Uganda Network of AIDS Service Organisations (UNASO) • Infectious Diseases Institute • Uganda Young Positives • Community Health Alliance Uganda (CHAU) • International Community of Women Living with HIV/AIDS Eastern Africa • Center for Health Human Rights and Development (CEHURD) • Mama's Club • Uganda Network on Law, Ethics and HIV/AIDS (UGANET) • PATH • Uganda Network of Young People Living with HIV (UNYPA) • National Forum of People Living with HIV Networks in Uganda (NAFOPHANU) • Sexual Minorities Uganda (SMUG) Spectrum Uganda • AVAC • Coalition for Health Promotion and Social Development Uganda (HEPS Uganda) • Health GAP

Civil society recommendations: Uganda COP 2016
We appreciate the opportunity to engage with PEPFAR Uganda as well as the ongoing work of PEPFAR to increase access to prevention, treatment and care in Uganda. We need a 2016 COP that describes an ambitious road map to ending the epidemic in Uganda by 2030 and to achieving the 90-90-90 targets by 2020—creating an environment where human rights of vulnerable populations are promoted protected and defended at the same time. *Below are our priority recommendations and areas of concern.*

1. Uganda's Test and Start timeline
The draft SDS predicts that Test and Start will only begin in Uganda at some point in US Fiscal Year 2017 (which starts September 30 2016, implementing COP 2016). Civil society believes Uganda can and must move more rapidly toward Test and Start implementation: we recommend an immediate government announcement (before the end of May 31, 2016) of commitment to national roll out of HIV treatment for all, with prioritization in June placed on accelerated planning, commodities forecasting, health worker training, strengthening community-led support interventions, and disseminating updated circulars so that by the time of the Durban International AIDS Conference Uganda has started to *implement* Test and Start, beginning with 113,000 patients currently in pre-ART care. There is value in COP 2015 funding being spent *now* to implement Test and Start; more importantly all partners should work with Ministry of Health to support a more urgent roll out, using national government and Global Fund resources.

The Ministry of Health's internal antiretroviral treatment quantification analyses show that the implementation of Test and Start creates virtually *no* additional cost compared with current guidelines, and the additional patient load is marginal. For example, Test and Start is estimated to cost an estimated $7 million in commodities annually, or less than 1.8% of the overall PEFPAR budget. Finding people with HIV through testing and outreach is costly and time consuming—immediately enrolling and supporting people in quality treatment programs is the right thing to do, in terms of the scientific evidence, the clinical benefit and the prevention benefit. It will also save money. **Urgent implementation of test and start is a priority for civil society, and will help correct the negative trends in testing yield and the slowdown in new people enrolled on treatment.** Finally the COP indicates that FY2017 targets will be established assuming 39% (however described as 47% on p. 32) of pre-ART patients are enrolled into care ("adjusted for eligibility," see p. 19 - 20)—there is no reason 100% of pre-ART patients shouldn't be supported on treatment, since all will be eligible. We strongly recommend the pre-ART patient pool be completely enrolled on treatment.

Finally, the COP notes that under Test and Start, HIV negative people identified will be linked with "other prevention services." What specific services will be provided? (p. 29)

2. Correctly estimating the cost of Uganda's commodities gap—and closing it
The major factors that have a marked impact on the size of Uganda's gap in ART are *not* related to test and start—they are related to whether or not it is assumed that Uganda will a) get prices from NMS for 6 first line medicines that are not unnecessarily inflated (as is

currently the case—36% higher on average than benchmark global prices) b) Procurement and Supply Chain Management (PSM) costs charged by NMS are not unnecessarily inflated and c) whether or not Uganda's government contribution will be paid in full in antiretroviral treatment (for the last three years only $12 million of $28 million has been used to purchase ART). All stakeholders must work together to address these outstanding problems. We believe Uganda should show a commitment in writing to resolving each of these issues before the 2016 COP is fully approved and before the Global Fund HIV costed extension funding request is provided (see below).

3. Transition and focus

The draft SDS indicates that 11 out of 26 "Saturation" Districts—nearly half—already achieved their targets during FY2016; for COP 2016 their targets will not support scale up but only correction for attrition (p. 19). These "replacement" targets are *not* scale up targets. We recommend that COP 2016 appropriately adjust targets among all the scale up Districts (61 in total—"Saturation" and "Scale Up") so that additional Districts, starting with those with highest prevalence and highest unmet need for treatment, are assigned "Saturation" District targets for COP 2016—as 11 Districts "graduate."

Importantly, the COP 2015 targets for 'Net New' people enrolled in treatment were more ambitious than COP 2016 treatment targets,despite lower funding levels overall in COP 2015 (233,610 in 2015 compared with 214,250 in 2016).

Given the substantial increase in program funding for FY2017 over COP 2015 levels as a result of $30 million in impact funds, we recommend the COP 2016 treatment target be increased to give missing Saturation targets to remaining Scale Up districts, prioritizing SNUs most in need. Importantly relatively simple steps such as enrolling all people in pre ART care on treatment, rather than only 39%, is an early and urgently needed intervention that can correct these flawed targets.

Likewise, we remain extremely concerned that many of the 41 "Sustain" Districts have substantial numbers of people with HIV who do not know their status and who are not linked to care and treatment—as well as HIV negative people at high risk of infection who are not linked to high impact prevention interventions. For Sustain Districts with the worst coverage and yields, what specific strategies are IPs being instructed to adopt in COP 2016 to correct these yawning service delivery gaps? Finally, the COP incorrectly describes these 41 Districts as not having key population or "hot spot" considerations (p. 18)—and states that hot spot HIV testing will not continue in COP 2016 (p. 36). We are extremely concerned by this—and do not agree that key populations and hot spots do not exist in the 41 Districts. **This change should be modified so targeted testing is still possible in "Sustain" Districts.**

Substantial numbers of transitions of clinic sites are planned for the coming months that will have an impact on substantial numbers of people with HIV. During the COP 2015 review process, we specifically requested and were promised engagement in the process of site transition planning and implementation in COP 2015 but PEPFAR never followed this up—despite our requests in subsequent face to face meetings (in August 2015 and December 2015).

427 sites providing direct services are being transitioned *now* (p. 36 – 37) and we have no idea the level and quality of planning. **Civil society must be directly engaged in national transition policy and planning efforts—alongside government—which is essential for accountability and for not only that ensuring communities have timely access to correct information but also that PEPFAR has direct feedback from people who require HIV prevention and treatment services.**

4. Increasing and strengthening the Government of Uganda contribution

In order to end the epidemic, government must expand its investment in high impact interventions. We are astonished that for the last three years government has not spent all of

its 100 billion UGX investment for HIV treatment, on HIV treatment—this must stop and we must change reporting obligations of MoFPED and NMS so that such flagrantly inappropriate actions do not happen again. Why did no donor partner, Parliamentarian, or other actor detect and report this? We must ensure that NMS' prices for first line HIV treatment are competitive with international best prices, and that PSM costs are drastically reduced. The National AIDS Trust Fund has stalled because of conflicts regarding where the Trust Fund would be housed and what the scope of its uses of funding would be. This is unacceptable—before the PEPFAR 2016 COP finally is approved, we urge PEPFAR to secure assurance from MoFPED, MoH and other stakeholders that the 10th Parliament will work with partners to prioritize and expedite operationalization of the National AIDS Trust Fund.

Laws, policies and practices in Uganda undermine efforts to defeat stigma and discrimination against people with HIV and people at high risk of HIV infection, including the HIV/AIDS Prevention and Control Act as well as the discrimination criminalized including sex workers and men who have sex with men experience in health care settings. We urge PEFPAR to clearly describe these concerns in the 2016 COP and to intensify efforts to change the policy and legal environment, for example through public and private advocacy.

5. Making the Global Fund investment deliver maximum results

Global Fund grant efficiency and impact is essential and also helps stretch PEPFAR investments further. We are concerned by poor Global Fund grant performance, artificially inflated prices charged by NMS for PSM, and lack of leadership and accountability by government stewards of the HIV response. Regarding poor performance, during COP 2015, the Global Fund Office of the Inspector General (OIG) uncovered scandalous waste and inefficiency but not outright fraud. Civil society has drawn attention to these findings through advocacy, strategic communications, and engagement with Ministry of Health leadership (see for example http://www.healthgap.org/globalfunduganda) but problems persist. Before PEPFAR's 2016 COP is finally approved, we call on PEPFAR to request evidence that government has a) dramatically changed its public sector grant implementation structure and b) is committing personal responsibility at the Executive Management Level of the Ministry of Health to correcting massive weaknesses in performance. The 2016-2017 Costed Extension for HIV should include these policy recommendations, and should reflect an assumption that artificially inflated medicine and PSM costs are eliminated (see below).

6. Treatment program quality

We recognize that since COP 2015 PEPFAR has been working on tools and policies to improve retention in care, viral suppression, and overall program quality. SIMS data shows major weakness in Facility–Community linkages—including for key populations, in retention care for pregnant and breastfeeding women, and in the EID program among others. Access to viral load test results is also low due to attrition following testing. But corrective actions proposed clearly have not worked and proposals in the 2016 COP are vague (for example: "PEPFAR will improve facility-community linkages through development of a community-based care and support strategy with a focus on District Community Development Offices (DCDOs) and community-based organizations (CBOs).")

During the COP 2015 review process, $12.9 million was set aside to address these challenges through a new investment in community care and support for adherence and retention. We cannot understand what has happened since that time to improve this serious program weakness. **The 2016 COP should be amended to include a clear set of technical considerations for implementing partners about the actions required in order to improve retention in care, viral suppression, and improved program quality.**[1]

[1] From Uganda's COP 2016: "Retention among women initiating ART during pregnancy or breastfeeding is only 65% at 6 months and 69% at 12 months, compared to 79+% among other ART clients." LTFU is 21% at month 1 and 27% month 3. EID testing coverage increased from 46% (FY13) to 60% (FY15), far short of the 80% target.

7. Key populations, in particular criminalized populations including men who have sex with men and sex workers
As with COP 2015, we recommend the service delivery coverage targets be increased for prevention for men who have sex with men as there is no basis for the extremely low targets of 40% (p. 22) be increased to 80%. We also note that the population size estimate of 11,573 men who have sex with men (p. 7) is likely extremely conservative. We urge PEPFAR to continue hot spot testing in the 41 "Sustain" Districts in order to comply with its own policies and to improve HIV testing yields and to prioritize efforts to update population size estimates.

In 2015 SIMS data showed poor performance in delivering services to KPs and in community linkage for KPs. The COP 2016 must include more robust, concrete corrective actions. Likewise, key population prevention interventions proposed are very vague, and focus on setting up condom dispensers as well as low impact interventions such as 'message delivery' ("HIV prevention messaging services reached 942,474 individuals in FY15.") This is very disappointment. Where is the ambitious strategy to roll out access to comprehensive prevention and treatment for key populations in particular for criminalized populations with high rates of unmet need? We note that very little is known about unmet HIV prevention and treatment needs of people who use drugs in Uganda, and PEPFAR should work with partners to begin evidence based roll out of services to these populations and to close the knowledge gap (see attached note prepared by CHAU on harm reduction and people who inject drugs).

Regarding key population programming, the COP states that PEPFAR will work "with community peer networks, the program will support hot-spot mapping and will engage peers in program planning, mobilization, implementation and monitoring. PEPFAR will continue to support GSD training that addresses stigma and discrimination against LGBT. Sensitization trainings will address non-discriminatory service provision for KP and PLHIV**.** In COP16, PEPFAR will enhance service integration and leverage the LCI, and Advocacy for Better Health to empower civil society to advocate for better services for marginalized populations. PEPFAR will support the cascade of the GSD training for IP and other key stakeholders. PEPFAR will continue to assist the MOH to harmonize the KP health service providers training curriculum." The COP also states that Peer-peer approaches will be used to access testing and linkage services in key populations. This will be done in partnership with KP/PP networks and other appropriate community platforms (p. 29). **These descriptions are extremely general. Please describe which partners will be engaged, particularly at the community level, the budgets provided for these activities, the outcomes and deliverables associated with these interventions.**

8. Expanding access to PrEP in Uganda
In COP 2016 we support the access to PrEP proposed (to 3417 people) and we are extremely concerned that on May 13 in a face to face meeting this was described as an error in the COP. **Given the number of Ugandans, particularly adolescent girls and young women, men who have sex with men, sex workers, and transgender women in urgent need of this prevention strategy who are not being protected by current interventions, this target is appropriate and should be maintained.** In addition, we want to ensure engagement of civil society by PEPFAR as roll out moves forward. We look forward to reviewing and commenting on the the draft PrEP strategy in development before it is approved.

Only 21% of HIV exposed infants are tested by 8 weeks. Only 48% of sites met the EID testing standard. A review of EID registers demonstrated that only 27% of enrolled HEI had final outcome documentation.

9. Adolescent girls and young women

67 per cent of new infections in Uganda are among AGYW. COP 2016 must make progress in reducing the vulnerability of this population. We welcome the proposal of the COP 2016 to extend DREAMS Initiative interventions to all Districts. Please describe the budget available for this expansion. In addition, programming and strategies must acknowledge that young HIV negative women (and men) are not living in isolation; HIV positive young people and their communities must be reached with services, in particular treatment scale up, given extremely low coverage rates and the unique support and outreach needs of adolescents. We want to see COP 2016 take creative and bold measures to close this gap.

10. Medical male circumcision

we are extremely concerned by the negative trends in new VMMC and note that this is a result of attrition associated with new requirements for protection against tetanus infection. The COP 2016 should describe in more detail the steps PEPFAR and partners will take to ensure these requirements do not massively undermine the impact of this vital prevention intervention. We are concerned that national prevention targets will not be reached without more ambitious leadership and investment in the national VMMC program. Likewise, we note the decline in VMMC targets from FY15 (248,618 in COP 2016 compared with 492,019)—and that PEFPAR has clarified in writing to civil society that Central Funding will see an increase in the proposed targets. Central Funding comes late in the fiscal year and makes planning very challenging for IPs—could PEPFAR signal clearly now that Central Funding will be forthcoming, to minimize program disruption? In addition, please explain when access will be provided to the USAID OIG report on allegations of fraud in a VMMC implementing partner.

10. Service delivery targets

We are extremely concerned by the persistent negative trends in current targets for new treatment enrollment, new people with HIV identified and linked to care and treatment, and new voluntary medical male circumcisions. We support the approach of not reducing national targets but instead developing solutions to these problems, and civil society wants the opportunity to contribute new thinking and approaches that will strengthen the national effort and reverse these trends. This slowdown must be corrected as a matter of priority. We note the new strategy of focusing on support to the public sector by 2017 for new treatment enrollment but we have not been provided with evidence that unmet need for HIV services would be identified and addressed more easily and with better quality through public sector clinics rather than the NGO/Private Not for Profit (PNFP) sector which serves the majority of Ugandans with vital health services.

11. Proposed COP 2016 spending changes

A number of changes are proposed in spending categories for COP 2016, in particular a substantial increase in Management and Operations costs to $29,522,789 from COP 2015 (a $11,611,572). Health systems strengthening is increased to increase from $12,427,580 to $23,148,876 (a $10,732,296 increase). Please explain these increases—what impact will it provide and why is it a priority?

12. Process concerns

When we expressed concerns about changes in COP 2015 we were told we would have timely access to SIMS and MER data in order to assess impact and the need for corrective action if appropriate. While Uganda has received more data than some other countries, we still experience routine delays. Going forward, we request a clear schedule describing when we can expect materials, and explanation for delays.

In addition, engaging with PEPFAR Technical Working Groups was raised during meetings with civil society as a new opportunity to discuss ongoing concerns, questions and ideas. We would like to implement this immediately. We also note that civil society is not currently represented on Government organs where crucial policy and technical issues regarding

treatment and prevention are debated. We need support to gain access to those discussions, and would like to work with Ministry of Health, PEPFAR and other AIDS Development Partners to ensure consistent, appropriate and meaningful representation.

Finally, we request that the civil society platform for ongoing engagement with PEPFAR also be the vehicle for civil society monitoring of implementation of the DREAMS Initiative. Civil society needs to be kept abreast of progress and challenges regarding this important Initiative.

13. Core, Near Core and Non Core activities

We are concerned by several activities categorized as 'near core': SIMS data highlight inadequate capacity to implement and document GBV services at sites, although violence against women is a key contributor to HIV infection risk. (p. 15). Why then are the following high impact interventions classified as 'near-core'? (p. 56) "Offer prevention package for priority populations; GBV: Ensure programs are screening for GBV and offering post-GBV care using the MCH, OPD as entry points for screening; Make PEP available for all eligible clients; Address harmful gender norms, beliefs and practices." We strongly recommend these interventions be maintained as core, and be strengthened to deliver impact.

We applaud the ambitious shift to viral load monitoring and recognize demand for CD4 testing will diminish greatly; however please explain how people who need CD4 testing following treatment initiation will gain access to that service.

Finally, human resources recruitment and retention (in maintenance districts) and ART patient monitoring are both described as 'near core' (p. 55) but the health worker shortage is a rate limiting factor to scale up (including in "Sustain" Districts) and should be maintained as a core activity (perhaps with a lesser focus than recruitment and retention in other Districts however).

Annex A.

Harm Reduction – PWIDs and PWUDs

Research conducted by Harm reduction international titled "Harm Reduction Decade" published in the Lancet of March 2016, shows that about $100bn is spent on the war on drugs annually. If 7.5% of the global drug control funding were to be redirected to scaling-up harm reduction by 2020, there would be 94% fewer new HIV infections among people who inject drugs by 2030, and 93% fewer HIV-related deaths.

Drug use in Uganda is on the rise. It should be noted that drug use is predicted to rise by 25% by 2050 with most of the increase in developing countries. The HIV prevalence stands at 17% among people using drugs in Uganda. Uganda continues to take a punitive approach to HIV and drugs, using arrests, incarceration, forced HIV testing and disclosure of certain priority populations upon arrest, criminal penalties and compulsory detention to criminalise and punish drug users

There is growing evidence which indicates that drug treatment and counseling programs are far more effective in reducing drug addiction and abuse compared to

incarceration. Treatment like methadone, nalexone that can save lives of PWUDs/PWIDs is still illegal in Uganda. Such medically assisted therapy (MAT) is a treatment for persons who are addicted to heroin using prescribed medication; unfortunately, this kind of treatment is prohibited in Uganda

COP 2016 should emphasize responsive treatment which encompasses the 9 harm reduction interventions which Uganda has not embraced. With Uganda's new HIV infection rate that stands at 300 people per day, there is need to build capacity but also engage with Government on provision of Harm Reduction Services to people injecting drugs including provision of MAT but also embrace needle, syringe program. It should highlight the need for including harm reduction interventions in polices and guidelines as per World Health Organization guidelines. Not to criminalize, stigmatize and discriminate people using and injecting drugs but rather emphasize the importance of providing services to all if Uganda is to end HIV/AIDS by 2030

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