (89%). Further, the HIV epidemic remains generalized in the population with concentrations within key and priority populations. These results indicate the need to intensify efforts towards identifying HIV positive individuals, especially among key and priority populations, and linking them to care. Further, underlying systemic hinderances to service access and delivery need to be addressed.

The key challenges and recommendations across the thematic areas are listed below.

Prevention

***Challenges**:*

- Only 44 out of the 62 high incidence priority districts have been covered with comprehensive AGYW interventions and further, coverage of AGYW is not yet at 100% nor has a package of services for non-high incidence districts been determined.
- Weak M&E system for AGYW interventions with inadequate referral tracking in the AGYW programme.
- There has been a waning of HIV prevention SBCC interventions; and "Time Up" campaign did not cover all districts.
- The M&E system for the condom programme is weak with limited data, management and use of evidence for condom programme decision making.
- 11% of PLHIV do not know their status as per the Epi-data estimates, recency testing is only available in 64% of ART sites and linkage to confirmation testing for HIVST is still low (67%).
- MTCT is increasing as evidenced by increase in positivity rate of HEI

Recommendations:

1. Scale up of AGYW interventions to remaining 18 high incidence districts and strengthen referral monitoring of the AGYW programme.
2. Scale up the "Time Up" campaign to all districts in the country; develop tailored messages for priority populations; develop a condom SBCC campaign to increase demand.
3. Fast-track the HIV MOT study to inform better planning for KPs.
4. Implement selected recommendations of the Legal Environment Assessment to address hinderances to service access by KP/PP.
5. Develop and establish a condom tracking system that will better inform quantification and planning for condom distribution.
6. Revise the HTS optimisation plan to include new guidance from the new HTS policy June 2022
7. Intensify mother-baby pair follow up through peer support groups.

Care & Treatment

***Challenges**:*

- ART coverage among children and adolescents continues to be a challenge.
- Integration with other disease programs (TB, SRHR, NCDs) is sub-optimal

Recommendations:

1. Scale up the YAPS program to the remaining 34 districts.
2. Review of DSD guidelines together with the Consolidated Guidelines for Prevention and Treatment of HIV and TB in Uganda as per the WHO guidance for patient-centred care, to allow clients to choose their preferred approaches for care.
3. Roll out guidelines for NCD integration into HIV care to more facilities

Social Support & Protection

***Challenges**:*

- Stigma and discrimination against PLHIV persist in the community especially for KPs.
- Gap between number of GBV/VAC events and perpetuators followed up for meting justice is wide.

***Recommendations**:*

5. Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels.

6. Scale up comprehensive AGYW socioeconomic intervention to remaining 18 high incidence districts.
7. Conduct a bottleneck analysis on the GBV/VAC cascade from event to conviction of perpetuators.
8. Invest in media relations to create favourable conditions for increased strategic reporting on HIV related cases.

Systems Strengthening

***Challenges**:*

- Inadequate resources to effect new service delivery models that factor in epidemic control measures.
- Inadequate HIV and AIDS mainstreaming across MDAs and LGs.
- Disruptions in supply chain management for ART due to overall health system challenges during the epidemic.
- Lack of a disaster management plan to counteract disruptions in HIV and AIDS service delivery

***Recommendations**:*

6. Complete district HIV/AIDS strategic plans
7. Fast-track implementation of the Resource Mobilization Strategy.
8. Fast-track and complete the roll out of HIV and AIDS mainstreaming across MDAs and LGs.
9. Roll out the Resource tracking Tool
10. Develop a HIV and AIDS Disaster Management Plan for the response, which can be activated when required.

Monitoring & Evaluation

Challenges:

- Lack of data for behavioural indicators
- Inadequate coordination of ongoing HIV related research studies.

Recommendations:

3. Determine behavioural indicators for routine monitoring.
4. Strengthen coordination of HIV and AIDS research efforts that are passed by different IRBs, to ensure use in improving programming and more efficient use of resources.

ANNEX I: BIBLIOGRAPHY

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ANNEX II: LIST OF UNDERTAKINGS FOR FY 2022/23

Undertaking	Activity	Deliverable / Output	Lead Agency
HIV prevention			
Primary Prevention	1. Scale up the "Time Up" campaign to all districts in the country	- SBCC campaigns conducted targeting youth	**UAC**, MOH, CSOs, UCC, Youth Leaders
HTS optimization	2. Revise the HTS optimisation plan to include new guidance from the new HTS policy June 2022.	- HTS Optimization package revised	**MOH**, IPs
AGYW	3. Scale up of AGYW interventions to remaining 18 high incidence districts and strengthen referral monitoring of the AGYW programme	- AGYW package of interventions implemented in 18 districts	**UAC, MOH**, MOGLSD, MOES
	4. Conduct a country wide survey to determine the impact of AGYW programming high teenage pregnancy on should be carried out.	- Survey to determine AGYW interventions impact on teenage pregnancy carried out	MoH, MoES, MoGLSD
KPs:	5. Fast-track the HIV MOT study to inform better planning for KPs.	Complete and disseminate the MOT Study for evidence-based planning.	**UAC,** MOH
	6. Implement selected recommendations of the Legal Environment Assessment to revise laws that are discriminative against KP and hinder access to integrated package of services including harm reduction policies in the context of HIV prevention: - Review employment laws and policy to specifically prohibit pre-employment HIV testing - Develop a national occupational health and safety policy that integrates protection from HIV in the working environment - Adapt/adopt and operationalize the UN system-endorsed core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections.	Laws and policies reviewed. Core package of nine essential harm reduction services for PHID adapted to Ugandan context	
Condom programming	7. Cost and implement the Last Mile Distribution Strategy	- Implement last mile distribution up to DICs.	**MOH**
	8. Develop and establish a condom tracking system that will better inform quantification and planning for condom distribution	- Condom tracking system developed and established	**MOH,** UNFPA, Private Sector
Care and Treatment			
Address gaps in retention, adherence and viral suppression	1. Review of DSD guidelines together with the Consolidated Guidelines for Prevention and Treatment of HIV and TB in Uganda as per the WHO	- Revised DSD Guidelines for HIV/TB Prevention and Treatment	**MOH;** ADPs

Undertaking	Activity	Deliverable / Output	Lead Agency
to achieve the 2nd and 3rd 95%	guidance for patient-centred care, to allow clients to choose their preferred approaches for care 2. Carry out a study on the effect/impact of DSDM on service uptake	- Study on impact of DSDM on service uptake conducted.	
	1. Scale up the YAPS program to the remaining 34 districts	- YAPS interventions implemented in remaining 34 districts	**MoH**
Strengthen integration of services (TB/HIV AHD, Cervical cancer) for quality care and improved clinical outcomes	2. Roll out guidelines for NCD integration into HIV care to more facilities	- HIV/NCD Integration Guidelines rolled out	**MOH**
Social Support and Protection			
Stigma and discrimination reduction	1. Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels. 2. Complete the Sigma Index Study (MakSPH)	- Anti-Stigma Policy Guidelines disseminated and implemented - Stigma study completed and disseminated	**MoH**, PLHIV-led Networks and CSOs, Human Rights CSOs, UAC.
	3. Invest in media relations to create favourable conditions for increased strategic reporting on HIV related cases	- Media engagements held to orient media houses on strategic reporting on stigma and discrimination	
Socio-economic strengthening	4. Scale up comprehensive AGYW socioeconomic intervention to remaining 18 high incidence districts	- Vulnerable AGYW reached with socioeconomic interventions	**MGLSD**, IPs, CSOs
	5. Continue with household economic recovery programs targeting households and individuals whose livelihoods have been severely affected by the COVID-19 pandemic and the associated measures and integrate into the PDM	- Resources for on-going programmes sustained and programmes integrated into PDM	**MGLSD**, MoFPED, IPs, CSOs
Gender Based Violence	6. Expand availability of psycho-social support to GBV survivors	- Psych-social support services scaled up	**MoGLSD,** MoH
	7. Scale up the training of PLHIV, KPs, vulnerable groups, law enforcement officer and communities in general about rights awareness and legal literacy to facilitate early reporting of GBV incidents	- PLHIV, KPs, vulnerable groups and communities trained in human rights and legal issues	**MoGLSD**, PLHIV Networks, PLHIV-led CSOs, Human Rights CSOs
	8. Conduct a bottleneck analysis on the GBV/VAC cascade from event to conviction of perpetuators	- Bottleneck analysis carried out	**MoH, MoGLSD, MoJCA**

Undertaking	Activity	Deliverable / Output	Lead Agency
Child Protection and Violence against Children (VAC)	9. Harmonise monitoring mechanisms for GBV/VAC	- Harmonised framework for reporting of GBV/VAC	**MoES**, MoGLSD, all stakeholders in the Education Sector
System Strengthening			
Governance and Leadership	1. Ensure district HIV/AIDS strategic plans completed and approved by councils using the online tool	- HIV and AIDS strategic plans completed for all districts	**UAC, MoH, MoGLSD, MoES**
Financing	1. Fast-track implementation of the Resource Mobilization Strategy. 2. Fast-track and complete the roll out of HIV and AIDS mainstreaming across MDAs and LGs 3. Roll out the Resource tracking Tool 4. Develop a HIV and AIDS Disaster Management Plan for the response, which can be activated when required	- Resource mobilisation strategy disseminated and interventions implemented - Resource Tracking Tool rolled out. - Disaster management plan developed	**UAC, ADPs,** MDAs
Strengthen M&E systems	1. Determine behavioural indicators for routine monitoring.	- Behavioural indicators for routine monitoring determined and disseminated to relevant MDAs	**UAC**
	2. Strengthen coordination of HIV and AIDS research efforts that are passed by different IRBs, to ensure use in improving programming and more efficient use of resources- develop SOPs.	- SOPs for HIV and AIDS research coordination developed	**MOH**, UNAIDS

ANNEX III: KEY HIV PREVENTION PERFORMANCE, FY 2021/22

	Indicator	Data Source	Disaggregation	NSP Target	2020/21	2021/22	Comment
1.Increased adoption of safer sexual behaviours and reduction in risky behaviours among key populations, priority population groups and the general population							
1.1	Percentage of adult males and females (15-49 and 50+ years) who have had sexual intercourse with more than one partner in the last 12 months	UPHIA, LQAs	15-49 M	10.5%			Population-based surveys; awaiting final UPHIA 2020 and UDHS 2022 report
			15-49 F	1%			
			50+ M	5%			
			50+F	0.5%			
1.2	Percentage of young women and men aged 15-24 years who correctly identify 3 ways of preventing sexual transmission of HIV and who reject 2 misconceptions about HIV transmission	UPHIA, LQAs	M	70%			
			F	70%			
1.3	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	UPHIA, LQAs	M	11%			
			F	5%			
2 Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up							
2.1	Number of condoms distributed	DHIS2, Program report	Total distributed	NA	181,574,979	192,077,257	↑ 4% increase in meeting the demand need
			Projected need	NA	288,788,198	282,887,601	
2.2	Number of individuals tested for HIV and received results	DHIS2	Overall	NA	4,932,250	4,440,868	↓ No. of people testing for HIV declined by 10%
			M	NA	1,736,681	1,445,334	
			F	NA	3,195,569	2,995,534	
			Self-testing	AN	256,892	468,898	↑ HIV Self testing almost doubled in the last two years
			Index testing	NA			Not Tracked
			APN	NA	105,745	105,412	
2.3	Number of individuals tested HIV Positive	DHIS2	Overall	NA	151,760	131,848	→ **3%** Positivity rate same as previous year
			Males	NA	54,365	48,389	
			Females	NA	97,395	83,459	
2.4	Number of individuals linked to ART	DHIS2	Overall	NA	140,202	122,583	**93%** were linked to ART
			Males	NA	50,070	44,830	
			Females	NA	90,132	77,753	
2.5	Number of KPs received HTS and received results	KP Tracker	Sex Workers	NA	285,583	220,477	**23%** decline in HIV testing ↓
			MSM	NA	21,785	33,749	

	Indicator	Data Source	Disaggregation	NSP Target	2020/21	2021/22	Comment
			PWID	NA	9,320	10,851	among KPs especially the Prisoners and FSW
			Transgender	NA	1,450	4,347	
			Prisoners	NA	88,899	59,608	
2.6	NUMBER of KPs that were HIV positive	KP Tracker	Sex Workers	NA		7,710	
			MSM	NA		476	
			PWID	NA		367	
			Transgender	NA		53	
			Prisoners	NA		1,192	
2.7	NUMBER of KPs enrolled on ART	KP Tracker	Sex Workers	NA		21,620	
			MSM	NA		1,117	
			PWID	NA		599	
			Transgender	NA		119	
			Prisoners	NA		11,663	
2.8	Recent infections	DHIS2	15-19 Male	NA	70	55	↑ **9%** increase in recent infections. **23%** occurred among young people aged 25-29
			20-24 Male	NA	353	292	
			25-29 Male	NA	474	478	
			30-34 Male	NA	458	457	
			35-39 Male	NA	365	438	
			40-44 Male	NA	258	302	
			45-49 Male	NA	155	180	
			50+ Male	NA	226	248	
			15-19 Female	NA	416	458	
			20-24 Female	NA	1,150	1,154	
			25-29 Female	NA	962	1,163	
			30-34 Female	NA	603	709	
			35-39 Female	NA	418	466	
			40-44 Female	NA	247	290	
			45-49 Female	NA	119	172	
			50+ Female	NA	210	228	
2.9	Number of safe male circumcisions performed	DHIS2	NA	NA	353,316	490,655	↑ **28%** increase in SMC
PMTCT							
2.10	Proportion of pregnant women attending ANC	DHIS2	NA	NA	90%	89%	Of 5% of the Population
2.11	Proportion of pregnant women that attended ANC in the first Trimester	DHIS2	NA	NA	35%	36%	
2.12	Proportion of pregnant women who knew their HIV status	DHIS2	NA	NA	99%	98%	At ANC1

	Indicator	Data Source	Disaggregation	NSP Target	2020/21	2021/22	Comment
2.13	Proportion of pregnant women that tested for syphilis	DHIS2	NA	NA	88%	84%	Declined by 4%
2.14	Proportion of pregnant women who tested for HBV	DHIS2	NA	NA	17%	22%	5% increase
2.15	Proportion of pregnant women that tested HIV positive	DHIS2	NA	NA	5%	5%	Higher than the average positivity rate of 3%
2.16	Proportion of HIV positive pregnant women enrolled on PMTCT	DHIS2	NA	90%	100%	100%	Surpassed NSP target of 90%
2.17	Retention of mothers at 12 months	DHIS2	NA	90%	81%	83%	2% increase but below 90% NSP target
2.18	Viral Load testing among pregnant women	DHIS2	NA	NA	59%	59%	
2.19	Viral Load suppression among pregnant women	DHIS2	NA	95%	100%	90%	10% decline, regressed from target of 95%
2.20	Number of HEI	DHIS2	NA	NA	80,141	83,613	Birth Cohorts
2.21	1st DNA/PCR in 2 months	DHIS2	NA	NA	80%	82%	8% decline
2.22	2nd DNA/PCR Uptake	DHIS2	NA	NA	97%	70%	27% decline
2.23	Rapid test at 18 months	DHIS2	NA	NA			Not Reported
2.24	Proportion of HEI linked to care	DHIS2	NA	90%	87%	95%	Surpassed NSP target of 90%
2.25	Final outcome	DHIS2	NA	NA	98%	99%	
2.26	LTFU	DHIS2	NA	NA	11%	6%	5% decrease in loss to follow up
PrEP							
2.27	Number of Facilities providing PrEP	DHIS2	NA	NA	259	473	No of sites almost doubled
2.28	Number of people eligible for PrEP	DHIS2	NA	NA	100,309	138,872	10% increment in no. receiving PrEP
2.29	Number receiving PrEP	DHIS2	All	NA	80,412	124,694	
			MSM	NA	5,295	8,554	38%
			Sex Workers	NA	50,587	68,474	26%

	Indicator	Data Source	Disaggregation	NSP Target	2020/21	2021/22	Comment
			PWID	NA	3,770	4,014	 6%
			Prisons	NA	2	0	200% 
			Transgender	NA	496	928	 47%
			Clients of sex workers	NA	17,421	32,237	 46%
			Displaced/	NA	43	97	 56%
			refugees	NA			
			Uniformed	NA	1,380	1,521	 9%
			Mobile populations	NA	5,921	8,334	 29%
			Non-injecting drug users	NA	8,049	3,360	140% 
			AGYW	NA	6,996	1,9250	 64%
			Pregnant women	NA	1,339	1,942	 31%
			Truck drivers	NA	1,877	2,987	 37%
			Fisher folks	NA	5,615	7,822	 28%
			Sero discordant couples	NA	8,049	9,499	 15%
			Others		6,277	8,069	 22%
2.30	Number getting refill						
PEP							
2.31	Number of people exposed (PEP)	DHIS2	Overall	NA	29,736	28,620	 **10%** increase in number of people initiated on PEP **49%** due to sexual assault/rape
			Occupational exposure	NA	4,802	5,063	
			Sexual assault/rape/defilement	NA	13,861	14,976	
			Other exposure	NA	11,073	8,581	
2.32	Number initiated (PEP)		Overall	NA	23,744	26,519	
			Occupational exposure	NA	3,976	4,344	
			Sexual assault/rape/defilement	NA	12.595	13.113	

	Indicator	Data Source	Disaggregation	NSP Target	2020/21	2021/22	Comment
			Other exposure	NA	7,173	9,062	
2.33	Number completed full course		Overall	NA	11,477	12,309	**7%** increment in number that complete full course
2.34	Proportion sero-converted (PEP)		Overall	NA	1%	1%	Sero conversion kept at minimal
3 Mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic							
3.1	Percentage of women (15-49 years) who experience sexual and gender-based violence		Overall	5%			Awaiting UPHIA 2020/UDHS 2020 final reports
3.2	Percentage of adult males and females that believe that a woman is justified to refuse sex or demand condom use if she knows that her husband has a STI		M				
			F				

ANNEX IV: HIV AND AIDS CARE AND TREATMENT PERFORMANCE, FY 2021/22

Indicators	Baseline	Targets	2020/21	2021/22	Comment
Outcome 1: Linkage to ART increased to 95% by 2025					
1.1 Proportion of diagnosed HIV persons who start ART within one month		95%	99.7%	94% All HIV-**diagnosed** persons	↓ *More effort is needed to ensure immediate treatment for all newly diagnosed patients, especially among KPs*
Adult women (15+ years)	93%	93%	99.7%		
Adult men (15+)	81%	93%	99.7%		
Older people (50+ years)	No data	95%			
Children (0-14 years)	74%	95%	98.7%		
KPs and PPs	No data	95%	94%	94% (8,750/9,279)	
Adolescents (15-19 years)	No data	95%	100%		
1.2 Percentage key and priority populations with HIV on ART			96%	96%	↑ ART coverage improved from an estimated 65% in 2019/20. Data quality is key challenge. *There is need to address the data quality gaps, use standardised size estimates for KP and PPs for performance monitoring, while addressing retention.*
Sex workers		95%	87%	95%	
Uniformed personnel		95%	93%		
Fishermen		95%	89%		
MSM		95%	86%	95%	
Truckers		95%	94%		
IDUs		95%	71%	93%	
Transgender persons		95%	86%	98%	
Prisoners		95%	111%	97%	
Outcome 2: Retention increased to 955 by 2025					
2.1 Proportion of PLHIV retained on ART at 12 months after initiation			**71.5%**	73.3%	↑ slight improvement, but retention at 12/12 is poor across all populations and performance declined from 2019/20 due to the COVID-19 pandemic. Retention is lowest among KPs, then adolescents, then adults. NB: the data for adults was not disaggregated. *There is need to strengthen early retention among PLHIV initiating ART, differentiating retention packages by population. Priority should be given to KPs, and adolescents.* *There is need to align KP targets with HLM targets and increase target to 95%*
Adult women & men (20+)	94%	95%	72.1%	74%	
Children (0-14)	68%	95%	87.2%	74%	
Adolescents (15-19)	No data	60%	56.2%	62.8%	
Key and priority populations	No data	60%	28%		

Indicators	Baseline	Targets	2020/21	2021/22	Comment
Outcome 3: Adherence to ART increased to 95% by 2025					
3.1 Proportion of active clients with adherence of >95% in the last clinical visit	95%	100%	96%		
Outcome 4: Viral suppression increased to 95%					
4.1 Proportion of PLHIV virologically suppressed	75%	95%	94%	96.1% (All)	↑ Improved and passed target Adult females and older males >40 years achieved the 3rd 95 Viral load suppression is lowest among children and adolescents due to adherence challenges, reliance on adults, psychosocial factors, higher drug resistance and lower use of optimised ART regimens (65% among children compared to 98% among adults) There is need to complete the ART regimen optimisation to improve viral suppression, in addition to enhancing efforts in adherence and retention.
Adults	80%	95%	95%	96.6%	
Males 20-29	68%	95%	93%		
Males 30-39	74%		94%		
Males 40- 49	84%		95%		
Females 20-29	77%		94%		
Females 30-39	84%		95%		
Females 40-49	87%		97%		
Older people (50+)	No data	95%	96%		
Adolescents (10-19)	65%(UNAIDS)		87%	89%	
Children (0-14)	75% (JAR)		84%	87%	
4.2 Percentage KPs and PPs on ART that are virally suppressed	No data. Est. 65%	95%	93%	93%	→ On track to achieve the 95% target. Viral suppression is lowest among PWID (89%) but the numbers of KPs are very small. Viral load testing coverage only 94% (15499/16524) *There is need to ensure KPs on ART access timely VL testing*
MSM	No data		94%	92%	
Prisoners	No data		94%	91%	
Injecting drug users	No data		89%	94%	
Sex workers	No data		92%	94%	
Transgender	No data		91%	94%	
Outcome 5: Integration of HIV care and treatment across programs strengthened					
% of estimated HIV positive incident cases that received both TB& HIV treatment within last 12 months	76%	100%	85%	86%	↑ Improved but below target *There is need to improve linkages across facilities and reporting on this indicator.*
Proportion of ART patients who started on TPT in the previous reporting period completed therapy	80%	100%	92%	95%	↑ Improved but achievement is below target. Continue to enhance adherence and retention.

ANNEX V: HIV AND AIDS SOCIAL SUPPORT AND PROTECTION PERFORMANCE, FY 2021/22

Indicators	Baseline	Targets	2020/21	2021/22	Data Source	Comments
Outcome 1: Stigma and discrimination minimized						
1.1 % of men and women aged 15-49 years with accepting attitudes towards PLHIV	Overall 66.8% Male: 71.3% Female 65.6%	Overall 80% Male: 85%% Female 80%	Male 71% Female 66%		UDHS 2016	→ No updated data
1.2% of men and women living with HIV who report experiences of HIV-related discrimination disaggregated by community (exclusion from social gatherings), health settings and workplace	Social gatherings: Overall 16.1%	N/A	Overall 4.3% Male 3.4% Female 4.8%		Stigma Index Survey 2019	→ 2019 achievement meets new HLM Targets. No updated data. Stigma index conducted every 3-5 years
	Religious events: Overall 7.1%	N/A	Overall 1.4% Male 0.95% Female 1.4%			
	Family activities: Overall 4.5%	N/A	Overall 3.6% Male 2.5% Female 4.2%			
	Employment	N/A	Overall: 7.9% Male: 7.6% Female: 8.1%			
1.3 % of PLHIV who self-report on the construct of feeling guilty or worthless due to being a PLHIV	Male Female		24%		Stigma Index Survey	→ No updated data
1.4 % of PLHIV reporting difficulty to disclose HIV status to other people.			36.4%		Stigma Index Survey	→ No updated data
Outcome 2: Reduced socio-economic vulnerability for PLHIV and other vulnerable groups						
2.1 Percentage of PLHIV and OVC households that are food secure	37.2%	70%	23.1%		LQAS	LQAS was conducted in 64 districts in northern and Eastern Uganda
Outcome 3: Reduced gender-based violence/discrimination						
3.1 Percentage of women and men 15-49 years who experience GBV from an intimate partner in the past 12 months (sex, physical and sexual violence)	Women: 9.6% (physical) 16.6 % sexual Men: No data	11% 8%	Women: 56% Men: 44%		UDHS 2016 GBV Dashboard	→ No updated data

Indicators	Baseline	Targets	2020/21	2021/22	Data Source	Comments
3.2 Percentage of GBV survivors who report to formal institutions such as police	6.6%	10%	Women: 33% Men: 30%		UDHS (2016)	 No updated data
3.3 Percentage of GBV survivors who access formal services- (Protection, health and legal services) by M, F	No data	50%	<5%		GBV Dashboard /HMIS	Post GBV Clinical care was 5% for age groups 30-34 years.
Outcome 4: Improved child protection and reduced Violence Against Children (VAC)						
4.1 Percentage of OVC aged 5-17 that have at least three basic needs met (M, F)	39%	70%	Female: 79.3% Male: 79%		OVCMIS	
4.2 Percentage of children and adolescents (13-17 years) by who report sexual violence	Overall:18% Girls: 25% Boys: 11%	Overall:6% Girls: 8% Boys: 4%	Female: 25% Male: 11%		Uganda VAC Survey, 2018	 No updated data
4.3 % of girls and boys 0-17-year survivors of sexual violence who receive formal services (Medical, Psychosocial and legal services)	Overall: 6.1 (13-17 yrs) Girls: 7.7% (13-17 yrs) Boys: 4.6% (13-17 yrs)	Overall: 50% (13-17 yrs) Girls: 60% (13-17 yrs) Boys: 45% (1317 yrs)	PSS 57% Legal 9% Clinical care 6% Referral 30 %		HMIS/OVCMIS	 Existing data outdated (for January -March 2021), from Gender Response Dashboard (GRD) Variable access to Post GBV care services. Need to improve access to clinical and legal services
4.4 % of children survivors of violence and SGBV who have completed PEP (M, F)	No data	60%	48%		HMIS	Target not met. *Need to enhance psychosocial and adherence support*
Outcome 5: Legal and policy framework on HIV and AIDS improved to ensure inclusive access by all PLHIV, Key Populations and other Vulnerable Populations						
5.1 % of PLHIV, KPs and other vulnerable groups who report rights violations	No data	5%			TBD	 No data

Indicators	Baseline	Targets	2020/21	2021/22	Data Source	Comments
5.2 % of PLHIV, KPs and other vulnerable groups accessing legal services in the face of rights violations	PLHIV 18.8% KPs: No data	48%			TBD	 No data NSP target not aligned to HLM target

ANNEX VI: KEY HIV AND AIDS SYSTEMS STRENGTHENING PERFORMANCE, FY 2021/22

	Indicator	Baseline	2020/21	2021/22	Comments
4.1 Governance and leadership of the multi-sectoral HIV and AIDs response at all levels strengthened					
4.1.1	Percentage of districts with functional DACs	50% (2017) (M&E Plan)	55% had plans in place	80%	 With Global Fund support, UAC and stakeholders have supported all DACs across the country
4.1.2	Percentage of districts with functional PLHIV Networks	90% (M&E Plan)	85% (115/136)	91% (125/136)	 Strengthened Sub-County networks by supporting elections at that level Registration status, constitution and bank account A district management handbook on governance, coordination and finance was developed and disseminated to all districts for reference Planning, finance and reporting templates were developed (incorporated into the District management handbook
4.2.3	Percentage of SCEs with functional HIV and AIDS committees	90% (M&E Plan)	92% (11/12)	92% (11/12)	 The average reporting rate was 81%; 58% submitted all their quarterly reports; 25% submitted 3/4
4.1.3	Percentage of large work places (more than 50 employees) with HIV and AIDS workplace programs	No Baseline	77% (206/267)	70%	 The creation of new cities/municipalities has raised the denominator for this indicator.
4.1.4	Percentage of sectors and districts mainstreaming HIV and AIDS	No Baseline	Sectors 89% (16/18)	Sectors 100% Districts: 74% (100/136)	 UAC and partners supported districts to develop HIV strategic plans, which are awaiting approval by their respective councils
4.2 Availability of adequate human resources for delivery of quality HIV and AIDS services ensured					
4.2.1	Percentage of health facilities with required staffing levels	73% (2016)	74% (HRH Audit 2020 Report)		 No updated data since there has been no new HRH Audit

	Indicator	Baseline	2020/21	2021/22	Comments
4.3 Stock outs of medicines and supplies in health facilities reduced					
4.3.1	Percentage of health facilities that had no stock out of one or more required essential medicines and health supplies within past 12 months	No Baseline	55% 1,115/ 2,037	43%	 MoH worked jointly with NMS and districts to conduct annual procurement planning. the Pharmacy Dept conducted integrated Joint support supervision, and The staff of health facilities which were forecasting poorly, were identified and trained Need to align indicator with MoH's
4.4 Health infrastructure responsive to HIV service needs					
4.4.1	Percentage of HC IIIs accredited and offering HTS, ART and EMTCT			79% (1280/1628)	Out of a total 5,506 health facilities in Uganda, 1,628 are HCIIIs and of these, 1,280 have been accredited to offer HTS, ART services (ACP Program data)
4.4.2	Percentage of testing facilities (laboratories) that are accredited according to national or international standards			21% (41/194)	The testing facilities (laboratories) eligible for accreditation are 16 RRHs and 178 GHs. To date, only 41 laboratories have been accredited.

ANNEX VII: KEY HIV AND AIDS M&E PERFORMANCE, FY 2021/22

Indicators	Baseline	Targets	Achievement		Data source	Comment
			2020/21	2021/22		
Outcome 1: Strong national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E strengthened						
1.1 Percentage of sectors and districts with up-to date costed HIV and AIDS M&E work plans	Sectors 100% Districts 80% (102)	100%	50% districts (67/133)	74.1%	Activity reports	↑ 100 districts supported *Expedite completion of district plans and M&E frameworks and submission before District Councils*
1.2 Percentage of sectors submitting quality data that meets standards	N/A	100%	50%	81%	Activity reports and score	↑ The MOES system (EMIS) and MOGLSD systems are still undergoing reinvigoration
1.3 Percentage of key sectors (MDAs) submitting timely and complete reports to UAC	N/A	100%	25%	81%	Activity reports and score	↑ *Need to ensure the functionality of sector systems* *MOLG needs support*
1.4 Percentage of Self Coordinating Entities (SCEs) submitting quality reports	N/A	100%	50%	89.6%	Activity reports submitted	↑ Average for the year; all SCEs submitted their quarterly reports for Q4
Outcome 2: Information sharing and utilization among producers and users of HIV and AIDS data/ information at all levels improved						
2.1 Percentage of implementers utilizing program generated HIV and AIDS data	N/A	100%	100%		Estimates TWG reports	HIV estimates for national and district level annually generated and share to all stakeholders
2.2 Percentage of the national research agenda items covered through operational research in each NSP thematic area	N/A	100%			Research Agenda not disseminated	No data
2.3 Percentage of stakeholders satisfied with NADIC	N/A	80%			Assessment not done	NADIC is still undergoing an upgrade

ANNEX VIII: IMPLEMENTATION STATUS FOR FY2021/2022 AIDE MEMOIRE UNDERTAKINGS

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
HIV prevention				
Primary Prevention	- Re-invigorate SBCC campaigns, using innovative approaches including technology-based channels to reach specific target groups such as adolescents and young people and men	- SBCC campaigns conducted targeting youth	**UAC**, MOH, CSOs, UCC, Youth Leaders	The time UP campaign was launched in Dec 2020 and has now been broadcast on several radio and TV media houses in the country in different languages
	- Dissemination of the HIV Prevention Roadmap	- Roadmap disseminated	**UAC**, MOH	Dissemination done
	- Disseminate the 2021 HIV Communication strategy and SBCC guidelines	- Communication strategy & SBCC guidelines disseminated	**UAC**, MOH, IPs	National dissemination was done awaiting regional and district dissemination
	- Conduct Modes of Transmission Study	- Modes of transmission report	**UAC**, MoH and IPs	Resources mobilised from GIZ and UNAIDS, the study is ongoing
HTS optimization	- Roll out HTS Optimization package to all health facilities to improve efficiencies in HTS (using screening tools to improve targeting, and implementing a differentiated linkage package)	- HTS Optimization package rolled out	**MOH**, IPs	The roll out has been done to all high-volume facilities. Currently clients are reached under different modalities of HIV testing including index testing PNS, SNS, HIVST, RTS But unfortunately, there is a challenge of health workers not prioritizing screening of clients. So, most clients at risk may miss out being tested. In the next year more, test kits will be availed to expand the testing.
	- Scale up family index testing to reach all children of PLHIV in care or newly identified.	- Index testing conducted targeting children of WLHIV	**MOH**, IPs, CSOs	This has been rolled out to all ART sites with fidelity

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
Scale-up targeted prevention interventions for prioritized populations including AGYW, KPs	AGYW & Adolescents and Young People (AYP) - Advocate with stakeholders on implementation of the National Sexuality Education Framework especially with religious and cultural institutions to facilitate ownership and roll out.	- Dialogue sessions held	**UAC**, MOES, FBO SCE	The Sexuality Education Framework was launched and roll our initiated with the training of 962 teachers on the New Lower Secondary Curriculum which incorporates sexuality education.
	- Roll out the national multi-sectoral action and accountability framework for elimination of HIV infection among AYP	- Accountability framework rolled out	**UAC**, MDAs	**Accountability framework rolled out**
	- Roll out the M&E tools for AGYW interventions to all stakeholders	- M &E tools for AGYW interventions rolled out	**UAC, MOH**, MOGLSD, MOES	With support from UNICEF, a consultant has been contracted to review and finalize the M&E Framework
	- Roll out the Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings	- Guidelines rolled out	**MOES**	The guidelines were issued by MoES; they **direct** all schools to prioritize the admission of pregnant and breastfeeding girls. The guidelines also provide directions to schools on how to tackle stigma, discrimination, and violence against learners who are pregnant or are parents.
	- Conduct case study on impact of COVID-19 on AGYW	- Case study conducted on COVID-19 and AGYW	**UAC,** MOGLSD, MOH, MOES	**This was done by MoH and UNICEF**
	- Secure approval and roll out the School Health Policy (MOES) – aimed at tackling teenage pregnancies and supporting school health (MOES)	- School Health Policy approved and rolled out	**MOES**	Revised guidelines for the prevention and management of teenage pregnancy in schools were issued by MoES
KPs:	- Finalize and disseminate the MARPs Priority Action Plan	- MARPs Priority Action Plan disseminated	**UAC,** MOH	National dissemination was done
	- Disseminate the KP data collection tools (MOH) to all stakeholders	- KP data collections tools launched	**MOH**	Tools were developed piloted and approved by MoH. The MoH issued

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
				Unique HMIS numbers for the tools. Currently awaiting final printing and trainings at regional, district, and facility level
	- Roll out the DIC guidelines, Harm reduction guidelines, Roll out the KP -DSD Tool kit	- Guidelines rolled out	**MOH**	Harm reduction and DIC guidelines were rolled out were rolled out virtually throughout the entire country. The DSD tool kit is awaiting final review and approval
	- Conduct data quality assessments –on KP data	- DQA report	**MOH**	This has been done under the GF on a biannual basis to improve data reporting in the KP tracker data base
	- Conduct national level population size estimates	- Updated KP size estimates	**MOH**	Crane survey has been conducted in Kampala, South Western Uganda, Acholi and West Nile. Eastern survey is yet to be conducted. Results are currently being analysed. Also, under BBS-lite MoH conducted a KP profile and size estimate and KP (SW & PWID) services utilization study in Mbale, Busia and Tororo. The study was completed and undergoing analysis
Condom programming	- Roll out the National Comprehensive Condom Programming Strategy & Implementation Plan 2020 – 2025 that embraces the Total Market Approach	- Plan rolled out	**MOH**	This has NCCPS 2020-2025 was approved, printed and rolled out to national and to all regions in the country
	- Formulate comprehensive last mile distribution plan and monitor implementation	- Last Mile Distribution Monitoring Report	**MOH** Condom Unit	The last mile guidelines were revised and will be disseminated in the quarter of Jul-Sept 2022
	- Develop and disseminate plan for replenishment of condom dispensers (MOH)	- Plan for dispenser replenishment disseminated	**MOH,** UNFPA, Private Sector	Nation-wide geo-mapping (using GIS) of community hotspots carried out and 1,138 dispensers

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
				distributed to hotpots/DICs. Condoms distributed to 14,175 hotspots.
Care and treatment				
Address gaps in retention, adherence and viral suppression to achieve the 2nd and 3rd 95%	- Complete the ART regimen optimization to improve viral suppression – transition all eligible children and adults to optimized regimens	- ART Regimen Optimization completed	**MOH;** ADPs	Guidelines in place, however final review is destined for the last week of first week of June 2021
	- Finalize development and dissemination of caregiver literacy guidelines to support retention among children	- Caregiver literacy guidelines developed and disseminated	**MOH**	This was done and disseminated nationally
	- Scale-up Young People and Adolescent Peer Support (YAPs) from current 72 districts and 320 facilities	- YAPs scaled up	**MOH**	YAPS program was expanded to reach the 72 districts with support from GF
	- Roll out the community strategy tool kit and curriculum (to improve self-care and patient literacy) including the caregiver literacy materials at facility & community level	- Community strategy tool kit rolled out	**MOH**	This was completed with support from PEPFAR. The community actors' engagement framework and literacy material were approved and disseminated
	- Scale-up Group ANC – to improve retention of young mothers	- G-ANC scaled up	**MOH**	G-ANC has now been scaled up to cover all high-volume facilities
	- Conduct evaluation on regional VL suppression to understand barriers, and strengthen HIVDR testing	- Study conducted and findings disseminated	**MOH**	Semi-annual regional viral load reviews are done regularly
Strengthen integration of services (TB/HIV AHD, Cervical cancer) for quality care and	- Roll out the HIV/TB quality improvement collaborative to improve outcomes for co-infected persons	- TB/HIV QI collaborative implemented	**MOH** (ACP; NTLP)	National TB/HIV collaborative was instituted and so far, weekly monthly and quarterly review meetings are being conducted to track performance. A dashboard at NTLP was created to monitor performance of the collaborative

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
improved clinical outcomes	- Roll out of device free CD4 testing – to improve testing coverage and implementation of AHD program	- Device free CD4 rolled out	**MOH, UNHLS)**	
	- Develop guidelines for NCD integration into HIV care	- Guidelines developed	**MOH**	Under GF, these guidelines will be finalized by the end of June 2022
Social Support and Protection				
Stigma and discrimination reduction	- Scale up training of health workers across the country to build HIV/AIDS competency and integrate the human rights approach; equip them to provide PLHIV and KP friendly services.	- Health workers across the country trained	**MoH**, PLHIV-led Networks and CSOs, Human Rights CSOs, UAC.	PACE, MILDMAY, and HRAPH have all prioritized scaling up training of health workers in their areas of operation especially on specific topics like KP friendly services. NAFOPHANU has gotten in partnership with PEPFAR through CSSA to pilot an HIV treatment literacy project in 10 districts starting February 2022 to overcome stigma
	- Roll out targeted SBCC materials	- SBCC Materials on stigma reduction rolled out	**MoH**, CSOs	SBCC materials disseminated by UAC and CSOs throughout the year via print and audio media.
	- Disseminate and roll out the Anti-Stigma Policy Guidelines	- Anti-Stigma Policy Guidelines disseminated and implemented	**MoH**, PLHIV-led Networks and CSOs, Human Rights CSOs, UAC	UAC through multi sectoral collaboration disseminated the guidelines to all 136 District Local Governments and some of the MDAs. There is need to monitor and track implementation of the guidelines. In order to address stigma and discrimination in the districts and communities
Socio-economic strengthening	- Scale up comprehensive interventions, including skills training, targeting AGYW to reach those affected by teenage	- Vulnerable AGYW reached with	**MGLSD**, IPs, CSOs	ASHWA-Uganda, PACE and UNASO have deliberately scaled up

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
	pregnancies and early marriage during the COVID-19 period	comprehensive packages.		comprehensive interventions targeting AGYW and OVCs
	- Implement household economic recovery programs targeting households and individuals whose livelihoods have been severely affected by the COVID-19 pandemic and the associated measures	- Vulnerable households and individuals reached with economic support packages	**MGLSD**, MoFPED, IPs, CSOs	CSOs such as CHAWOA implement projects to boost household incomes and food security. National programs such SAGE, UWEP, YLP continued to operate reaching vulnerable AYP and the elderly.
Psycho-social and mental health	- Include counsellors to the staffing structure of health facilities	- Positions for counsellors established at HCIII and above	**MOH**	MOH is intensifying training of expert clients to complement the existing staff at health facilities
	- Strengthen psycho-social support / counselling services at all HIV service delivery outlets including DSD outlets through mechanisms such as peer support groups and expert clients.		**MoH**	YAPS peer support groups, PMTCT mentor mothers trained and deployed to support others
Gender Based Violence	- Streamline and integrate mechanisms for reporting of GBV cases and tracking responses/ Review and harmonize GBV data and reporting systems - Ensure full functionality and update of the GRD dashboard	- GRD dashboard fully functional	**MoGLSD,** UAC, MOGLSD, police, MOH, MOES)	Gender Dashboard is functional however, it is still limited with real time data. Discussions are ongoing with key stakeholders for timely access to data
	- Expand availability of psycho-social support to GBV survivors	- Psych-social support services scaled up	**MoGLSD,** MoH	Post violence care provided to 56,612 AGYW through DREAMS initiative
	- Scale up the training of PLHIV, KPs, vulnerable groups and communities in general about rights awareness and legal literacy to facilitate early reporting of GBV incidents	- PLHIV, KPs, vulnerable groups and communities trained in human rights and legal issues	**MoGLSD**, PLHIV Networks, PLHIV-led CSOs, Human Rights CSOs	CHAWOA, HRAPF, Mild May, URHNs and PACE have scaled up trainings of PLHIV, KPS and OVCs PLHIV and KPs. Sensitization meetings have been integrated with in other ongoing activities for instance expert clients have been

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
				trained in legal processes to address GBV. GBV still needs strong collaboration with implementing partners, police and health facilities to address issues of costs incurred in the process of getting justice
	- Conduct study on the wellbeing of women and girls in Uganda with a focus on GBV	- Study conducted	**MOGLSD**	
Child Protection and Violence against Children	- Operationalize and implement the Guidelines for the Prevention and Management of Teenage Pregnancy in Schools	- Guidelines for Prevention and Management of Teenage Pregnancy in Schools rolled out	**MoES**, MoGLSD, all stakeholders in the Education Sector	Revised guidelines for the prevention and management of teenage pregnancy in schools were issued by MoES.
	- Establish and implement monitoring mechanisms to track progress of school continuation / re-entry by young mothers	- Number of teenage mothers re-enrolled into schools tracked	**MoES**, MoGLSD, all stakeholders in the Education Sector	Reviewed indicators for incorporation into the EMIS
System Strengthening				
Coordination	- Revive the SCE and DACs to improve functionality - Strengthen national and decentralized capacity for multisectoral coordination for HIV prevention	- SCEs and DACs fully functional	**UAC,** MDAs, CSOs	MUCOBADI, CHAU and UNASO supported 16 districts in the Eastern Uganda to revive quarterly DAC meetings
Infrastructure gaps	- Strengthen the internet cable network capacities at RRHs, district hospitals, HCIVs – to facilitate virtual technology for telemedicine & program management	- Hospitals and HCIVs connected to internet	**MOH**, National Information Technology Authority (NITA)	Most health facilities have adopted this more especially with the virtual innovation are able to conduct CME including participation in conferences.
Financing	- Identify innovative resource mobilization strategies for the response	- New innovative financing strategies identified	**UAC, ADPs,** MDAs	✓ HIV mainstreaming being rolled out in the DLGs ✓ Collaboration and partnerships with non-state actors to provide free commodities

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
				✓ Provision and sharing of free airtime to air out the HIV messages across the country under the RDC free airtime ✓ Proposal development to raise additional resources in some MDAs
	- Strengthen ODI	- ODI meets fund-raising target	**ODI team**/Private Sector	✓ COVID-19 affected contributions from the private sector ✓ Financial contribution of 430,000/= (and banked) from training and 2,560,000/= (in-kind) from free hotel venues was mobilized in the quarter (Jan-March 2022)
	- Strengthen HIV Mainstreaming through enhanced monitoring	- Monitoring Report	**UAC,** MDAs	✓ MDAs have conducted joint supervision and monitoring of HIV and AIDS interventions through project audit e.g., in Monitoring of Works and Transport, OPM, Water and Environment
	- Institutionalize and Implement NASA recommendations. Pilot HIV resource tracking tool	- Resource tracking tool piloted	**UAC,** ADPs, MDAs, IPs, CSOs	Resource tracking has been piloted and validated by stakeholders for roll out
Strengthen M&E systems	- Strengthen integrated HIV information System. Reactivate Situation Room	- Situation Room, NADIC, GBV Dashboard functional	**UAC**	Technical Assistance was hired to develop a Data Ware house and the whole process is almost complete
	- Update the district burden estimates for planning	- Updated burden estimates	**MOH**, UNAIDS	Annual National Estimates for 2021 to be released and being used for planning
	- Disseminate UPHIA findings	- Dissemination conducted	**MOH,** UAC	Preliminary report was released in March and the results used for reference and programming

Undertaking	Activity	Deliverable / Output	Lead Agency	Status
	- Strengthen Research Agenda SCE and FastTrack research agenda implementation	- Research Agenda SCE functional		**The research Agenda was finalised**
	- Institutionalize the National Scientific meetings – to be convened every 2 years as a pre-ICASA event	- National Scientific meetings institutionalized	**UAC**	The National scientific meetings have now been institutionalized. The JAR will always take the conference mode
UAC	- Gazette and roll out the new regulations	- New Regulations operationalized	**UAC**	Regulations were gazetted and launched on 15th May during the Candle Light Commemoration. The regulations will be rolled out to all regions
	- Update the National HIV and AIDS Policy	- National HIV and AIDS Policy updated	**UAC**	Process is ongoing and the Policy will be launched

ANNEX IX: LIST OF PARTICIPANTS AT THE JAR WRITING WORKSHOP, JINJA

No	Name	Institution
1.	Rodgers Naijuka	MoGLSD
2.	Susan Wandera	MoH/ACP
3.	Dr. Peter Kyambadde	MoH/ACP
4.	Lordwin Kasambula	MoH/ACP
5.	Julliet Cheptoris	MoH/ACP
6.	Dr. Linda Nabitaka	MoH/ACP
7.	Dr. Katureebe Cordelia	MoH/ACP
8.	Mugumya Richard	NAFOPHANU
9.	Dr. Nelson Musoba	UAC
10.	Dr. Wakooba Peter	UAC
11.	Dr. Vincent Bagambe	UAC
12.	Sarah Khanakwa	UAC
13.	Enid Wamani	UAC
14.	Etii Tom	UAC
15.	Lillian Tatwebwa	UAC
16.	Dr. Daniel Byamukama	UAC
17.	Charles Otai	UAC
18.	Dr. Zepher Karyabakabo	UAC
19.	Karugonjo Christine	UAC
20.	Jotham Mubangizi	UNAIDS
21.	Sylvia Nakasi	UNASO
22.	Dr. Maureen Kwikiriza	USAID/SITES
23.	Rose Nauma	Consultant

ANNEX X: LIST OF PARTICIPANTS AT THE TWG VALIDATION MEETINGS

No	Name	Organization
Systems Strengthening TWG		
1.	Anthony Mutema	AHF- Uganda Cares
2.	Charles Otai	UAC
3.	Christine Karugonjo	UAC
4.	David Walusimbi	NDA
5.	Elizabeth Ekochu	Consultant
6.	Evelyne Akello	METS
7.	James Wafula	UAC
8.	Jotham Mubangizi	UNAIDS
9.	Jude Emunyu	Mildmay
10.	Margie Bayigga	UAC
11.	Peter Wakooba	UAC
12.	Restituta Nabwire	AMICAALL
13.	Richard Waiswa	UAC
14.	Romano Adupa	SEDC
15.	Rose Nauma	Consultant
16.	Ruth Nandugwa	UAC
17.	Shakirah Namwanje	UNASO
18.	Stephen Pande	MoH/ Moroto RRH
19.	Susan Candiru	UAC
20.	Susanne Kiwanuka	MaSPH
HIV Prevention TWG		
21.	Aggrey Mukose	MaSPH
22.	Capt. Gilbert Arinaitwe	UPDF
23.	Charles Otai	UAC
24.	Christine Karugonjo	UAC
25.	Daniel Byamukama	UAC
26.	Daniel Kasozi	MoH
27.	Elizabeth Ekochu	Consultant
28.	Falal Faith Rubanga	UGANET
29.	Flavia Kyomukama	AGHA
30.	Gladys Tugume	
31.	Ivan Ssegawa	Makerere Lung Institute
32.	Jane Mwirumubi	ICWEA

No	Name	Organization
33.	Jennipher Knight Johnson	
34.	Jesse Baraka	JCRC
35.	Josep K.B Matovu	MaSPH
36.	Margie Bayigga	UAC
37.	Norah Katushabe	UNASO
38.	Patricia Mwebaze Songa	USAID
39.	Peter Kyambadde	MoH
40.	Peter Wakooba	UAC
41.	Restituta Nabwire	AMICAALL
42.	Richard Lusimbo	SMUG
43.	Rita Nalwadda	WHO
44.	Rose Nauma	Consultant
45.	Ruth Nandugwa	UAC
46.	Susan Candiru	UAC
47.	Vanessa Namutebi	AGHA
48.	William Kidega	IAVI
49.	Willy Kafeero	USAID
Care and Treatment TWG		
50.	Alice Namale	METS
51.	Augustine Lubanga	Uganda Care-AHF
52.	Bridget Amutwongire	MOHWA
53.	Charles Otai	UAC
54.	Christine Karugonjo	UAC
55.	Daniel Kabango	Naguru TC
56.	Elizabeth Ekochu	Consultant
57.	Francis Ssali	JCRC
58.	Isaac Lwanga	Mengo Hospital
59.	Isabella Nattu	NTHC
60.	Joseph Emiku	QPPU/MoH
61.	Jude Emunyu	Mildmay
62.	Kaggwa Mugagga	WHO
63.	Margaret Happy	AQH-Uganda
64.	Margie Bayigga	UAC
65.	Martin Kigozi Ssennoga	NUDIPU
66.	Peter Wakooba	UAC

No	Name	Organization
67.	Rose Nauma	Consultant
68.	Ruth Nandugwa	UAC
69.	Sharifa Nakabubi	Naguru
70.	Stephen Watiti	NAFOPHANU
Social Support and Protection TWG		
71.	Alex Ndaada	UAC
72.	Anne Peace Baguma	SALT Project
73.	Betty Kwagala	NUWODU
74.	Betty Nabirye	TASO
75.	Charity Orishaba	AGHA
76.	Charles Otai	UAC
77.	Christine Karugonjo	UAC
78.	Elizabeth Ekochu	Consultant
79.	Enid Wamani	UAC
80.	Firmina Acuba	MoWE
81.	Flavia Zalwango	HRAPF
82.	George Aguze	
83.	Gideon B.Byamugisha	FOCAGIFO
84.	Grace Nayiga	UGANET
85.	Hope Murungi	UAC
86.	Jane Mwirumubi	ICWEA
87.	Judith Namusisi	UAC
88.	Juliet Cheptoris	MoH
89.	Lydia Nsubuga	MOHA
90.	Mark Tuhaise	UYP
91.	Maxenia Nakibuuka	MOWHA
92.	Peter Wakooba	UAC
93.	Rose Nauma	Consultant
94.	Ruth Nandugwa	UAC
95.	Ruth Ninsiima	FOCAGIFO
96.	Sunday Kumakech	Baylor-Uganda
97.	Susan Candiru	UAC
98.	Tom Etii	UAC
99.	Trevor Kafuko	KCCA
100.	Vanessa Namutebi	AGHA

No	Name	Organization
Gender and Human Rights		
101.	Alex Ndaada	UAC
102.	Beatrice Were	ICWEA
103.	Betty Kwagala	POWODU
104.	Betty Nabirye	TASO
105.	Bridget Nakigozi	AGHA
106.	Charles Otai	UAC
107.	Christine Karugonjo	UAC
108.	Doreen Nassamula	CSO
109.	Dorothy Namutamba	ICWEA
110.	Florence Buluba	NACWOLA
111.	Irene Murungi	TASO-GMU
112.	James Wafula	UAC
113.	Jesse Baraka	JRCR
114.	Jethro Avikuru	AGHA
115.	Lilian Mworeko	ICWEA/ Chair
116.	Lilian Tatwebwa	UAC
117.	Lydia Mungherera	Mama's Club
118.	Margie Bayiga	UAC
119.	Martha Atai	Uganda Cares-AHF
120.	Mary Kataike	UAC
121.	Peter Wakooba	UAC
122.	Richard Waiswa	UAC
123.	Rose Nauma	Consultant
124.	Sarah Nakku	UNAIDS
125.	Sharifa Nakabubi	Naguru
126.	Sharon Acen	MoH
127.	Stella Kentutsi	NAFOPHANU
128.	Susan Candiru	UAC
Resources and Costing TWG		
129.	Alex Ndaada	UAC
130.	Anne Peace Baguma	Salt Project
131.	Augustine Odwee	
132.	Christine Karugonjo	UAC
133.	Elizabeth Ekochu	Consultant

No	Name	Organization
134.	Eugene Oola	UAC
135.	Ezrah Trevor	MoH
136.	Flavia Kyomukama	AGHA
137.	Gerald Karegyeya	USAID/UHSS
138.	Grace Muhuruzi	UAC
139.	Hargaret Happy	AQH-Uganda
140.	Hudson Balidawa	Consultant
141.	Isabella Nattu	NTHC
142.	James Wafula	UAC
143.	Jane Mwirumubi	ICWEA
144.	Jenipher Musoke	
145.	Jesse Baraka	JCRC
146.	Joel Chemusto	UNASO
147.	Julius Mukobe	Consultant
148.	Kennedy Otundo	UNASO
149.	Naome Mujuni	UWESO
150.	Peace Nabukenya	UAC
151.	Rose Nauma	Consultant
152.	Sarah Khanakwa	UAC
153.	Sophia	
154.	T. Kafuko	KCCA
155.	Tom Etii	UAC
156.	Yonah Ahabwe	UAC
Monitoring and Evaluation TWG		
157.	Alex Ndaada	UAC
158.	Anne Peace Baguma	SALT Project
159.	Bamulangeyo M.O.	AHF-Uganda Cares
160.	Brian Masimbi	MoGLSD
161.	Charles Otai	UAC
162.	Charles Serwanja	IRCU
163.	Christine Karugonjo	UAC
164.	David Damba	Baylor-Uganda
165.	Elizabeth Ekochu	Consultant
166.	Elizabeth Mushabe	UNWomen
167.	Flavia Kyomukama	AGHA

No	Name	Organization
168.	Florence Abesigye	NAFOPHANU
169.	Hannington Mutabarura	ICWEA
170.	Henry Tailisobola	USAID
171.	Isabella Nattu	NTHC
172.	Joel Chemusto	UNASO
173.	Justine Katwesigye	USAID
174.	Kennedy Otundo	UNASO
175.	Lordwin Kasambula	MoH
176.	Ochwo	
177.	Peter Wakooba	UAC
178.	Prossy Namakula	GCOWAU
179.	Richard Mugumya	NAFOPHANU
180.	Rose Nauma	Consultant
181.	Ruth Nabagala	MoH
182.	Sarah Mutiiga	GCOWAU
183.	Vincent Irumba	CCM