

**THE PEOPLE'S
VOICE
UGANDA**

COMMUNITY PRIORITIES

PEPFAR COUNTRY OPERATIONAL PLAN 2019



Today, an estimated 1.3 million adults and children are living with HIV in Uganda¹ – and 1.1 million of those people have access to antiretroviral treatment.² Despite this important achievement, much more needs to be done to achieve epidemic control in Uganda and truly defeat HIV.

In 2018 alone, 28,322 people died needlessly of AIDS related illnesses in the country – and still each year 48,254 people newly acquired HIV.³ PEPFAR's most recent program data indicate persistently low retention and poor quality treatment program performance at a level that is gravely concerning. FY18 quarter 4 program data indicates that while 225,939 people had been newly enrolled on treatment in total during the year, the NET_NEW target stood at only 108,646 overall – or only 48.1%. Only 5 districts are retaining greater than 95% of newly initiated people over the year while 40 districts are losing more than 10% of those newly initiated.⁴

Substantial barriers are obstructing attainment of the goal of defeating HIV as an epidemic by 2030 in the country. In addition to unacceptably high rates of loss to follow up, Uganda ranks lowest among a subset of countries recently completing surveys of viral load suppression with an estimated 59.6% of all HIV-positive Ugandans having suppressed viral load – pediatric and adolescent rates of viral suppression are much lower (39.3% for Ugandans aged 0-14).⁵ Gender inequality puts women and girls at particularly high risk of HIV infection; men with HIV meanwhile are less likely to know their status, seek treatment and to have suppressed viral load. Key populations, including men who have sex with men (MSM), transgender people, people who use drugs (PWUD), and sex workers are facing an unmet need for quality HIV treatment and prevention services.

Extremely high levels of stigma, discrimination and criminalization systematically continue to fuel the spread of HIV. In March 2017, President H.E. Yoweri Museveni launched the “Presidential Fast Track Initiative on Ending HIV in Uganda by 2030,” but the June 2019 year one report fails to mention stigma even one time.⁶

Index testing – a major focus of PEPFAR's programs – is being rolled out in communities without a plan to ensure index testing does not cause harm. While PEPFAR facilities are failing to consistently track gender based violence, community-based organizations that have created internal violence tracking tools are reporting increasing rates of GBV and stigma faced by women. Without adequate consideration for human rights and protections, index testing may increase levels of violence faced by people living with HIV. PEPFAR needs to ensure that PLHIV are protected from violence and criminalization as a result of testing strategies implemented by partners on the ground and that violence is systematically tracked and addressed.

Chronic stockouts of essential medicines for opportunistic infection treatment and prevention, as well as antiretroviral treatment, are compromising disease outcomes. 570 new HIV infections occur weekly among young Ugandan women aged 15-24, a crisis exacerbated by the Government's reluctance to provide evidence-based, comprehensive HIV prevention to young people.

Strategies such as same-day ART initiation, increased access

1. Uganda Population-Based HIV Impact Assessment (UPHIA) 2016-2017. Extended Summary Sheet. https://phia.icap.columbia.edu/wp-content/uploads/2018/07/3430%E2%80%A2PHIA-Uganda-SS_NEW.v14.pdf

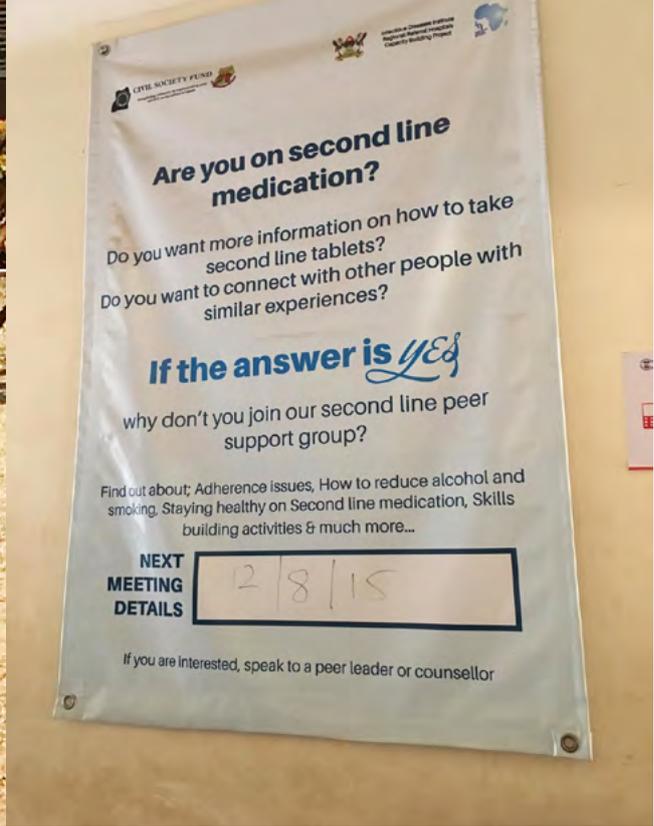
2. 29 November, 2019. “PEPFAR FY18 Quarter 4 Review.”

3. Uganda 2018 Strategic Direction Summary, p. 4.

4. See supra note 2

5. See supra note 1, p. 3

6. Year 1 Report of the Presidential Fast Track Initiative, available here: <http://www.aidsuganda.org/images/documents/PFTI%20Report%202018.pdf>



to pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), and expanded prevention services for adolescent girls and young women through DREAMS, have greatly improved progress in prevention and treatment. However, a closer look at PEPFAR's program data show important gaps, with men, young people, and key populations too often left behind by current testing, treatment and retention strategies. Increased funding for high performing, peer-led treatment linkage and retention strategies – in particular an increased investment in adequately paid and trained community health workers who are themselves living with HIV and/or members of key population groups – is urgently needed to ensure a course correction.

In addition to HIV, Uganda also faces a substantial tuberculosis (TB) burden, affecting many people living with HIV. According to the World Health Organization (WHO), 86,000 people had

TB in 2017 – of these people, 34,000 were living with HIV⁷. As a result of this, 25,000 people died that same year, including 14,000 people living with HIV. While getting more than 90% of people on HIV treatment has dramatically reduced deaths, TB still accounts for around half of all deaths among people living with HIV, a challenge that PEPFAR must address.

Uganda's crisis of insufficient, poorly remunerated, and inequitably deployed professional health workers undermines timely enrollment of people with HIV on ART and effective disease management. Overburdened health facilities contribute to unacceptably high rates of loss to follow up and overwhelmed staff result in high rates of absenteeism and demotivation. The informal ban on recruitment and the cap on the wage bill ceiling means qualified clinical staff are prevented from doing the work that motivates them.

This is the “People’s Voice” – containing Uganda’s community priorities and recommendations for PEPFAR for the Country Operational Plan 2019. The recommendations have been developed by people living with HIV and health activists using information gathered in February 2019 during community consultations and additionally through facility monitoring carried out at seven PEPFAR supported sites in four high burden Districts including: Mbale (Mbale Regional Referral Hospital and TASO Mbale); Lira (Lira Regional Referral Hospital and Amach HCIV); Jinja (Walukuba HCIV and JIACOFE); and Tororo (Mukuju HCIV).

This facility level monitoring assessed the state and quality of HIV and TB service provision through a series of questions targeting healthcare providers and healthcare users at the facilities, developed in consultation with community advocates from Uganda’s civil society advocacy coalition that has taken on PEPFAR-related advocacy and monitoring. Results of this monitoring are outlined in the recommendations below. Further consultations were held with people living with HIV, LGBTI communities, and relevant community-based organization (CBOs) and non-government organizations (NGOs).

7. Global TB Report, 2018. World Health Organization (WHO). Available at: <https://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf?ua=1>

PRIORITY INTERVENTIONS FOR COP 2019

1. Fund support for at least 620 additional front-line professional health workers in priority cadres and geographies, and at least 930 additional community health workers.

1a. Fund at least 620 front-line professional health workers.

Without sufficient numbers of health workers, the quality of the HIV response is at risk of further decline--this will undermine disease control outcomes, resulting in avoidable clinical progression, death and onward HIV transmission. The sustainability of the national HIV program will be threatened and the country will be unable to respond effectively to the TB epidemic. Human resource shortages cause longer waiting times at clinics and an overburdening of the few healthcare workers in place. Extended and lengthy clinic visits, especially for people to simply collect ART refills, increases the risk of an individual disengaging from care. Adequate staff at the frontline of HIV and TB service delivery, and differentiated service delivery models, are critical to ensuring people remain in care and can access quality services that promote good linkage and retention.

620 represents approximately 50% of the total of PEPFAR-supported health workers who have been absorbed by GoU; 620 new health workers would enable continued expansion at pace, so that current critical program gaps are filled. Currently there is a major shortage of healthcare workers across the country – despite the fact that the overall rate of approved health worker posts filled by the public sector has increased to 73%.⁸ The WHO estimates at minimum 2.5 professional medical staff (physicians, nurses and midwives) per 1,000 people are needed to provide adequate coverage with primary care interventions.⁹ However in Uganda the rate is woefully inadequate at one physician to 28,202 people, and just one nurse to 11,000 people.¹⁰ Monitoring by activists at health facilities only confirmed the challenge of human resource shortages and its impact on healthcare users and people who attempted to collect medicines. Staff and patients at all facilities monitored during our investigation lamented having too few staff in place to provide adequate HIV services. Most of the facilities had few clinicians and a large number of people living with HIV. The waiting lines were visibly long and clinicians moved from room to room providing multiple services to multiple patients. A nurse in Tororo told us that “**people living with HIV linked in the facility increase by day but the numbers of health workers have remained the same since I got here**”.

At the majority of facilities monitored, both healthcare users and management teams highlighted that there had been cuts in the number of healthcare workers attached to the facilities. All the facilities monitored highlighted a worsening in their results after the healthcare worker cuts.

In addition, poor implementing partner hiring practices assessed by the team show that lay workers attached to 5 out of 7 of the facilities had been hired on voluntary basis. Further, clinicians in certain sites were paid by the number of days worked, and services provided during weekends and public holidays were not paid for.

At TASO Clinic in Mbale District, 75% of HIV services are provided in the community and only 25% at the facility level. This in a bid to ensure that the clinic targets people who need more attention, such as the virally unsuppressed. The facility focuses on supporting 70 community drug distribution points and 61 Community ART Adherence Groups. However, in the last year (2018) the program had had reductions in staffing from 35 to 18 due to funding cuts, and a reduction from 60 to 30 lay workers. An administrator at the facility told us that “**when we had the 60 lay workers, we were able to test, link and initiate 1 400 new clients in one year because they were motivated. Since remuneration has been going down, the bad pay is equal to a lot of service delivery challenges and affects our work. Because of the reduction a lot of people left and it affected our output.**”

People living with HIV interviewed at facilities all reported that the lack of staff members affected the quality of services provided – including that the healthcare workers had no time to listen to the adherence issues, and offer quality services. Roll out of index testing--a focus of COP19--in a manner that supports the human rights of people with HIV will also require additional staff capacity. PEPFAR has consistently supported funding for health workers; investment during COP19 is required in order to continue to increase clinician concentration, following the absorption of approximately 50% of PEPFAR supported workers into the public system.

COP19 must fund 620 additional front-line professional health workers through the public health system to ensure quality HIV and TB service delivery at a primary level. These health workers should be prioritised at sites with the greatest human resource shortages, and PEPFAR should secure GoU commitment to their timely absorption by Ministry of Public Service. PEPFAR must provide a breakdown of healthcare workers employed, at what level, and in which facilities. An increase in 620 health workers would ensure critical capacity gaps are filled, while PEPFAR continues to work with GoU to absorb remaining PEPFAR-supported staff, consistent with the COP18 target of 50% of staff secondments absorbed by GoU by the end of COP18.

8. Ministry of Health. Statistical Review of Progress to Inform the Mid-Term Review of the Uganda Health Sector Development Plan. Available at: <https://health.go.ug/download/file/fid/2028>

9. World Health Organisation. World Health Report 2006.

10. See supra note 6.



1b. Fund a minimum of 930 additional lay health workers.

Uganda, like many other countries with a high HIV burden and few health workers, has turned to lay workers to support with HIV service provision. The PEPFAR program has invested in expert clients, linkage facilitators and peer educators in a bid to provide services to an ever increasing number of people living with HIV. Community Health Extension Workers (CHEWs) have long been recognised as an important part of a primary healthcare system in Uganda, although their voluntary status means they are not able to provide the comprehensive package of services people with HIV require, in particular extensive peer-led retention and support services. Community based non-professional health workers have the potential to bring health services closer to the community while reducing the burden on an already overstretched primary healthcare services. More community based capacity is also needed to ensure quality roll out of new COP19 priorities such as index testing in a manner that promotes and protects the human rights of people with HIV. Increased human resource capacity is required to roll out this modality appropriately; including increased time spent on counselling and support as well as follow up.

The functions of the CHW include (but are not limited to):

- + Understand HIV and TB fully to offer up to date prevention and treatment literacy information;
- + Promote HIV testing at a facility level and offer information to prevent sexual transmission of HIV;
- + Promote and provide HIV self-testing kits and/or finger prick tests to marginalised and hard to reach communities not currently accessing health services through the clinic, linking those who gain positive results to facility services;
- + Provide lay counselling and support services at facility and community level;
- + Provide people living with HIV with treatment and adherence support, ensure people who access HIV treatment keep taking it and engage in defaulter tracing;
- + Provide basic mental health assessments in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges;
- + Improve linkage of people living with HIV between the facility and community HIV services;

- + Follow up with people living with HIV who have missed appointments (both through telephone calls and home visits);
- + Ensure quality implementation of index testing in a manner that protects the human rights of people with HIV and prevents criminalization, stigma and violence; and
- + Trace people with TB or who are close to people with TB and ensure that they have access to, and take, treatment effectively.

PEPFAR has already invested in lay workers at supported sites which is commendable, and has improved the reach of HIV services into the community. However, in all facilities monitored, the lay workers were either poorly remunerated (1 facility) or not remunerated at all (4 facilities).

COP19 must prioritize the appropriate remuneration of lay health workers, and must focus on recruitment of people with HIV and other directly affected populations (such as KPs) rather than taking the approach of Village Health Teams (VHTs). This surge in investment will address the massively off track retention indicators. Health workers including lay workers play a critical role in ensuring people are linked to and retained on treatment and that hard to reach individuals who do not know their status are tested and linked to care. Quality HIV service delivery can only be achieved by investment in facility and community systems and lay health workers are vital to the success of the program.

The PEPFAR-funded lay workers must be well trained and capacitated, with appropriate supervision structures, and have access to all relevant tools of their trade, in order to ensure they are able to carry out their duties effectively. They should have a standardised and sufficient salary above the living wage.

COP19 must remunerate all existing lay health workers attached to PEPFAR supported sites. COP19 must fund an additional 930 lay health workers, reflecting the "HIV share" (6.2%) of the target density of the new cadre of Community Health Extension Workers (two CHEWs per parish) to increase community outreach and quality of adherence and retention of clients. These lay health workers will be formally paid, trained, capacitated, and equipped with communications and transportation needed to be effective.

2. Improve linkage and retention rates through quality interventions including through providing differentiated service delivery (DSD) including group and fast track models of care, population specific service delivery and outreach (for key populations, men and AGYW), and ensuring annual viral load testing and rapid access to results.

2a. Ensure 100% of PEPFAR supported sites have functional group models of care including support groups and community client-led ART delivery (CCLAD) groups, as well as fast track models of care such as Community Drug Distribution Points (CDDP) by end of COP19.

Long waiting times were a common complaint among individuals interviewed during our facility monitoring visits. Long waiting times ranged from between one to six hours. One individual in Amachi Level 4 Hospital told us that “it is first come first served basis, but on most days it takes 1-3 hours”. Another in Jinja told us that “even with the early arrival they can stay at the facility from 7am to -1pm. Clinicians go to work late and are prompt to go for lunch breaks and take long lunch break”. Each time an individual is asked to return to the facility, especially for a lengthy visit, there is a risk of that person disengaging from care.

For PLHIV stable on ART and virally suppressed, differentiated service delivery models such as community client-led ART delivery (CCLAD) groups, and fast track models such as community drug distribution points (CDDP) need to be scaled up. These models support long-term retention by providing aspects of peer support as well as speeding up the process of collecting ART refills. DSD models also subsequently ease the burden on healthcare workers at the facility.

Support groups: Support groups linked to each public health facility are critical to provide ongoing counselling and peer support services to PLHIV including those having difficulty adhering to treatment. Ensuring PLHIV have access to support groups will improve retention rates, reduce the likelihood of people disengaging from care and thus lower mortality rates. All facilities that we monitored had no funding provision for support groups resulting in few groups functioning – either two, one or none in some cases.

Community Client Led ART Delivery (CCLAD): These groups are a simple, friendly and quick system to allow PLHIV stable on ART to collect treatment outside the local facility setting. Groups also act as a platform for peer support and to join discussions related to treatment literacy and mental and physical health and well-being that foster long-term treatment adherence. Groups not only promote better adherence, but they also relieve the burden on already stretched health facilities. As outlined below, group membership should be considered for specific populations including youth and AGYW, key populations, and men. Only one facility out of seven monitored on our investigation had a CCLAD in place for key populations, funded by the Elton John Foundation (EJAF). In order to provide quality HIV services, PEPFAR needs to support people on treatment to become and remain virally suppressed

on treatment through the use of functional CCLAD groups.

Community Drug Distribution Points (CDDP): By offering ART collection in the community CDDP will reduce the potential for missed appointments as services are brought closer to community members, becoming less time consuming, and easing challenges of transportation to the health facility.

Of the facilities monitored, 4 out of 6 were implementing some form of CCLAD or CDDP, however aggressive scale-up is required to ensure more stable PLHIV can utilise these models.

2b. Ensure 100% of PEPFAR supported sites provide “male friendly” services by end COP19 including male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups and CCLAD groups, and where possible access to male healthcare workers.

None of the 7 facilities reviewed had CCLAD groups targeting men, despite men lagging behind in viral suppression. Among the male population, HIV prevalence peaks at 14.0% among men aged 45 to 49, but only 67.3% of men living with HIV know their status, and only 86.7 of men who know their status were on antiretroviral treatment.¹¹ Testing strategies by implementers such as Jinja Area Communities Federation (JIACOFE), that conduct testing outreach at the community level and are targeted and integrated with other services such as immunization and malaria control, need to be expanded to target men and key populations. Increasing more programs that also travel with starter packs will ensure that those tested are linked immediately to care and ensuring physical escort to the facility by linkage facilitators will increase linkage and retention rates.

2c. By end COP19, all clinical and non-clinical staff at 100% of PEPFAR supported sites must have been sensitized on issues related to key populations (including MSM, transgender people, sex workers and PWUD). COP19 will roll out targeted community testing strategies aimed at key populations in all high burden districts.

As the country moves closer to epidemic control, finding the remaining people living with HIV who do not know their status will be more and more challenging and targeted community testing and scale up of collaboration with communities

11. See supra note 1.



of people living with HIV will help reduce stigma among communities, and increase testing. More of the people that the program will be looking for are healthy people living with HIV who are not visiting the facilities, as well as populations that are less likely to visit the facilities for services such as men and key populations. Scale up of community awareness on HIV status, self-testing and adherence support will be key.

Key population and priority population groups were reported as receiving services at 6 out of 7 facilities. The populations included MSM, SW, PWUD, transgender people, fisher folks and prisoners but none of the facilities provided comprehensive services for PWUDs that included needle and syringe exchange and/or methadone and/or buprenorphine. Some facilities such as TASO had a separate location for key population service delivery, and Mbale District hospital partners with Hope Mbale, a key population organisation to reach key populations. Stigma was raised as a key barrier to service access by men having sex with men.

“People found in outreaches fear being referred to nearby health facility but they faces challenges with transport. We have people who link clients to the facility and they now do it physically because when they asked clients to go on their own they would not go. There are challenges with the distance to the facility which affects the retention of clients. Stigma is a barrier and KPs who go to the general facility are not fast tracked and have to stay on the line with everyone else which is difficult for trans people especially.”

COP19 must support key population-led comprehensive service delivery to increase retention and train health workers on key population service delivery to reduce stigma. Services must be provided by peers themselves. Support for key population lay workers attached to general facility who fast track key populations seeking services at the facility will also increase retention among key populations. PEPFAR should prioritize supporting key population organisations to offer comprehensive service delivery to peers to increase testing, linkage and retention. KP targets must be more ambitious for COP19, in particular for MSM. For PWUD, PEPFAR should support a pack of treatment services consistent with community priorities.

2d. Ensure that COP19 reaches the most vulnerable AGYW (pregnant, married or girls who had given birth) with the DREAMS program. Ensure 100% of PEPFAR sites, specifically in DREAMS districts, establish youth clubs (for young people aged 15 – 24) in order to provide HIV clinical management, ART refills, peer support, and counselling to ensure better linkage & retention of young people by end COP19. Ensure that sexual prevention programs, including those provided under PEPFAR’s new faith based initiative, do not compromise access to correct, comprehensive and non-stigmatizing HIV prevention services, including for girls aged 9 – 14.

Young people, particularly adolescent girls and young women (AGYW), are disproportionately affected by the HIV epidemic, and are at high risk for infection with approximately 570 young women acquiring HIV in Uganda each week.¹² Further viral load suppression among adolescents is shockingly low. Models of care remain largely undifferentiated for this vulnerable population, despite commitments to shift in COP18.

Layering was particularly strong for girls enrolled through school and for girls identified as high risk for engaging in transactional sex, yet less than 50% of pregnant, married, or girls in who had given birth were reached with three or more interventions. COP19, under the DREAMS initiatives must:

- + Fund development and implementation of standard criteria and risk assessment tools across partners and districts to ensure that the most vulnerable AGYW are being reached with DREAMS;
- + Ensure scale up of services to three or more high impact services to AGYW including those who are married, pregnant or who have given birth to >80% by end of COP19;
- + Ensure that HIV testing is not a prerequisite for DREAMS enrollment, and that the frequency of testing for individual AGYW is in accordance with their HIV risk;

12. UNAIDS. The Gap Report. 2014. As cited in: <https://www.monitor.co.ug/News/National/Uganda-fight-HIV-Aids-official/688334-3470130-trp7kxz/index.html>

- + Ensure that all curricula reaching DREAMS beneficiaries aligns to curriculum fidelity and complies with DREAMS and COP 2019 Guidance, regardless of whether the partner is DREAMS or OVC;
- + Strengthen HIV and violence prevention programming for 9-14 year olds; and
- + Fund community health workers and lay cadres to support PrEP adherence which is very low among AGYW.

PEPFAR should continue to scale up PrEP, particularly among high-risk AGYW through DREAMS, invest in user-centered design of PrEP implementation, and rapidly identify, test, validate and use strategies to pair PrEP together with couples testing and supported self-test for male partners and women, particularly AGYW who are pregnant, married or have given birth.

PrEP roll out should include messages for segmented audiences within high risk groups such as MSM and sex workers. Partnership with civil society groups to deliver and support services, launch of a full-scale national communications campaign, and analysis of data as suggested in the PEPFAR planning letter should be rapid – as all available evidence on effective delivery of primary prevention suggests that development of tailored messages, provider training and community-based partnerships are essential to uptake of new prevention. Condom procurement and provision should also be part of all PrEP programs.

During the monitoring exercise, communities reported that most primary health facilities do not cater to the specific needs of young people, and youth friendly facilities are not common. **“Most facilities do not have youth friendly facilities. Having a youth corner does not make a facility youth friendly. If a young person goes to the facility and sees an adult they know they don’t go back. Make sure the services are available and there is human resource. Clinicians at youth clinics need to be flexible to accommodate adolescents or adolescent don’t come back.”**

Young people seeking HIV services as well as contraceptives need to be accommodated to ensure they uptake services, and engage in care. COP19 should ensure that all clinical and non-clinical staff at all PEPFAR sites are sensitised to provide youth friendly services.

In addition, young people and adolescents need group models of care away from adults that meet at convenient times (such as weekends), to accommodate learners. Yet only 3 out of 7 of the facilities monitored offered youth clubs.

COP19 should saturate PEPFAR districts with youth clubs which target losses from HIV diagnosis throughout lifelong treatment journey, with a specific focus on retention after initiating ART. Closed membership groups should be established which integrate psychosocial support, HIV clinical management (including ART initiation), family planning and ART refills for approximately 20 members who include a combination of HIV positive youth ineligible for ART, youth newly initiated on ART or youth stable on ART. Groups will be led by young people with mentorship from a club facilitator and adults/older youth. They should meet monthly and discuss adherence and other topical issues. They should include diverse membership including in and out of school youth, key populations etc.

Finally, AGYW who are living with HIV must be included in DREAMS—we appreciate that PEPFAR has accepted this request, and look forward to programming based on it. DREAMS should not further stigmatize AGYW living with HIV or exacerbate inequities in access to capacity building services.

COP19 must ensure the most vulnerable AGYW are reached through the DREAMS program, including

AGYW who are pregnant, married, or had given birth – and AGYW living with HIV. COP19 must establish youth clubs (for young people aged 15 – 24) in order to provide HIV clinical management, ART refills, peer support, and counselling to ensure better linkage & retention of young people by end COP19. PEPFAR must ensure that all clinical and non-clinical staff in PEPFAR supported sites are sensitized to young people’s needs.

2e. COP19 must support the staffing and other costs to ensure that all people living with HIV receive a viral load test 6 months after ART initiation and then annually – and receive the results of those tests rapidly. Detectable viral load results should trigger appropriate clinical action.

It is empowering for PLHIV to understand their own viral load and what this means for their long-term health and their risk of transmitting the virus to another person through sexual intercourse. There is clear evidence that early treatment benefits the health of people living with HIV, as serious AIDS-related events like cancer and TB can be prevented. Research has also shown that people on ART with suppressed viral loads will not transmit HIV. It is imperative that all people living with HIV on ART should be given a viral load test at least annually and that they should be provided with their test results in a timely manner.

At present, results of viral load tests are reportedly taking between two weeks to two months to arrive in some facilities. National data show only 36% of second line patients with non-suppressed viral load have had a repeat viral load test. During our monitoring visits, challenges were raised regarding results printing, and the high number of people at clinics leading to a two month turnaround time for results post testing. A two month delay in receiving the results of viral load tests greatly hinders quick responses required to reach people with unsuppressed viral loads and provide a medical package of care and a psychosocial package of support.

COP19 must support the staffing, commodities and other costs to ensure that all people living with HIV receive a viral load test 6 months after ART initiation and then annually – and receive the results of those tests rapidly. People with detectable viral load results should be linked with appropriate clinical action in a timely manner.

3. Invest in TLD transition for women of reproductive age to improve retention and treatment outcomes.

Dolutegravir (DTG) is the first integrase inhibitor that will be widely used by people living with HIV in the developing world. It is a critically important antiretroviral medicine that is set to become the backbone of many countries HIV programs.

Studies show that DTG represents an important improvement over existing treatments. Some of the advantages of DTG include that: it is highly effective, well-tolerated, and easier to take; has fewer interactions with other medicines (although some exist); has a high barrier to resistance; and has the capacity to be produced more affordably¹³. While in May 2018, preliminary findings from an observational study in Botswana raised a potential safety concern about the use of DTG for women at the time of conceiving a child, subsequent findings as the study has progressed has revealed reduced risk of this being associated with DTG use. However, once the potential safety concern was identified, women of childbearing age in Uganda have been limited in accessing the DTG based regimen (tenofovir-lamivudine-dolutegravir – TLD) that is being widely offered to men. During the monitoring visits, access to TLD for women was being restricted in all facilities. Women had to show that they were on reliable contraception or tubal ligation, and sign consent forms. All clinicians interviewed were clear that only the women who “insisted” were offered TLD.

For COP19 to increase access to TLD to women, the program needs to ensure that health workers are offering TLD as an option to all women, and not dismissing it when offering services

to women of reproductive age. Basic tenets of a patient’s right to informed consent require that women living with HIV must be told of the benefits and risks of being on TLD as compared to alternative available treatment options (e.g. tenofovir-lamivudine-efavirenz – TLE). The decision to be on TLD belongs to the woman. PEPFAR must ensure full TLE to TLD transition while upholding the human rights of women living with HIV.

In addition, all women should also be able to access family planning information, services and commodities to make an informed decision on contraceptive options, and all PEPFAR supported facilities must be equipped with sufficient family planning commodities for all women who choose to utilise them. Forced and/or coerced access to contraceptives by women living with HIV must not be tolerated with TLE to TLD transitioning.

COP19 must support full roll out of TLD optimization among women of reproductive age. Clinicians must be trained on the need to allow women to make an informed choice for TLD initiation/transition. COP19 must also support the staffing and commodities needed to ensure that all women have the option to utilise a family range of family planning options.

4. Minimise barriers to medicine accessibility by strengthening supply chain management to stop understocking, stockouts and shortages of HIV, TB, STI, contraceptives and opportunistic infection medicines as well as other commodities such as male and female condoms and lubricant.

Stockouts and shortages of ARVs, TB, and opportunistic infection medicines as well as contraceptives are unacceptable and dangerous. In some cases they create a life threatening barrier to service delivery and in all cases threaten the success of the HIV and TB response in Uganda. An individual’s ability to adhere to treatment regimen as prescribed is detrimentally impacted if there is no available stock, affecting long-term health outcomes and increasing the possibility of developing a resistance profile. Furthermore disruptions through no or inadequate supply, or dosage changes, can lead to individuals disengaging from care altogether. There are also cost implications: return travel to the facility, opportunity cost of missed work days, referrals to facilities that charge user fees for accessing medicines, individuals procuring medicines with prescriptions directly from pharmacies. Yet many people are unable to afford any of these additional costs.

Our investigation in February 2019 revealed a number of ongoing shortages and stockouts of medicines at each of the facilities monitored. These included:

- + Septrin, for the virally unsuppressed, was the highest on the list of reported stockouts;
- + 1st line ARVs – with one facility in Tororo having to give

- stable PLHIV one month supply of medicines instead of three months due to lack of stocks;
- + 2nd and 3rd line drugs, lopinavir and atazanavir in Lira;
- + TB medicines, opportunistic infection drugs, STI medicines, lubricants and condoms in Mbale.
- + Contraceptives. The type of contraceptive most widely used by women was DMPA, condoms, oral contraceptives and IUD.

13. “Six advantages of dolutegravir”. Health GAP. Available at: <https://healthgap.org/six-advantages-of-dolutegravir/>

+ Most facilities had stockouts of Depo Provera, Sayana Press and implants in the last 6 months. TASO Mbale branch does not receive contraceptives in the list of commodities that is usually given by their supplier. At a facility in Jinja, the Family Planning clinic required all women to undergo HIV testing as a requirement to access the family planning commodities.

As the country transitions to TLD, ensuring the supply chain has the capacity to support supplies of medicines to the facilities is vital. COP19 needs to ensure that the country has the capacity forecast and deliver medication to facility in time to avoid stockouts.

COP19 must support the health worker staffing, transportation, and other needs to strengthen the supply chain and ensure that facilities in all PEPFAR supported districts are adequately stocked with HIV, TB, STI, and opportunistic infection medicines and diagnostics, contraceptives and HIV prevention tools such as PEP, PrEP, male and female condoms, and lubricants.



5. Reduce mortality of PLHIV by upscaling interventions aimed at preventing, diagnosing and treating active TB and cryptococcal meningitis.

5a. Increase rates of TB screening and testing to improve detection rates and lower the number of people undiagnosed.

One key driver of TB is people with TB symptoms being missed and going undiagnosed. According to the National Prevalence Survey of TB in 2014-2015, approximately half of all TB cases go undiagnosed each year¹⁴. Further it reveals that while 50 percent of people with TB have symptoms, only 10 percent of them are screened for TB.

GeneXpert MTB/RIF Ultra should be the initial TB test in all PLHIV and their household and other close contacts, including HIV-negative persons with TB symptoms. Training and equipment necessary to obtain specimen samples from children for Ultra testing and culture, and to support clinical TB diagnosis among the 80% of children with TB in whom microbiological confirmation cannot be achieved, should also be supported by PEPFAR. Training and tools to rule out active TB disease should be supported by PEPFAR, especially for groups in which existing TB diagnostics have limited sensitivity (PLHIV and children) – this is especially important for initiating people at risk of TB on TB Preventive Therapy (TPT) (see section 5c).

GeneXpert platforms at PEPFAR sites can be used for TB diagnosis, viral load monitoring, and early infant diagnosis (EID). At sites where pregnant women, infants, and children present for care, it is important for PEPFAR to ensure Ultra availability, given increased risk of TB among infants and

children and the poor performance of symptom-based TB screening among pregnant women with HIV.

COP19 must ensure the human and other resources necessary to screen all people presenting at primary healthcare facilities for TB symptoms. People with TB symptoms should receive TB testing with GeneXpert MTB/RIF Ultra; those diagnosed with TB should be started on treatment; people in whom active TB is ruled out should receive TPT (see section 5c).

5b. Improved access to TB LAM testing in hospital, outpatient, and primary care settings at all facilities in PEPFAR districts

The TB LAM test is an affordable, quick and easy to use TB urine test that requires no electricity or reagents and where the results are ready in 25 minutes. Studies show that it allows earlier TB diagnosis in people with advanced HIV, and reduces TB mortality¹⁵. TB LAM testing has been recommended by the WHO for use in people with advanced HIV since 2015, and Global Fund and PEPFAR funding should be used for TB LAM procurement and implementation. An observational cohort study of both ambulatory and hospitalized HIV-positive adults in Kenya indicated the utility of expanding TB-LAM testing to people with CD4<200/mm³ to increase diagnostic yield¹⁶.

14. National Prevalence Survey of TB in 2014-2015. Available at: <http://health.go.ug/content/uganda-national-tuberculosis-prevalence-survey-2014-2015-survey-report>

15. "Effect on mortality of point-of-care, urine-based lipoarabinomannan testing to guide tuberculosis treatment initiation in HIV-positive hospital inpatients: a pragmatic, parallel-group, multicountry, open-label, randomised controlled trial". The Lancet. Available at: <http://thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2901092-2/fulltext>

16. Hueriga H, et al. Incremental Yield of Including Determine-TB LAM Assay in Diagnostic Algorithms for Hospitalized and Ambulatory HIV-Positive Patients in Kenya. PLoSOne. 2017 Jan 26;12(1):e0170976. doi: 10.1371/journal.pone.0170976

TB LAM procurement was not included in COP18 despite being a life saving test and an important component of care for people living with HIV. Based on available evidence, COP19 should ensure that TB LAM test is available for all people living with HIV in hospital settings and among those with CD4 counts less than 200/mm³ with TB symptoms in outpatient and primary care settings. PEPFAR should develop an indicator for TB LAM use to measure its implementation and impact on people living with HIV.

COP19 should procure and distribute LF LAM tests and related commodities (including urine cups, pipettes, gloves etc.) to all facilities in PEPFAR supported districts together with information on use. COP19 should develop an indicator for LF LAM to measure usage.

5c. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.

TB preventive therapy (TPT) is proven to reduce morbidity and mortality among PLHIV, including PLHIV on ART. For this reason, TPT should be considered a routine and integral part of the HIV clinical care package. According to PEPFAR targets, in COP17 Uganda only initiated 12.44% of the target (17 542 of 140 958) on IPT, showing there is major progress still to be made in scaling up TPT. Further, the WHO Global TB report shows that in 2017, only 8.4% of child household contacts of people with pulmonary TB started IPT¹⁷.

Given Uganda's high HIV/TB co-infection rates, in COP19 the country should aim to reach 75% of PLHIV using either IPT, or, preferentially newer regimens such as 3HP. To reach this goal:

- + All PLHIV should be screened for TB with the outcome of this screening one of two mutually exclusive clinical decisions:
 - 1) diagnosis of active TB and initiation of TB treatment; or
 - 2) initiation and completion of TB preventive therapy.
- + All PLHIV diagnosed with active TB should receive household contact investigation to identify TB in their families and among their close contacts, with TPT offered to household members who screen negative for TB. Household contact investigation is especially important for preventing TB in young children who living in the same household as an adult with TB.

PEPFAR Uganda should aim to put a significant proportion of PLHIV who receive TPT on 3HP. While currently more costly than IPT, the 3HP regimen is shorter, safer, easier for people to complete, and has been shown to be as effective in preventing TB as IPT. Generic producers of 3HP are expected to enter the market soon, making it important for PEPFAR Uganda to lay the groundwork for transitioning more PLHIV to rifapentine-based TPT as the cost of rifapentine comes down and information on the safety of its use with dolutegravir becomes available (expected March 2019). Anyone receiving IPT should receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB), which is available for USD 1.99.

Children receiving TPT should receive the 3HR regimen, which

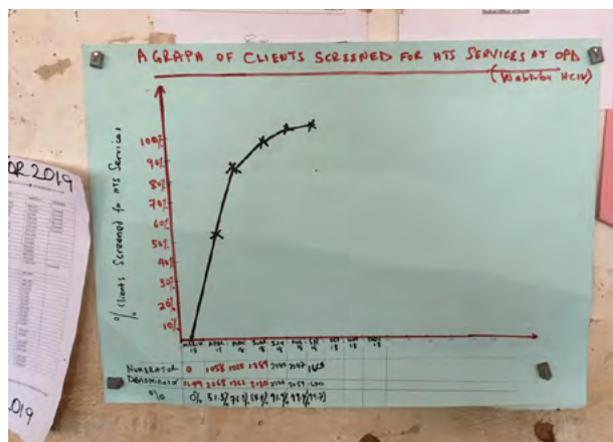
is available in a child-friendly dispersible tablet. Children with HIV requiring TPT can receive 3HR if they are on efavirenz-based ART; children on nevirapine, lopinavir/ritonavir, or dolutegravir-containing regimens should receive IPT to avoid drug-drug interactions with the rifampicin in 3HR.

COP19 should expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.

5d. Improve access to CrAg screening, lumbar puncture and flucytosine to screen, diagnose and treat cryptococcal meningitis.

Cryptococcal meningitis, a severe form of the disease that affects the brain, continues to drive illness and death among people living with HIV. WHO guidelines published in 2017 outline recommendations for screening/diagnosing and treating people with cryptococcal meningitis,¹⁸ however these guidelines have not yet been implemented in Uganda. Currently no policy on advanced HIV diseases exists in the country. Given the impact on PLHIV, PEPFAR has a responsibility to support measures to curb mortality of PLHIV from cryptococcal meningitis.

In line with WHO recommendations, COP19 should ensure the resources to allow CrAg LFA screening in all PLHIV with CD4<200, and subsequent lumbar puncture for diagnosis in all PLHIV with CD4<100 who have screened positive for CM using CrAg. PEPFAR should establish an indicator to track progress; number of PLHIV with baseline CD4<200 with CrAg tested; number of PLHIV with baseline CD4<100 leading to Lumbar Puncture. COP19 should also fund the procurement of flucytosine treatment and ensure free access for antifungals to all people with CM. PEPFAR should change current restriction on CD4 support for regional referral hospitals only, given the urgent need for CD4 staging to be easily accessible so that advanced HIV disease is actually adequately detected and acted upon.



17. WHO 2018 Global TB Report. Available at: <https://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf?ua=1>.

18. WHO July 2017 Guidelines for Management of Advanced Disease and Rapid Initiation of Antiretroviral Therapy. Available at: <https://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/>



6. Pediatric HIV: Improve timely diagnosis of perinatal HIV with point of care (POC) testing and scale up optimized HIV treatment for infants.

Despite important progress in combating perinatal HIV transmission, far too many children are living with HIV without viral load suppression or timely linkage to treatment. Early HIV testing, prompt return of test results, and rapid initiation of treatment are needed to reduce morbidity and mortality among HIV-infected infants.

HIV-exposed infants have a right to a timely and accurate diagnosis and POC testing results in significantly improved early infant diagnosis (EID) outcomes when compared with conventional EID, delivering dramatically reduced turnaround time for test results (median of 49 days with conventional testing versus 0 days with POC). POC EID is cost-effective and saves lives.

Nevirapine based pediatric regimens are far too common in Uganda, when infants <20 kgs need access to lopinavir/ritonavir based combinations in order to achieve viral load suppression. PEPFAR must expand funding for extensive

training for health workers to provide counseling and support to families and caregivers so treatment is provided correctly and common acceptability issues are resolved. Caregiver training and user friendly educational materials must also be funded.

COP19 must fully fund an immediate scale up of lopinavir/ritonavir based ART for children <20kg and DTG based regimens for children >20kg. POC EID should be expanded in all sites providing pediatric treatment so that families can immediately link infants with HIV with the treatment they need to survive.

7. Implement a strategy to prevent index testing and assisted partner notification (APN) from causing violence, criminalization and other human rights violations.

In the 2019 Uganda Planning letter, PEPFAR notes that incredible gains were made in FY 2018, particularly in case-identification and initiation on treatment as a result of programmatic shifts, including among other interventions, index testing and assisted partner notification (APN). However, while gains can be seen in increase to positivity yield, preliminary data from Uganda from April to June 2018 show a high ratio of gender based violence (GBV) after index testing: 7 people (5 men, 2 women) experienced GBV after index testing in order to identify just 48 new people living with HIV.

PEPFAR must roll out index testing in a way that protects communities from violence and must ensure competent and complete tracking of adverse events resulting from index testing. COP19 should ensure that providers of index testing as well as lay workers are engaged to monitor, document and rapidly respond to harms related to index testing. PEPFAR must communicate to implementing partners that it expects to see

index testing used consistently, not simply as a strategy targeting a subset of people who have newly learned they are HIV positive.

COP19 must ensure index testing is rolled out in a manner that does not cause harm and is inclusive of systematic monitoring of and prompt reaction to any evidence of adverse events associated with index testing or APN.

SPECIFIC LANGUAGE REQUESTED IN COP19

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	1a. Fund at least 620 facility-based professional health workers, in order to fill critical capacity gaps that are holding back achievement of epidemic control.		
	<p>“Transition 1,751 PEPFAR seconded staff to government payroll</p> <p>1) Increased number of critical cadres in public sector facilities.” p117</p> <p>“Revised staffing structures including lab cadres implemented.” p120</p> <p>“Increase in number of dispensers trained and deployed in the public sector.” p120</p>	<p>COP19 will support remuneration for 620 new mission-critical facility-based professional health workers through the public health sector, with a commitment to timely absorption of these new health workers by the GoU. These healthcare workers will be deployed at PEPFAR sites with the highest human resource shortages, and will provide critical capacity that is required for the country to achieve epidemic control.</p>	<p>Target: Fund at least 620 facility based professional health workers in COP19.</p>
	1b. Fund a minimum of 930 additional lay health workers.		
	<p>“The CHEW policy finalized and approved and rolled out in an initial 12 PEPFAR- supported districts.” p120</p>	<p>COP19 will fund an expansion of an additional 930 lay health workers, reflecting the “HIV share” (6.2%) of the target density of the new cadre of Community Health Extension Workers (two CHEWs per parish) to increase community outreach and quality of adherence and retention of clients. These lay health workers will be formally paid, trained, capacitated, and equipped with communications and transportation needed to be effective.</p>	<p>Target: Fund 930 additional lay health workers in COP19.</p>
	2a. Ensure 100% of PEPFAR supported sites have functional group models of care including support groups.		
	<p>“Critical inputs for enhanced linkage, retention, and adherence include: uninterrupted supply of ARVs; staffing to support psychosocial support; and client tracking. PEPFAR support to the public sector will facilitate commodity security thus contributing to adherence and retention.” p62</p> <p>“Package of Linkage Interventions.</p> <p>Documented referral of all newly identified PLHIV to peer networks or community support groups” p63</p>	<p>In COP19, every PEPFAR-supported site will aim to have both group and fast track models of care in place. This will include group models of Community Client-Led ART Delivery (CCLAD) groups with integrated ART delivery as well as support groups up and running at both facility and community level. Each facility will have a target for the portion of PLHIV engaged in CCLAD groups. Where PLHIV are adhering, fast track models of care and collection of ART will be made available including Community Drug Distribution Points (CDDP). PEPFAR will support the clinical and community health worker staffing needed to establish and maintain these programs for at least 3 years.</p>	<p>Target: 100% of PEPFAR sites will have CCLAD groups and CDDP models for ART delivery as well as support groups running by end of COP19 and will report portion of patients in CCLAD and CDDP. Each district will have identified communities for targeted group and fast track models of care based on adherence levels. For PLHIV stable on ART: Implement at least one fast track individual ART refill collection system and at least one group simplified model of care in every clinic/clinic's feeder community.</p>

COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
2b. Ensure 100% of PEPFAR supported sites provide “male friendly” services by end COP19 including male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups and CCLAD groups, and where possible access to male healthcare workers.		
<p>“Retention for men was suboptimal at APR17 with 70 percent 12-month cohort retention. To address retention barriers (stigma, disclosure, distance to facilities, busy work schedules, long waiting times), the program will ensure implementation of the recommended package of tested interventions at scale as summarized in section 4.3. Interventions currently being implemented in some sites but needing to be scaled include quality, age-appropriate adherence counseling by age and gender-specific peers, pre-appointment reminders, adolescent/youth focused clinic hours, and linkage to community support groups. Additional interventions tailored to the specific needs of men, especially young men, to be introduced and taken to scale include peer-driven DSDM for adolescent and youth (modeled after the Zimbabwe Zvandiri model) and active tracking/case management of newly initiated young men In FY17, for men, overall viral load (VL) coverage was 63 percent with 87 percent viral load suppression among those who received a VL test. Among men 15–24, viral suppression was only 76 percent while among men over age 25 it was 88 percent.” p38 – p39</p> <p>“For men, PEPFAR Uganda will support the use of male peers to escort clients from testing points to ART points for initiation and the pairing of male linkage facilitators with newly diagnosed HIV- positive men for more effective linkage to ART. Male-friendly services will be supported through extended working hours and alternative patient flow systems that reduce clinic wait times and minimize work interruptions, as well as through strengthened retention tracking through via peers.” p61</p>	<p>In order to address sub-optimal testing and retention of men, COP19 will implement and take to scale a package of services tailored to the specific needs of men including male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups and Community Client-Led ART Delivery (CCLAD) groups, and where possible access to male healthcare workers.</p>	<p>Target: 100% of PEPFAR sites will provide services aimed specifically at men including at least one of: male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups, and male only CCLAD groups.</p>
2c. By end COP19, all clinical and non-clinical staff at 100% of PEPFAR supported sites must have been sensitized on needs of key populations (including MSM, transgender people, sex workers and PWUD). COP19 will roll out targeted community testing strategies aimed at key populations in all high burden districts.		
<p>“For KPs, stigma, high mobility, limited access to KP-friendly services, unconducive legal environments, and alcoholism and drug abuse contribute to suboptimal retention. COP18 will continue to orient service providers on KP services, conduct outreaches to provide services, strengthen drop-in centers, and provide tailored adherence counseling and peer-led tracking.” p62</p>	<p>COP19 will support key population led comprehensive service delivery to increase retention and train health workers on key population service delivery to reduce stigma. Services must be provided by peers themselves. Support for key population lay workers attached to general facility who fast track key populations seeking services at the facility will also increase retention among key populations. PEPFAR will prioritize supporting key population organisations to offer comprehensive service delivery to peers to increase testing, linkage and retention.</p>	<p>Target: 100% of PEPFAR sites receive sensitisation training to provide KP friendly services.</p> <p>At least 5 KP-led and community based organisations will be funded to provide comprehensive services to key populations in the all high burden districts.</p>

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COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
<p>2d. Ensure that COP19 reaches the most vulnerable AGYW (pregnant, married or girls who had given birth) with the DREAMS program. Ensure 100% of PEPFAR sites, specifically in DREAMS districts, establish youth clubs (for young people aged 15 – 24) in order to provide HIV clinical management, ART refills, peer support, and counselling to ensure better linkage & retention of young people by end COP19. Ensure that sexual prevention programs, including those provided under PEPFAR’s new faith based initiative, do not compromise access to correct, comprehensive and non-stigmatizing HIV prevention services, including for girls aged 9 – 14.</p> <p>“However, recognizing the importance and influence of peer interaction for adolescents, PEPFAR is allocating US \$2.4 million to support the scale-up of a package of adolescent friendly services that have demonstrated success but are not yet widely implemented per the results of the APR17 implementing IP survey. The package consists of an adolescent focal person at each facility; adolescent peer counselors; mentorship for supported disclosure; alignment of appointments to school holidays; peer support groups; a dedicated space or day for adolescent-focused care; linkages to community services and programs including those addressing and preventing violence against children; and routine documentation for OVC assessment and enrollment (see section 4.3). Uganda will also be introducing the Zvandiri CATS DSDM for adolescents at high volume sites.” p47 – p48</p> <p>“Among young people aged 15–24 years, factors contributing to poor adherence and retention include stigma and non-disclosure, school programs conflicting with clinic attendance, inadequate psychosocial support, and inadequate youth friendly services. In COP18, PEPFAR Uganda will scale up adolescent and youth-friendly DSDM models with robust psychosocial support systems addressing stigma reduction and supported disclosure. These support systems will be linked to OVC and DREAM programs.” p61</p>	<p>COP19 will ensure that all clinical and non-clinical staff in PEPFAR sites are sensitised to provide youth friendly services. PEPFAR will develop closed membership youth clubs for young people living with HIV that integrate psychosocial support, HIV clinical management (including ART initiation), family planning and ART refills. DREAMS will reach most vulnerable AGYW (including pregnant, married or girls who had given birth) as well as AGYW living with HIV.</p>	<p>Target: 100% of PEPFAR sites receive sensitisation training to provide youth friendly services.</p> <p>100% of sites in DREAMS districts establish closed membership youth clubs to support adherence and retention of young people in the area – where young people are collecting ART.</p>
<p>2e. COP19 must support the staffing and other costs to ensure that all people living with HIV receive a viral load test at 6 months after ART initiation and then annually – and receive the results of those tests rapidly, triggering appropriate clinical action.</p> <p>“By the beginning of FY19, PEPFAR Uganda expects all sites to adopt the revised national VL monitoring guidelines to include VL testing at ANC1 for all pregnant women already on ART and VL tests for all pregnant and breastfeeding women every 6 months. This will help to further reduce MTCT by identifying non-suppression early, with time to intervene to return VL to undetectable levels. Aggressive VL monitoring will be achieved through using VL stickers to identify eligible clients, CQI interventions (such as ongoing peer-led support and counseling for women), and rollout of a VL non-suppressed register that will longitudinally track management of non-suppressed HIV-positive pregnant and breastfeeding women. At national and subnational level, regular VL data review meetings based on the VL dashboard will be conducted.” p43</p>	<p>COP19 will support the staffing, commodities and other costs to ensure that all people living with HIV receive a viral load test at 6 months after ART initiation and then annually – and receive the results of those tests rapidly, linked with appropriate clinical action.</p>	<p>Target: All PLHIV receive a viral load test in COP19 – and receive results within two weeks.</p>

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	3. Invest in TLD transition for women of reproductive age to improve retention and treatment outcomes.	<p>“Due to high HIV pre-treatment drug resistance (PDR) to non-nucleoside reverse transcriptase inhibitors (NNRTIs) of 15.4% percent in 2016, Uganda revised the treatment guidelines in February 2018 and recommended TLD as the preferred adult first-line ARV regimen. As per the national plan, TLD transition will begin in July 2018. TLD coverage is then projected to reach 35 percent of all eligible PLHIV by December 2018. By September 2019, 90 percent of all adult first- line patients are projected to be on TLD. Eligible patients are adults and adolescents newly initiating ART and those currently on first line regimens who have a suppressed VL within the previous six months. Pregnant women and TB/HIV coinfecting patients are also eligible for TLD.” p66</p>	<p>COP19 will support full roll out of TLD optimization among women of reproductive age. Clinicians must be trained on the need to allow women to make the choice for initiation. PEPFAR will also support the provision of family planning options for all women living with HIV.</p>
4. Minimise barriers to medicine accessibility by strengthening supply chain management to stop understocking, stockouts and shortages of HIV, TB, STI, contraceptives and opportunistic infection medicines as well as other commodities such as male and female condoms and lubricant.	<p>“Major weaknesses in supply chain systems remain a concern. PEPFAR Uganda is filling a major gap in public sector ARVs for calendar year 2018. This gap fill will ensure that Ugandans on ART do not experience disruptions in their drug supply due to public sector stock-outs or rationing due to low stocks at the facility level. With COP18 funding, PEPFAR Uganda will greatly increase funding to public sector ARV procurement, continue work on supply chain reform within the public sector as part of a longer-term process to strengthen the supply chain from the national level to health facilities, and engage regional health structures to play a role in ensuring proper allocation of ARVs to health facilities at the district level and below.” p13</p> <p>“IPs are using real-time HIV commodities tracking systems to avert stock outs and maldistribution of supply. These tracker dashboards are updated on a weekly basis to monitor supply for HIV services. This will be done with district logistics persons and health facility stores managers. It is expected that this tracking process will maintain HIV commodities stock levels to maximize identification of HIV-positive persons and enrollment of each on ART.” p71</p> <p>“Year One (COP18) Annual Benchmark (Planned) <5 % of sites reporting ARV drug stock outs” p114</p>	<p>COP19 will support the health worker staffing, transportation, and other needs to strengthen the supply chain and ensure that facilities in all PEPFAR supported districts are adequately stocked with HIV, TB, STI, and opportunistic infection medicines and diagnostics, contraceptives and HIV prevention tools such as PEP, PrEP, male and female condoms, and lubricants. PEPFAR will establish a rapid response plan for addressing reported health technology stockouts and shortages.</p>	<p>Target: <5 % of sites reporting ARV, TB, STI, opportunistic infection drug stockouts.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	<p>5a. Increase rates of TB screening and testing to improve detection rates and lower the number of people undiagnosed.</p> <p>“COP18 will build upon PEPFAR Uganda’s COP17 focus by intensifying identification of missing TB/HIV co-infected cases, optimizing utilization of GeneXpert for TB diagnosis” p44</p> <p>“PEPFAR Uganda will intensify facility-based case finding by improving the quality of TB/HIV screening at ART clinics and at inpatient, outpatient, and MNCH departments. For HIV screening, documentation of HIV status among new and relapsed TB cases increased from 75 percent at APR16, to 84 percent in FY17 Q1/Q2, to 91 percent in FY17 Q3/Q4 through improvements in both service provision and data quality. Furthermore, HIV testing of presumptive TB cases demonstrated 20 percent positivity among 130 high volume facilities. COP18 will scale up HIV testing of presumptive TB patients as one of the modalities for identifying and treating new PLHIV. PEPFAR is working with the MOH to include data on TB screening and HIV testing for presumptive TB cases in DHIS2 reporting in order to track progress of partners using this approach. In addition, PEPFAR will focus on scaling up routine screening for both HIV and TB in institutional settings such as prisons and military barracks. Household contact investigation will also be scaled as a part of the community care strategy. For children, use of chest x-ray for both TB screening and diagnosis will continue to be supported, especially for TB contacts.” p45</p> <p>“Analysis of GeneXpert utilization revealed that the machines are only being utilized at 54 percent of their capacity. In order to optimize utilization of the GeneXpert machines as the primary modality for adult TB diagnosis, COP18 will implement systematic tracking of all presumptive TB cases, ensuring routine, biweekly sputum sample transport and results return, procure US \$1 million in additional cartridges to complement the Global Fund’s US \$3.5 million investment, and invest in demand creation and health care worker mentorship to implement GeneXpert as the first-line test for at least 75 percent of presumptive TB cases.” p45 – 46</p>	<p>PEPFAR will integrate TB screening into HIV case finding, and ensure that 100% of people presenting for care are screened for TB using the TB symptom screen and, where indicated, chest X-ray.</p> <p>PEPFAR will use GeneXpert MTB/RIF Ultra as the initial TB diagnostic test for all people who screen with TB symptoms, and support training and equipment necessary to obtain specimen samples for Ultra testing and culture from adults with possible extrapulmonary TB and children, and to support clinical TB diagnosis in children.</p> <p>PEPFAR will ensure that the outcome of TB screening results in one of two mutually exclusive decisions: 1) people diagnosed with TB should be started on treatment; 2) people in whom active TB is ruled out should receive TPT.</p>	<p>Target: 100% of people presenting for care screened for TB using TB symptom screen and, where indicated, chest X-ray.</p> <p>100% of people with TB symptoms identified during screening are tested using GeneXpert MTB/RIF Ultra, including children.</p>
<p>5b. Improved access to TB LAM testing in hospital, outpatient, and primary care settings at all facilities in PEPFAR districts.</p> <p>No reference to LAM in COP18.</p>	<p>PEPFAR SA will make LAM testing available in all settings where PLHIV present for care, including both inpatient and outpatient settings. In inpatient, hospital settings, PEPFAR SA will use TB LAM as a screening test in all hospitalized patients with HIV. In outpatient, ambulatory settings, PEPFAR SA will provide LAM testing to all people presenting to care with clinical signs of apparent serious illness, or, if CD4 testing is available, with CD4<200.</p> <p>PEPFAR SA will support training in the use of TB LAM and ensure the procurement of required commodities (TB LAM Ag urine assays, urine cups, pipettes, pipette tips, timers) within laboratory costs. PEPFAR SA will also support sensitization of health care workers on the utility of TB LAM and its place in the TB diagnostic algorithm. Task sharing should be considered as the test is easy enough to be conducted by nurses.</p> <p>PEPFAR SA will preferentially support the use of more sensitive TB urine LAM tests, if they become available and are recommended by WHO within COP19.</p>	<p>Target: LAM testing provided to 100% of PLHIV who are hospitalized.</p> <p>LAM testing provided to all PLHIV presenting to care in outpatient settings with signs of advanced illness or with CD4<200.</p>	

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	<p>5c. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.</p>	<p>“COP18 will build upon PEPFAR Uganda’s COP17 focus by intensifying identification of missing TB/ HIV co-infected cases, optimizing utilization of GeneXpert for TB diagnosis, and expanding the coverage of TB preventive therapy (TPT).” p44</p> <p>“In COP17, PEPFAR Uganda began to invest in TPT with the goal of providing TPT to 126,000 PLHIV at 200 high volume facilities, prioritizing newly-identified PLHIV who are at higher risk of developing active TB disease. COP18 expands this support to an additional 226,000 at 500 high volume facilities. PEPFAR will provide technical assistance in procurement, distribution, and management of TPT supplies, standard operating practices (SOP) and mentoring of health workers, and coordination of a systematic and phased TPT rollout.” p46</p> <p>“COP18 funding will also provide GeneXpert cartridges and TPT commodities for the public sector.” p86</p> <p>TB_PREV in COP17:</p> <p>Result: 17,542 (through Q4)</p> <p>Target: 140,958</p> <p>Achievement: 12.44%</p>	<p>TPT for PLHIV: PEPFAR will support the GoU to scale-up TB preventive therapy (TPT), ensuring that all PLHIV newly enrolled into care who screen negative for active TB disease initiate and complete a course of TPT. All PLHIV in PEPFAR programs newly diagnosed with active TB disease receive contact investigations of their families and close contacts, with contacts offered TPT.</p> <p>PEPFAR will pilot the use of the short-course, rifapentine-based 3HP regimen as an alternative to isoniazid preventive therapy (IPT) for XX% of PLHIV started on TPT, pending confirmation that rifapentine is safe to use with dolutegravir. Individuals receiving IPT will receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB).</p> <p>TPT for children: PEPFAR will support contact investigations for all PLHIV diagnosed with active TB disease. Children of PLHIV with TB identified by contact investigations will be offered TPT with the regimen determined by HIV status. HIV-negative children will be offered the 3HR regimen, which is available as a child-friendly FDC. Children with HIV will be offered 3HR (if on EFV-based ART) or 6H (if on nevirapine, lopinavir-ritonavir, or dolutegravir-based ART). 6H is also available in a child-friendly dispersible tablet. (3HR = three months of daily isoniazid + rifampicin; 6H = six months of isoniazid preventive therapy)</p> <p>PEPFAR will integrate training on TPT initiation and adherence support into preparations to rollout dolutegravir-based ART, recognizing that TB prevention is a routine and integral part of the HIV clinical care package.</p> <p>PEPFAR will ensure that TPT implementation respects human rights and minimizes stigma. In particular, that TPT initiation is always voluntary, introduced with full information and proper counselling on the risk/benefits, and never mandatory. Contact investigations should be designed and carried out in a way that minimizes the potential impact of stigma in the community (e.g., identifying a household as having TB or disclosing the TB or HIV status of a PLHIV without their consent).</p>
<p>5d. Improve access to CrAg screening, lumbar puncture and flucytosine to screen, diagnose and treat cryptococcal meningitis.</p>	<p>No reference in COP18 apart from laboratory capacity: “National CrAg EQA production and distribution section established capacity” p134</p>	<p>COP19 will provide resources to allow CrAg LFA screening in all PLHIV with CD4<200, and subsequent lumbar puncture for diagnosis in PLHIV with CD4<100 who have screened positive for CM using CrAg. PEPFAR should establish an indicator to track progress; number of PLHIV with baseline CD4<200 are CrAg tested; number of PLHIV with baseline CD4<100 leading to Lumbar Puncture. COP19 should also fund the procurement of flucytosine treatment and ensure free access for antifungals to all people with CM. COP19 must make CD4 staging easily accessible so that advanced HIV disease is actually adequately detected and acted upon.</p>	<p>Target: 100% of PLHIV with CD4<200 provided with CrAg screening.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	<p>6. Pediatric HIV: Improve timely diagnosis of perinatal HIV with point of care testing and optimized HIV treatment for infants.</p> <p>“Uganda estimates a pediatric HIV prevalence of 0.5 percent with 88,437 children under age 15 living with HIV (CLHIV).” p46</p> <p>“Identification of missing HIV cases in all age groups is the critical starting point for closing this gap. In FY17, 61,211 HIV-exposed infants received an EID test within 12 months of age, translating to an EID1 coverage of 76 percent.⁹⁶ By the end of FY18 Q1, EID1 (0–12 months) coverage had significantly improved to 86.7 percent.⁹⁷ Despite this improvement in overall EID coverage, the proportion that received an EID test within 0-2 months of age is still very low (54 percent).⁹⁸ It is conservatively estimated that in FY17 about 600 HIV-positive infants were not identified based on the FY17 EID coverage of 76 percent.” p46</p> <p>“COP18 supports provision of more optimal ARV regimens for children under age 3. With expected improved availability of lopinavir/ritonavir (LPV/r) pellets during the second half of FY18, PEPFAR aims for all sites to provide LPV/r pellets going into COP18. Adolescents taking adult formulations will be part of the nationwide transition to TLD. Lastly, COP18 will support intensive mentorships of health workers and viral load switch teams to improve timely switching and confidence in the use of pediatric second-line regimens for those with virologic failure.” p48</p>	<p>COP19 will fully fund an immediate phase out nevirapine based regimens and scale up of lopinavir/ritonavir based ART for children <20kg and DTG based regimens for children >20kg.</p> <p>POC EID will be expanded in all sites providing pediatric treatment. COP19 will include funding for cartridges and operational support needed to achieve this.</p>	<p>Target: In FY19 95% of HIV exposed infants will receive the results of an EID test before two months.</p> <p>In FY19, PEPFAR will fund procurement of WHO recommended and optimal ARV regimens for all CLHIV including dolutegravir 50 mg for children >20kg; lopinavir/ritonavir 100/25 mg tablets as soon as children >10kg can swallow whole tablets; and lopinavir/ritonavir pellets/granules/tablets/syrup for children <20 kg. PEPFAR will fund intensive training and capacity building for health workers and caregivers in administering pediatric formulations in order to ensure maximum clinical benefit for children.</p>
<p>7. Implement a strategy to prevent index testing and assisted partner notification (APN) from causing violence, criminalization and other human rights violations.</p> <p>“the TST_POS target was distributed across the service delivery modalities to form the thrust of the HIV testing services (HTS) program in COP18. These modalities are: index testing (20 percent in facility and 15 percent in community both with an anticipated yield of 15 percent); outpatient clinic (35 percent with an anticipated yield of 3 percent); mobile/community approaches (15 percent with a targeted yield of 4 percent); in-patient wards (10 percent with a yield of 5 percent); and STI clinics (5 percent with a yield of 5 percent).” p35</p> <p>“Overall, 35% of the HIV POS target are from index testing and although the proportion of the target is high, it translates into a modest and achievable number of positives identified (about 24,000 individuals in total). The yield of 15% from the index testing modality is achievable given that pilots on assisted partner notification (APN) yield on average 30% if the approach is rolled out correctly. We have earnestly begun implementing partner notification (effective FY 18 Q2) and through the weekly data reviews, we are seeing yields of 8%-15%. In addition, effective March, 2018 and through COP18, all HIV+ individuals in care will be assisted to notify their sexual partner(s) including casual ones. Initially, the definition of “partner” was misunderstood to mean a spouse and consequently a good number of patients in care have not declared partners beyond their spouses. Although the focus is on partners of newly identified HIV positive, we are starting to work with patients currently in care and we aim to have at least 70% of them having their partners identified and notified.” p35</p>	<p>COP19 will implement a strategy to prevent index testing and assisted partner notification (APN) from causing violence, criminalization and other human rights violations.</p> <p>COP19 will ensure inclusive of systematic monitoring of and prompt reaction to any evidence of adverse events associated with index testing or APN.</p>	<p>Target: PEPFAR will implement index testing in a manner that prevents violence and will track violence associated with partner notification and index testing in all PEPFAR supported sites.</p>	

