

THE PEOPLE'S VOICE UGANDA

COMMUNITY PRIORITY RECOMMENDATIONS

FOR PEPFAR UGANDA FOR 2023





Civil Society Partnership Award

Uganda Community Led
Monitoring Consortium
(ICWEA, SMUG, HEPS-Ug, UKPC)

2022



DEVELOPING “THE PEOPLE’S VOICE”

In 2023, People living with HIV (PLHIV), Key Populations, Priority Populations and Civil Society Organisations (CSOs) are maintaining in 2023 their longstanding commitment to meaningfully engage with PEPFAR’s Country Operational Planning (COP) processes. Uganda is one of the first countries to benefit from PEPFAR opening up its processes to communities in order to secure more transparent and democratic COP planning. We acknowledge this COP cycle will be different, building on a new PEPFAR 5-year strategy.¹ Although PEPFAR is testing out two year planning cycles, we have maintained our focus on annual recommendations, given the need for constant improvement and pivots to ensure impact.

Under the leadership of 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), and Uganda Key Populations Consortium (UKPC), communities in Uganda have released this, the fifth edition of The People’s Voice. Earlier versions were published in 2019², 2020,³ 2021,⁴ and 2022.⁵

This edition contains our priorities, building on PEPFAR’s existing promises from COP22 as well as areas where PEPFAR did not address community demands in COP22. We also introduce new priority recommendations.

The People’s Voice was developed using data from Community Led Monitoring (CLM) in health facilities; accountability meetings with Implementing partners (IPs) and extensive consultation with a range of duty bearers and civil society. In addition, we participated in consultations with the Ministry of Health, Uganda AIDS Commission (UAC), PEPFAR and AIDS Development Partners during the annual PEPFAR strategy retreat.

Uganda’s CLM program began initially with a pilot project in 2019 but has since grown rapidly to cover 80 Districts across Uganda. Community monitors gather evidence that is analysed and used to uncover chronic problems undermining access to quality, accessible services. Communities then generate solutions to these problems and use advocacy to hold duty bearers accountable to resolve the problems at the facility, sub national, and national level.

We have achieved several milestones as a result of this vital, community-led strategy. For example, the CLM program uncovered the fact that CHWs were being remunerated at unacceptably low rates, despite carrying out essential work to reach people who have been pushed out of health care. As a result, PEPFAR and the Government of Uganda (GoU) committed to the remuneration of all community health workers with at least \$50 per month. CLM infrastructure has then been deployed to continuously monitor timely implementation of this commitment.

Likewise, CLM program focused on the services actually being provided at the facility and community level to key populations (KPs), providing the opportunity for KPs to design and advocate for their own solutions to barriers to access to quality treatment and prevention services they illuminated. This included the recommendation to fund Drop-in Centers (DICs) led by KPs

to provide a full complement of HIV clinical and preventative services, in order to improve linkage and retention on ART and reduce stigma and human rights violations. Likewise, CLM data have helped make the case for the need for the introduction of harm reduction programs in Uganda, eventually leading to the establishment of the first MAT program in the country and the development of harm reduction guidelines, which has opened the door for further regional expansion building on lessons learned. The impact of Uganda’s CLM program has been highlighted by partners, including UNAIDS, who highlighted our program in a case study on the impact of CLM, published in the UNAIDS annual global update report (2022), [In Danger](#). CLM Uganda’s engagement strategy and community partnership with the program and other relevant program stakeholders earned it the “Civil Society Partnership Award” from PEPFAR during the PEPFAR Global Partners Meeting, held during the International AIDS Conference in Montreal in 2022.

This edition of the People’s Voice on COP23 Priorities is closely aligned with the new [PEPFAR 5-year strategy](#), which focuses on 5 Pillars and 3 Critical Enablers. Uganda’s civil society engagement to hold PEPFAR accountable to community needs is guided by a commitment to putting the 5 pillars into practice. Equity, Sustaining the Response, Supporting Health Systems.

WHAT IS NEW WITH CLM IN COP23?

- + Documentation of working models by other partners and other resources at different levels in the HIV response for possible partnership and/or adoption of good practices
- + Community performance measures for;
 - » Quality of services
 - » Overall satisfaction with the quality and comprehensiveness of services
 - » Quality of service delivery models
- + Activate focused partner relationships (Multilateral partners, Philanthropies, Private sector and Government)
- + Reimagining CLM programming and planning (Governance, Leadership, Financing, Human Resources and Strategic Information) for increased efficiency and effectiveness
- + Improve paediatric services through AP3 monitoring in high volume health facilities
- + Intensify Key Populations DIC monitoring

1. [PEPFAR’s Five-year Strategy - Fulfilling America’s Promise to End the HIV/AIDS Pandemic by 2030](#)

2. [The People’s Voice on COP19 Community Priorities](#)

3. [The People’s Voice on COP20 Community Priorities](#)

4. [The People’s Voice on COP21 Community Priorities](#)

5. [The People’s Voice on COP22 Community Priorities](#)



RESPONSIVENESS OF COP22 SDS TO CIVIL SOCIETY DEMANDS

After the publication of [PEPFAR's 2022 Country Operational Plan for Uganda](#), communities compared their recommendations, contained in "The People's Voice of COP22 Community Priorities," with the text contained in PEPFAR Uganda's 2022 SDS, 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 is contained in the third edition of *Measuring Up*, an advocacy guide that tracks PEPFAR's accountability to

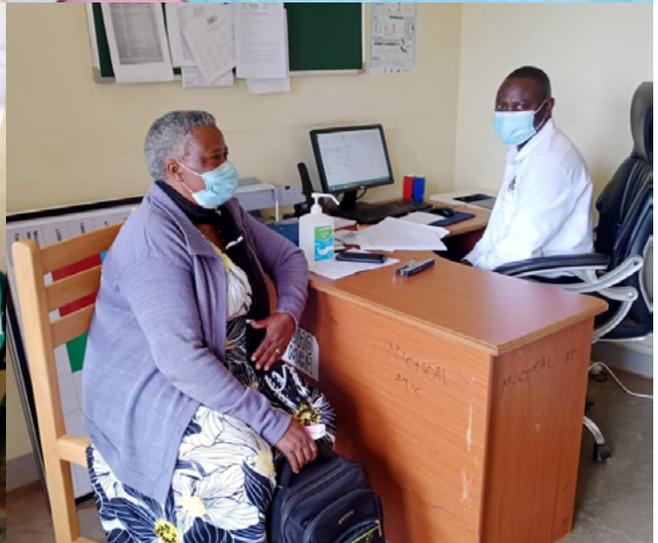
people living with HIV, for the 2022-23 period. (Uganda's analysis is available [here](#) and in Table 1, below.) Civil society also carried out this analysis as part of the COP 2021 planning cycle, in the second edition of [Measuring Up](#), comparing the recommendations contained in "The People's Voice on COP21 Community Priorities" with [PEPFAR's 2021 Country Operational Plan for Uganda](#).

According to this analysis, PEPFAR's COP for 2022-23 for Uganda is deemed "partially responsive," with a score of 46% out of a possible 100%, while in 2021 PEPFAR's COP was also deemed "partially responsive" but scored slightly lower, at 38.3% out of a possible score of 100%.⁶

Table 1. Analysis of responsiveness of COP22 SDS to civil society demands

Priority Area in People's COP	2022 Grade	Assessment
1.1 Accelerate expansion of PrEP by rolling out a national program, using a "hub and spoke" approach	50% (1 point / 1 demand)	Partially included
1.2 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	0% (1 demand)	Not included
1.3 Fast track PrEP innovations in products and service delivery models	16.7% (1 point / 3 demands)	Limited inclusion
1.4 The Dapivirine vaginal ring - prevention by choice for women	50% (3 points / 3 demands)	Partially included
2.1 Expanding KP-led infrastructure for HIV/ TB prevention and treatment services	33.3% (2 points / 3 demands)	Partially included
2.2 Expanding funding for indigenous KP organizations and networks	50% (1 point / 1 demand)	Partially included
2.3 Expanding harm reduction services in Uganda	50% (2 points / 2 demands)	Partially included
3. Expand PLHIV-designed and -implemented treatment literacy	0% (1 demand)	Not included
4. Improve ART retention and reduce interruptions in treatment	66.7% (4 points / 3 demands)	Mostly included
5.1 TB screening, diagnosis, prevention, and treatment integration	27.8% (5 points / 9 demands)	Limited inclusion
5.2 Close remaining AHD commodity coverage gaps	62.5% (5 points / 4 demands)	Partially included
5.3 Cervical cancer	50% (1 point / 1 demand)	Partially included
6. Stop commodities stockouts	50% (2 points / 2 demands)	Partially included
7.1 HIV testing services: Protect human rights	50% (3 points / 3 demands)	Partially included
7.2 HIV testing for pregnant and breastfeeding women	25% (1 point / 2 demands)	Limited inclusion
8.1 HIV positive pregnant and breastfeeding women	60% (6 points / 5 demands)	Partially included
8.2 HIV-exposed infants (HEI)	50% (3 points / 3 demands)	Partially included
8.3 Youth-friendly services	100% (3 demands)	Included
9. DREAMS	50% (3 points / 3 demands)	Partially included
10.1 Combating discrimination, stigma, and overcoming legal barriers including criminalization	75% (3 points / 2 demands)	Mostly included
11. Aging with HIV and associated challenges	100% (1 demand)	Included
12. Expanding community-led monitoring for advocacy	50% (2 points / 2 demands)	Partially included
13. COVID and access to services	0% (2 demands)	Not included

6. "Measuring Up: Tracking PEPFAR's Accountability to People Living with HIV 2022-23," preliminary country analysis for Uganda compared with [Measuring Up: Tracking PEPFAR's Accountability to People Living with HIV 2021-22](#), p 23.



List of health facilities monitored and corresponding PEPFAR Implementing Mechanism

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

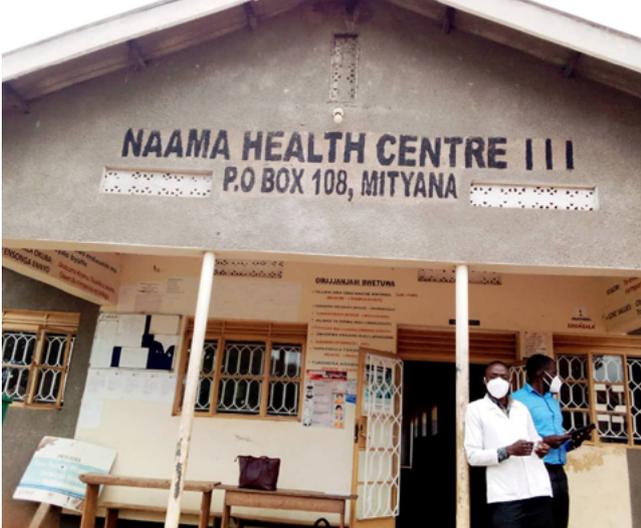
IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
Makerere University Walter Reed Project (MUWRP)	Buvuma	+ Namatale HC III + Buvuma HC IV + Bugaya HC III + Busamuzi HC III
	Mukono	+ Mukono General Hospital + Mukono COU Hospital + Kojja HC IV + Goma HC III + Nakifuma HC III
	Kayunga	+ Kayunga Hospital + Bbaale HC IV + Lugasa HC III + Kangulumira HC IV
Infectious Diseases Institute (IDI)	Wakiso	+ Joint Clinical Research Center (JCRC) HC IV + Kasangati HC IV + Wakiso HC IV + Nsangi HC III + Kajjansi HC IV
	Kampala	+ Kawempe National Referral Hospital + Kisenyi HC IV + Kawaala Health Centre HC III + Mulago NRH - MJAP ISS Clinic + Alive Medical services special clinic
Rakai Health Sciences Program (RHSP)	Ssembabula	+ Ssembabule HC IV + Ntuusi HC IV + Lwemiyaga HC III + Mateete HC III
	Bukomansibi	+ Butenga HC IV + Makukuulu HC III + Mirambi HC III + Bigasa HC III
	Kyotera	+ Kalisizo HOSPITAL + Kakuuto HC IV + Kabira (Kyotera) HC III + Mitukula HC III
	Masaka	+ Masaka RRH + Kitovu Hospital + Bukakata HC III + TASO Masaka Special Clinic
	Kalangala	+ Bukasa HC IV + Kalangala HC IV + Mazinga HC III + Mugoye HC III
	Lyantonde	+ Lyantonde HOSPITAL + Lyantonde Muslim HC III + Kaliiro HC III + Kasagama HC III
	Kalungu	+ Villa Maria HOSPITAL + St. Joseph Of the Good Shepherd Kyamulibwa HC IV + Lukaya HC III + Kasambya (Kalungu) HC III
	Gomba	+ Maddu HC IV + Kifampa HC III + Bukalagi HC III + Kanoni HC III

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
Rakai Health Sciences Program (RHSP)	Butambala	+ Gombe (Butambala) Hospital + Kyabadaza HC III + Bulu HC III + Kibibi Nursing Home HC III
Makerere University Joint AIDS Program (MJAP)	Bugiri	+ Bugiri HOSPITAL + Nankoma HC IV + Muterere HC III + Bugiri MC HC III
	Busia	+ Masafu Hospital + Dabani HOSPITAL + Busia HC IV + Nabulola HC III
	Iganga	+ Iganga HOSPITAL + Iganga Islamic Medical Centre HC III + Iganga Town Council HC III + Namungalwe HC III
	Luuka	+ Kiyunga HC IV + Irongo HC III + Bukanga HC III + Bukooya HC III
	Mayuge	+ Buluba HOSPITAL + Kigandalo HC IV + Kityerera HC IV + Mayuge HC III
	Jinja	+ Jinja RRH + Walukuba HC IV + Buwenge HC IV + Budondo HC IV
	Bugweri	+ Busesa HC IV + Lubira HC III + Busembatya HC III + Makuutu HC III
	Buyende	+ Kidera HC IV + Irundu HC III + Bugaya HC III + Buyende HC III
	Kamuli	+ Kamuli Hospital + Kamuli Mission Hospital + Namwendwa HC IV + Nankandulo HC IV
	Kaliro	+ Bumanya HC IV + Nawaikoke HC III + Namwiwa HC III + Gadumire HC III
Baylor Mbale	Manafwa	+ Bugobero HC IV + Bubulo HC IV + Lwanjusi HC III + Butiru Chrisco (UCMB) HC III
	Bududa	+ Bududa HOSPITAL + Bulucheke HC III + Bukigai HC III + Bukalasi HC III

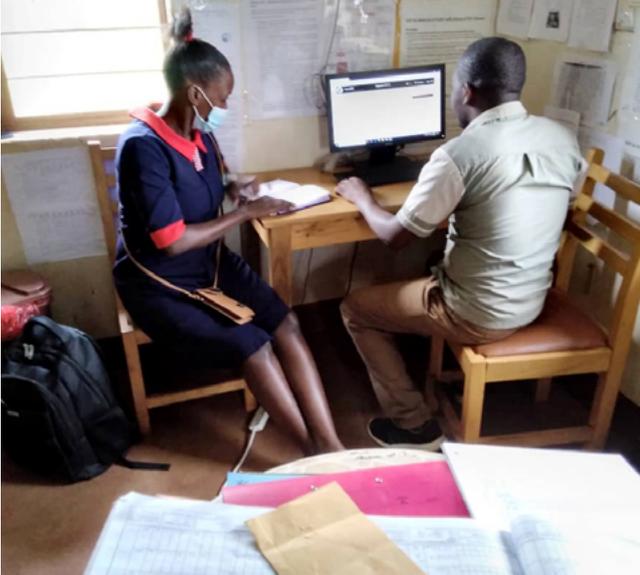
IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
Baylor Mbale	Mbale	+ Mbale RRH + Kolonyi HC IV + Ahamadiya HC IV + Namataala HC IV
	Sironko	+ Budadiri HC IV + Buwasa HC IV + Sironko HC III + Buwalasi HC III
	Tororo	+ Tororo Hospital + Mukuju HC IV + TASO Tororo Special Clinic + Malaba HC III
	Butaleja	+ Busolwe HOSPITAL + Nabiganda HC IV + Budumba HC III + Bubalya HC III
	Butebo	+ Butebo HC IV + Kabwangasi HC III + Kakoro HC III + Nagwere HC III
	Kapchorwa	+ Kapchorwa HOSPITAL + Sipi HC III + Kabeywa HC III + Kaserem 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
TASO Acholi	Nwoya	+ Anaka HOSPITAL + Purongo HC III + Alero HC III + Koch Goma HC III
	Amuru	+ Amuru Lacor HC III + Kaladima HC III + Pabbo (Govt) HC III + Otwee HC III
	Gulu	+ Gulu RRH + St. Mary's Lacor Hospital + Awach HC IV + Aywee HC III
	Omoro	+ Lalogi HC IV + Lacor Opit HC III + Bobi HC III + Odek HC III
	Kitgum	+ Kitgum HOSPITAL + St. Joseph's Hospital + Namokora HC IV + Akuna Laber HC III
	Pader	+ Pajule HC IV + Pader HC III + Acholi-Bur HC III + Atanga HC III

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
JCRC LANGO	Oyam	+ Aber Hospital + Anyeke HC IV + Otwal HC III + Agulurude HC III
JCRC LANGO	Kole	+ Aboke HC IV + Alito HC III + Bala HC III + Apalabarowo HC III
	Lira	+ Lira RRH + Amach HC IV + Pag Mission HC IV + Ober HC III
	Alebtong	+ Alebtong HC IV + Apala HC III + Abako HC III + Omoro HC III
	Kwania	+ Aduku HC IV + Abongomola HC III + Nambieso HC III + Inomo HC III
	Apac	+ Apac HOSPITAL + Ibuje HC III + Teboke HC III + Akokoro HC III
TASO ANKOLE	Mbarara	+ Mbarara RRH + Bwizibwera HC IV + Mbarara Municipal Council HC IV + TASO Mbarara Special Clinic
	Isingiro	+ Kabuyanda HC IV + Rugaaga HC IV + Rwekubo HC IV + Nakivale HC III
	Ntungamo	+ Itojo HOSPITAL + Ntungamo HC IV + Rubare HC IV + Kitwe HC IV + Rwashamaire HC IV
	Rwampara	+ Kinoni HC IV + Bugamba HC IV + Mwizi HC III + Ndeija HC III
	Sheema	+ Kitagata HOSPITAL + Kabwohe HC IV + Kigarama HC III + Kyangyenyei HC III
	Buhweju	+ Tumu Hospital + Butare HC III + Nsiika HC IV + Bihanga HC III
	Kazo	+ Kazo HC IV + Engari Community HC III + Kiruhura Kanoni HC III + Lamezia HC III
	Rubirizi	+ Rugazi HC IV + Kicwamba) HC III + Katunguru HC III + Katerera HC III

IMPLEMENTING MECHANISM	DISTRICT	FACILITIES
TASO ANKOLE	Bushenyi	+ Ishaka Adventist HOSPITAL + Comboni HOSPITAL + Bushenyi HC IV + Kyabugimbi HC IV + KIU Teaching HOSPITAL
JCRC Kigezi	Kabale	+ Kabale Regional Referral Hospital + Rushoroza Hospital + Rugarama HOSPITAL + Kamukira HC IV + Maziba HC IV
	Rubanda	+ Muko HC IV + Bubare HC III + Hamurwa HC IV + Muko Ngo HC III
	Rukungiri	+ Karoli Lwanga (Nyakibale) Hospital + Buhunga HC IV + Rukungiri HC IV + Kebisoni HC IV
	Kanungu	+ Bwindi Community HOSPITAL + Kambuga HOSPITAL + Kanungu HC IV + Kihihi HC IV
	Kisoro	+ Kisoro Hospital + Mutolere Hospital + Rubuguri HC IV + Busanza HC IV
TASO Soroti	Soroti	+ Soroti Regional Referral Hospital + Kichinjaji HC III + Princess Diana HC IV + TASO Soroti Special Clinic
	Ngora	+ Ngora Freda Carr Hospital + Ngora HC IV + Mukura HC III + Kapir HC III
	Kumi	+ Atatur HOSPITAL + Kumi (Ongino) Hospital + Kumi HC IV + Mukongoro HC III
	Katakwi	+ Katakwi Hospital + Toroma HC IV + Astu HC IV + Magoro HC III
	Kapelebyong	+ Kapelebyong HC IV + Obalanga HC III + Acowa HC III + St. Francis Acumet HC III
	Kaberamaido	+ Kaberamaido Hospital + Kaberamaido Catholic Mission HC III + Ochero HC III + Kobulubulu HC III
	Kalaki	+ Lwala HOSPITAL + Otuboi HC III + Kalaki HC III + Bululu HC



KEY POPULATION DROP IN CENTRES	<ul style="list-style-type: none"> + Kampala + Mukono + Soroti + Lira + Gulu + Luweero + Fort Portal + Mubende + Kasese + Masaka + Mbarara + Jinja + Mbale
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THE HIV RESPONSE IN UGANDA

An estimated 1,453,891 people are living with HIV in Uganda and of these, 1,379,316 are currently on treatment.⁷ The Uganda Population-based HIV Impact Assessment 2020-21 found viral load suppression on average for people >15 years old at 75%.⁸ According to UNAIDS modelling data, Uganda is among the subset of countries with an increasing HIV epidemic, with “a trend of increasing or flat rates of HIV incidence (new infections) and/or total all-cause mortality among people living with HIV and have not yet achieved a viral load suppression rate of at least 73% among all people living with HIV.”⁹

During 2022, Uganda added 47,364 on treatment (TX_NET_NEW), which represents 66% of the annual target of 71,526 people on treatment and fewer than the 50,645 people started on treatment in 2021. While trends in interruptions in treatment (IIT) are improving following increased focus on HIV program quality by PEPFAR and the Government of Uganda, 25,838 people still experienced treatment interruptions in 2022 Q4.

This is likely an underestimate of IIT, because only 72% of PEPFAR supported sites report IIT currently.¹⁰

Despite progress, new HIV infections are not reducing, AIDS-related deaths persist, and the COVID-19 pandemic has increased community vulnerability. For example, during 2020-2022 women experienced sharp increases in gender based violence and unplanned pregnancy, unsafe labour and delivery, alongside loss of livelihood.

7. FY22Q4 PEPFAR Oversight and Accountability Review Team (POART), slide 16.

8. [UPHIA 2020-21 Summary Sheet 2020-2021](#)

9. [FY 2024 Technical Considerations](#), p 19

10. supra note 7, slide 45



COMMUNITY PRIORITY INTERVENTIONS FOR COP23

1. Key Populations: Service delivery, Human Rights and Structural Interventions

Uganda’s Key Population program has made strategic progress in scaling up access to prevention and treatment services and to responding to gaps in the prevention and treatment cascades,¹¹ despite serious challenges. Closing the gaps in access to services experienced by KPs is key to achieving equitable access for all.

But a new crisis has emerged for Key Populations (KPs) in Uganda, compounded by existing oppressive laws and policies that not only criminalise their existence but also amplify discrimination and stigma against KPs, resulting in adverse HIV outcomes for the entire nation. For the last year, KPs, particularly the LGBTQ+ community and civil society organisations, have faced an escalating wave of hostility from government officials, religious leaders, educational institutions, and the general public.

Starting in 2022, there has been a series of policy moves aimed at limiting the freedoms of civil society groups that support the human rights of Key Populations (KPs) by falsely claiming that their work promotes homosexuality. The NGO Bureau has targeted them and shut many of them down, despite freedom of association enshrined in the Constitution. As a result, the very civil society infrastructure that KPs have been building for years to fight against HIV is being shut down.

Most recently, Uganda’s Parliament adopted a motion made by Bugiri Municipality MP, Hon. Asuman Basalirwa to table the Anti-Homosexuality Bill, 2023 as a private member’s Bill. The Speaker of Parliament has announced it will be tabled by the Parliament March 1, 2023.¹² Decriminalisation is a requisite part of an effective AIDS response yet Uganda is moving in the opposite direction. The country risks regressing on the achievements so far accomplished for the AIDS response. Uganda must uphold her commitment to work within the UNAIDS Strategic Framework 2020-2025 especially where it relates to societal enablers for de-stigmatisation and decriminalisation.

It is crucial for all partners, including PEPFAR, to prioritise human rights and follow scientific evidence. During COP23, PEPFAR must accelerate progress in supporting KP-led service delivery of high-quality prevention and treatment, particularly by utilising KP-led Drop In Centers (DICs). Moreover, PEPFAR,

11. Uganda Country Operational Plan (COP) 2022, Strategic Direction Summary p 102

12. Motion Seeking Leave of Parliament to Introduce a Private Members Bill Entitled, “Anti-Homosexuality Bill,” February 28 2023. Office of the Clerk of Parliament.

the full diplomatic corps, and the UN family, should work with the government of Uganda to intensify their efforts to safeguard Uganda's constitutionally protected human rights to liberty, assembly, association, and health.

1a. Intensify advocacy for improved policies, laws, and an enabling political environment

PEPFAR should accelerate its advocacy for "improved KP friendly policies, legal reforms, and an enabling political environment,"¹³ an action step PEPFAR committed to in Uganda's 2022 Country Operational Plan, emanating from the Legal Environment Assessment (LEA) carried out in 2022. This LEA, which was supported by Uganda's Ministry of Health, also identified that the human rights of KPs were routinely violated, including the right to equality, freedom from discrimination, the right to health, access to justice, freedom from torture, cruel and inhuman treatment, the right to work, the right to privacy, confidentiality and informed consent.¹⁴

+ **COP23 TARGET:** the US government, including PEPFAR, should intensify its public advocacy to improve the legal, policy and human rights environment for KPs in Uganda.

1b. Expand funding to KP-led organisations and networks

Funding allocated to Key Population (KP) organisations for essential advocacy, improving laws and policies, providing quality services, and promoting community leadership is insufficient. While larger PEPFAR-funded prevention and/or care and treatment Implementing Partners (IPs) frequently subcontract indigenous KP-led organisations to provide critical services, such as HIV testing, loss-to-follow-up prevention, and community outreach, KP implementers report inadequate compensation for time and programming; and working in hazardous conditions, including the risk of police harassment.

+ **COP23 TARGET:** PEPFAR should expand sub-granting to KP organisations and networks, through direct funding, investment in consortia, and support for results-based program funding as well as coordination of KP-led indigenous CSOs.

+ **COP23 TARGET:** accelerate KP size estimates, including a focus on trans Ugandans.

1c. Expand KP-led service delivery

While HIV prevention and treatment services for Key Populations (KPs) have been extended in Uganda, challenges such as linkage to treatment, retention in care, and viral load

suppression persist. The primary driver of these obstacles is the prevalent stigma in healthcare facilities, which is further fueled by the current model of relying on referrals of KPs to clinics that serve the general population.

A recent Community-Led Monitoring (CLM) exercise that focused on Key Population (KP) service delivery and service accessibility found that stigma and discrimination against KPs are significant challenges across both facility and non-facility-based healthcare delivery settings. The assessment also revealed that 94% of Drop-In Center (DIC) managers interviewed believed that receiving all services from the same DIC contributes to improving service delivery efficiency.¹⁵ Additionally, the biggest challenge for linkage of DIC clients to health facilities was the lack of transport funds to reach health facilities (79%), followed by clients' fear of going to the facility where they are referred (65%).¹⁶ Moreover, DIC managers report they do not have flexibility in using their expertise to develop or refine a service delivery model that works best for communities and instead are prescribed a set of actions by IPs—a move which undermines effectiveness and fails to leverage the expertise of communities.¹⁷

The current service package for Key Populations (KPs) is often suboptimal, as non-KP-focused clinics lack the full range of services that KPs require, and KP-led Drop-In Centers (DICs) need more funding to provide comprehensive services in their facilities. In Uganda, the Key Population Investment Fund (KPIF) was a groundbreaking initiative that facilitated significant involvement and engagement of KPs in service delivery and capacity-building. However, the decision to shut down KPIF by PEPFAR, with no clear plan to sustain its programs, has dealt a significant blow to the KP community, which is still struggling to recover from its impact.¹⁸

+ **COP23 TARGET:** In the COP22 final Strategic Direction Summary, PEPFAR committed to fund full operationalisation and accreditation of all KP-led DICs¹⁹ to provide clinical and preventive HIV and STI services, including antiretroviral treatment, in order to improve linkage, retention, viral load suppression and reduce human rights violations. This promise has not been kept. It should be carried out immediately.

+ **COP23 TARGET:** Beyond compliance with core standards, IPs must explicitly grant KP-led DICs the flexibility they need to implement service delivery models that ensure clients are safe and comfortable, and access quality services with dignity.

1d. Accelerate expansion of harm reduction services

Uganda has progressively expanded provision of MAT and other harm reduction services through the program in Butabika, but the program is not performing well, having achieved only 59% of the MAT_PREV target.²⁰ The expansion of MAT services in Mbale, committed to in COP22, is currently hindered by inadequate demand

13. Ibid p 189

14. supra note 7, slide 101

15. Key Population Voice of 1,000: Access to Healthcare Services in Uganda. January 2023, p 8

16. Ibid p 15

17. supra note 23, p 7

18. cf *Where is PEPFAR's Strategy for Key Populations?* p 6

19. supra note 11, p 104

20. supra note 7, slide 95



from communities despite the presence of more than 1600 people who use and inject drugs (PWIDs) in the region.²¹ Community engagement should be strengthened as a priority in order to ensure the improvements in program performance that are greatly needed.

- + **COP23 TARGET:** Expand funding for community-led demand creation, livelihood support, and advocacy interventions led by PWID communities for both the Butabika and the new Mbale MAT Facilities respectively.
- + **COP23 TARGET:** Harm Reduction DICs within Kampala and Wakiso must be supported by PEPFAR to improve PWID linkage to and retention on MAT and other prevention services, to improve services uptake and retention in care through PWUD community mobilisation and empowerment
- + **COP23 TARGET:** Support MAT innovations, including MAT dispensing “spokes” and mobile van dispensing models to improve MAT accessibility in communities.

1e. Expanding Services for Priority Populations

In order to reach 95-95-95, PEPFAR and the GoU must prioritise implementation of new efforts to overcome barriers to quality treatment, combination prevention, and access to accurate HIV and health information for fishing communities and their children, given their pronounced unmet need for treatment and combination prevention services.

- + **COP23 TARGET:** Support development of a comprehensive, community-designed and community-led combination prevention and treatment program targeting fisherfolk and their children, which will address unmet need for biomedical and structural prevention interventions as well as innovations to overcome their daily struggles in accessing uninterrupted, quality HIV treatment and care.

21. supra note 7, slide 96

“Yes, the facility does a good job in serving youth because there are DREAMS focal persons and DREAMS peers who are our contacts in accessing health services in all these facilities. On the other hand it becomes difficult to access health services from these facilities especially when you go to the facility and find our DREAMS focal person and DREAMS peers absent. We become stigmatised by health workers who actually don’t know us,” —AGYW focus group participants who receive services from Ngoma HC IV, Kikooma HC III, and Katikamu HC III

2. Prevention for adolescent girls and young women: DREAMS and beyond

The National Health sector strategy guides implementation of AGYW programs; despite this and the Global Fund and PEPFAR’s commitment of funds for HIV prevention for AGYW, young people 10-24 years are more vulnerable to HIV infection with 43% of new HIV infections occurring in this age group. AGYW are even more vulnerable; four in five (75% or 15,000 of 20,000) of new HIV infections in young people occur in adolescent girls and young women aged 10-24 years.^{22,23} Results from UPHIA 2020/21 show that AGYW (15-24 years) had the highest HIV incidence rate at 0.62% compared to all other age groups—0% for young men of the same age and 0.29% for adults 15+ years.²⁴ Flattening this inequity and providing HIV negative AGYW the comprehensive biomedical and structural prevention interventions they require to reduce their unacceptable vulnerabilities to HIV acquisition should be a priority focus of COP23.

AGYW seeking prevention services experience a range of barriers, from limited prevention options for HIV prevention and other STIs, to suboptimal linkage to confirmation testing for HIV self testing (67%), to the sex partners of AGYW often being unwilling to seek services.

Based on modelling data from Spectrum, 62 districts with a high HIV incidence (0.4% or more) among AGYW were identified and prioritised for targeted AGYW interventions under the DREAMS initiative. During the reporting period, only 44 (71%) of the 62 districts received a comprehensive package of interventions for AGYW.²⁵

Community evidence reveals that a peer approach is critical to ensure linkage with prevention services and other support services. AGYW have felt comfortable to access services when DREAMS Ambassadors and YAPS are their point of contact.

When compared to the population of AGYW in the country (approximately 7.5 million), the efforts supported by DREAMS are still very inadequate.

There are approximately 18 high incidence districts that have not been reached with DREAMS or similar AGYW programs. Mechanisms for referral and tracking referrals are very weak. There is poor access among DREAMS participants to comprehensive access to sexual and

reproductive health and rights (SRHR) services, due unfriendly policies, poor care provider attitudes and stock-outs. There is inadequate access to and knowledge about PrEP; poor access to violence prevention and justice services for gender based violence (GBV) survivors; and low DREAMS completion rates across age bands, due to lack of program relevance and impact.²⁶

Promising innovations being explored in COP21 and COP22, such as expanded socioeconomic support (SES), education subsidies, and linkage of DREAMS participants with jobs that pay a living wage²⁷ are extremely important and should be urgently taken to scale in COP23.

+ **COP23 TARGET:** Building on commitments made to civil society in COP22 to adapt DREAMS,²⁸ increase funding for enhanced/robust socio-economic strengthening, employment training and linkage to waged employment, as well as education support to 100% of DREAMS participants screened to be at risk of dropping out of school starting with the worst performing Districts.

+ **COP23 TARGET:** Expand DREAMS programs to 18 high incidence Districts currently not reached with similar AGYW interventions.

22. Joint Annual AIDS Review Report, November 2022

23. Uganda HIV/AIDS Fact Sheet, Uganda AIDS Commission, UNAIDS (2022).

24. supra note 8

25. Joint Annual AIDS Review Meeting Report, November 2022

26. As noted in the *COP22 People’s Voice*, “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’ (see FY21 Quarter 4 POART, slide 11). 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,” p 22

27. supra note 7, slide 132

28. supra note 11, p 86-87



“No, the facility doesn’t do good job serving youth because most health workers are unfriendly to us, whenever our DREAMS peer is absent at the facility we don’t receive our service—health workers tell us to wait for him to come back then we can be able to access our services at the facility through him,” —DREAMS participant, Luwero Hospital

+ **COP23 TARGET:** Increase funding to support a range of PrEP options, youth friendly family planning services, and GBV services for all DREAMS participants, focusing on expanding successful models of peer-led service provision. PrEP provision in DREAMS safe spaces should be funded so that it can be taken to scale in COP23.

+ **COP23 TARGET:** Expand PrEP for AGYW with increased targets. In COP22, the targets increased from 38,634 to 70,196. In COP23 the increase should be at minimum to 140,392 AGYW.

+ **COP23 TARGET:** Increase funding so that 100% of DREAMS programs can provide a complement of relevant secondary services including family planning services.

3. Youth-Friendly HIV Treatment Services

The disproportionately high rates of loss to follow up and HIV treatment interruption, poor viral load suppression, high rates of mortality and advanced HIV disease, and high rates of stigma and discrimination among young people living with HIV must be corrected as a matter of urgency in COP23.²⁹ For example, only 65% of young women with HIV aged 10-19 are on treatment and only 60% are virologically suppressed, compared with 112% and 97% of women with HIV aged 40-49, respectively.³⁰ Young men 20-24 years also have low rates of viral load coverage at only 87%.³¹

Treatment interruptions are routinely attributed to non-disclosure, stigma, pill burden and side effects of ART. Adolescents are also grappling with socio-economic challenges including no means of self-reliance yet the current economic empowerment programs targeting adolescents exclude HIV positive young people.

In COP22, PEPFAR Uganda committed to rolling out the Young Adolescent Program Support (YAPS) program to remaining districts where YAPS had not yet been introduced in order to reduce high rates of interruptions in treatment (IIT).³² But even where YAPS is implemented, facility coverage of YAPS is limited to only a few high-volume sites.

+ **COP23 TARGET:** Accelerate YAPS scale up planned in COP22 to 100% of districts, and expand YAPS coverage to multiple strategically located facilities, beyond the highest volume sites.

+ **COP23 TARGET:** Reach 100% of eligible young people with MMD and all Differentiated Service Delivery (DSD) options that reduce IIT and improve outcomes for young people.

+ **COP23 TARGET:** Expand access for all young people with HIV to peer-led support and counselling to address stigma, non-disclosure and other common barriers adolescents face.

29. CLM sites reporting lack of or inadequate access to youth friendly services including youth corners include: Kibaale HC IV, Mbarara Municipal Council HC IV, Siipi HC III, Mugarama HC III

30. supra note 7, slide 17

31. supra note 7, slide 53

32. supra note 16, p 4

4. Expanding Community-led Monitoring (CLM) for Impact

CLM is an invaluable tool used by independent communities to increase accountability of funders of the HIV response including PEPFAR to those most affected by HIV, and to improve service delivery accessibility and quality. CLM improves true program sustainability, by challenging duty bearers to engage with community evidence and simultaneously building the power of national and sub-national civil society and community structures. Uganda's CLM program continues to expand. New requests emerging for CLM focused on the HIV response for children and their caregivers, for example, creates important opportunities to improve access to quality services, but also creates substantial new obligations.

Through CLM, service providers, implementing mechanisms and other duty bearers have an opportunity to receive constant feedback on the quality, comprehensiveness, availability, accessibility, and affordability of HIV/TB services in the country. Service providers are able to get information on what models are working, which ones are failing and best practices that can be duplicated in another setting.

CLM relies on the systematic collection of data and the use of that data to advocate for change. This is necessary in order to overcome the most important challenges Uganda is facing

in its AIDS response and to strengthen the impact of PEPFAR, Government of Uganda, and Global Fund funded programs.

+ **COP23 TARGET:** PEPFAR should increase the annual CLM budget to \$2.0 million at minimum to support national expansion and build on program impact. Increased funding will be invested in strengthening the current CLM program (\$300,000), strengthening CLM for key populations programming (\$300,000) and building out a CLM paediatrics program (\$200,000).

5. Scaling Up Access to Pre-exposure Prophylaxis (PrEP)

COP22 supported a surge in PrEP_NEW targets in Uganda, from approximately 100,000 people in COP20, to 130,000 in COP21 and 180,000 people in COP22. This surge should continue, alongside geographic expansion and increased budget, in order to continue to extend access to this critically important biomedical prevention tool, particularly for key populations, AGYW, and pregnant and breastfeeding women.

5a. Increase Community-led Demand Creation

CLM data show that there are many clients who want to access PrEP but lack information, transportation to reach PrEP sites, and have limited PrEP choices. While demand for PrEP in Uganda is reasonably high, it could grow higher if PrEP was rolled out as a national program and if there were robust PrEP literacy interventions targeting people at substantial risk of HIV infection and health workers. Bringing PrEP access closer to communities is a high priority in Uganda, from educational institutions, to community pharmacies, YAPS corners, DICs, and DREAMS safe spaces. Pushing PrEP beyond the health facility setting is an important strategy that should be pursued aggressively in COP23.

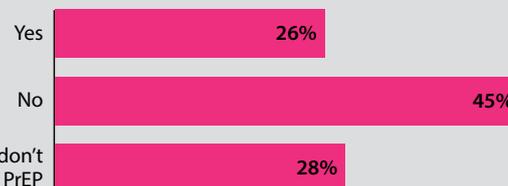
+ **COP23 TARGET:** Increase PREP_NEW targets to continue current momentum, from 180,000 in COP22 to 250,000 PREP_NEW, building on the 50,000 increase from COP21-COP22. These targets should support geographic expansion to new facilities and new districts.

+ **COP23 TARGET:** PrEP literacy programs led by AGYW, KPs, and other community ambassadors must expand with PrEP ambassadors employed at each site where PrEP is available. Health workers must also be targeted for ongoing training, so that proportion

of KPs, AGYW and pregnant and breastfeeding women screened, determined to be eligible and linked to PrEP continues to increase rapidly.

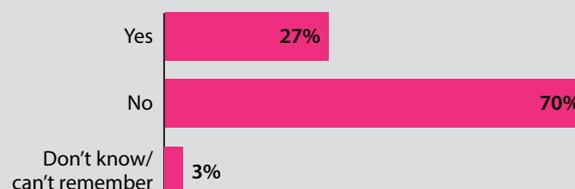
Do you know where to get PrEP in case you need it?

Patients surveyed: 11 744



Have you tried accessing PrEP at this facility?

Patients surveyed: 3 594





5b. Fund a Robust PrEP National Referral Network

Despite expanding PrEP targets, PrEP is currently restricted in its availability—not all facilities and not all Districts offer PrEP. In COP22, PEPFAR committed to rolling out a national referral system but it has not been created. CLM findings indicate lack of funds for transport to a site where PrEP is provided is a major barrier to access.

+ **COP23 TARGET:** PEPFAR should fund a coupon-based or other simple system for eligible clients to get free, rapid initiation on PrEP if they are forced to travel to a site where PrEP is provided.

5c. Fast Track PrEP innovation in products and service delivery models

Likewise, communities want choice to facilitate uptake, including access beyond oral PrEP, to the vaginal dapivirine

ring (DVR) as well as injectable PrEP. Uganda's PrEP program should prioritise rolling out WHO guidance on simplified PrEP implementation, MMD for PrEP and event-driven PrEP. DVR is included on WHO's list of prequalified medicines and should be made available to AGYW in Uganda who prefer that method. Injectable PrEP 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.

+ **COP23 TARGET:** PEPFAR and MoH should fast track implementation of new WHO Guidance on differentiated and simplified PrEP, including the community PrEP pharmacy model.

+ **COP23 TARGET:** Support PrEP delivery that is peer led, to increase demand and prevent stigmatisation of PrEP services.

+ **COP23 TARGET:** PEPFAR should support acceleration of roll out of CAB LA and the DVR including participation in pooled procurement, supporting roll out of information package on DVR and CAB-LA and training of health workers).

6. Perinatal HIV: Prevention and Treatment

One of the most glaring disparities in the HIV response in Uganda is the failure to meet the HIV prevention, testing and treatment needs of pregnant and breastfeeding women and their infants. While Uganda's PMTCT program has secured declines in transmission and access to PMTCT services, major gaps remain.

Challenges pregnant and breastfeeding (PBF) women and their children face include: stigma and discrimination (particularly for PBF women who are KPs) lack of access to quality antenatal services during pregnancy and breastfeeding, IIT throughout pregnancy and breastfeeding, as well as high rates of HIV incidence during pregnancy and breastfeeding due to the lack of tailored combination HIV prevention services, especially for AGYW. HIV incidence during pregnancy and breastfeeding is still high and should be a focus of attention.

AGYW, tailored to their evolving needs and integrated with comprehensive sexuality education (both in and out of school), and with sexual and reproductive health services (including contraception) and rights.

6b. Preventing perinatal transmission

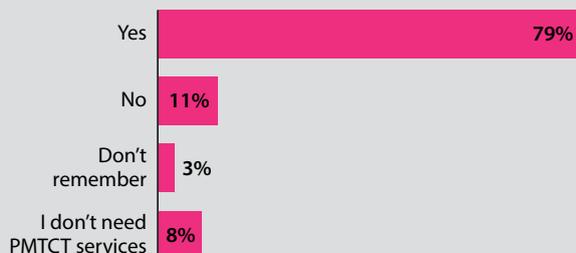
Women receiving ART who are pregnant or breastfeeding, require additional interventions and support—particularly AGYW who are at disproportionately high risk of transmitting HIV and whose rates of viral load suppression while pregnant and breastfeeding are disproportionately low and whose rates of IIT are high.

CLM and PEPFAR program data indicate persistent barriers including unacceptably long turnaround time for returning PCR test results to HIV exposed infants, health facilities not simplifying appointments for mother-baby pairs, along with lack of availability of ART refills at HCLIs where the vast majority of women seek ANC services. Treatment literacy among caregivers of HIV positive infants is extremely low, with CLM data showing only 29% of children had had a viral load test and only 39% of caregivers reported understanding their child's viral load test results. Finally, electronic medical records are extremely rare among even high volume ANC facilities HIV positive women use for maternal health services, making tracking mother-baby pairs who are lost to follow up more difficult and decreasing their quality of care.

- + **COP23 TARGET:** Scale up intensive peer-led support from HIV positive mothers to 100% of PBF women with HIV at PEPFAR supported sites including provision of treatment literacy, transport funds to reach clinic visits, nutritional support, and supportive case management to reduce IIT and viral load non-suppression.
- + **COP23 TARGET:** PEPFAR should support the Ministry of Health to revise the national VL policy to allow 3-monthly VL monitoring for PBF women.

In the past 3 months, did a health care worker at this facility talk to you about taking HIV treatment while pregnant (also called PMTCT services)?

Patients surveyed: 1 880



Were you able to get eMTCT/PMTCT services at the facility?



Further support in COP23 in Uganda for the AP3 (Accelerating Progress for PMTCT and Pediatrics) initiative represents a critical opportunity to address this crisis. This will build on the "surge" support that was funded in Uganda through COP22 as part of PEPFAR's 7-country initiative to intensify efforts to end paediatric HIV.

6a. Preventing infection during pregnancy and breastfeeding

To close the gaps in PMTCT, combination prevention services, particularly for AGYW, must be brought to scale.

- + **COP23 TARGET:** Increase PEPFAR funding for a package of testing/retesting services and combination prevention services including PrEP for all pregnant and breastfeeding women with particular focus on

6c. Pediatric Diagnosis and Treatment

Even though COP22 committed to completion of the roll out of paediatric DTG by October 1 2022, by Q4 only 83% of children <20 kgs had been transitioned.³³ Other challenges with access to HIV diagnosis and treatment services for paediatrics include; long turn around times for PCR and viral load tests that has subsequently led to the low uptake of 2nd and 3rd PCR tests, stock outs of essential diagnostic supplies including test kits as well as stigma and discrimination that can lead to caregivers inconsistently providing their HIV exposed infants with HIV prophylaxis.

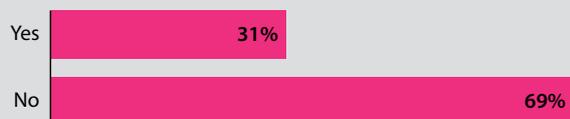
33. supra note 7, slide 48

Orphans and vulnerable children living with HIV have unique challenges especially with staying on treatment. Some of the challenges include; lack of access to food, negligence of care givers, delayed viral load results to inform clinic diagnosis, and no efforts by clinicians to follow up and closely monitor non-suppressed children for AHD and drug resistance.

Importantly, Uganda’s expansion of POC EID coverage has been associated with progress in achieving increased PCR testing coverage at 2 months, at 94% for Q4 2022.³⁴

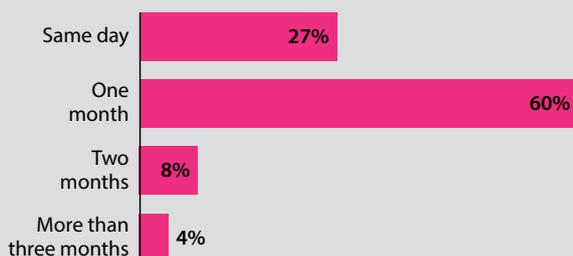
Does the clinic merge your appointment with your baby’s appointment?

Patients surveyed: 548



How long did it take for you to receive the HIV test results of your HIV exposed infant back?

Patients surveyed: 961



Orphans and vulnerable children living with HIV have unique challenges especially with staying on treatment. Some of the challenges include; lack of access to food, negligence of care givers, delayed viral load results to inform clinic diagnosis, and no efforts by clinicians to follow up and closely monitor non-suppressed children for AHD and drug resistance. At least 8,733 children still remain non-suppressed³⁵ due to low levels of treatment literacy, lack of support for caregivers, and stockouts of medicines.

+ **COP23 TARGET:** Scale up POC EID for infants, continuing to strive for 100% coverage, beyond the current split of 45:55, focusing on machine placement to increase equitable access.

+ **COP23 TARGET:** 100% of PBF women living with HIV should be given the option of pairing their child’s appointments with their own and being tracked as a pair in clinical care.

+ **COP23 TARGET:** Further accelerate accreditation of HCIs to an additional 400 facilities (totally 1350 HCIs), in order to provide ART where the majority of women receive ANC services and build on the progress that will finally be made in COP22.

+ **COP23 TARGET:** Ensure 100% access to DTG for children < 20 kgs and > 20kgs.

+ **COP23 TARGET:** Implement an integrated community service delivery model focusing on supporting families to address household issues resulting in poor clinical outcomes for all HIV positive children (lack of access to food, money for transport, etc).

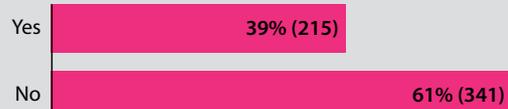
Have you ever taken your child for a viral load test?

Patients surveyed: 576



Do you understand your child’s viral load results?

Patients surveyed: 556



6d. Accelerate HBV testing and treatment as part of triple elimination among PBFW and children

PEPFAR in COP22 committed to investments in testing for hepatitis B (HBV) as part of triple elimination of HIV, syphilis and HBV among women living with HIV. CLM data indicates that even when mothers are willing to test their children for HBV and to vaccinate at 87.10% and 75.53% respectively, there is inadequate knowledge about the comprehensive eMTCT package of HIV, HBV and syphilis services. Challenges with the quality and accessibility to HBV services documented in CLM data include; information on HBV testing is not rendered as part of routine health talks, no specific IEC materials on HBV in place, women are tested for HBV without their knowledge and most cases that outcomes of the testing are not provided. Information on vaccination for HBV is not rendered in the majority of CLM sites; neither were there any efforts demonstrated for referral or linkage to other points of care.

+ **COP23 target:** Invest in community designed demand creation and sensitization regarding HBV.

+ **COP23 target:** Procure and rollout the HBV birth dose.

34. supra note 7, slide 69

35. CPHL Viral Load Dashboard



7. Stop Interruptions in Treatment (IIT) and Expand Peer-to-Peer Treatment Literacy

Despite progress in addressing IIT, 25,838 people still experienced treatment interruptions in 2022 Q4, an underestimate due to the fact that only 72% of PEPFAR supported sites report IIT currently. Deep dives into 15 health facilities reporting consistently high rates of suboptimal viral load show 1) regional disparities and 2) lack of suppression was consistently linked to poor follow up, lack of access to DSD, and sub optimal regimens.³⁶

+ **COP23 TARGET:** Immediately audit national treatment cohort to identify PLHIV still on non-DTG based regimens, and connect them with counselling regarding switching and linkage to PLHIV-centered DSD models.

During COP22 negotiations PEPFAR and the Government of Uganda committed to expanding treatment literacy programs focusing on the districts contributing to 80% of IIT. In COP21 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).

7a. Treatment Literacy

Expansion of peer-to-peer treatment literacy programs is needed to address unacceptably high rates of IIT and persistently low viral load suppression in Uganda, particularly among key populations, adolescents, and adult men and among key regions with IPs that are underperforming in providing quality care and treatment. The most effective treatment literacy programs are designed and implemented by PLHIV themselves, and are distinct from information and educational campaigns and materials which are already well funded in Uganda.

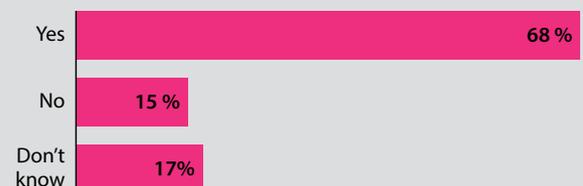
People answered when asked “Undetectable viral load means the treatment is working well”

Patients surveyed: 629



People answered when asked “Undetectable viral load means a person is not infectious”

Patients surveyed:



+ **COP23 TARGET:** PEPFAR should increase funding to \$2 million to implement a national community designed and led treatment literacy program to reach facilities that represent 80% of IIT. This program must be designed and led by PLHIV in all their diversity—men, women, key populations, young people, and people with disabilities.

36. supra note 7, slide 55

8. Preventing Deaths from TB, Cryptococcal meningitis and Cervical Cancer

8a. Tuberculosis

Tuberculosis is the leading cause of HIV-related deaths because of lack of timely diagnosis and treatment. TB treatment coverage has reached 60% while TB case finding has declined by 0.2% in 2017. The rate of decline has decelerated since 2016.³⁷ Whereas there has been a reduction of TB mortality rates from 19,000 in 2021 to 16,000 in 2022, this is unacceptably high and below the NSP targets of reducing TB deaths by 75% by 2025. Transition from INH to 3HP is also not to full scale. 100% of facilities monitored through CLM are still offering INH for TB prevention.

- + **COP23 TARGET:** Roll out 3HP for TB prevention among PLHIV.
- + **COP23 TARGET:** Introduce the 4 month drug-sensitive TB treatment regimen using rifapentine.
- + **COP23 TARGET:** Adopt and rollout 100% WHO recommended AHD package of care.³⁸
- + **COP23 TARGET:** PEPFAR should intensify efforts to roll out CD4 testing to reach full coverage for all TX_NEW from the current level of 55%. This effort should include children as well as adults.

8b. Cryptococcal meningitis

Globally, Cryptococcal meningitis (CCM) accounted for 14% of all HIV related deaths in 2020. Even with ART coverage, life threatening opportunistic infections continue. There is still resistance from national HIV programs and global health actors to prioritising investments in diagnosis and treatment of life threatening opportunistic infections.

Key gaps in rendering CCM services in Uganda include (i) treatment for CCM is not easily accessible (the services are centralised at regional referral hospitals which are difficult to access for people without any funding for transport) and (ii) lack of community awareness regarding CCM.

- + **COP23 TARGET:** Support training of cadres of community health workers to carry out community based follow up with people recovering from CCM and scale up points of care for CCM.

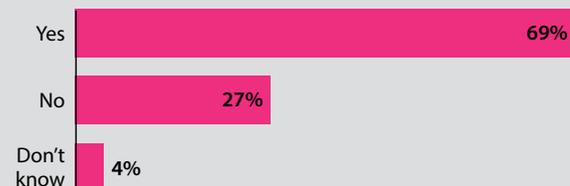
- + **COP23 TARGET:** Integrate CCM into routine SBC messaging and facility health talks
- + **COP23 TARGET:** Introduce the use of single dose Liposomal amphotericin B (L-AmB), accompanied by flucytosine for 2 weeks for the treatment of CCM.

8c. Cervical Cancer

Following discussions during COP22, CLM has found that cervical cancer screening is still being carried out in a way that does not promote access but instead discourages people with HIV from accessing the service. Services for managing confirmed cases (cervical cancer) are not readily available across the country—and where it exists it is expensive.

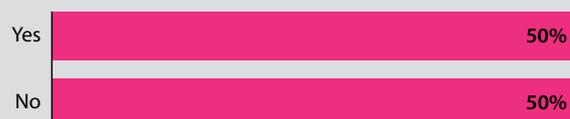
Is cervical cancer screening for women living with HIV voluntary?

PLHIV surveyed: 4 961



If no, is it a precondition for access to any services or clients can get other services without cervical cancer screening?

PLHIV surveyed: 1 168



- + **COP23 TARGET:** Invest in self-test kits for cervical cancer screening; and conduct last-mile distribution of self-test kits to DICs targeting sex workers.

37. https://pdf.usaid.gov/pdf_docs/PA00KGDD.pdf

38. WHO package of care for management of AHD: CD4 at baseline (all people initiated on HIV treatment and subsequent after 6 months); TPT (1 or 3HP–TB Preventive Therapy – 1 month or 3 months therapy); TB-LAM (TB test for those with low CD4 count); CrAg (test to detect Cryptococcal Meningitis for those with CD4 <200); fluconazole pre-emptive CCM treatment (1st line treatment for CCM); Optimal Cryptococcal Meningitis (CM) Treatment: single dose of liposomal amphotericin B (LAmB) with two weeks fluconazole/flucytosine for confirmed positive cases.

9. Supply Chain and Commodity security

During 2022 acute stockouts of third-line treatment following the shift of procurement from PEPFAR to the Global Fund, resulted in major disruptions in access to lifesaving medicines. Communities have no assurance that this will not keep occurring.

+ **COP23 TARGET:** Return procurement of second and third line treatment to PEPFAR to

prevent further harm to PLHIV centered care

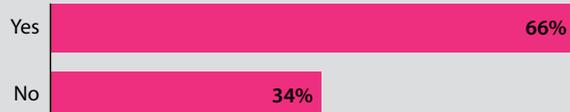
10. Human rights and structural interventions

10a. HIV testing

While community evidence and advocacy has helped improve the quality of Uganda's Index Testing program, adverse events are still occurring.

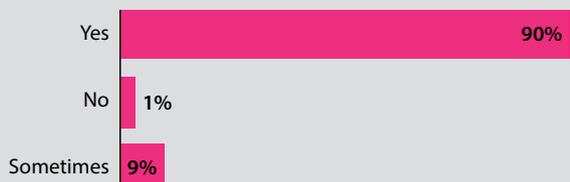
Did the healthcare worker tell you that you could say no or refuse to give the names of your sexual partners or children for HIV testing?

Patients surveyed: 5653



As part of index testing do you ask clients if they have experienced any violence from their sexual partners?

Facility staff surveyed: 476



+ **COP23 TARGET:** Invest in onsite and offsite violence prevention and response interventions resulting from index testing

+ **COP23 TARGET:** Invest in training of professional and

community health workers regarding human rights based approach to rendering index testing (training and training materials should include language around voluntary index testing, refusal to provide sexual contacts and close relatives or family members)

+ **COP23 TARGET:** Invest in follow up, monitoring and documentation of occurrence of adverse events following index testing and adverse events data utilisation for engagement at site level and decision making in TWG discussions

10b. People with Disabilities (PWDs)

PWDs are one of many vulnerable populations left out by the health systems in Uganda. Even when the persons with disability Act 2006 Section 7 (1, 3-a, b, c) and Section 8 (a) emphasise a health system that is responsive to the needs of PWDs, the health system has not been responsive to these needs. Some of the issues documented include; (i) service delivery tools are not being utilised to document the specific needs of persons with disability; and (ii) Community led organisations for persons with disability do not have the necessary capacities for compete for funding from such donors as PEPFAR, Global Fund among others.

+ **COP23 Target:** PEPFAR should conduct a service delivery audit to whether service delivery tools for PWDs are being deployed.

+ **COP23 Target:** Fund PWD-led organisations to roll out PWD- led programs including support for PWDs as CHWs for sign language interpretation and other essential services.

People with disabilities are one of many vulnerable populations left out by the health systems in Uganda.



11. Human Resources for Health

Gaps in human resources for health (HRH) have severe consequences for the health of Uganda's citizens across health areas—from reproductive, maternal, newborn, child, and adolescent health (RMNCAH), to the testing, treatment, and prevention of HIV, TB, and malaria. Without doctors, nurses, midwives, lab technicians, and other skilled professionals, Ugandans are unable to receive the health care they need in public health facilities in a timely manner and without compromise to quality. While some Ugandans turn to the private sector, where high out-of-pocket expenses can quickly chip away at household savings and income, others give up on seeking professional health care.

Staff shortages among doctors and midwives that provide maternal health services are a key reason that more than 17 pregnant women in Uganda die each day from preventable causes. Currently, only 49% of approved positions for doctors and 75% of approved positions for midwives are filled. Additionally, 30% of married Ugandan women still have an unmet need for family planning, many citing unavailable or inadequately trained healthcare workers, who often exhibit negative attitudes, as reasons for not seeking care in government facilities.³⁹ Meanwhile, Uganda has reduced its budget allocation for the health sector.

Poor remuneration and poor funding for the health sector drive this crisis, along with poor working conditions and failure to effectively motivate skilled health care workers. Likewise, staffing norms in Uganda have not been updated in decades, despite massive population growth. That were approved when Uganda had a small population and maybe the disease burden wasn't so big. PEPFAR, Global Fund and other Development Partners have supported Uganda to fill gaps in HRH. Civil society has urged the Government of Uganda to close the patient-skilled health care worker ratio with limited success. PEPFAR COP/ROP Guidance highlights the need for fair remuneration for health workers;

Do you think there are enough clinical and non-clinical staff at the facility?

Patients surveyed: 482



- + **COP23 TARGETS:** Review and change the staffing norms in the health sector (with input from key stakeholders), including CHWs, and monitor implementation
- + **COP23 TARGETS:** Complete GoU absorption of PEPFAR-supported health care workers
- + **COP23 TARGETS:** Strengthen the Community Health Worker model with a formal job aid, remuneration with a living wage, ongoing training and support supervision, and the tools required to work.

39. See: [Improving Human Resources for Health in Uganda](#), USAID



CLIENTS

21	101	M	20/01/2018	3.6	340	F	3591	40	361
22	102	M	20/01/2018	3.7	341	M	3592	41	362
23	103	F	20/01/2018	3.8	342	F	3593	42	363
24	104	M	20/01/2018	3.9	343	M	3594	43	364
25	105	F	20/01/2018	4.0	344	F	3595	44	365
26	106	M	20/01/2018	4.1	345	M	3596	45	366
27	107	F	20/01/2018	4.2	346	F	3597	46	367
28	108	M	20/01/2018	4.3	347	M	3598	47	368
29	109	F	20/01/2018	4.4	348	F	3599	48	369
30	110	M	20/01/2018	4.5	349	M	3600	49	370

HIV-EXPOSED INFANT VISIT SCHEDULE



SERVICES OFFERED

- OPD SERVICES
- MATERNITY SERVICES
- ANC
- STD MANAGEMENT
- TB MANAGEMENT
- SNC SERVICES
- FAMILY PLANNING
- IMMUNISATION
- IN PATIENT SERVICES
- LABORATORY SERVICES
- ENVIRONMENT SERVICES
- GROWTH MONITORING
- HIV TESTING COUNSELLING
- AND TREATMENT ART
- OUT REACH SERVICES
- POSTNATAL
- SCHOOL HEALTH EDUCATION AND COMMUNITY

ACTION PLAN FOR MUBENDE DISTRICT

ITEM	ACTION	WHEN	RESP PERSON
Formulation of the WhatsApp platform for the Network.	Sharing	10/9/2021	Prossy Mbabazi
Documenting advocacy issues	Presenting documented issues to the DHE for action	on going	DHE HIV focal person
Preaching the People's voice in the facilities we came from	Sensitization of the people's voice in facilities and PTA groups.	On ART clinic days	Trained Participants/Community monitors
Giving feedback	Reporting on findings/ progress/ non progress	quarterly/ as need arises	



