

THE PEOPLE'S VOICE UGANDA

COMMUNITY PRIORITY RECOMMENDATIONS
FOR PEPFAR UGANDA FOR 2022





INTRODUCTION: DEVELOPING “THE PEOPLE’S VOICE”

Communities of People living with HIV (PLHIV), Key and Vulnerable Populations, and Civil Society Organisations (CSOs) have continued in 2022 their longstanding commitment to meaningfully engaging with PEPFAR’s Country Operational Planning (COP) processes. This commitment started in 2012, a time when there were no minimum standards for the involvement of PLHIV, KVPs and CSOs in COP planning.

Under the leadership of Coalition Coordinators the International Community of Women Living with HIV Eastern Africa (ICWEA), the Coalition for Health Promotion and Social Development (HEPS-Uganda) and Sexual Minorities Uganda (SMUG), communities in Uganda have released this, the fourth edition of The People’s Voice. Earlier versions were published in 2019¹, 2020² and 2021.³

As in earlier editions, we describe the recommendations and priorities from PLHIV, KVPs and CSOs. These recommendations are built on PEPFAR’s existing promises from COP21 as well as areas where PEPFAR did not address community demands in COP21. We also introduce new priority recommendations.

The People’s Voice was developed using the following process: Community Led Monitoring (CLM) in health facilities took place during Quarter 3 of 2021 and during Quarter 1 of 2022; data from monitoring informed the People’s Voice priorities. (See Table A, below.) Accountability meetings with Implementing partners (IPs) and engagement with District-level duty bearers also generated information reflected herein.

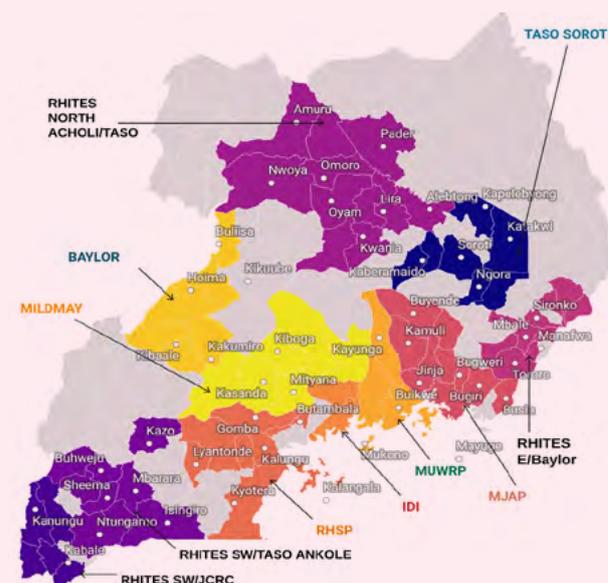
We carried out a national validation meeting with CSOs; reviewed PEPFAR and Ministry of Health HIV and TB program performance data; and conducted interviews with key informants from national government and local government. In addition, we participated in consultations with the Ministry of Health, Uganda AIDS Commission (UAC), PEPFAR and AIDS Development Partners during their annual strategy retreat. We used these engagements to monitor the implementation status of existing policy commitments made in response to community recommendations from previous years.

After the publication of PEPFAR’s 2021 [Country Operational Plan for Uganda](#), communities compared their recommendations, contained in “The People’s Voice of COP21 Community Priorities,” with the text contained in PEPFAR Uganda’s 2021 COP, in order to determine which recommendations were adopted, not adopted, or partially adopted by PEPFAR

and to determine PEPFAR’s responsiveness to civil society priorities. This analysis was carried out as part of the COP 2020 planning cycle, comparing the recommendations contained in “The People’s Voice on COP20 Community Priorities” with [PEPFAR’s 2020 Country Operational Plan for Uganda](#).

According to this analysis, PEPFAR’s COP for 2021 for Uganda is deemed “partially responsive” to civil society overall. In 2020 PEPFAR’s COP was also deemed “partially responsive.” However, PEPFAR’s score for COP 2021 is lower compared with PEPFAR’s score for its 2020 COP. In 2020, the COP showed “reasonable inclusion” of civil society priorities, while in 2021, the COP showed only “limited inclusion.”⁴

Figure 1. Regional coverage of PEPFAR Implementing Mechanisms and Districts where CLM is taking place



1. [The People’s Voice on COP19 Community Priorities](#)
 2. [The People’s Voice on COP20 Community Priorities](#)
 3. [The People’s Voice on COP21 Community Priorities](#)
 4. “Measuring Up: Tracking PEPFAR’s Accountability to People Living with HIV 2021-22,” preliminary country analysis for Uganda compared with [Measuring Up: Tracking PEPFAR’s Accountability to People Living with HIV 2020-21](#), p 20.

Table A: List of health facilities monitored and corresponding implementing mechanism

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
MILDMAY	Mubende	+ Nabingoola HC III + Mubende Regional Referral Hospital + Madudu HC III + Mubende Kasambya HC III Govt + Kitenga HC III
	Kassanda	+ Bukuya HC III + Kiganda HC IV + Kassanda HC IV + Myanzi HC III
	Kiboga	+ Bukomero HC IV + Kiboga HOSPITAL + Lwamata HC III + Kambugu HC III
	Mityana	+ Bulera HC III + Naama HC III + Mityana Hospital + Kyantungo HC IV
	Luwero	+ Luwero Hospital + Nyimbwa HC IV + Ziobwe HC III + Kalagala HC IV
	Nakaseke	+ Semuto HC IV + Ngoma HC IV + Kiwoko Hospital + Nakaseke Hospital
BAYLOR UGANDA	Hoima	+ Dwoli HC III + Azur HC IV + Kigoroby HC IV + Hoima Regional Referral Hospital
	Kikuube	+ Kabwoya HC III + Buhimba HC III + Kyangwali HC IV + Kikuube HC IV
	Kagadi	+ Isunga HC III + Mpeefu B HC III + Kagadi HOSPITAL + St. Ambrose Charity HC IV
	Kibaale	+ Kibaale HC IV + Kyebando HC III + Nyamarwa HC III + Mugarama HC III
	Kakumiro	+ Nalweyo HC III + Kakumiro HC IV + Kakindo HC IV + Kisiita HC III
	Buliisa	+ Buliisa Hospital + Biiso HC III + Buliisa HC IV + Butiaba HC III
Makerere University Walter Reed Project (MUWRP)	Buikwe	+ St Francis Nkokonjeru Hospital + St Francis Nyenga Hospital + Kawoolo General Hospital + Lugazi SCOUT Hospital
	Buvuma	+ Namatale HC III + Buvuma HC IV + Bugaya HC III + Busamuzi HC III
	Mukono	+ Mukono General Hospital + Mukono COU Hospital + Kojja HC IV + Goma HC III + Nakifuma HC III

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
	Kayunga	+ Bbaale HC IV + Lugasa HC III + Kayunga Hospital + Kangulumira HC IV
Infectious Diseases Institute (IDI)	Wakiso	+ Mildmay Uganda HOSPITAL + Joint Clinical Research Center (JCRC) HC IV + Wakiso HC IV + Nsangi HC III + Kasangati HC IV
Rakai Health Sciences Program (RHSP)	Ssembabula	+ Mateete HC III + Lwemiyaga HC III + Ssembabule HC IV + Ntuusi HC IV
	Bukomansibi	+ Bigasa HC III + Butenga HC IV
	Kyotera	+ Kakuuto HC IV + Kalisizo HOSPITAL + Kabira (Kyotera) HC III + Mitukula HC III
	Masaka	+ Bukakata HC III + TASO Masaka Special Clinic + Masaka Regional Referral Hospital + Kitovu Hospital
	Kalangala	+ Bukasa HC IV + Kalangala HC IV + Mazinga HC III + Mugoye HC III
	Lyantonde	+ Lyantonde Muslim HC III + Lyantonde HOSPITAL + Kaliiro HC III + Kasagama HC III
	Kalungu	+ Villa Maria HOSPITAL + Lukaya HC III + St. Joseph Of the Good Shepherd Kyamulibwa HC IV + Kasambya (Kalungu) HC III
	Gomba	+ Kanoni HC III + Kifampa HC III + Bukalagi HC III + Maddu HC IV
	Butambala	+ Kyabadaza HC III + Gombe (Butambala) Hospital + Bulu HC III + Kibibi Nursing Home HC III
RHITES EC/Makerere University Joint AIDS Program (MJAP)	Bugiri	+ Bugiri HOSPITAL + Muterere HC III + Nankoma HC IV + Bugiri MC HC III
	Busia	+ Busia HC IV + Dabani HOSPITAL + Nabulola HC III + Masafu Hospital
	Iganga	+ Iganga HOSPITAL + Iganga Islamic Medical Centre HC III + Iganga Town Council HC III + Namungalwe HC III
	Luuka	+ Amach HC IV + Ober HC III + Pag Mission HC IV + Lira Regional Referral Hospital
	Mayuge	+ Buluba HOSPITAL + Kigandalo HC IV + Mayuge HC III + Kityerera HC IV

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
RHITES EC/Makerere University Joint AIDS Program (MJAP)	Jinja	+ Jinja Regional Referral Hospital + Walukuba HC IV + Buwenge HC IV + Budondo HC IV
	Bugweri	+ Busematya HC III + Lubira HC III + Busesa HC IV + Makuutu HC III
	Buyende	+ Irundu HC III + Kidera HC IV + Buyende Bugaya HC III + Buyende HC III
	Kamuli	+ Kamuli Hospital + Nankandulo HC IV + Namwendwa HC IV + Kamuli Mission Hospital
	Kaliro	+ Bumanya HC IV + Nawaikoke HC III + Namwiwa HC III + Gadumire HC III
RHITES E/Baylor Mbale-Karamoja region	Manafwa	+ Lwanjusi HC III + Butiru Chrisco (UCMB) HC III + Bubulo HC IV + Bugobero HC IV
	Bududa	+ Bukigai HC III
	Mbale	+ Kolonyi HC IV + Mbale Regional Referral Hospital + Ahamadiya HC IV + TASO Mbale Special Clinic
	Sironko	+ Sironko HC III + Buwalasi HC III + Budadiri HC IV + Buwasa HC IV
	Tororo	+ Mukuju HC IV + Tororo Hospital + TASO Tororo Special Clinic + Malaba HC III
	Butaleja	+ Bubalya HC III + Busolwe HOSPITAL + Budumba HC III + Nabiganda HC IV
	Butebo	+ Nagwere HC III + Kabwangasi HC III + Kakoro HC III
	Kapchorwa	+ Kaserem HC III + Sipi HC III + Kabeywa HC III
	Kween	+ Kiriki HC III + Kwanyiy HC III + Chemwom HC III + Ngenge HC III
	Bukwo	+ Bukwo Hospital + Bukwo HC IV + Kapkoloswo HC III + Chesower HC III
RHITES NORTH ACHOLI/TASO	Nwoya	+ Alero HC III + Purongo HC III + Anaka HOSPITAL + Koch Goma HC III
	Amuru	+ Amuru Lacor HC III + Kaladima HC III + Pabbo (Govt) HC III + Otwee HC III

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
	Gulu	+ Awach HC IV + St. Mary's Lacor Hospital + TASO Gulu Special Clinic + Gulu Regional Referral Hospital
	Omoro	+ Bobi HC III + Lacor Opit HC III + Lalogi HC IV + Odek HC III
	Kitgum	+ Namokora HC IV + Akuna Laber HC III + Kitgum HOSPITAL + St. Joseph's Hospital
	Pader	+ Pader HC III + Pajule HC IV + Acholi-Bur HC III + Atanga HC III
RHITES NORTH LANGO	Oyam	+ Agulurude HC III + Otwal HC III + Anyeke HC IV + Aber Hospital
	Kole	+ Aboke HC IV + Alito HC III + Bala HC III + Apalabarowo HC III
	Lira	+ Amach HC IV + Ober HC III + Pag Mission HC IV + Lira Regional Referral Hospital
	Alebtong	+ Alebtong HC IV + Apala HC III + Abako HC III + Omoro HC III
	Kwania	+ Abongomola HC III + Aduku HC IV + Nambieso HC III + Inomo HC III
	Apac	+ Apac HOSPITAL + Ibuje HC III + Teboke HC III + Akokoro HC III
	RHITES SW/TASO ANKOLE	Mbarara
Isingiro		+ Nakivale HC III + Rugaaga HC IV + Rwekubo HC IV
Ntungamo		+ Ntungamo HC IV + Itojo HOSPITAL + Rubare HC IV + Kitwe HC IV + Rwashamaire HC IV
Rwampara		+ Ndejja HC III + Bugamba HC IV + Mwizi HC III + Kinoni HC IV
Sheema		+ Kitagata HOSPITAL + Kyangyenyi HC III + Kigarama (Kigarama) HC III + Kabwohe HC IV
Buhweju		+ Bihanga HC III + Butare HC III + Nsiika HC IV + Tumu Hospital

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
	Kazo	+ Kazo HC IV + Engari Community HC III + Kiruhura Kanoni HC III + Lamezia HC III
	Rubirizi	+ Katunguru HC III + Kicwamba (Rubirizi) HC III + Rugazi HC IV + Katerera HC III
	Bushenyi	+ Bushenyi HC IV + Comboni HOSPITAL + Ishaka Adventist HOSPITAL + Kyabugimbi HC IV + Kiu Teaching HOSPITAL
RHITES SW/JCRC	Kabale	+ Maziba HC IV + Kabale Regional Referral Hospital + Rushoroza Hospital + Kamukira HC IV + Rugarama HOSPITAL
	Rubanda	+ Bubare HC III + Muko HC IV + Hamurwa HC IV + Muko Ngo HC III
	Rukungiri	+ Kebisoni HC IV + Buhunga HC IV + Rukungiri HC IV + Karoli Lwanga (Nyakibale) Hospital
	Kanungu	+ Bwindi Community HOSPITAL + Kambuga HOSPITAL + Kanungu HC IV + Kihihi HC IV
	Kisoro	+ Busanza HC IV + Kisoro Hospital + Rubuguri HC IV + Mutolere Hospital
TASO SOROTI	Soroti	+ Soroti Main Prisons HC III + TASO Soroti Special Clinic + Soroti Regional Referral Hospital + Kichinjaji HC III
	Ngora	+ Mukura HC III + Ngora HC IV + Ngora Freda Carr Hospital + Kapir HC III
	Kumi	+ Kumi HC IV + Kumi (Ongino) Hospital + Atatur HOSPITAL + Mukongoro HC III
	Katakwi	+ Astu HC IV + Magoro HC III + Katakwi Hospital + Toroma HC IV
	Kapelebyong	+ Obalanga HC III + Kapelebyong HC IV + Acowa HC III + St. Francis Acumet HC III
	Kaberamaido	+ Alwa HC III + Kobulubulu HC III + Ochero HC III + Kaberamaido Hospital
	Kalaki	+ Otuboi HC III + Lwala HOSPITAL + Kalaki HC III + Bululu HC III







THE HIV RESPONSE IN UGANDA

Despite substantial progress in the AIDS response, Uganda has not yet achieved the 95-95-95 targets, and has not yet achieved epidemic control. An estimated 1,420,812 people are living with HIV in Uganda.⁵ Preliminary data from the Uganda Population-based HIV Impact Assessment 2020 (UPHIA 2020) point to larger than previously estimated gaps in achieving the “first 95”—the number of Ugandans living with HIV who know that they are HIV-positive.⁶ Achieving the COP21 targets of 97% of people living with HIV diagnosed, 94% of people on treatment and 86% of people on treatment virally suppressed, should use the new UPHIA estimates, not prior data,⁷ given the increased number of undiagnosed adults and children living with HIV.

During FY 2021 (October 1 2020–September 30 2021), 124,603 people started ART,⁸ fewer than the 148,563 started during FY 2020.⁹ The overall number of people on treatment grew by only 50,645, fewer than last year’s growth of 51,006. Currently, PEPFAR reports FY21 Quarter 4 (Q4) results of 1,266,588 million people living with HIV on antiretroviral treatment (ART)¹⁰, with an estimated 1,140,851 people having suppressed viral load.¹¹ In Uganda, ART coverage and viral load suppression varies substantially by age bands. ART coverage for adolescent girls and boys aged 10-19 is 63 and 60%, respectively.¹² For women aged 20-29 and men aged 20-29, along with all people aged 0-19,¹³ viral load suppression rates are suboptimal—for example, only 50% of adolescents aged 10-19 years had suppressed viral load at Q1 FY21.¹⁴ This points to the need for urgent community-led corrective actions as described in this

2022 edition of the People’s Voice. In particular, community interventions to prevent and respond to Interruptions in antiretroviral treatment should be a priority for COP22.

Over FY21, communities continued to experience serious service disruptions and human rights violations stemming from the COVID-19 pandemic, including interruptions in access to HIV prevention and treatment services, increased violence in their homes and communities; loss of livelihood; loss of education; unintended pregnancies; unsafe deliveries; as well as harassment, violence and detention at the hands of police. Repairing harm caused by COVID-19 to the HIV response should continue to be a feature of PEPFAR’s program investments, with a particular emphasis on repairing harms experienced at the community level.

5. FY21Q4 PEPFAR Oversight and Accountability Review Team (POART 4), slide 11.
6. Ibid., slide 40
7. [Uganda Country Operational Plan COP21 Strategic Direction Summary May 20, 2021](#), p 8
8. [Uganda 2022 Planning Level Letter](#), PEPFAR January 19, 2022, p 4
9. [Uganda 2021 Planning Level Letter](#), PEPFAR January 13, 2021, p 3
10. Supra note 1, slide 9
11. Supra note 1, slide 11
12. Supra note 1, slide 12
13. Supra note 1, slide 88
14. Supra note 6, p 52

COMMUNITY PRIORITY INTERVENTIONS FOR COP22

1. PrEP Access and Retention

Whereas PrEP has been scaled-up considerably since its introduction in Uganda, implementation as a core prevention strategy has been very slow. This has contributed to holding back Uganda from achieving the 95-95-95 targets. Likewise, PEPFAR's strategy of annually building out PrEP availability in only a limited subset of facilities in the country is keeping this highly-effective prevention tool out of the hands of vulnerable Ugandans, in particular key and vulnerable populations (KVPs), adolescent girls and young women (AGYW), pregnant and breastfeeding women (PBFW), and serodiscordant couples. PrEP is a women-controlled HIV prevention tool that should be available nationally but access and retention are low—while new infections are increasing, particularly among women aged 15-24.

The People's Voice has recommended several years in a row that PrEP be implemented as a national program; this recommendation has been rebuffed. With a 150% increase in PrEP budgets earmarked for AGYW and KPs described in the PEPFAR Planning Level Letter, 15 COP22 should be the year for strategic change.

PrEP should be fully integrated among other HIV prevention interventions and delivered or minimum described at facilities that do not currently offer it, similarly to Voluntary Medical Male Circumcision (VMMC), an intervention that is introduced to people even if it is not offered at all facilities.

Community-led monitoring (CLM) data has revealed persistently low levels of PrEP awareness among communities, health workers, and health officials. It is fundamentally unethical that, more than ten years after Ugandans helped generate the clinical trial data that showed the effectiveness of PrEP, it is still being kept out of their hands.

Health workers and communities are not demanding PrEP implementation, because levels of community knowledge about PrEP remain frustratingly low. This vicious cycle of restricted availability and limited PrEP literacy is fueling new HIV infections in Uganda.

1a. Accelerate expansion of PrEP by rolling out a national program, using a 'hub and spoke' approach

Since PrEP is currently only available at 250 facilities, communities depend on limited and sporadic community outreach and referral networks to secure access. In COP22, we call on PEPFAR to roll out a "hub and spoke" model to accelerate PrEP scale up.

Existing PrEP sites can act as "hubs," with KP- and AGYW-led expansion to cover geographic areas left behind. An ambitious training, demand creation and outreach strategy focused on AGYW, PBFW, serodiscordant couples and KPs should be rolled out, led by communities. Coordination

with DICs, YAPS, high-volume ANC sites, and DREAMS program implementers will result in strategic outreach to people eligible for PrEP but who are currently unable to access it. PEPFAR must allocate funds to train staff to offer services at DICs and ensure that DICs are supported with the tools needed to enable them to deliver services.

COP22 TARGET: PrEP should be rolled out across the country as a national program, using 250 existing PrEP facilities as a hub-and-spoke model linking to communities demanding for services. Adaptations already tested in Uganda such as same-day PrEP initiation, outreach-based initiation, and use of HIV self-testing (HIVST) should be scaled up nationwide.

1b. Improve PrEP reach and quality: Increase funding for community-designed and community-led demand creation, outreach, and PrEP literacy efforts, targeting key populations, AGYW, PBFW, and serodiscordant couples

PEPFAR made progress in FY21 scaling up PrEP eligibility screening, access and retention, overachieving overall PrEP_NEW targets for COP20. But while the PrEP_NEW target was surpassed for KPs at 167.8% of the target, for AGYW and PBFW the PrEP_NEW target was missed, with 30.9% and 89.1% of the target reached, respectively.¹⁶ This disappointing underachievement indicates that major gaps exist in access to and retention on PrEP across communities, that there is substantial untapped community capacity to link people with this essential service, and that PrEP_NEW

15. Supra note 11, p 7

16. Supra note 4, slides 15-17



targets for all three populations must increase substantially. PEPFAR should allocate funding to strategies that have been proven effective in supporting retention, such as:

- + Using peer leaders who are trained and remunerated, to provide retention support and to carry out PrEP Differentiated Service Delivery (DSD); and
- + Supporting Drop-in Centres (DICs) with training and funds to carry out PrEP outreach, literacy, initiation, refills, and other activities.

Data from CLM include reports that PrEP packaging is not KP/AGYW friendly, undermining uptake and retention. Moreover, PrEP literacy and promotion efforts have not been led by communities and PrEP availability among AGYW and PBFW is extremely low; along with low knowledge. CLM data also indicated some private not-for-profit clinics have been resisting providing PrEP, citing reasons associated with religion. Community leadership is needed in designing successful PrEP expansion in order to accelerate uptake and improve retention.

COP22 TARGET: Fund community-led PrEP demand creation, and service delivery outreach programs, that rely on community health workers building PrEP literacy among communities and health workers, and immediately link people with screening and same-day initiation.

1c. Fast track PrEP innovations in products and service delivery models

PrEP service delivery approaches have become simplified and streamlined globally, and new PrEP products are approved for use. Uganda's expanding program should reflect the latest scientific advances—in particular MMD for PrEP, WHO's guidance on simplified PrEP implementation, and implementation of event-driven PrEP. The Vaginal Dapivirine Ring (DVR) and Long-Acting Cabotegravir (CAB LA) bimonthly injection are new biomedical interventions that should be rolled out nationally. DVR is included on WHO's list of prequalified medicines and should be made available to AGYW in Uganda who prefer that method. CAB LA is superior compared with oral PrEP for communities at high risk of HIV infection and should be fast tracked for regulatory approval and urgent roll out.

COP22 TARGET: PEPFAR should fast track implementation of new WHO Guidance on Simplified PrEP Implementation.

COP22 TARGET: PrEP delivery should be AGYW- and KP-led, simplified, with minimal testing barriers. Fast track rollout of event driven PrEP and DSD for PrEP, using HIVST to ensure testing does not create a barrier to PrEP roll out.

COP22 TARGET: PEPFAR should support acceleration of roll out of CAB LA and the DVR.

1d. The Dapivirine Vaginal Ring—prevention by choice for women

To end AIDS by 2030, prioritizing CHOICE for girls and women is fundamental. Today, women account for more than half of all people living with HIV globally, and face persistently high HIV infection rates. The Eastern and Southern African regions are the epicenter of the HIV epidemic, with 800,000 new HIV infections each year, just under half of the global total. Adolescent girls and young women aged 15-24 years have up to eight-fold higher rates of HIV infection compared to their young men. This calls out for more HIV prevention options that cater to the diverse unmet needs of women.

Although access to daily oral PrEP is increasing around the world, a daily pill is not a suitable or desirable prevention method for everyone. When providing HIV prevention services for women it is important to offer various HIV prevention choices. To reach epidemic control, countries must expand HIV prevention options to meet women's needs in their diversity including for women who experience intimate partner violence. The DVR is therefore an important option and high-risk communities should be supported to access it. PEPFAR should invest in training and support for providers to understand and be able to offer the DVR in a respectful manner.

Countries must prepare for rollout of the DVR; this is the time to invest in acceptability assessments and implementation science to inform its roll out.

We demand PEPFAR make the DVR a core programmatic requirement during COP22. With countries successfully adapting programs to continue prevention service delivery in the time of COVID-19, this is the time for global scale up of effective biomedical prevention options.

COP22 TARGET: PEPFAR should support the development of guidelines, procurement of and roll out of DVR as part of a package of comprehensive primary prevention services.

COP22 TARGET: PEPFAR should support women's access to comprehensive information about the DVR in order to make an informed choice and to create demand.

COP22 TARGET: PEPFAR should invest in updating the current national guidelines to include the DVR as another HIV prevention option.



2. Prevention and treatment for Key Populations (KPs)

By the end of FY21, PEPFAR programs were showing some improvement in delivery of services to KPs: 291,774 KPs were tested for HIV, with an overall yield rate of 4%, linkage to treatment of 96%, and VL suppression of 91%.¹⁷ This evidence of long overdue progress, combined with PEPFAR’s new 2022 Global COP/ROP Guidance stating for the first time a Minimum Program Requirement (MPR) that countries “demonstrate progress in equity, stigma, discrimination, and human rights,” while adding KP-led and women-led organizations among local partners,¹⁸ distinguishes COP22 as a critical year to deliver impact and accountability for men who have sex with men, transgender communities, LBQ women, sex workers, and people who use drugs in Uganda.

Importantly, for COP22 OGAC has expressed support for PEPFAR Uganda exploring “funding KP-led indigenous civil society organisations to provide KP-centred services and offer capacity building (e.g., training in grants management, HR, SI) to enable local CSOs to apply for USG funding; explore CSO sustainability with social enterprise through small grants; and support formal accreditation of community clinical service delivery points.”¹⁹

2a. Expanding KP-led infrastructure for HIV/ TB prevention and treatment services

DICs have been expanded nationally year after year, but KPs require improvement to the model, so that co-located KP-led clinical services are provided, building on evidence from CLM that psychosocial support, treatment, prevention and testing are all best provided by KP-led

organizations. The vast majority of community Drop-in Centers (DICs) are still not accredited to provide the comprehensive package of clinical services that KPs require.

COP22 TARGET: PEPFAR should work with the Ministry of Health to accredit all remaining community DICs to provide KP-led clinical services as soon as possible, providing core and overhead funding for community DICs to expand so that they are able to provide comprehensive clinical services.

COP22 TARGET: PEPFAR should establish KP-led DICs designed to reach KPs with disposable income who typically patronise private sector clinics.

COP22 TARGET: Improve KP size estimates by rolling out a BBS of key populations, in particular trans* people and men who have sex with men. The methodology should be developed in collaboration with communities, who should advise at each step: inception, research, and dissemination.

17. Supra note 11, p 18-19

18. COP/ROP 2022 Guidance for All PEPFAR-Supported Countries, p 127-128

19. Supra note 11, p 19



2b. Expanding funding for indigenous KP organizations and networks

Since the collapse of the Key Population Investment Fund (KPIF) in Uganda with no replacement funding or strategy, KP-led organizations and networks have struggled to deliver service delivery and advocacy targeting KPs. Evidence from CLM has revealed substantial setbacks in service delivery among KP-led organisations. For example, in Masaka the KPIF-funded community DIC has closed although it served over 500 sex workers. In Kyotera, the DIC is now staffed by only one person (compared with 10 staff). Since October 2021, the DIC is no longer able to provide PrEP retention services to PrEP enrollees. The Masaka KP HIV Prevention and Support Organization (MAHIPSO) had used KPIF funding to provide a range of services including mental health and GBV services, PrEP and ART refills, HIV testing, and STI screening. They had been providing PrEP refills to an estimated 300 people, but they were forced to stop service provision when there was no follow on strategy after KPIF stopped. COP22 should build on the lessons from KPIF, and prioritize investment of substantial new funding in KP-led community organizations, consistent with the instructions in Uganda’s PLL.²⁰

COP22 TARGET: KP-led organizations can deliver effective services ONLY IF they have predictable funding and are

NOT dependent on extremely small sub grants from large national and US government contractors. PEPFAR should prioritise substantial increases in funding for indigenous, KP-led community organisations to deliver quality prevention, linkage and continuous treatment services for KPs.

2c. Expanding harm reduction services in Uganda

PEPFAR should urgently build on lessons learned from the establishment of the MAT clinic at Butabika, and explore expansion of the initiative to other regions (Wakiso, Arua, Kibale, Uganda, Jinja, Mbale and Tororo) as already agreed to during the COP20 RPM.²¹ Lessons learned, described in the 2021 SDS, provide a helpful roadmap for program strengthening.²² Role out of additional harm reduction interventions, such as NSP services, should be piloted in COP22.

COP22 TARGET: PEPFAR Should support efforts to strengthen service delivery at the Butabika MAT clinic, and expand to other regions.

COP22 TARGET: NSP services should be piloted in COP22.

20. Ibid.
 21. Supra note 3, p 14
 22. “Proposed remedial actions which will inform and improve MAT implementation in COP21 include: Recruitment of more highly networked peers; training current MAT users to educate and refer PWID peers; continue to line list clients from DICs and the PWID community; developing demand creation messages by working with PWID communities: using an incentivized coupon model to increase identification and enrolment; extending services to community refill points through the mobile van services; and partnering with CSOs to advocate for relevant organizations for social services support to MAT clients.” Supra note 11, p 85-6.



3. Expand PLHIV-designed and implemented treatment literacy

In COP21 in response to recommendations of the People’s Voice 2021,²³ PEPFAR implemented a treatment literacy program pilot in 10 Districts: West Nile (Zombo, Nebbi, Yumbe, Moyo, Koboko) and Acholi (Amuru, Gulu, Kitgum, Lamwo and Agago), at 4 facilities per District, funded with \$272,000 from USAID/CSSA (for Feb 2022-Jan 2023). This approach, designed program by CSSA, MOH, USAID/SBCA, USAID, PEPFAR, member networks and CSOs, is built on peer-to-peer support at facility and community level, targeting children, young people, caregivers of HIV positive children, newly enrolled, unstable and those ageing with HIV. CLM data show low levels of treatment literacy with most PLHIV and caregivers neither able to explain which treatment regimens they are taking, nor understand why they are switched, or conversant in key concepts such as “U=U.” This contributes to interruptions in treatment, poor Viral Load Suppression (VLS), and limited community demand for quality services.

We propose expansion of these critical efforts, building on the work of the National CQI Collaborative, with ongoing mentoring and education efforts to improve practice.

COP22 TARGET: PEPFAR should provide new funding

to implement a national treatment literacy program to reach all regions and 100% of ART centers. This program should be designed and led by PLHIV in all their diversity—men, women, young people, and people with disabilities.

4. Improve ART retention and reduce interruptions in treatment

Despite progress, interruptions on ART are continuing, exacerbated by widespread shortages of professional and community health workers, poor quality clinical services, long wait times at facilities, poor staff attitudes, low levels of treatment literacy, and lack of access to all prongs of differentiated service delivery (DSD), particularly community-based DSD interventions that support people on treatment.

Recent transition to new sets of clinical IPs has highlighted many of these concerns, for example, CLM in 2021 has captured evidence that shifts to new IPs in some regions have resulted in months-long interruptions in remuneration for CHWs and other core staff providing community services. This has unnecessarily undermined retention in care.

Data from CLM point to additional concerns, including lack of true community ownership over CCLAD group development, lack of financial support for CDDPs to deliver medicines, inadequate psychosocial support and health education by health workers undermining adherence. Moreover, facilities are still extremely congested despite some progress in expanding MMD coverage (Q1 FY21, 49% of adults received 3-5-month and 26% received 6+ month MMD).

Not all IPs are fully implementing the directive to pay all CHWs a minimum of \$50/month, with some CHWs reporting part of their wage retained at the district

level rather than being provided to them in full.

We also note that the PEPFAR/G2G strategy to invest in Regional Referral Hospitals as “centres of excellence” is in advanced stages yet has not featured engagement with communities who need improved ART and other clinical services.

COP22 TARGET: PEPFAR should expand and fully functionalize adherence support groups and all other community-led DSD approaches that promote retention in care.

COP22 TARGET: Ensure all IPs are uniformly implementing the requirement that CHWs be paid a minimum of \$50/month, in full.

COP22 TARGET: PEPFAR should accelerate efforts to provide 6-month ART refills.

23. Supra note 3,

5. Stop preventable AIDS deaths from TB, cryptococcal meningitis and cervical cancer

According to PEPFAR program data, about one in four newly diagnosed persons with HIV who does not have a suppressed viral load in Uganda has CD4<200 and is therefore living with Advanced HIV Disease (AHD) or AIDS.²⁴ Despite progress in reducing AIDS deaths and in increasing the number of people newly enrolled on treatment, AHD still results in unacceptably high numbers of deaths, and COP22 should expand investment in stopping preventable AIDS deaths among adults, adolescents and children.

In Uganda access to CD4 testing is extremely low (approximately 18% of new and non-suppressed people). In COP21, PEPFAR committed to increasing commodity support for AHD management to improve access to TB-LAM, CD4, and CrAg testing. PEPFAR also committed to improving health worker capacity for managing AHD.²⁵

CLM data indicate that people living with AHD are reporting being referred to private facilities to pay for AHD treatment out of pocket, at catastrophic cost.

5a. TB screening, diagnosis, prevention and treatment integration

In COP21 PEPFAR reported that \$2,550,000 was requested to increase community case finding efforts for TB using dedicated community health workers/peers, in response to People's Voice recommendations regarding the urgent need to find missing TB cases.^{26, 27} PEPFAR reported that an estimated 33% of 9627 TB/HIV incident cases in PEPFAR-supported regions are neither diagnosed or reported. Improving case finding among Ugandans of all ages is a critical priority.²⁸

Data from CLM reveals major weaknesses in the TB/HIV response. During recent monitoring, 61.3% of PLHIV knew they were screened for TB symptoms (15.7% reported "sometimes" they are asked, 18.4% reported they were "not asked" and 4.6% reported they "did not know"). Findings show less than half (41%, or 154/372 of facilities monitored) had coughing corners, increasing the risk of TB transmission among clients attending facilities without coughing corners. The majority of clinics monitored (43%, 159/372 clinics) did not have any IEC materials for TB prevention; for example, those telling people to cover their mouths when coughing or sneezing.

In Tororo District, the TB focal person reported extensive challenges, similar to other District findings. They have only one GenXpert machine in Tororo General Hospital for the entire District, delaying the turnaround time of results to communities. While they have a chest x ray machine at the hospital, power shortages mean it is inoperable. The clinic has no trolleys to carry patients who arrive in critical condition. Health workers must refer clients for MDR treatment to the regional referral hospital (Mbale Hospital). IPs have also cut budgets allocated to the District Hospital per TB sample collected from far flung communities, without explanation.

CLM staff found that TB management registers including TB contact tracing registers for most districts in Ankole

and Kigezi were not fully updated, while some districts lacked the registers. Health workers interviewed reported too few staff to maintain up-to-date registers, and limited knowledge on how to use DHIS2 and updated tools.

Despite progress in securing additional funding for case finding, health workers reported limited facilitation for health workers to conduct contact tracing – only initial visits are conducted for less than 30% of the targeted index clients and TB yield is very low compared to the national target.

TB deaths rose in 2020 for the first time due to COVID-19; in COP22 PEPFAR should urgently improve TB case detection and same day linkage to treatment.²⁹

COP22 TARGET: Ensure 100% of PLHIV, including Children living with HIV, are screened for TB and COVID-19 upon presentation to care at every clinical encounter at 100% of PEPFAR-supported facilities.

COP22 TARGET: 100% of PLHIV, including Children living with HIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among Children living with HIV) upon their first presentation to care.

COP22 TARGET: 100% of PLHIV, including Children living with HIV, with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results.

COP22 TARGET: 100% of PLHIV, including Children living with HIV, who are co-infected with TB receive confirmatory diagnostic test results and are linked to TB treatment in less than five days after their first presentation to care.

CLM also identified persistent IPT stockouts. Because of rampant community level stigma and discrimination, many PLHIV provided inaccurate contact information, making contact tracing difficult. Lack of investment in TB/HIV treatment literacy means clients are given limited and/or no information on the importance of taking IPT, discontinuing IPT as a result. While PEPFAR reports 92% of PLHIV completed TPT, this is not reflected in TPT registers reviewed during CLM.

COP22 TARGET: Contact tracing carried out with 100% of index cases.

COP22 TARGET: 100% of healthcare workers at PEPFAR-supported sites are trained to perform TB screening,

24. Supra note 6, p 63

25. Supra note 6, p 64

26. Supra note 6, p 45

27. Supra note 3, p 23

28. Supra note 6, p 17

29. PEPFAR COP22 Strategy Retreat, Care and Treatment Technical Working Group Break Out Session Read Out, slide 23, Feb 4 2022

urine-LAM, and rapid molecular testing among PLHIV in accordance with WHO recommendations and algorithms.

COP22 TARGET: Procurement quantities of commodities required for urine-LAM and rapid molecular testing each exceed the estimated number of PLHIV, including Children living with HIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease or TB signs and symptoms in COP22.

COP22 TARGET: PEPFAR should increase funding for health workers to better manage TB, including funding for remuneration for TB case finding.

COP22 TARGET: Fast track national rollout of 3HP & introduction of 1HP as TPT.

5b. Close remaining AHD commodity coverage gaps

Gaps in commodities to screen, diagnose, prevent and treat the main causes of AIDS deaths among adults and children should be closed in COP22.

COP22 TARGET: Close gaps in supply of AHD commodities including point-of-care CD4 tests. These include funding for point-of-care (POC) CD4 testing, CrAg testing, TB-LAM, and current recommended treatment and prevention regimens for CM, including Liposomal amphotericin B (L-amB), flucytosine and fluconazole.

COP22 TARGET: CM treatment with L-amB should be implemented beyond the 52 hospitals where they are currently being rolled out, to reach all facilities that currently provide infusions.

COP22 TARGET: Expand health worker training to expand capacity to identify and manage cryptococcal meningitis and cryptogenemia.

COP22 TARGET: Train and pay CHWs to carry out intensive community-based follow-up with a package of interventions that will reduce morbidity and mortality in this vulnerable group.

5c. Cervical cancer

PEPFAR's support for cervical cancer screening and treatment among women with HIV has been an important development considering the high risk women face of sickness and death from undiagnosed and untreated disease. Civil society welcomes PEPFAR's commitment in COP21 to include women >49 years in cervical cancer screening and treatment in response to recommendations by the People's Voice in COP20.³⁰ Program quality issues should be urgently addressed, however, starting with IPs forcing women to undergo cervical cancer screening. Poor IP performance in delivering against targets will only be exacerbated by lack of engagement with women eligible for this service.

Data from CLM has revealed disturbing cases of women coming to their ordinary treatment refill appointment and being required by IPs to undergo screening for cervical cancer in order to receive their ART—without any advance warning or treatment literacy efforts.

During a private interview with a monitor, one woman with HIV reported that women “complain of being forced to undergo cervical cancer screening. We are also required to come with [our partners] during the health education talks so that when it comes to medication precautions the husband supports the wife.”

Turnaround time for processing cervical cancer samples at Central Public Health Laboratories (CPHL) is excessive. Women report that samples that were sent July 2021 have not yet been returned. In some cases, health workers opt to refer clients to private laboratories where TAT is quicker but women are charged UGX100,000 for the test.

COP22 TARGET: PEPFAR should require all IPs to commit that they will never condition any service such as providing ART refills on whether or not women undergo cervical cancer screening. PEPFAR should require IPs to invest in awareness raising in communities about the purpose of cervical cancer screening among women living with HIV, so that communities are empowered with knowledge.

6. Stop commodities stockouts

Despite PEPFAR's commitment in response to the People's Voice 2021 to increase budgets for STI medicines, routine stock outs have continued. For example, CLM at Malaba HCIV, a clinic serving about 700 people on ART including about 80 KPs, revealed that 6 months have passed without STI treatment at the facility—despite requests for medicine.

Of note, comparing the COP 2021 budget for the “other drugs” category of cotrimoxazole, INH, STI/OI drugs and B6 with the COP 2020 budget for the same category, there is no difference—despite a pledge from PEPFAR to increase the budget.³¹ PEPFAR states “There has been a 32% (1,674,471 in COP20 to 2, 477,035) increase

in funding allocated to STIs on both the KP and PrEP platforms where we expect to find the highest number of STI infections.”³² Our further review of the PEPFAR program indicates that these medicines are only available as attached to HIV testing efforts, rather than as part of the platform of clinical care for HIV positive Ugandans.

30. Supra note 6, p 42

31. Compare: Table 2.3.2, p 28, supra note 7 with Table 2.3.2, p 32, supra note 6

32. Supra note 6, p 44

CLM data point to routine shortages: of facilities monitored, 31% of facility staff reported shortages and stock outs of essential HIV/TB medicines specifically DTG (29%), FDC first-line (12%) and pediatric HIV medicines (18%). Supply chain difficulties especially bureaucratic procurement processes to delayed delivery of medicines to health facilities were reported. When medicines are delivered, they often expire before they can be dispensed, as a result of lengthy delays. Facility store managers shared with monitors that requisition and approval processes

that are time consuming and cumbersome during the procurement process. In addition, CLM data indicate ongoing shortages of condoms and lubricant at the facility level.

COP22 TARGET: PEPFAR should at least double the budget for STIs for clinical care for PLHIV and KPs.

COP22 TARGET: PEPFAR should ensure uninterrupted supplies of free condoms and lubricant as core tools in effective HIV prevention.

7. HIV testing services

PEPFAR committed in COP21 to several decisive shifts in the index testing program. Now PEPFAR's QI efforts should track these commitments and ensure their robust implementation. They include an end to "monetization" of index testing services, a halt to index testing in Uganda Prisons Service (UPS), a commitment to improving "health provider competencies to ensure that safe and ethical index testing would be implemented without human rights violations, ensuring all counselors are certified to provide HTS according to PEPFAR and World Health Organization (WHO) standards.... screening for intimate partner violence (IPV) prior to and one month after [assisted partner notification], provision of post-GBV services, and IPV adverse event monitoring in the APN register."³³ Furthermore, PEPFAR committed in COP21 that "index testing targets are disaggregated up to district level and IPs are discouraged from apportioning and communicating these targets down to facility level."³⁴

7a. Protect human rights

Data collected during CLM points to the complex counselling and support needs of people newly diagnosed with HIV. For example, during a recent CLM visit at one facility, a person initially refused initiation on ART; her fear was of her husband's reaction. However the CLM monitor watched her health worker provide supportive counselling and the newly diagnosed person agreed to schedule an appointment with her husband. She said, "I need prayers to convince him to come so that we can be initiated on treatment."

However there is not yet an increased awareness that providing information about sex partners as an index client is completely voluntary. Among one set of facilities, data from CLM indicated an increase in the number of clients who reported that health workers asked them for their partners' names in order to contact them to undertake an HIV test from 75% to 87% over a period of 6 months. At the same time, some reports from monitoring have revealed that forced index testing is still taking place—especially for pregnant women who are being required to test alongside their partners. This clearly violates PEPFAR's promises in COP21 and the national commitment to the "5 Cs." Persistently high rates of non-disclosure of status to partners due to stigma, as well as high rates of gender based violence in intimate relationships, have to be acknowledged by testing providers.

COP22 TARGET: All HIV testing sites should provide quality services for victims of violence; any HIV index

testing site that cannot provide onsite services for victims of violence or referrals for victims of violence should stop carrying out HIV index testing.

COP22 TARGET: PEPFAR will ensure that all HIV test providers understand that index testing is *always* voluntary, for both sexual contacts and children, where individuals are not required to give the names of their sexual partners or children if they do not want to, and that this is explained to all PLHIV.

COP22 TARGET: After contacting partner(s), healthcare providers will follow-up with the individual to assess whether any adverse events occurred, including but not limited to violence, and refer them to IPV services if relevant. Data on such occurrences should be shared by IPs with PEPFAR, CSOs and the Ministry of Health.

7b. HIV testing for pregnant and breastfeeding women

The higher risk of seroconversion during pregnancy and breastfeeding means provision of testing and retesting services—along with linkage to PrEP—are critical. However, implementation of retesting provision has been suboptimal, with only 24% of HIV negative women retested in their third trimester in FY21Q4.³⁵ Furthermore, index testing of pregnant women has not been consistent with the "5 Cs." Data from

33. Supra note 6, p 15

34. Supra note 6, p 42

35. Supra note 4, slide 81

CLM includes cases of forced index testing—pregnant women being told they must bring in their partners for testing. This clearly violates national commitments to the 5 Cs.

COP22 TARGET: Pregnant and breastfeeding women need expanded access to testing and retesting services. These services must be non coercive and

supportive, including when PBFW do not agree to share the names of their partner(s) for testing.

COP22 TARGET: No facility should be permitted to deny of services if they do not agree to bring in their partner(s) for testing or they do not provide the name(s) of their sex partner(s).

8. Services for adolescents and children living with HIV and HIV-exposed infants

Closing clinical gaps in the 95-95-95 cascade for newborns, children and adolescents living with HIV should be treated as a major priority in COP22. From poor viral load coverage and suppression, to low levels of community treatment literacy among young people and caregivers, high rates of treatment interruptions, and persistent stigma and discrimination, children and adolescents with HIV deserve better.

Disruptions during COVID-19 have only further undermined the physical and mental health of young people with HIV. All of the prongs of differentiated service delivery (DSD) must be provided with key adaptations to meet the needs of young people across the country, alongside psychosocial support, socioeconomic support, and food security. Uganda is one of 7 PEPFAR-supported countries that is being requested by PEPFAR to prioritize improvement of PMTCT service delivery and services for children and adolescents living with HIV. Uganda has a unique opportunity during COP22 to accelerate progress in saving lives and to improve the quality of services for these communities.

during COP22 to ensure HCIs are equipped to provide PMTCT services when women seek ANC services and services after delivery.

COP22 TARGET: Scale up the mentor mothers program so that 100% of PEPFAR supported sites link HIV positive PBFW with the support of a mentor mother who is trained, paid a living wage, and is also living with HIV.

COP22 TARGET: PEPFAR should focus in particular on expanding services for PBFW in the 60 Districts not included in the OVC program.

8a. HIV-positive pregnant and breastfeeding women

The HIV response is currently not meeting the needs of HIV-positive PBFW for continuous HIV treatment services provided with respect and consideration for their human rights. This is particularly true for PBFW who are also adolescents; their babies are more vulnerable to perinatal infection than their counterparts who are >25 years old.³⁶

Despite commitments to use funding during COP20 and COP21 to equip HCIs (where the majority of pregnant women seek ANC services) with PMTCT services, this still has not taken place,³⁷ exacerbating interruptions in treatment that put the health of women and their babies at risk.

COP22 TARGET: PEPFAR should urgently scale up provision of POC viral load for pregnant and breastfeeding women (PBFW), building on the findings of the Ministry of Health PMTCT Impact Evaluation revealing low VL coverage.

COP22 TARGET: PEPFAR should support the Ministry of Health to revise national VL policy to allow 3-monthly VL monitoring for PBFW.

COP22 TARGET: PEPFAR should increase funding

8b. HIV-Exposed Infants (HEI)

While EID coverage at 2 months has increased from 68% (FY20 Q4) to 86% (FY21 Q4), and POC EID coverage has expanded to 25% of all EID tests, TAT is still extremely slow on conventional EID platforms in Uganda and outcomes for HEI at the end of breastfeeding in Uganda are still too often unknown. Only POC EID provides the opportunity for same-day linkage to treatment for HIV-positive newborns who face extremely high risk of death if they are not immediately started on ART.³⁸

Because the most recent UPHIA excludes children <15 years for the first time, there will also be fewer data points regarding the actual 95-95-95 cascade for people aged 0-15 with HIV in Uganda.

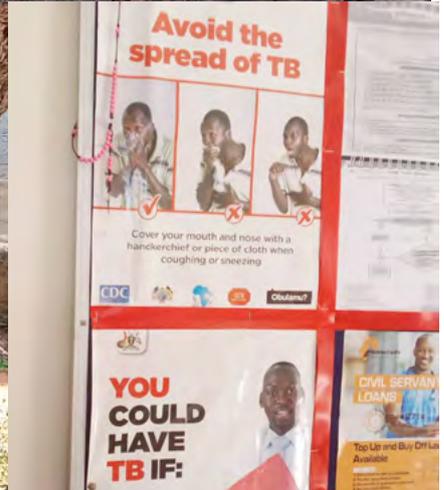
COP22 TARGET: PEPFAR should further expand POC EID for HEI beyond the 45:55 POC EID/Conventional EID split proposed in COP22, striving toward 100% coverage.

COP22 TARGET: PEPFAR should provide nutritional support, socioeconomic support, transport vouchers and peer-led psychosocial support in order to ensure mothers and other caregivers of HEIs are able to secure continuous access to treatment for themselves as well as prophylaxis and diagnostic services for HEIs. PEPFAR should focus in

36. Supra note 4, slide 27

37. Supra note 11, p 15-16; p 75

38. Supra note 4, slide 91-92



particular on expanding services for HEIs and their caregivers in the 60 Districts not included in the OVC program.

COP22 TARGET: PEPFAR should reinstate coverage of children 0-15 years in the PHIA.

8c. Youth-friendly services

Interruptions in treatment for children and adolescents living with HIV (C/ALHIV) are persistently high, while many young people are falling through the cracks without psychosocial support, access to YAPS, peer-led treatment literacy, socioeconomic support for themselves or their caregivers. 3MMD is only available to 51% of young people.

COP22 TARGET: Scale up YAPS to reach remaining 46 districts, and increase funding for YAPS nationally to close coverage gaps in peer-led supportive services for C/AWHIV and their families, focusing on programs designed and implemented by peers, to address stressors unique to C/ALHIV. YAPS should be paid a living wage, trained, supported and equipped with the tools to carry out their work, such as airtime.

COP22 TARGET: PEPFAR should expand MMD for children and adolescents from 51% to 90% receiving 3+ month refills.

COP22 TARGET: PEPFAR should focus in particular on expanding services for young people with HIV and their caregivers in the 60 Districts not included in the OVC program.



9. DREAMS

Women and girls are extremely vulnerable to HIV acquisition in Uganda, with two years of COVID exposing and exacerbating those vulnerabilities. DREAMS was designed to address these vulnerabilities, but there are a number of challenges undermining the impact of the program that should be resolved in COP22. DREAMS in Uganda is still plagued by low completion rates. AGYW report that causes of their low completion rates include: refusal by partner/parent, COVID-19, delayed income generating activities, and a view that their time could be better spent doing other things.³⁹ In many DREAMS districts, increased rates of physical and sexual abuse as well as transactional sex among AGYW are meanwhile resulting in trauma, injustice and increased risk of HIV acquisition.

AGYW report that skills being taught to DREAMS beneficiaries are not increasing economic strengthening capacity. Household incomes have not increased, discouraging other AGYW from completing the program. Predetermined courses don't address the immediate needs of these AGYW. During COVID-19, many AGYW became pregnant, and have increased risk of HIV infection. The restriction of the DREAMS program to only a subset of Districts, and only to HIV negative AGYW, should be reconsidered given the drastically changed situation for AGYW in the context of COVID-19. 17,004 10-14 year olds did not complete the primary package of DREAMS programs.⁴⁰ These and other serious program weaknesses should be addressed. In COP21, PEPFAR stated in response to recommendations made by The People's Voice that the program would "explore whether it is feasible to begin supporting the implementation of comprehensive clinical care services for select eastern districts where AGYW are under-served to ensure that

vulnerability and risk are reduced and new infections are averted. This approach must first be discussed and agreed upon by the PEPFAR Uganda agencies and S/GAC."⁴¹

COP22 TARGET: PEPFAR should expand DREAMS districts to include key underserved sub-regions (including Teso, Bugisu, Busoga) that have high rates of new HIV infections among AGYW.

COP22 TARGET: Change the DREAMS program in Uganda to increase completion rate, including by creating a platform for trainees to select their own enterprises; support those who complete to start viable economic ventures.

COP22 TARGET: Expand funding under DREAMS for socio-economic empowerment, behaviour change communication, and skills training for AGYW to respond to skyrocketing teen pregnancy and violence during the COVID period in the affected districts.

39. Supra note 11, p 18

40. Ibid.

41. Supra note 6, p 27

10. Structural interventions: human rights, gender based violence, criminalization

HIV-related stigma, discrimination, and violence, reduce access to, and use of, essential health services, and undermine effective HIV responses. The UNAIDS 10-10-10 targets require focus on removal of legal and other societal barriers that limit access to and utilisation of HIV services. These include continuing fear of breach of confidentiality and experience of stigma at healthcare facilities for key populations and priority populations and people living with HIV. Fear of and actual breaches of confidentiality by health workers bring fear of everything from stigma to criminal charges for communities already lacking support, particularly PWID, sex worker and LGBTI populations.

These structural barriers undermine progress toward 95-95-95 at the national level and increase the risk of interruptions in treatment, HIV acquisition, and poor clinical outcomes for adults, adolescents and children. The harm caused by these structural barriers extend far beyond effects on HIV-related outcomes—they constitute fundamental human rights violations and PEPFAR should strengthen its efforts to combat these violations and to correct the laws, policies and social norms that fuel them.

While violence against women, girls and children has increased exponentially during the first two years of COVID-19 in Uganda, the response from duty bearers, including PEPFAR, has not kept pace with the crisis. COP22 presents an important opportunity to overcome these structural barriers.

For the first time, OGAC has prioritised using COP22 funding to overcome structural barriers in Uganda: “Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government,

multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.”⁴²

10a. Combating discrimination, stigma, and overcoming legal barriers including criminalization

Civil society welcomes the work of PEPFAR on its two Legal Assessments and looks forward to a robust PEPFAR-supported road map to overcome the barriers identified by the assessments.

COP22 TARGET: PEPFAR should scale up funding of KP- and PLHIV-led efforts to secure changes in laws and policies that will deliver more enabling environments, combat inequalities, and defend human rights.

COP22 TARGET: PEPFAR should publicly and actively support decriminalisation of HIV and of KPs in order to increase uptake of life-saving services, decrease new infections, and ensure an evidence-based HIV response in Uganda.

11. Ageing with HIV and associated challenges

Preliminary data from the UPHIA2020 data indicate that HIV prevalence among people aged 60-64 years has increased from 6.2 to 7%.⁴³ yet HIV programming in Uganda does not focus on people aged >50 years.

Data from CLM indicate that older PLHIV face challenges at health facilities while accessing care—they prefer to receive HIV services separate from younger people. Importantly, comorbid conditions are common among older PLHIV; the health needs of older adults are different from those of younger adults, and older PLHIV have higher all-cause mortality.

Older PLHIV face adverse effects of non communicable diseases, including diabetes, hypertension, cancer as well as mental health challenges. They need management of NCDs

alongside treatment and care for their HIV disease. HIV programs should program NCD medicines in a fast track with ART in order to support long life for ageing HIV positive Ugandans. may protect these vulnerable clients and may be lifesaving.

COP22 TARGET: PEPFAR should support a PLHIV-designed and PLHIV-led program targeting older people living with HIV that delivers integrated screening and management of NCDs as well as mental health services at the facility and community level.

42. Supra note 11, p 20-21.

43. Press Statement, Ministry of Health Uganda, Release of Preliminary Results of the 2020 Population-based HIV Impact Assessment (UPHIA2020), 10 Feb 2022



12. Expanding Community-led monitoring for advocacy

In COP22 independent civil society organisations will continue to carry out CLM in order to improve the accessibility and quality of HIV services across the country, and ensure the accountability of PEPFAR and other investors in Uganda’s health systems to directly impacted communities.

A strong, national independent CLM program is more crucial than ever, as Uganda gets closer to achieving the 95-95-95 targets but is still unable to resolve chronic barriers to truly durable epidemic control, including interruptions on ART; poor viral load suppression for young men and women; stockouts of medicines and reagents, stigma, criminalization and discrimination; and persistently high numbers of new infections.

CLM also strengthens indigenous community systems in a manner that increases the impact of the national HIV/TB response. In COP22, CLM efforts will continue to use data to shape program and policy through national and subnational platforms including District performance review meetings,

budget advocacy meetings, District AIDS Committee meetings, regional IP performance and update meetings and at national level through Uganda’s health assemblies, annual Joint AIDS Reviews, PEPFAR POART meetings and more.

COP22 TARGET: PEPFAR should support consolidated, scaled up independent CLM nationally in order to strengthen independent community accountability of the HIV response.

COP22 TARGET: PEPFAR should increase the CLM budget to \$1.5 million at minimum to support national expansion and build on program impact, prioritising continued barriers to achieving 95-95-95 targets.

13. COVID and access to services

The COVID-19 pandemic, an extended lockdown, closure of schools, the economy, and increased rates of violence have resulted in new problems, from increased teenage pregnancies to likely new HIV infections. Peoples’ treatment was interrupted and Investments in community networks to aid in recovery were inadequate. Restoration of the accessibility and quality of HIV/TB services must be a priority in COP22. Country planning of USAID global VAX funding is meanwhile happening without engagement of civil society and in a manner that is not coordinated with PEPFAR planning, to the detriment of accessibility and quality of services.

COP22 TARGET: PEPFAR should Increase funding for COVID-19 community recovery initiatives to repair harm from the effects of lockdown and increase community resilience to pandemics.

COP22 TARGET: Global VAX country plans for Uganda should be developed with meaningful community engagement and accountability, and ongoing PEPFAR coordination.



PEOPLE'S COP22 PRIORITY RECOMMENDATIONS

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
1. PrEP Access and Retention		
1a. Accelerate expansion of PrEP by rolling out a national program, using a 'hub and spoke' approach		
<p>"PEPFAR Uganda made significant strides in scaling PrEP among high-risk populations, overachieving PrEP targets. Challenges remain with suboptimal screening, with only 57% of HIV-negative clients screened for PrEP; however, linkage of eligible clients improved from 56% in FY20 to 73% initiating PrEP in FY21. Community-led monitoring also identified gaps in provider knowledge about PrEP. Person-centered approaches are being refined and scaled this year to improve continuity and adherence, including DSD models and addressing stigma." - PLL22 pg. 10</p>	<p>In COP22, PEPFAR Uganda will roll out PrEP across the country, using 250 existing PrEP facilities as a hub-and-spoke model linking to communities demanding for services. Adaptations already tested in Uganda such as same-day PrEP initiation, outreach-based initiation, and use of HIV self-testing (HIVST) will be scaled up nationwide.</p>	<p>COP22 TARGET: PrEP should be rolled out across the country as a national program, using 250 existing PrEP facilities as a hub-and-spoke model linking to communities demanding for services. Adaptations already tested in Uganda such as same-day PrEP initiation, outreach-based initiation, and use of HIV self-testing (HIVST) should be scaled up nationwide.</p>
1b. Improve PrEP reach and quality: Increase funding for community-designed and community-led demand creation, outreach, and PrEP literacy efforts, targeting key populations, AGYW, PBFW, and serodiscordant couples		
<p>"PEPFAR will continue to work with SBCA our communication Partner and the Health Promotion department at the MOH to increase PrEP awareness not only for pregnant women in ANC but also among other eligible sub-populations like AGYW and PBFW." - SDS21 pg. 39</p>	<p>In COP22, PEPFAR Uganda will fund community-led PrEP demand creation, and service delivery outreach programs that rely on community health workers building PrEP literacy among communities and health workers, and immediately link people with screening and same-day initiation.</p>	<p>COP22 TARGET: Fund community-led PrEP demand creation, and service delivery outreach programs that rely on community health workers building PrEP literacy among communities and health workers, and immediately link people with screening and same-day initiation.</p>
1c. Fast track PrEP innovations in products and service delivery models		
<p>"Discussions are already underway with the MoH to agree on a process for introducing the dapivirine ring and, eventually, long acting cabotegravir for HIV prevention into prevention programming." -SDS21 pg. 44</p>	<p>In COP22, PEPFAR Uganda will fast track implementation of new WHO Guidance on Simplified PrEP Implementation. PrEP delivery will be AGWY- and KP-led, simplified, with minimal testing barriers. Fast track rollout of event driven PrEP and DSD for PrEP, using HIVST will ensure testing does not create a barrier to PrEP roll out.</p> <p>In COP22, PEPFAR Uganda will support the acceleration of roll out of CAB LA and the DVR. The age restriction for DVR will be changed from >18yrs to >15yrs.</p>	<p>COP22 TARGET: PEPFAR should fast track implementation of new WHO Guidance on Simplified PrEP Implementation.</p> <p>COP22 TARGET: PrEP delivery should be AGWY- and KP-led, simplified, with minimal testing barriers. Fast track rollout of event driven PrEP and DSD for PrEP, using HIVST to ensure testing does not create a barrier to PrEP roll out.</p> <p>COP22 TARGET: PEPFAR should support acceleration of roll out of CAB LA and the DVR.</p>
1d. The Dapivirine Vaginal Ring — prevention by choice for women		
<p>"discussions are already underway with the MoH to agree on a process for introducing the dapivirine ring and, eventually, long acting cabotegravir for HIV prevention into prevention programming" - SDS21 pg. 44</p>	<p>In COP22, PEPFAR Uganda will support the development of guidelines, procurement of, and roll out of DVR as part of a package of comprehensive primary prevention services. PEPFAR will further invest in updating the current national guidelines to include the DVR as another HIV prevention option. PEPFAR will support women's access to comprehensive information about the DVR in order to make an informed choice and to create demand.</p>	<p>COP22 TARGET: PEPFAR should support the development of guidelines, procurement of and roll out of DVR as part of a package of comprehensive primary prevention services.</p> <p>COP22 TARGET: PEPFAR should support women's access to comprehensive information about the DVR in order to make an informed choice and to create demand.</p> <p>COP22 TARGET: PEPFAR should invest in updating the current national guidelines to include the DVR as another HIV prevention option.</p>

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
2. Prevention and treatment for Key Populations (KPs)		
2a. Expanding KP-led infrastructure for HIV/TB prevention and treatment services		
<p>“Refocus the PEPFAR-supported Key Populations (KP) program to expand safe spaces, increase reach, and improve quality and outcomes of services for Key & Priority Populations.” - SDS21 pg. 8</p> <p>“The KP program has expanded over the years to the current 55 SNU, whose selection was informed by triangulation of UNAIDS size estimation, incidence, KP category specific prevalence and program performance.” - SDS21 pg. 44-45</p> <p>“We maintained the categorization of nine (9) SNU with high incidence and high KP populations as high priority. Forty-six (46) SNU now categorized as priority SNU were “high to moderate” for both KP population and incidence.” - SDS21 pg. 83</p> <p>DICs are not mentioned in the COP.</p>	<p>In COP22, PEPFAR Uganda will work with the Ministry of Health to accredit all remaining community DICs to provide KP-led clinical services as soon as possible. Core and overhead funding will be provided for community DICs to expand so that they are able to provide comprehensive clinical services. KP-led DICs will also be established, designed to reach KPs with disposable income who typically patronise private sector clinics.</p> <p>KP size estimates will be improved by rolling out a BBS of key populations, in particular trans* people and men who have sex with men. The methodology will be developed in collaboration with communities, who should advise at each step: inception, research, and dissemination.</p>	<p>COP22 TARGET: PEPFAR should work with the Ministry of Health to accredit all remaining community DICs to provide KP-led clinical services as soon as possible, providing core and overhead funding for community DICs to expand so that they are able to provide comprehensive clinical services.</p> <p>COP22 TARGET: PEPFAR should establish KP-led DICs designed to reach KPs with disposable income who typically patronise private sector clinics.</p> <p>COP22 TARGET: Improve KP size estimates by rolling out a BBS of key populations, in particular trans* people and men who have sex with men. The methodology should be developed in collaboration with communities, who should advise at each step: inception, research, and dissemination.</p>
2b. Expanding funding for indigenous KP organizations and networks		
<p>“The KPFI funding was a one-time, one-off two-year grant from OGAC. It is not an ongoing source of funding.” - SDS pg. 41. No other indication of KP budget in the COP.</p> <p>Finally, PEPFAR Uganda will continue to support CSOs through FCI. In COP20, this has occurred through funding PLHIV-led, KP-led, and other CSOs to reach people in faith communities through FCI activities. This will continue in COP21, and PEPFAR Uganda will integrate CQI into FCI programming to ensure that interventions are client-centered, impactful, and responsive to the needs of the community and gaps in PEPFAR programming.” - SDS21 pg. 102</p> <p>“PEPFAR Uganda should explore funding KP-led indigenous civil society organizations to provide KP-centered services and offer capacity building.” - PLL22 pg. 18</p>	<p>In COP22, PEPFAR Uganda will prioritise substantial increases in funding for indigenous, KP-led community organisations to deliver quality prevention, linkage and continuous treatment services for KPs.</p>	<p>COP22 TARGET: KP-led organizations can deliver effective services ONLY IF they have predictable funding and are NOT dependent on extremely small sub grants from large national and US government contractors. PEPFAR should prioritise substantial increases in funding for indigenous, KP-led community organisations to deliver quality prevention, linkage and continuous treatment services for KPs.</p>
2c. Expanding harm reduction services in Uganda		
<p>“Development and implementation of policies and guidelines for harm reduction programs; establishment of a package of harm reduction services for people who use and inject drugs (including Medication-Assisted Therapy or MAT).” SDS21 pg. 47</p>	<p>In COP22, PEPFAR Uganda will support efforts to strengthen service delivery at the Butabika MAT clinic, and expand to other regions.</p> <p>Needle and syringe services will be piloted in COP22.</p>	<p>COP22 TARGET: PEPFAR Should support efforts to strengthen service delivery at the Butabika MAT clinic, and expand to other regions.</p> <p>COP22 TARGET: NSP services should be piloted in COP22.</p>

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
3. Expand PLHIV-designed and implemented treatment literacy		
<p>“The national CQI Collaborative sub-groups updated and disseminated treatment guidelines and literacy materials, with ongoing mentoring and education efforts to improve practice. Civil society organizations, community-led monitoring leadership, and communication partners contributed to treatment literacy efforts and improving U=U messaging. COP 2021 includes additional resources for community-developed messaging.” - PLL22 pg. 11</p>	<p>PEPFAR will provide new funding to implement a national PLHIV-designed and PLHIV-implemented treatment literacy program to reach all regions and 100% of ART centers in COP22.</p>	<p>COP22 TARGET: PEPFAR should provide new funding to implement a national PLHIV-designed and PLHIV-implemented treatment literacy program to reach all regions and 100% of ART centers.</p>
4. Improve ART retention and reduce interruptions in treatment		
<p>“PEPFAR Uganda will also intensify support for treatment continuity for these populations to address high levels of treatment interruption.” - SDS21 pg. 165</p> <p>“PEPFAR will also provide additional airtime and data for YAPS to facilitate their efforts to track and bring back the high numbers of adolescents with treatment interruption.” - SDS21 pg. 164</p> <p>“While treatment interruption remains a challenge, over the course of the fiscal year, treatment interruption for clients newly initiating ART (<3 months) improved from over 15% in FY 2020 to 10% by FY 2021 Q4.” PLL22 pg 4</p>	<p>PEPFAR will expand and fully functionalize adherence support groups and all other community-led DSD approaches that promote retention in care in COP22, including accelerating efforts to provide 6-month ART refills.</p> <p>By COP22, all IPs will uniformly implement the requirement that CHWs be paid a minimum of \$50/month, in full.</p>	<p>COP22 TARGET: PEPFAR should expand and fully functionalize adherence support groups and all other community-led DSD approaches that promote retention in care.</p> <p>COP22 TARGET: Ensure all IPs are uniformly implementing the requirement that CHWs be paid a minimum of \$50/month, in full.</p> <p>COP22 TARGET: PEPFAR should accelerate efforts to provide 6-month ART refills.</p>

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
5. Stop preventable AIDS deaths from TB, cryptococcal meningitis and cervical cancer		
5a. TB screening, diagnosis, prevention and treatment integration		
<p>“\$2,550,000 are being requested to increase community case finding efforts for TB using dedicated community health workers/peers.” - SDS21 pg. 45</p> <p>“PEPFAR will implement a joint screening algorithm and surge the community TB activities through deployment of dedicated community health care workers for contact tracing, community TB screening and facility based intensified TB case finding. PEPFAR will revamp community case finding activities and improve HIS for TB point of service data capture to improve case finding and monitoring of treatment adherence.” - SDS21 pg. 165</p> <p>“The MoH has already adopted the new TB LAM guidelines, PEPFAR partners are in process of sensitizing providers and the community, and the TB LAM commodity need for COP21 is fully funded.” - SDS21 pg. 45</p>	<p>In COP22, 100% of PLHIV, including CLHIV, will be screened for TB and COVID-19 upon presentation to care at every clinical encounter at 100% of PEPFAR-supported facilities. All PLHIV who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV) upon their first presentation to care. All PLHIV with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results. All healthcare workers at PEPFAR-supported sites will be trained to perform TB screening, urine-LAM, and rapid molecular testing among PLHIV in accordance with WHO recommendations and algorithms.</p> <p>PEPFAR Uganda will procure quantities of commodities required for urine-LAM and rapid molecular testing to each exceed the estimated number of PLHIV expected to present to care at PEPFAR-supported sites with advanced HIV disease or TB signs and symptoms in COP22.</p> <p>In COP22, PEPFAR Uganda will increase funding for health workers to better manage TB, including funding for remuneration for TB case finding.</p> <p>In COP22, PEPFAR Uganda will fast track national rollout of 3HP & introduction of 1HP as TPT.</p> <p><i>Contact tracing carried out with 100% of index cases.</i></p>	<p>COP22 TARGET: Ensure 100% of PLHIV, including CLHIV, are screened for TB and COVID-19 upon presentation to care at every clinical encounter at 100% of PEPFAR-supported facilities.</p> <p>COP22 TARGET: 100% of PLHIV, including CLHIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV) upon their first presentation to care.</p> <p>COP22 TARGET: 100% of PLHIV, including CLHIV, with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results.</p> <p>COP22 TARGET: 100% of PLHIV, including CLHIV, who are co-infected with TB receive confirmatory diagnostic test results and are linked to TB treatment in less than five days after their first presentation to care.</p> <p>COP22 TARGET: Contact tracing carried out with 100% of index cases.</p> <p>COP22 TARGET: 100% of healthcare workers at PEPFAR-supported sites are trained to perform TB screening, urine-LAM, and rapid molecular testing among PLHIV in accordance with WHO recommendations and algorithms.</p> <p>COP22 TARGET: Procurement quantities of commodities required for urine-LAM and rapid molecular testing each exceed the estimated number of PLHIV, including CLHIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease or TB signs and symptoms in COP22.</p> <p>COP22 TARGET: PEPFAR should increase funding for health workers to better manage TB, including funding for remuneration for TB case finding.</p> <p>COP22 TARGET: Fast track national rollout of 3HP & introduction of 1HP as TPT.</p>

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
5b Close remaining AHD commodity coverage gaps		
N/A	<p>In COP22, PEPFAR Uganda will close gaps in supply of AHD commodities including point-of-care (POC) CD4 testing, CrAg testing, TB-LAM, and current recommended treatment and prevention regimens for cryptococcal meningitis, including Liposomal amphotericin B (L-amB), flucytosine and fluconazole. Cryptococcal meningitis treatment with L-amB should be implemented beyond the 52 hospitals where they are currently being rolled out, to reach all facilities that currently provide infusions. Health worker training will be expanded to increase capacity to identify and manage cryptococcal meningitis and cryptogenemia. PEPFAR Uganda will train and pay CHWs to carry out intensive community-based follow-up with a package of interventions that will reduce morbidity and mortality in this vulnerable group.</p>	<p>COP22 TARGET: Close gaps in supply of AHD commodities including point-of-care CD4 tests, These include funding for point-of-care (POC) CD4 testing, CrAg testing, TB-LAM, and current recommended treatment and prevention regimens for CM, including Liposomal amphotericin B (L-amB), flucytosine and fluconazole.</p> <p>COP22 TARGET: CM treatment with L-amB should be implemented beyond the 52 hospitals where they are currently being rolled out, to reach all facilities that currently provide infusions.</p> <p>COP22 TARGET: Expand health worker training to expand capacity to identify and manage cryptococcal meningitis and cryptogenemia.</p> <p>COP22 TARGET: Train and pay CHWs to carry out intensive community-based follow-up with a package of interventions that will reduce morbidity and mortality in this vulnerable group.</p>
5c. Cervical cancer		
<p>“Cervical cancer programming was launched and screened over 123,000 WLHIV in its first year.” - PLL22 pg. 4</p> <p>“Uganda should consider expanding policies and programming to include NCDs such as mental health, hypertension, diabetes mellitus, weight measurement, and cervical cancer screening.” - PLL22 pg. 13</p> <p>“As agreed during COP20, PEPFAR has included one-off cervical cancer screening with HPV testing for WLHIV>50 and treatment for those who screen positive.” - SDS21 pg. 44-45</p> <p>“PEPFAR is also investing \$1,399,830 in commodities and equipment to diagnose and treat cervical cancer for the proportion (40%) of the targeted women living with HIV that will not be reached in COP20.” - SDS21 pg. 95</p> <p>“In COP21, PEPFAR Uganda was allocated \$3M for the cervical cancer program and as such Uganda plans to expand the program to 225 new static health facilities and 947 outreach sites, this in addition to the 604 COP20 health facilities. With this investment we shall reach 282,559 WLHIV aged 25-49 years in COP21, accounting for 50% of HIV-positive women aged 25-49 years in HIV care and treatment. A one-off HPV screen will be offered to WLHIV aged above 50 years receiving care at the 23 health facilities offering HPV testing as the primary screening tool.” - SDS21 pg. 109</p>	<p>In COP22, all IPs will be required to commit that they will never condition any service, such as providing ART refills, on whether or not women undergo cervical cancer screening. IPs will be required to invest in awareness raising in communities about the purpose of cervical cancer screening among women with HIV, so that communities are empowered with knowledge.</p>	<p>COP22 TARGET: PEPFAR should require all IPs to commit that they will never condition any service such as providing ART refills on whether or not women undergo cervical cancer screening. PEPFAR should require IPs to invest in awareness raising in communities about the purpose of cervical cancer screening among women with HIV, so that communities are empowered with knowledge.</p>

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6. Stop commodities stockouts		
<p>“Regarding large stocks, PEPFAR will continue to work with GOU (MOH, NMS, JMS) and partners to ensure all patients receive medicines without any break in service.” SDS21 pg 43</p>	<p>In COP22, PEPFAR Uganda will at least double the budget for STIs for clinical care for PLHIV and KPs.</p> <p>In COP22, PEPFAR Uganda will ensure uninterrupted supplies of free condoms and lubricant as core tools in effective HIV prevention.</p>	<p>COP22 TARGET: PEPFAR should at least double the budget for STIs for clinical care for PLHIV and KPs.</p> <p>COP22 TARGET: PEPFAR should ensure uninterrupted supplies of free condoms and lubricant as core tools in effective HIV prevention.</p>
7. HIV testing services		
7a. Protect human rights		
<p>“Mitigation efforts include building health provider competencies to ensure that safe and ethical index testing would be implemented without human rights violations. These efforts ensured that all counselors are certified to provide HTS according to PEPFAR and World Health Organization (WHO) standards. PEPFAR IPs shared the MOH circular with all facilities, reiterating the need to implement index testing according to WHO guidelines, i.e., emphasis on the 5Cs (Consent, Confidentiality, Counseling, Correct Results, and Connection) when implementing assisted partner notification (APN), screening for intimate partner violence (IPV) prior to and one month after APN, provision of post-GBV services, and IPV adverse event monitoring in the APN register.” - SDS21 pg. 15</p> <p>“Index testing protocols include screening and treatment for IPV. PEPFAR Uganda has assessed 91% of applicable sites for Safe and Ethical Index Testing, and assessments and remediation effort are ongoing.” -SDS21 pg. 149</p> <p>In response to this ask, the COP says, “Agree: The national guidelines stipulate that sites that fail REDCap baseline assessment should be halted from offering index testing services until gaps identified are addressed and re-assessments are done with 100% pass. In line with the guidance index testing was suspended at all the sites that failed baseline assessments. Throughout June 2021, PEPFAR Uganda will be working with IPs to discern the technical and capacity gaps in these sites and drawing up remedial plans.” - SDS21 pg. 41-42</p>	<p>By COP22, all HIV testing sites will provide quality services for victims of violence; any HIV index testing site that cannot provide onsite services for victims of violence or referrals for victims of violence should stop carrying out HIV index testing. PEPFAR will ensure that all HIV test providers understand that index testing is always voluntary, for both partners and children, where individuals are not required to give the names of their partners or children if they do not want to, and that this is explained to all PLHIV. After contacting partner(s), healthcare providers will follow-up with the individual to assess whether any adverse events occurred, including but not limited to violence, and refer them to IPV services if relevant. Data on such occurrences will be shared by IPs with PEPFAR, CSOs and the Ministry of Health.</p>	<p>COP22 TARGET: All HIV testing sites should provide quality services for victims of violence; any HIV index testing site that cannot provide onsite services for victims of violence or referrals for victims of violence should stop carrying out HIV index testing.</p> <p>COP22 TARGET: PEPFAR will ensure that all HIV test providers understand that index testing is always voluntary, for both sexual contacts and children, where individuals are not required to give the names of their sexual partners or children if they do not want to, and that this is explained to all PLHIV.</p> <p>COP22 TARGET: After contacting partner(s), healthcare providers will follow-up with the individual to assess whether any adverse events occurred, including but not limited to violence, and refer them to IPV services if relevant. Data on such occurrences should be shared by IPs with PEPFAR, CSOs and the Ministry of Health.</p>

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7b. HIV testing for pregnant and breastfeeding women		
<p>“Re-testing and active follow-up of HIV-negative pregnant women in ANC/FP clinics will be done to identify those that could have seroconverted. Close to 23% of positive women will be identified through the PMTCT platform.” - SDS21 pg. 59</p>	<p>In COP22, PEPFAR Uganda will ensure expanded access to testing and retesting services for pregnant and breastfeeding women. These services will be non coercive and supportive, including when PBFW do not agree to share the names of their partner(s) for testing. No facility will be permitted to deny of services if they do not agree to bring in their partner(s) for testing or they do not provide the name(s) of their sex partner(s).</p>	<p>COP22 TARGET: Pregnant and breastfeeding women need expanded access to testing and retesting services. These services must be non coercive and supportive, including when PBFW do not agree to share the names of their partner(s) for testing.</p> <p>COP22 TARGET: No facility should be permitted to deny of services if they do not agree to bring in their partner(s) for testing or they do not provide the name(s) of their sex partner(s).</p>
8. Services for adolescents and children living with HIV and HIV-exposed infants		
8a. HIV-positive pregnant and breastfeeding women		
<p>“Since the rollout of Option B+ in 2013, the proportion of HIV-positive pregnant women initiated on ART increased from 84% (FY13) to 100% (FY20). HIV-positive women on ART at the beginning of pregnancy increased from 33% (FY13) to 73% (FY19), although the proportion of pregnant women who are known positive and already on ART at the time of diagnosis has plateaued SDS21 pg 74</p> <p>COP21 activities (detailed below) will strengthen existing strategies and introduce innovations where gaps have been identified, in order to provide high-quality care for pregnant women and mother-baby pairs.” - SDS21 pg. 75</p> <p>“In COP20 and COP21, PEPFAR Uganda will improve the efficiency of EID testing platforms to improve early identification of HIV-exposed infants and timely ART initiation and treatment continuity for all eligible infants, including by expanding POC EID, consistent with the new WHO technical guidance.” - SDS21 pg. 27</p> <p>“PEPFARs goal is for universal access for EID testing and rapid linkage of HIV positive infants to HIV treatment. For COP 21, PEPFAR Uganda will support the MOH to scale up EID POC services. Program implementation will be strengthened to support optimal EID POC scale-up, ensure commodity availability and effective Laboratory Management Information systems for EID POC data at all supported site.” - SDS21 pg. 41</p>	<p>In COP22, PEPFAR will urgently scale-up provision of POC viral load for pregnant and breastfeeding women (PBFW), building on the findings of the Ministry of Health PMTCT Impact Evaluation revealing low VL coverage. PEPFAR will support the Ministry of Health to revise national VL policy to allow 3-monthly VL monitoring for PBFW.</p> <p>PEPFAR Uganda will increase funding during COP22 to ensure HCIs are equipped to provide PMTCT services when women seek ANC services and services after delivery.</p> <p>In COP22, the mentor mothers program will be scaled so that 100% of PEPFAR supported sites link HIV positive PBFW with the support of a mentor mother who is trained, paid a living wage, and is also living with HIV. PEPFAR will focus in particular on expanding services for PBFW in the 60 Districts not included in the OVC program.</p>	<p>COP22 TARGET: PEPFAR should urgently scale up provision of POC viral load for pregnant and breastfeeding women (PBFW), building on the findings of the Ministry of Health PMTCT Impact Evaluation revealing low VL coverage.</p> <p>COP22 TARGET: PEPFAR should support the Ministry of Health to revise national VL policy to allow 3-monthly VL monitoring for PBFW.</p> <p>COP22 TARGET: PEPFAR should increase funding during COP22 to ensure HCIs are equipped to provide PMTCT services when women seek ANC services and services after delivery.</p> <p>COP22 TARGET: Scale-up the mentor mothers program so that 100% of PEPFAR supported sites link HIV positive PBFW with the support of a mentor mother who is trained, paid a living wage, and is also living with HIV.</p> <p>COP22 TARGET: PEPFAR should focus in particular on expanding services for PBFW in the 60 Districts not included in the OVC program.</p>

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8b. HIV-Exposed Infants (HEI)		
<p>“Uganda has a centralized VL and mixture of centralized and POC EID testing system. [...] For FY22 (COP21), Uganda plans to maintain the EID POC at 133 sites and focus on optimal utilization of the existing POC platforms, timely screening and internal referral for EID POC testing from alternative entry points (pediatric, nutrition, immunization, TB wards, etc.), HCW re-training, multiplex testing on both.” - SDS21 pg. 109</p> <p>“Nutritional support for severely malnourished children continues to be included in the COP budget.” - SDS21 pg. 45</p>	<p>PEPFAR will further expand POC EID for HEI beyond the 45:55 POC EID/Conventional EID split proposed in COP22, striving toward 100% coverage.</p> <p>PEPFAR Uganda will provide nutritional support, socioeconomic support, transport vouchers and peer-led psychosocial support in order to ensure mothers and other caregivers of HEIs are able to secure continuous access to treatment for themselves as well as prophylaxis and diagnostic services for HEIs. PEPFAR will focus in particular on expanding services for HEIs and their caregivers in the 60 Districts not included in the OVC program.</p> <p>PEPFAR will ensure that coverage of children 0-15 years is reinstated in the PHIA.</p>	<p>COP22 TARGET: PEPFAR should further expand POC EID for HEI beyond the 45:55 POC EID/Conventional EID split proposed in COP22, striving toward 100% coverage.</p> <p>COP22 TARGET: PEPFAR should provide nutritional support, socioeconomic support, transport vouchers and peer-led psychosocial support in order to ensure mothers and other caregivers of HEIs are able to secure continuous access to treatment for themselves as well as prophylaxis and diagnostic services for HEIs. PEPFAR should focus in particular on expanding services for HEIs and their caregivers in the 60 Districts not included in the OVC program.</p> <p>COP22 TARGET: PEPFAR should reinstate coverage of children 0-15 years in the PHIA.</p>
8c. Youth-friendly services		
<p>“PEPFAR will also increase the training of Youth, Adolescents and Peer Support (YAPS) and provide an additional 2 YAPS at each high-volume facility. PEPFAR will also provide additional airtime and data for YAPS to facilitate their efforts to track and bring back the high numbers of adolescents with treatment interruption.” - SDS21 pg. 164</p> <p>“USG will continue to work to strengthen the national distribution system and ensure the availability of commodities needed to transition full ARV regimen optimization for both adults and children, as well as MMD and delivery model (DSDM) whereby ARVs could be distributed through private pharmacies, community-based and non-clinical locations as Decentralized Drug Distribution points.” - SDS21 pg. 117</p>	<p>In COP22, PEPFAR Uganda will scale-up YAPS to reach the remaining 46 districts, and increase funding for YAPS nationally to close coverage gaps in peer-led supportive services for C/AWHIV and their families, focusing on programs designed and implemented by peers, to address stressors unique to C/ALHIV. YAPS will be paid a living wage, trained, supported and equipped with the tools to carry out their work, such as airtime.</p> <p>PEPFAR will expand MMD for children and adolescents from 51% to 90% receiving 3+ month refills in COP22.</p> <p>In COP22, PEPFAR will focus in particular on expanding services for young people with HIV and their caregivers in the 60 Districts not included in the OVC program.</p>	<p>COP22 TARGET: Scale up YAPS to reach remaining 46 districts, and increase funding for YAPS nationally to close coverage gaps in peer-led supportive services for C/AWHIV and their families, focusing on programs designed and implemented by peers, to address stressors unique to C/ALHIV. YAPS should be paid a living wage, trained, supported and equipped with the tools to carry out their work, such as airtime.</p> <p>COP22 TARGET: PEPFAR should expand MMD for children and adolescents from 51% to 90% receiving 3+ month refills.</p> <p>COP22 TARGET: PEPFAR should focus in particular on expanding services for young people with HIV and their caregivers in the 60 Districts not included in the OVC program.</p>

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9. DREAMS		
<p>“PEPFAR has expanded the geographical coverage for the DREAMS program from 10 to 24 districts since COP16 and will expand to Kampala in COP21. The first two years of DREAMS were a Proof of Concept and we demonstrated a reduction in HIV incidence in 8 of the 10 original DREAMS districts. Since then, we have continued to refine the Program to align with new implementation Guidance. Overall, AGYW_PREV progress over the last six months shows good program completion rates of primary and additional secondary services across all age bands and the performance will continue to improve as the safe spaces reopen following the COVID 19 restrictions.” - SDS21 pg. 44</p> <p>“The DREAMS initiative will focus on continued program realignment to respond to emerging AGYW challenges due to COVID-19, such as addressing increases in teenage pregnancies, and increased GBV cases.” - SDS21 pg. 67</p>	<p>PEPFAR will expand DREAMS districts to include key underserved sub-regions (including Teso, Bugisu, Busoga) that have high rates of new HIV infections among AGYW. The DREAMS program will be changed in Uganda to increase completion rate, including by creating a platform for trainees to select their own enterprises; support those who complete to start viable economic ventures. Funding under DREAMS will be expanded for socio-economic empowerment, behavior change communication, and skills training for AGYW to respond to skyrocketing teen pregnancy and violence during the COVID-19 period in the affected districts.</p>	<p>COP22 TARGET: PEPFAR should expand DREAMS districts to include key underserved sub-regions (including Teso, Bugisu, Busoga) that have high rates of new HIV infections among AGYW.</p> <p>COP22 TARGET: Change the DREAMS program in Uganda to increase completion rate, including by creating a platform for trainees to select their own enterprises; support those who complete to start viable economic ventures.</p> <p>COP22 TARGET: Expand funding under DREAMS for socio-economic empowerment, behavior change communication, and skills training for AGYW to respond to skyrocketing teen pregnancy and violence during the COVID period in the affected districts.</p>
10. Structural interventions: human rights, gender based violence, criminalization		
10a. Combating discrimination, stigma, and overcoming legal barriers including criminalization		
<p>“Under COP20, two Legal Environment Assessments are underway, one focuses on Ugandan PLHIV, and the other focuses on Key Populations. We will utilize in COP21 the findings from the two Legal Environment Assessments to help shape and inform legal advocacy and policy reforms related to KP and PP. Moreover, PEPFAR Uganda will use the Legal Environment Assessment findings, together with the Stigma Index data, to explore options to improve the legal environment, which currently in Uganda is not conducive for some client groups to access quality care in health facilities and at the community level. Under COP21, PEPFAR Uganda will take concerted action to counter the persistent barriers to quality care that are posed by legislation such as the “Sexual Offences Bill” passed by the Ugandan Parliament in May 2021.” -SDS21 pg. 85</p> <p>“The program will continue trainings in KP and PP Friendly Service Delivery, including Gender & Sexual Diversity (GSD) trainings to address stigma and discrimination at the facility level and community level.” - SDS21 pg. 83</p>	<p>PEPFAR will scale-up funding of KP- and PLHIV-led efforts to secure changes in laws and policies that will deliver more enabling environments, combat inequalities, and defend human rights. PEPFAR will publicly and actively support decriminalisation of HIV and of KPs in order to increase uptake of life-saving services, decrease new infections, and ensure an evidence-based HIV response in Uganda.</p>	<p>COP22 TARGET: PEPFAR should scale up funding of KP- and PLHIV-led efforts to secure changes in laws and policies that will deliver more enabling environments, combat inequalities, and defend human rights.</p> <p>COP22 TARGET: PEPFAR should publicly and actively support decriminalisation of HIV and of KPs in order to increase uptake of life-saving services, decrease new infections, and ensure an evidence-based HIV response in Uganda.</p>
11. Ageing with HIV and associated challenges		
<p>N/A</p>	<p>PEPFAR will support a PLHIV-designed and PLHIV-led program targeting older people living with HIV that delivers integrated screening and management of NCDs as well as mental health services at the facility and community level.</p>	<p>COP22 TARGET: PEPFAR should support a PLHIV-designed and PLHIV-led program targeting older people living with HIV that delivers integrated screening and management of NCDs as well as mental health services at the facility and community level.</p>

COP21 SDS, Planning Letter & MER Data	Language to include in COP22 SDS	COP22 Target
12. Expanding Community-led monitoring for advocacy		
<p>“Several approaches to monitoring the quality of services will be used, including the development and implementation of national dashboards accessible at all levels of the health systems, adapted SIMS/surge assessments to address unique facility challenges, and the expansion of the Uganda CSO CLM program that was launched in June 2020.” - SDS21 pg. 17-18</p> <p>“In COP21, PEPFAR Uganda will utilize this platform to rapidly respond to findings from the community-led monitoring and will support districts and health facilities in implementing tailored QI interventions to address these findings and recommendations.” - SDS21 pg. 59</p> <p>“In COP21 PEPFAR will build on the innovative indigenous model of “Community Led Monitoring” (CLM) developed by Ugandan CSOs. The CLM will be expanded and institutionalized with support first from COP19 PEPFAR Small Grants, and then through funding via UNAIDS Headquarters to Ugandan CSOs for COP20 CLM.” - SDS21 pg. 112</p>	<p>PEPFAR Uganda will support consolidated, scaled-up independent CLM nationally in order to strengthen independent community accountability of the HIV response.</p> <p>CLM funding will be increased to \$1.5 million at minimum to support national expansion and build on program impact, prioritizing continued barriers to achieving 95-95-95 targets.</p>	<p>COP22 TARGET: PEPFAR should support consolidated, scaled up independent CLM nationally in order to strengthen independent community accountability of the HIV response.</p> <p>COP22 TARGET: PEPFAR should increase the CLM budget to \$1.5 million at minimum to support national expansion and build on program impact, prioritizing continued barriers to achieving 95-95-95 targets.</p>
13.COVID and access to services		
<p>“COVID recovery interventions identified for ARPA funding include: additional support for child justice and violence response, community TB case finding, enhancement and expansion of DSD for PBFW, adolescents, and KPs; provision of PPE for PEPFAR-funded peers; and transport vouchers for vulnerable PLHIV in non-OVC supported districts.” - SDS21 pg. 37</p>	<p>PEPFAR will increase funding for COVID-19 community recovery initiatives to repair harm from the effects of lockdown and increase community resilience to pandemics. Global VAX country plans for Uganda will be developed with meaningful community engagement and accountability, and ongoing PEPFAR coordination.</p>	<p>COP22 TARGET: PEPFAR should Increase funding for COVID-19 community recovery initiatives to repair harm from the effects of lockdown and increase community resilience to pandemics.</p> <p>COP22 TARGET: Global VAX country plans for Uganda should be developed with meaningful community engagement and accountability, and ongoing PEPFAR coordination.</p>

