National HIV Prevention Committee Report on the Development of a Domestication Plan Meeting for the Global 2025 HIV Prevention Roadmap 10-14/01/2023

Introduction

Consequent to the 2021 United Nations High-Level Meeting on HIV and AIDS, a new Global HIV Prevention Roadmap 2025 has been released to provide countries with the needed guidance for improving HIV prevention. The Global 2025 Road Map builds on the previous HIV Prevention 2020 Road Map and responds to the need for more decisive action against the inequalities that hold back progress. The 2025 Road Map focuses on scaling up the primary Prevention of HIV infections and introducing the policy, legal and societal enablers to prevent people from acquiring HIV infection. It also highlights the considerable complementarity and interaction between primary HIV prevention, testing, treatment, and the Prevention of vertical transmission of HIV. It introduces a new set of targets and commitments and charts ten essential country-level actions towards a more data-driven, precise, people-centred, scaled and innovative prevention response.

Overview of the meeting

To operationalize the Global 2025 Prevention Road map at national and sub-national levels, there is a need to develop immediate actions for domesticating the Global HIV Prevention Road map in Uganda. More so, this also calls for the need to deliberate on priorities and steps needed to domesticate the road map and conduct Country HIV Prevention Program Self-Assessment for the AGYW and CCP Pillars to agree on priorities for the Global fund NFM4 Application. Therefore UAC, with financial assistance from TASO, and Technical support from UNFPA, UNICEF and Alive Medical Services, UPS, ICWEA, MILDMAY, UNYPA, BUTABIKA NRMH, MOH, MoGLSD, HEPS, AWAC, UNICEF, Spectrum Uganda and UNESCO, a meeting with the National Multi-sectoral HIV Prevention Committee (NPC) was conducted to bring together ideas to agree on the immediate priorities and actions needed to domesticate the road map. The meeting was held at The MANSION Hotel JINJA from 10th to 14th January 2023. Using PowerPoint presentations and brainstorming discussions, the meeting was moderated by Dr Elizabeth Kihika. She led the discussions within the context of the Global Coalition for HIV Prevention 2025 roadmap launched at the International AIDS conference. Different milestones, priorities and action points were generated from the discussions.

Methodology

The meeting started with reviewing the HIV Prevention Self-Assessment Tool, where two teams worked on different sections of the tool. First, the HIV Prevention Self-Assessment Tools (PSAT) were used to self-assess the progress made on comprehensive prevention programming. The overall aim of the review of the PSAT was to help define the performance of the HIV programme against a global standardized set of programmatic components, thereby allowing them to prioritize where additional assistance, resources or other investments are required. The review of the self-assessment PSAT tool was done by looking at the following five HIV prevention pillars:

1. Strengthened national condom and related behavioural change programmes (Condom);
2. Combination prevention programmes for all key populations (KP);
3. Offering pre-exposure prophylaxis (PrEP);
4. Voluntary medical male circumcision (VMMC); and
5. Combination prevention for adolescent girls, young women and their male partners in high-prevalence locations (AGYW).

From the PSAT, the following HIV prevention components needed attention regarding HIV programming. In addition, the program areas were reviewed regarding program management, implementation, and outcomes.

Condom Programming priorities (PSAT)

Element that needs to be addressed	**Reason for low performance**	**Proposed actions (e.g. support required or corrective actions)**
Government Capacity to manage a total market approach (TMA)	• Limited resources from the government for market analysis and programming activities, e.g. demand creation	• Advocacy and stakeholder engagement, lobby meetings for resource allocation, especially for programming activities
M&E strategy	• The M&E strategy and framework are still under development	• Finalize, validate, and roll out the M&E framework
Data collection, analysis, management, and use	• Suboptimal reporting by cost recovery and no data is reported from the commercial side. • Only distribution data from the national bodies (JMS and NMS) exists. • Only about 20% of condoms distributed at health facilities are reported under family planning.	• Adopt and institutionalize tools to capture data for both community-level and private sector (Develop, pilot, and conduct mentorships and performance reviews)
	• Partially done for cost recovery and non-existent for the commercial sector	• Operationalize the distribution guidelines nationally
	• Limited commitment and prioritization from the government to the TMA in terms of resources for market analysis and programming activities, e.g. demand creation and stigma attached to condom programming.	• Conduct market surveys to identify the information needs and preferences
	• Limited engagement of all sectors to collect the data	• Strengthen PPP(Representative TWG, dedicated Focal person to coordinate the private sector and explore the need for incentives)
	• The data collection tools are not fully integrated into relevant points of care in the facility	• Integrate Condom data collection tools at all relevant points of care(Review tools to integrate parameters for condom utility in existing tools)
Budget support	• Existing funding, which is exclusively external, has a limited component dedicated to condom programming activities, e.g. demand creation, targeted distribution market analysis	• Advocacy and stakeholder engagement, lobby meetings for resource allocation, especially for programming activities.
	• The country has no SBCC-dedicated programs for condom use	

Behavioural data used to inform demand-creation activities	• to inform behaviour change interventions for priority populations • Risk factors are measured, but they don't show a significant improvement • No dedicated program strategy to drive intervention design for segmentation by demographic, behaviour though under development • There are no standard operating procedures to guide interventions for prioritized populations • There are no communication strategies to guide interventions for prioritized populations • There is no clear guidance to support coordinated outreach reaching prioritized populations • Inadequate support for last-mile distribution to get a community • In priority populations with targeted programs, condoms are available. In areas with no programs, condoms are sub-optimally accessed at a community level • No coordinated mechanism is available to measure the proportion of appropriate outlets that carry condoms Objectively, and there is Insufficient reporting • There no surveys have been conducted to understand condom availability	• Align the current SBCC strategy with a people-centred and data-driven approach
Segmentation strategies	• No dedicated program strategy to drive intervention design for segmentation by demographic, behaviour though under development Finalise and roll out the TMA strategy	• Finalize and roll out the TMA strategy
Demand creation guidance	• There are no standard operating procedures to guide interventions for prioritised populations	• Work with communities to develop Standard operating procedures
Existence of communication strategies	• There are no communication strategies to guide interventions for prioritised populations	• Align the Condom SBCC strategy to people-centred design and data-driven
Existence of guidance to support coordinated outreach reaching prioritized populations	• There is no clear guidance to support coordinated outreach reaching prioritised populations	• Finalise and operationalise the DSD guidelines for condoms
Perceived accessibility/condom availability	• Inadequate support for last-mile distribution to reach a community	• Each donor must include a percentage to cater to last-mile distribution (at least 3 %). Support the last-mile structures
	• In priority populations with targeted programs, condoms are available.	• Scale up drop-in centres in all relevant areas and Regular mapping to increase distribution to community user pick points like hot spots

	• Areas with no programs for condoms are sub-optimally accessed at the community level.	• Target and strengthen available community structures that reach community user pick points
	• No coordinated mechanism is available to Objectively measure the proportion of appropriate outlets that carry condoms and there is Insufficient reporting	• Conduct periodic surveys to understand condom availability

NEXT STEPS VMMC PSAT

Reason for low performance	**Proposed actions (e.g. support required or corrective actions).**
	Negotiate with government to take up VMMC and commit resources to VMMC
Lack of national VMMC communication strategy	
Weak programmatic response to the strategic goal and objectives due to inadequate coordination structure at national level	Mainstream the coordination structure. Advocate for public ownership of the VMMC program
There is no theory of change that identifies each stakeholders' contribution and outlines success factors, activities & stakeholders	Need to domesticate the available one
Champions at national and subnational levels do not represent various sectors. Only health service providers are trained as champions	
Champions are not mobilised and given a platform to represent the local VMMC	
Only Health service providers receive sensitisation training and support from the local VMMC programme	

There is no National costed strategic and operational plan to transition toward sustainability	Develop a clearly articulated strategic plan and costed operational plan to transition toward sustainability (consisting of the following areas: programme management and coordination; VMMC service delivery; programme quality; demand generation; strategic information; programme financing)
inadequate integration of VMMC into the national and country health strategy (NSP and MOHNHIVSP) and operational planning process	MOH needs to mainstream VMMC programs and funding the combination prevention programs. Precison targeting and planning with priority action plans for VMMC programs.
There is no national VMMC infrastructure and resources mapped to inform planning and implementation. Only PEPFAR has done mapping but ths is not national	
inadequate access to strategic information including programme performance and financial data to inform programme monitoring	Mainstream M&E plan
Procurement and distribution of VMMC supplies and equipment are done by development partners/donor	NSP needs to set up clear targets and rollout plans for VMMC programs/activities. Need to Appoint team to represent team, sit with logistics team,develop HIV prevention supplies plan assumption work book for quantification and forcasting as well as to to give scheduled updates of forecasts
Inadequate waste management system that addresse segregation, storage, transport, treatment, and disposal of all relevant VMMC related waste according to national guidelines. Inadequate infrastructure for interim storage, segregation and inceneration services	
There is no direct domestic funding to VMMC program,Strategic plan not in place, Costed integrated plan not in place	
There is a Current training curriculum but implementation is not to scale. There is no comprehensive training plan of who is to be trained where	
There is no technical assistance plan for VMMC	Develop a Technical assistance plan for VMMC
There is no Advocacy strategy and toolkit developedthat is nationally approved and implemented	Develop advocacy strategy and tool kit
The national operational plan though available is not adequately funded, not contributed by all stakeholders	
The VMMC TWG has not met in last 4 years due lack of resources/funding	
Inadequae funding for the TWG communication plan	
The TWG does not contribute to implementing plans and programmatic reforms to address cross cutting issues	
The TWG does not support resource mobilization and coordination through development and cultivation of partnerships and investments	
There is weak coordination with stakeholders and a few are engaged due to inadequate funding and human resource	

There is no regular feedback from Stakeholders to the national programme (MoH) at all levels who are accountable through accountability mechanisms	
Inadequate VMMC Programme multisectoral collaboration	
The VMMC implemetation guidelines were not disseminated so are not known at subnational level	Integrate in national dissemination plan for HIV Prevention, Explore virtual dissemination
There is no budget and resource allocation guidelines	
Where as some assessments are done to identify the gaps, they are not used to develop costed implementation plan	
There is no consolidated resource mobilisation plan/strategy	Develop a consolidated resource mobilisation plan/strategy for VMMC. Adopt the MoH resource mobilisation plan/strategy.
There is no social contracting for VMMC programming	
Multiple funding sources have not been identified	TWG to actively identify multiple funding sources for VMMC
Less that 10% propotion of VMMC programme is financed domestically	
The country health budget and plans do not allow for integration,scale up and sutainability for VMMC Programme	
Population size estimates rely only on UPHIA	Conduct a targeted VMMC-specific estimation
Mapped areas of unmet need for prioritization is only done by PEPFAR with limited involvement of MoH and other stakeholders	MoH should take lead in mapping unmet need for prioritization
HR needs assessment not done	Need to conduct a national HR needs assessment
Accurate and updated targets are not at facility level, only at national and subnational	Need to have facility targets
Target set by epidemiological impact is only done by PEPFAR	Scale-up beyond PEPFAR
Sustainability targets are not available	MoH to set sustainability targets
Target setting doesn't involve every stakeholder	MoH should take lead in target setting
Schedule of services limited to PEPFAR area	Scale-up beyond PEPFAR
Outreach for hard-to-reach groups is not done especially for MSM other KPs	Need to introduce outreaches for hard-to-reach groups and areas
No operating hours for some target groups like working men	Introduce flexible hours for working class
Transport for clients is not for all	Should be harmonized
Appointment system not available (only walk-in)	Appointment would be good if VMMC is integrated into the facilities
Services not offered in nearby facilities (providers move beyond areas of their jurisdiction) service is available on provider convenience	Need for scale-up of facility-based services and less of outreaches
VMMC services integration is not there, it's still a vertical program	Need integration
Limited scale-up of accredited service centers	Scale-up accreditated health services
Training to deliver VMMC is absent, limited to areas of clinical and medical officers	Training for VMMC should be included in pre-service training
Coverage in eligible population is at 54%	

Tranining for VVMC is only for Medical Doctors and Clinical Officers, Nurses not trained to conduct VMMC	Do task shifting for VMMC to nurses
All circumcisers are not offered re-fresher training and accreditation every two years	Conduct refresher training every two years, training should be led by MoH
Trained and capacitated are not placed in facilities according to need and they are over-transferred based on other needs	More collaboration among stakeholders at the sub-national level
there is no national plan for procurement and all VMMC supplies because procurement is done by the donors	Mainstream in the MoH quantification and procurement plan
Standards are there but not fully enforced	Follow the national standards and regulatory authority
No information systems to track the health workforce for VMMC	Include in the strategic plan
No information systems to track the health workforce utilization	Include in the strategic plan
Policy doesn't provide for task shifting for VMMC	Update policy to include task shifting
Age-differentiated guidelines in place but not implemented due to inadequate financing	
Some elements the commuincation are not age differentiated	Develop communications guidelines for ages not catered for
Limited funding to extend services to neonates and early infants	
Circumcision after viral suppression is not being done	Need to update the guidelines according to WHO
Follow-up calls not done	Update guidelines to include follow-up call
Health screening is not done where there is high client load	
No communication strategy in place	Draft a VMMC communication
Strategy is absent and there is no integration of VMMC services	Integrate VMMC into other maintream health services
No theory of change	
Limited innovation in demand creation activities	strategies/ innovations to improve demand creation
Hard to reach groups are always left out	update key messages to include hard to reach groups
MoH M&E plan lacking	to be developed
	to conduct demand creation research/ new innovations
Quarterly review meetings lacking	Quarterly VMMC disemination meetings and an annual symposium to the same. Annual HIV program symposium
Lack of funds to standardise and integrate traditional leaders in SMC	
No framework on MOUs for traditional leaders engagement in VMMC	Develop frame works on MoUs and other agreements
	Framework should include roles and responsibilities of the traditional leaders
	Update the TWG to include community players
Integration in AGYW	
No up-to-date research available for implementation practices	deliberate implementation research in VMMC program
	targeted funding of R &D in VMMC
Routine monitoring done / funded by PEPFAr	Mainstream VMMC program

	Involvement of MoH
Inaccurate client datatracking	
Limited use of EMR data capture tools	Mainstreaming of VMMC and MoH involvement
Data quality assesssments are not used to address data issues/ improvement	MoH to task IPs to enter all client forms in the EMR data
PEPFAR doesnot take action from data issues raised both qualitative and quantitative	Improvement of accountability and capacity building in M&E
	Scale up EMR entry across the country
Accountabilty mechanisms in place	improvement needed
Data stops at national level	improve the responsiveness of data at sub national levels as well
	improve collaboration
Inaccurate data not used in decision making/ data quality issues	Continuous data quality improvement programs
patient tracking system to monitor program performance not used fully	scale up use of EMR
Financial monitoring not optimal/ limited to PEPFAR involvement	Mainstream VMMC
no referral directory in place	develop a comprehensive referral directory
No followup on outcomes	develop a digital referral system
No compliance certificate	Develop a compliance certificate
Undereporting of AE	Improve reporting
QA process does not include the traditional sector	Include traditional sector in programming framework
Gaps in standards for QA	
Limited funding for targets	Include other sources of funding in targets
Changes over years	survey every 2 years

PROPOSED ACTIONS FROM THE PEP PSAT

Reason for low performance	**Proposed actions (e.g. support required or corrective actions).**
Long-acting PrEP (i.e. DVR and injectables) not yet included as part of comprehensive HIV prevention in National HIV Strategy	Update the National HIV strategic plan to include injectable and vaginal ring
Insufficient detail to guide implementation of PrEP programs leaving out guidance of injectable and Vaginal ring. Does not give guidance of implementation	Update the National HIV strategic plan to include injectable and vaginal ring
Lack of regulatory approval of injectable PrEP	Advocate for regulatory approval for injectable PrEP
Insufficient funding to adequately monitor nationally	
Not all groups have been engaged substantially like Prisoners, AGYW, Pregnant women.	

Inadequate involvement due to inadequate capacity to have meaningful involvement	
Not all sector involved in coordination with other ministries/departments (e.g. finance, law enforcement, education, development, etc.) takes place	
The Oral costed plan is outdated The Injectable and vaginal ring modalities have not been costed	Conduct updated costing to include injectable and vaginal ring
PrEP budget is not integrated due to parallel funding	
Inadequate domestic funding towards PrEP Programming	
Budget gaps have been identified but no domestic funding opportunities plans to fill the gaps	Prioritisation of domestic funding towards PrEP programming
Target populations are involved in harmonisation	
suboptimal participation of stakeholders in the quarterly performance review meetings	
Targets at subnational level do not include the gender and age bands	
Targets not set based on the need	Set targets to be set based on the need
Although there is a national HIV strategic M&E framework which also captures some of the PrEP indicators, there is no M&E plan and framework for PrEP Program that is tailored and robust	Develop a PrEP M&E plan and framework
The PrEP communication strategy needs to be updated to include new technologies like the injectable Prep, Vaginal ring, AGYW etc. and disseminated	Update and disseminate and disseminate the Prep communication strategy
Some Media are not optimally engaged in mobilisation of PrEP	
Demand creation messages are not differentiated based on priority populations	
Communication strategy around PrEP is not part of the broader sexual health promotion communication strategy	
Supply and demand forecasting is based on availability of funds and not on the need	
Apart from drugs and HIV testing ,other essential clinical components of the PrEP programme, as well as PrEP adjacent supplies depend on the normal health service delivery process	
There is no Manufacturer contract to purchase / supply essential components of PrEP clinical service package in place	
Procurement supply does not meet growing demand	

AS a country we do not procure PrEP	
Need to step up Social contracting for PrEP programming	
Inadequate linkage to preventive options (including PrEP) at all HIV testing points due to absence of services at all testing points	
PrEP is not available at all health facilities offering SRHR, STI,ANC,OPD services	
Not all Facilities providing PrEP services are conveniently located geographically	
PrEP is not included in core training package for all health care workers	
Not all PrEP Managers and providers trained on non-judgemental and non-biased PrEP service provision	
Not all PrEP Managers and providers receive effective position specific training and ongoing mentoring and support due to turn over	
Tools do not take into consideration unique needs of differing populations	
inadequate Direct linking from HIV testing services to prevention services (including PrEP services) are in place	Conduct RCA
Not All methods of available PrEP prevention options are discussed. Ring and injectable not currently included.	
Lobby for adequate supplies to screen Syphilis and other STI	
Implement event driven PrEP	
Lobby for adequate testing kits- pregnancy	
Provide more funding for follow up and other peer activities	
Not all partners are compliant with global quality standards	Strengthen system to promote adherence to global quality standards of PrEP
Findings from quality assessments are not communicated to all stakeholders and appropriate action is enforced	
Not all stakeholders report on AEs on a defined regular basis	
Inaccurate reporting of AEs	
Patient feedback / follow-up takes place and is documented. Mild often not reported	
Indicators for [selected PrEP modality] are not disaggregated by geographic unit	
Not all Nationally defined target (i.e. quarterly, annual) is met	Needs RCA to be done

No PrEP program evaluation for effectiveness has been done	
Not all health facilities offer PrEP	Scale up PrEP Program
PrEP has vertical supply chain	
Financing for PrEP is majorly partner supported	Advocate for Mainstreaming funding of PrEP Programming

PROPOSED ACTIONS FROM THE AGYW PSAT

Element that needs to be addressed	**Reason for low performance**	**Proposed actions (e.g. Support required or corrective actions).**
National Strategy and Strategic Plan	No comprehensive multisectoral framework for AGYW	Develop a multi-sectoral AGYW specific national strategic plan
National and Sub-National plans	Process of developing started but stalled due to lack of finances	Facilitate completion of the capacity building and technical assistance plan
National Technical working group (TWG) for AGYW/Youth Prevention	HIV response still heavily dependent on donor support	Solicit Technical and financial support for the process
Accountability	Lack of a comprehensive multi-sectoral AGYW framework to be costed	Technical and financial support to develop a costed comprehensive multi-sectoral framework
Capacity building and technical assistance plan	Insufficient funding for a comprehensive AGYW response	Advocacy for additional funding
Sustainability plan and transition roadmap	HIV response still heavily dependent on donor support, but government contribution poorly quantified	Technical support to assess and document sources of funding for the AGYW response to inform advocacy for additional resources
Policies and Laws	Concept still poorly understood at national level	Capacity building to create champions to lead national dialogue on social contracting
Guidelines	Poorly coordinated and disjointed planning processes	Develop a multi-sectoral AGYW framework to guide joint planning
Costing	This has not been prioritized and allocated resources	Solicit Technical and financial support for the process
Resource mobilisation and financing	The prioritisation and investment matrix and decision making aide not a tool known to us	Building capacity in the use of the prioritisation and investment matrix and decision making aide

Domestic resourcing	No comprehensive AGYW M&E framework with local targets	Technical and financial support to develop a comprehensive AGYW M& E framework
Social contracting	No Theory of change in any of the frameworks	Facilitated stakeholder discussion on a results framework for the AGYW response
Budget planning	Not yet prioritized or allocated resources	Technical and financial support to develop operational plan
Demographic assessment & disaggregation	Funding plans not developed yet	Technical and financial support to develop funding plan
Needs assessment	Weak M&E system that cannot aggregate comprehensive data	Technical assistance to strengthen M&E system for the AGYW response
Characterisation of male partners of AGYW	Referal system tracking not yet prioritized by the response	Technical support to develop a referral tracking system
Target setting	Quality Assessment not yet prioritized by the program	Technical support to develop and implement Systems to collect data on programme quality
Populations size estimate - moderate incidence	Intervention not yet prioritized nor allocated resources	Technical and financial support needed to develop and implement a surveillance program
Population size estimate - high incidence	No effective M&E system for the AGYW response	Technical and finacial support to develop an effective M&E system
Epidemiological assessment (sero-prevalence survey & determinants of risk)	No Unique Identifier system in place	Technical and finacial support to develop an d operationalize a unique identifier system
Behavioural risk factors	Activity not prioritized by the program	Capacity building for stakeholders and technical support to put relevant systems in place
Biological risk factors	No comprehensive Sexuality Education program	Ongoing advocacy with key stakeholders
Structural risk factors	Services at only a limited facilities	Capacity buildinmg for service providers in all districts
Define & prioritise HIV prevention packages per applicable incidence category	Services at only a limited facilities	Capacity building for service providers in all disrtricts
Results Framework/Theory of Change Includes	Unresolved socio-cultural challenges	Continued advocacy with stakeholders

Programmatic Coverage Targets		
Results Framework/Theory of Change Includes Cross-Cutting activities & Complementary Action	Inadequate funding for community initiatives	Advocate for Social contracting
Develop/ensure health platforms	Challenges related to socia-cuture setting	
Develop/ensure education platforms	Implemented on a limited scale due to inadeqyuate resources and local capacity	Advocate for more funding for the AGYW program
Develop/ensure community platforms (lead non-governmental organisations (ngos)/civil society organisations (csos))	Limited scale, government initiatives inaccessible to those less than 18 years	Continued advocacy
Accessible services	Limited scale of implementation due to inadequate resources	Continued advocacy for resources
Youth-friendly/Acceptable services	Low levels of secondary education completion rates	Continued advocacy for enforcement of government laws
Tailored/Appropriate services	Coordination structures for AGYW response at local level non-existent	Develop a functional coordination structure and local level
Peer outreach educators (POE), Peer testers and Community Health Workers (chws)	Position not part of establishment	Advocacy for inclusion of position in establishment at local level

Recommended Next Steps - Sex workers' PSAT

Element that needs to be addressed	Reason for scoring	Proposed actions (e.g. support required or corrective actions)
National Key Populations (KP) strategy	• Some clusters are not represented. For example, SW is diverse; diversities like SWs with a disability, male sex workers, and SWs in closed settings-refugee settings are not included.	• Review strategy to cater for all clusters
Accountability	• Leadership in UAC, ACP present. There is a need to strengthen leadership at the sub-national level	• Strengthen leadership and engagement with other sectors and at the subnational Level. Improve multisectoral response
Technical working group	• National KP technical working group with SW representation present. Some KP working groups available at the sub-national level	• TORs need to be updated and improve regular meeting attendance With transgender network representation
Stakeholder coordination	• Coordination mechanisms are not optimal	• Strengthen coordination mechanisms at all levels
Capacity building and technical assistance plan	• Draft plan in place, not formalised	• Develop a national capacity-building and technical assistance plan
Sustainability plan and transition roadmap	• There is no sustainability plan to transition the roadmap	• Develop a sustainability plan, and a transition roadmap is in place which outlines the transition from donor-supported to domestically-supported interventions for SW.
Laws and policies	• The law still criminalises sex work which aggravates the stigma and discrimination against sex workers	• Advocate for change in the law that criminalises sex work
Guidelines	• The package is not updated with global guidance and new prevention technologies	• Need to update the package and align it with global guidance and new technologies
Costing	• There is no national budget costing for the standard package per unit cost for sex worker	• National-level unit cost based on the updated standard service package for SW
Budget planning	• No well-managed budget planning process links to the SW programme's national and subnational operational plans.	• Harmonise the budget planning process to link to the SW programme's national and subnational operational plans.
Resource mobilisation and financing	• in sufficient funding and is majorly donor funded is partner supported available to address holistic programme needs and provide the full package of services for SW.	• Lobby for an increase in partner funding as well as domestic financing of the SW program
Domestic resourcing	• There is minimal domestic funding for SW Programs	• Advocate for domestic financing for SW programs
Social contracting	• No social contracting mechanisms are developed and implemented with priority to SW-led organisations.	• Advocate and Develop Social contracting mechanisms implemented with priority to SW-led organisations.

Demographic assessment	• Irregular Population size estimation and microplanning at the local level inform interventions needs, funding, and target setting.	• Conduct Population size estimation and microplanning regularly at a national and local level to inform interventions needs, funding, and target setting.
Epidemiological assessment	• No completed Sero prevalence estimates and assessments on the determinants of risk for SW have been done in the last 3-5 years	• Finalise the ongoing Sero-prevalence estimates and assessments on the determinants of risk for SW, and this should be done regularly within 3-5 years
Needs assessment	• Outdated needs assessment has been completed at the implementation and local level to identify gaps and access barriers for SW service provision.	• Conduct a current comprehensive needs assessment to identify gaps and access to barriers
Target setting	• There are no targets based on Age- and gender-disaggregated targets for SW based on size estimation, risk assessment data, and consultation with implementers and SW networks.	• Set targets that are Age- and gender-disaggregated based on size estimation, risk assessment data, and consultation with implementers and SW networks
Maintain an access platform	• Whereas there is a platform, there is low coverage for DICs	• Strengthen the access platform/mechanisms by increasing coverage of the facility and community DIC model across the country; popularise the DIC guidelines.
Management structure	• There is an informal management structure for managing KP programming at multisectoral levels.	• Establish management structures for SW programming implemented at all levels with clear Terms of Reference, supervision plans, career progression plans, and remuneration for all individuals on the programme.
Data flow	• There is no mechanism for capturing data from the community. • In addition, the tools did not capture some aspects like mental health. • Need to update the tools to capture mental health indicators and indicators and mechanisms for capturing community-level data.	• Update tools to capture the indicators for mental health and develop tools and systems for community reporting.
Peer outreach workers	• Peer outreach workers are from the SW community, appropriately trained, and used effectively in the programme.	
Meaningful engagement of affected communities in leadership & coordination	• SW-led organisation/network is represented and actively participates in the national coordination body or Technical Working Group for SW.	
Acceptable services	• There are hardly any specialised services for Transgender. • They access services as the general public apart from the few DICs. • Inconvenient operating hours(Weekends, nights), thus interrupting service of and product supply. • Low scale and scope.	• Develop specialised services for SW, scale up and align with global guidelines
Tailored / appropriate services	• The scope and scale of services are limited. • There is no special consideration for those with special needs.	• Develop a program to cater for the unique needs of Transgender in their Diversity, e.g. those with disability.

	• Develop a program to cater for special requirements for SW, e.g. those with disability.	
Condoms and lube	• Accessibility is usually faced with challenges ranging from last-mile distribution and access.	• Address issues with last-mile distribution and access. • Schedule regular demonstrations of condom use
HIV testing services	• SW HIV testing services are not at full scale. • Limited testing coverage in rural areas. • Other HIV testing service challenges for SWs include stock outs of testing kits. • HIV testing resources are donor supported.	•
Pre-exposure prophylaxis	• PrEP coverage is very low.	• Scale up coverage of PrEP services nationally.
Sexually transmitted infection prevention, screening and treatment	• STI screening is done as per the guideline. STI testing and treatment at the service delivery point is not done according to the STI treatment and management guidelines because of service challenges, including, for example, stock-outs of the recommended treatments, resource constraints to procure the required STI treatments and capacity gaps among service providers	• Invest in supply for testing supplies and drugs to adhere to national guidelines. Enhance the capacity of Health service providers
Family planning and SRH	• Partially available. Family planning and other reproductive health services have access challenges ranging from care providers' capacity, end-user levels of information around family planning and related myths and misconceptions.	• Improve access by taking services closer to them, create awareness and Health education to address myths and misconceptions, Increase availability of Family planning commodities and supplies, e.g. Self-care commodities
Post-violence care	• Low coverage for GBV shelters for SW	• Educate SW communities about Violence how to respond, safe spaces and where the services can access the services. Enhance multisectoral responses and coordination
TB prevention, screening and treatment	• Inadequate coverage for TB prevention services for SW. Poor adherence	• Increase coverage for TB prevention Services and adherence support for SW
PMTCT	• Access challenges. Information gaps among SWs	• Create awareness and health education for SW about PMTCT. Increase coverage of tailored PMTCT services for SW. Increase functional staff
Viral hepatitis prevention, vaccination, screening and treatment	• Viral hepatitis B and C prevention, vaccination, screening, and treatments are partially available to meet the specific needs of Transgender due to Inadequate supplies and commodities to offer these services	• Increase in availability of HB and HC supplies commodities and coverage
Drug and alcohol use screening and treatment	• Screening and treatment for a problem with alcohol and drug in all clinical settings are generally absent.	• Integrate routine screening and treatment for problem alcohol and drug in clinical service delivery

	• Screening and treatment have not been integrated into routine clinical service delivery	
Mental health care	• Mental health care is not generally integrated into routine clinical service delivery	• Integrate Mental health care in routine clinical service delivery Enhance HW's capacity to provide mental health care Invest in community mental health
COVID-19	• The program does not track COVID-19 Vaccination uptake among Transgender.	• Continue Promoting Vaccination uptake and enhance tracking
Social behaviour change communication (SBCC)	• SBCC messages are generally generic and not evidence-based or tailored to SW. Inadequate planning and budgeting for SBCC messaging. Minimal Input Of SW in SBCC message development.	• Develop Evidence-based SBCC messages with input from SW tailored to SW. Increase planning budgeting of SBCC
Violence prevention and response	• Inadequate funding for programmes to comprehensively address violence against SW.	• Scale-up programs for multisectoral GBV prevention and response
Stigma and discrimination reduction	• Efforts to reduce stigma and discrimination against SW Partially run campaigns and sensitisation events, have weak coordinating and reporting mechanisms of follow up on incidents.	• Strengthen Efforts to reduce stigma and discrimination against SW to run campaigns and sensitisation events, coordinate and report mechanisms of follow-up of incidents
HIV-related legal services	• Coverage is mainly in a few urban areas.	• Scale up Coverage of HIV-related legal services to meet the needs of SW populations and cover dispute resolution, referrals, advice and representation.
Monitoring law-enforcement	• Implementing policies, regulations and laws are regularly monitored to assess the impact on SW, mainly by civil society organisations. However, the assessments are not robust and are not regularly done.	• The impact should be assessed regularly (2 years) and be robust to look at the relevant policies and laws.
Legal literacy ("Know your rights")	• HRAPF UGANET has been doing legal literacy training for KP through Legal AIDS camps. However, this is done on a small scale.	• Scale up legal literacy training through legal AIDS camps and Paralegal programs
20 Sensitization of law-makers and law-enforcement agents	• Inadequate sensitization training regarding SW for law-makers and law-enforcement officers. Insufficient resources for supporting the sensitisation training.	• Mobilise lobby and allocate adequate resources for sensitization training regarding SW for law-makers and law-enforcement officers.
Training for health care providers on human rights and medical ethics related to HIV	• Inadequate sensitisation training on human rights and medical ethics adapted to the country context is conducted for health care providers—insufficient resources for supporting the sensitisation training.	• Mobilise lobby and allocate adequate sensitization training regarding sensitisation training on human rights and medical ethics, adapted to the country context, is conducted for health care providers
Reducing discrimination against women in the context of HIV	• Inadequate resources and service package to implement programmes to address gender inequality and GBV against SW in the context of HIV. • SW have compounded stigma issues compared to other populations	• Mobilise and lobby for resources to support the programs for stigma reduction campaigns amongst Transgender. • Train health workers on the reduction of stigma and Discrimination.

Safe spaces / drop-in centres	• Safe spaces are very few and majorly around urban areas—sustainability challenges of the Safe Spaces.	• Increase coverage and develop and implement a sustainability strategy for safe spaces.
Community committees	• Committee meetings are irregular and do not have national coverage due to inadequate resources and support.	• Mobilise resources to support regular meetings and national coverage.
Routine monitoring	• Not all facilities are reporting regularly	• Support Facilities to report regularly
Community-led monitoring for accountability	• Community-led monitoring is not integrated into national monitoring platforms.	• Finalise integration of Community-led monitoring into national monitoring platforms.
Referral system tracking	• Manual referral systems tools are present; however, operationalisation is a challenge. • Delayed updating directory, inadequate mapping of different stakeholders for services they provide, Feedback mechanism not functioning well. Stock-outs of Recording and Reporting.	• Strengthen the referral system, preferably making it electronic. Regular update of the directory
Quality assessment	• A client satisfaction survey is done annually but is for the general population. Monitoring of program quality is not done systematically and is not up to scale.	• Develop program quality indicators, define how data is collected for the indicators, determine the tools and provide clarity on reporting mechanism.
Surveillance	• Not done regularly, and utilisation is not optimal. Passive surveillance is done at the facility level through program data.	• Generate a clear framework to define what needs to be done under surveillance (What, when, coverage)—Mobilise funding to support active surveillance and set up a robust surveillance system.
Data for decision making	• Not done regularly, and utilisation is not optimal	• Strengthen the national program for monitoring evaluation, ensure quality and use it fro information and share with people who need it for decision making.
Unique Identifier Code for programme monitoring	• There is a plan and structure to assign unique IDS, and tools have been aligned to that.	• MoH is in the process of developing guidelines for assigning Unique IDs for EMR
Budget monitoring	• National resources that support are not known due to the diversity of the support; thus, financial program performance monitoring is lacking. This is done at the Partner level.	• Harmonise finance and non-financial program performance monitoring by involving all stakeholders to feed into it. • The non-financial program monitoring should include both quantitative and qualitative monitoring. • Conduct impact cost-benefit analysis for program monitoring.

Next Steps - Men who have sex with men

Element that needs to be addressed	Reason for scoring	Proposed actions (e.g. support required or corrective actions)
National Key Populations (KP) strategy	• Some clusters are not represented. Transgender are diverse; diversities like Transgender with a disability, male MSM, and Transgender in closed settings-refugee settings are not included.	• Review strategy to cater for all clusters
Accountability	• Leadership in UAC, ACP present. There is a need to strengthen leadership at the sub-national level	• Strengthen leadership and engagement with other sectors and at the subnational Level. Improve multisectoral response
Technical working group	• National KP technical working group with Transgender representation present. TORs need to be updated, and improve regular meeting attendance. Some KP working groups available at the sub-national level	• TORs need to be updated and improve regular meeting attendance With transgender network representation
Stakeholder coordination	• Though coordination mechanisms are in place, this is not optimal	• Strengthen coordination mechanisms at all levels
Capacity building and technical assistance plan	• Draft plan in place, not formalised	• Finalise and disseminate the national capacity building and technical assistance plan that prioritises programme components and policy issues based on a gap assessment
Sustainability plan and transition roadmap	• There is no sustainability plan to transition the roadmap	• Develop a sustainability plan and transition roadmap is outlines the transition from donor-supported to domestically-supported interventions for MSM.
Laws and policies	• The law still criminalises MSM which aggravates the stigma and discrimination against Transgender.	• Advocate for change in the laws that criminalises MSM
Guidelines	• The package is not updated with global guidance and new prevention technologies	• Need to update the package and align it with global guidance and new technologies
Costing	• There is no national budget costing for the standard package per unit cost for MSM	• National-level unit cost based on the updated standard service package for MSM
Budget planning	• No well-managed budget planning process is in place, which links to national and subnational	• Harmonise the budget planning process to link to national and

	operational plans for the Transgender programme.	subnational operational plans for the Transgender programme.
Resource mobilisation and financing	• There is insufficient funding, and it is majorly Partner funded to address holistic programme needs and provide the full package of services for Transgender.	• Lobby for an increase in partner funding as well as domestic financing of the Transgender Program
Domestic resourcing	• There is minimal human and financial domestic funding for Transgender Programs	• Advocate for domestic funding for transgender programs
Social contracting	• No social contracting mechanisms are developed and implemented with priority to Transgender-led organisations.	• Advocate and Develop Social contracting mechanisms implemented with priority to Transgender-led organisations.
Demographic assessment	• Irregular Population size estimation and microplanning at the local level to inform interventions needs, funding, and target setting.	• Conduct Population size estimation and microplanning regularly at a national and local level to inform interventions needs, funding, and target setting.
Epidemiological assessment	• No completed Sero-prevalence estimates and assessments on the determinants of risk for Transgender have been done in the last 3-5 years	• Finalise the ongoing Sero-prevalence estimates and assessments on the determinants of risk for Transgender, and this should be done regularly within 3-5 years
Needs assessment	• No needs assessment has been completed at the implementation and local level to identify gaps and access barriers for Transgender service provision.	• Conduct a current comprehensive needs assessment to identify gaps and access to barriers for Transgender service provision
Target setting	• There are no targets based on Age- and gender-disaggregated targets for Transgender persons based on size estimation, risk assessment data, and consultation with implementers and Transgender networks.	• Set targets that are Age- and gender-disaggregated based on size estimation, risk assessment data, and consultation with implementers and transgender networks
Maintain an access platform	• An access platform promotes coordinated community and clinic-based efforts that build trust, reach Transgender in high numbers, and encourage their uptake, retention and active participation in the programme. Whereas there is a platform, there is low coverage for DICs	• Strengthen the access platform/mechanisms by increasing coverage of the facility and community DIC model across the country; Popularise the DIC guidelines.

Management structure	• There is an informal management structure for managing KP programming at multisectoral levels.	• Establish management structures for MSM programming implemented at all levels with clear Terms of Reference, supervision plans, career progression plans, and remuneration for all individuals on the programme.
Data flow	• There is no mechanism for capturing data from the community. In addition, the tools did not capture some aspects like mental health. Need to update the tools to capture mental health indicators and indicators and mechanisms for capturing community-level data.	• Update tools to capture the indicators for mental health and develop tools and systems for community reporting.
Peer outreach workers	• Not all Peer outreach workers from the Transgender community are appropriately trained and used effectively in the programme.	• Train all Peer outreach workers from the Transgender community
Meaningful engagement of affected communities in leadership & coordination	• There is no formal management structure for a Transgender-led organisation/network that is represented and actively participates in the national coordination body or Technical Working Group for Transgender.	• Formalise Management structure for a Transgender-led organisation/network that is represented and actively participates in a national coordination body or Technical Working Group for Transgender.
Acceptable services	• There are hardly any specialised services for Transgender. They access services as the general public apart from the few DICs. Inconvenient operating hours (Weekends, nights), thus interrupting service of and product supply. Low scale and scope.	• Develop specialised services for MSM, scale up and align with global guidelines
Tailored / appropriate services	• The scope and scale of services are limited. Not all MSM in their diverse there is no special consideration for those with special needs. Develop a program to cater for special requirements for MSM, e.g. those with disability.	• Develop a program to cater for the unique needs of Transgender in their Diversity, e.g. those with disability.
Condoms and lube	• Accessibility is usually faced with challenges ranging from last mile distribution and access.	• Address issues with last mile distribution and access. • Schedule regular demonstration of condom

HIV testing services	• MSM HIV testing services are not to full scale-limited testing coverage in rural areas. Other HIV testing service challenges for MSMs include stock outs of testing kits. HIV testing resources are donor supported.	
Pre-exposure prophylaxis	• PrEP coverage is very low.	• Scale up coverage of PrEP services nationally.
Sexually transmitted infection prevention, screening and treatment	• STI screening is done as per the guideline. STI testing and treatment at service delivery point is not done according to the STI treatment and management guidelines because of service challenges including for example stock outs of the recommended treatments, resource constraints to procure the required STI treatments and capacity gaps among service providers	• Invest in supply for testing supplies and drugs to adhere national guidelines. Enhance capacity of Health service providers
Family planning and SRH	• Partially available. Family planning and other reproductive health services have access challenges ranging from capacity of care providers, end user levels of information around family planning and related myths and misconceptions.	• Improve access by taking services closer to them, create awareness and Health education to address myths and misconceptions, Increase availability of Family planning commodities and supplies e.g. Self-care commodities
Post-violence care	• Low coverage for GBV shelters for MSM	• Educate MSM communities about Violence, how to respond, safe spaces and where the services can access the services. • Enhance multisectoral responses and coordination
TB prevention, screening and treatment	• Inadequate coverage for TB prevention services for MSM. Poor adherence	• Increase coverage for TB prevention Services and adherence support for MSM
PMTCT	• Access challenges. Information gaps among MSMs	• Create awareness and health education to MSM about PMTCT. • Increase coverage of tailored PMTCT services for MSM. • Increase functional staff

Viral hepatitis prevention, vaccination, screening and treatment	• Viral hepatitis B and C prevention, vaccination, screening, and treatments are partially available to meet specific needs of Transgender due to Inadequate supplies and commodities to offer these services	• Increase on availability of HB and HC supplies commodities and coverage
Drug and alcohol use screening and treatment	• Screening and treatment for problem alcohol and drug in all clinical settings is generally absent.Screening and treatment has not been integrated in routine clinical service delivery	• Integtate routine screening and treatment for problem alcohol and drug in clinical service delivery
Mental health care	• Mental health care is not generally integrated in routine clinical service delivery	• Integrate Mental health care in routine clinical service delivery Enhance HW capacity to provide mental health care Invest in community mental health
COVID-19	• The program does not track COVID 19 Vaccination uptake among Transgender.	• Continue Promoting Vaccinaction uptake and enhance tracking
Social behaviour change communication (SBCC)	• SBCC messages are generally generic and not evidence based or tailored to MSM. Inadequate planning and budgeting for SBCC messaging. Minimal Input Of MSM in SBCC message development.	• Develop Evidence based,SBCC messages with input from MSM tailored to MSM. Increase planning budgeting of SBCC
Violence prevention and response	• Inadequate funding for programmes to comprehensively address violence against MSM.	• Scale up programs for multisectoral GBV prevention and response
Stigma and discrimination reduction	• Efforts to reduce stigma and discrimination against MSM Partially run campaigns and sensitisation events, have weak coordinating and reporting mechanisms of follow up on incidents .	• Strengthen Efforts to reduce stigma and discrimination against MSM to run campaigns and sensitisation events, coordinate and report mechanisms of follow up of incidents
HIV-related legal services	• Coverage is mainly in a few Urban areas.	• Scale up Coverage of HIV-related legal services to meet the needs of MSM populations and cover dispute resolution, referrals, advice and representation.
Monitoring law-enforcement	• The implementation of policies, regulations and laws is regularly monitored to assess the impact on MSM is largely done by civil society organisations. The assesments not robust and not regularly done.	• The impact should be assesed regularly(2 years) and be robust to look at the relevant policies and laws.

Legal literacy ("Know your rights")	• HRAPF UGANET have been doing legal literacy training for KP through Legal AIDS camps. However this is done on a small scale.	• Scale up leagal literacy training through legal AIDS camps and Paralegal programs
Sensitization of law-makers and law-enforcement agents	• Inadequate sensitization training regarding MSM for law-makers and law-enforcement officers. Indadequate resources for supporting the sensitisation trainings.	• Mobilise lobby and allocate adequate resources for sensitization training regarding MSM for law-makers and law-enforcement officers.
Training for health care providers on human rights and medical ethics related to HIV	• Inadequate sensitisation training on human rights and medical ethics, adapted to the country context, is conducted for health care providers.. Indadequate resources for supporting the sensitisation trainings.	• Mobilise lobby and allocate adequate for sensitization training regarding sensitisation training on human rights and medical ethics, adapted to the country context, is conducted for health care providers
Reducing discrimination against women in the context of HIV	• Programmes are partially implemented to address gender inequality and gender-based violence against MSM in the context of HIV. Inadequate resources and service package to implement programmes to address gender inequality and GBV against MSM in context of HIV. MSM have compounded stigma issues compared to other populations	• Mobilise and lobby for resources to support the programms for stigma reduction compaigns amongst Transgender. Train health workers on reduction of stigma and Discrimination.
Safe spaces / drop-in centres	• Safe spaces are very few and majorly around urban areas. Sustainability challenges of the Safe Spaces.	• Increase coverage and develop and implement sustainability strategy for safe spaces.
Community committees	• Committee meetings are irregular, and do not have national coverage due to inadequate resourrces and support.	• Mobilise resources to support regular meetings and cational coverage.
Routine monitoring	• Not all facilities are reporting regularly	• Support Facilities to report regularly
Community-led monitoring for accountability	• Community-led monitoring is not integrated into national monitoring platforms.	• Finalise Integration of Community-led monitoring into national monitoring platforms.
Referral system tracking	• Manual referral systems tools are present however operationalisation is challenge. Delayed updating directory, inadequate mapping of different stakeholders for services they provide, Feedback mechanism not	• Strengthen referral system preferably making it electronic. Regular update of directory

	functioning well. Stock outs of Recording and Reporting.	
Quality assessment	• Client satisfactory survey done annually but is for the general population. Monitoring of program quality is not done systematically and not up to scale.	• Develop program quality indicators, define how data is to be collected for the indicators, determine the tools and provide clarity on reporting mechanism.
Surveillance	• Not done regularly and utilisation is not optimal. Passive surveillance is done at facility level through program data.	• Generate clear framework to define what needs to be done under surveillance (What, when, coverage). Mobilise funding to support active surveillance and set up a robust surveillance system.
Data for decision making	• Not done regularly and utilisation is not optimal	• Strengthen the national program for monitoring evaluation, ensure quality and use it from information and share with people who need it for decisions making.
Unique Identifier Code for programme monitoring	• There is a plan and structure to assign unique IDS and tools have been aligned to that.	• MoH is in process to developing guidelines for assigning Unique IDs for EMR
Budget monitoring	• National resources that support are not known due to the diversity of the support thus financial program performance monitoring is lacking. This is done at Partner level.	• Harmonise finance and non-financial program performance monitoring by involving all stakeholders to feed into it. The non-financial program monitoring should include both quantitative and qualitative monitoring. Conduct impact cost benefit analysis for program monitoring.

Next Steps - Transgender people

Element that needs to be addressed	**Reason for scoring**	**Proposed actions (e.g. support required or corrective actions)**

National Key Populations (KP) strategy	Some clusters are not represented. Transgender are diverse, diversities like Transgenders with disability, male Transgender Persons, Transgenders in closed settings-refugee settings are not included.	Reveiw strategy to cater for all clusters
Accountability	Leadership in UAC, ACP present. There is need to strengthen leadership at sub-national level	Strengthen leadership and engagement with other sectors and at subnational Level. Improve multisectoral response
Technical working group	National KP technical working group with Transgender representation present. TORs need to be updated and improve regular meeting attendance. Some KP working groups available at sub-national level	TORs need to be updated and improve regular meeting attendance With transgender network representation
Stakeholder coordination	Though coordination mechanisms is in place, this is not optimal	Strengthen coordination mechanisms at all levels
Capacity building and technical assistance plan	DRAFT PLAN IN PLACE, NOT FORMALISED	Develop a national capacity building and technical assistance plan that prioritises programme components and policy issues based on a gap assessment
Sustainability plan and transition roadmap	There is no sustainability plan to transition roadmap	Develop a sustainability plan and transition roadmap is outlines the transition from donor-supported to domestically-supported interventions for Transgender Persons.
Laws and policies	The law still criminalises Transgender persons which aggravates stigma and discrimination against Transgender.	Advocate for change in the laws that criminalises Transgender Persons
Guidelines	Package not updated with global guidance and new prevention technologies	Need to update package and align it with global guidance and new technologies
Costing	There is no national budget costing for standard package per unit cost for Transgender Persons	National level unit cost based on hte updated standard service package for Transgender Persons
Budget planning	There is no well-managed budget planning process is in place which links to national and subnational operational plans for the Transgender programme.	Harmonise the budget planning process to link to national and subnational operational plans for the Transgender programme.
Resource mobilisation and financing	There is insufficient funding and is majorly Partner funded to address holistic programme needs and provide the full package of services for Transgender.	Lobby for increase in partner funding as well as domestic funding for Transgender program
Domestic resourcing	There is minimal human and financial domestic funding for Transgender Programs	Advocate for domestic funding for transgender programms

Social contracting	There are no Social contracting mechanisms developed and implemented with priority to Transgender-led organisations.	Advocate and Develop Social contracting mechanisms implemented with priority to Transgender-led organisations.
Demographic assessment	Irregular Population size estimation and microplanning at local level to inform interventions needs, funding, and target setting.	Conduct Population size estimation and microplanning regularly at a national and local level to informs interventions needs, funding, and target setting.
Epidemiological assessment	No completed Seroprevalence estimates and assessments on the determinants of risk for Transgender have been done in the last 3-5 years	Finalise the ongoing Seroprevalence estimates and assessments on the determinants of risk for Transgender and this should be done regularly within 3-5 years
Needs assessment	There is no needs assessment that has been completed at the implementation and/or local level to identify gaps and access barriers for Transgender service provision.	Conduct a current comprehensive needs assesment to identify gaps and access to barriers for Transgender service provision
Target setting	There are no targets based on Age- and gender-disaggregated targets for Transgender person based on size estimation, risk assessment data, and consultation with implementers and Transgender networks.	Set targets that Age- and gender-disaggregated based on size estimation, risk assessment data, and consultation with implementers andTransgender networks
Maintain an access platform	An access platform promotes coordinated community and clinic-based efforts that build trust, reach Transgender in high numbers, and encourage their uptake, retention and active participation in the programme. Whereas there is a platform, there is low coverage for DICs	Strengthen the access platform/mechanisms through increasing of coverage of the facility and community DIC model across the country; Popularise the DIC guidelines.
Management structure	There is an informal management structure for managing KP programming at multisectoral levels.	Establish management structures for Transgender Persons programming implemented at all levels with a clear Terms of Reference, supervision plan, career progression plans, and remuneration for all individuals on the programme.
Data flow	There is No mechanism for capturing data from the community. The tools did not capture some aspects like mental health. Need to update the tools to capture mental health indicators and indicators and mechanisms for capturing community level data.	Up date tools to capture the indicators for mental health and develop tools and systems for community reporting.
Peer outreach workers	Not all Peer outreach workers from the Transgender community are appropriately trained and used effectively in the programme.	Train all Peer outreach workers from the Transgender community
Meaningful engagement of	There is no formal management structure for Transgender-led organisation/network that is represented	Formalise Management structure for Transgender-led organisation/network that

affected communities in leadership & coordination	and actively participates in national coordination body or Technical Working Group for Transgender.	is represented and actively participates in national coordination body or Technical Working Group for Transgender.
Acceptable services	There are hardly any speciaised services for Transgender. They access services as the general public apart from the few DICs.Inconvenient operating hours(Weekends,nights)thus interrupting service of and product supply. Low scale and scope .	Develop specialised services for Transgender persons,scale up and align with global guidelines
Tailored / appropriate services	The scope and scale of services is limited. Not all Transgender Persons in their diversity a There is no special consideration for those with special needs. Develop program to cater for special needs for Transgender Persons eg those with disability.	Develop program to cater for special needs for Transgender in their Diversity eg those with disability.
Condoms and lube	Accessibility is usually faced with challenges ranging from last mile distribution and access.	Address issueTransgender Personsith last mile distribution and access. Schedule regular demostration of condom
HIV testing services	Transgender Persons HIV testing services are not to full scale-limited testing coverage in rural areas. Other HIV testing service challenges for Transgender Personss include stock outs of testing kits. HIV testing resources are donor supported.	
Pre-exposure prophylaxis	PrEP coverage is very low.	Scale up coverage of PrEP services nationally.
Sexually transmitted infection prevention, screening and treatment	STI screening is done as per the guideline. STI testing and treatment at service delivery point is not done according to the STI treatment and manangement guidelines because of service challenges including for example stock outs of the recommended treatments, reource contraints to procure the required STI treatments and capacity gaps among service providers	Invest in supply for testing supplies and drugs to adhere national guidelines. Enhance capacity of Health service providers
Family planning and SRH	Partially available. Family planning and other reproductive health services have access challenges ranging from capacity of care providers, end user levels of information around family planning and related mysths and misconceptions.	Improve access by taking services closer to them,create awareness and Health education to address myths and misconceptions, Increase avalability of Famaily planning commodities and supplies eg Selfcare commodities
Post-violence care	Low coverage for GBV shelters for Transgender Persons	Educate Transgender Persons communities about Violencehow to respond,safe spacesand where the services can access

		the services.Enhance multisectoral responses and coordination
TB prevention, screening and treatment	Inadequate coverage for TB prevention services for Transgender Persons. Poor adherence	Increase coverage for TB prevention Services and adherence support for Transgender Persons
PMTCT	Access challenges. Information gaps among Transgender Personss	Create awareness and health education to Transgender Persons about PMTCT. increase coverage of tailored PMTCT services for Transgender Persons. Increase functional staff
Viral hepatitis prevention, vaccination, screening and treatment	Viral hepatitis B and C prevention, vaccination, screening, and treatments are partially available to meet specific needs of Transgender due to Inadequate supplies and commodities to offer these services	Increase on availability of HB and HC supplies commodities and coverage
Drug and alcohol use screening and treatment	Screening and treatment for problem alcohol and drug in all clinical settings is generally absent.Screening and treatment has not been integrated in routine clinical service delivery	Integtate routine screening and treatment for problem alcohol and drug in clinical service delivery
Mental health care	Mental health care is not generally integrated in routine clinical service delivery	Integrate Mental health care in routine clinical service delivery Enhance HW capacity to provide mental health care Invest in community mental health
COVID-19	The program does not track COVID 19 Vaccination uptake among Transgender.	Continue Promoting Vaccinaction uptake and enhance tracking
Social behaviour change communication (SBCC)	SBCC messages are generally generic and not evidence based or tailored to Transgender Persons. Inadequate planning and budgeting for SBCC messaging. Minimal Input Of Transgender Persons in SBCC message development.	Develop Evidence based,SBCC messages with input from Transgender Persons tailored to Transgender Persons. Increase planning budgeting of SBCC
Violence prevention and response	Inadequate funding for programmes to comprehensively address violence against Transgender Persons.	Scale up programs for multisectoral GBV prevention and response
Stigma and discrimination reduction	Efforts to reduce stigma and discrimination against Transgender Persons Partially run campaigns and sensitisation events, have weak coordinating and reporting mechanisms of follow up on incidents .	Strengthen Efforts to reduce stigma and discrimination against Transgender Persons to run campaigns and sensitisation events, coordinate and report mechanisms of follow up of incidents

HIV-related legal services	Coverage is mainly in a few Urban areas.	Scale up Coverage of HIV-related legal services to meet the needs of Transgender Persons populations and cover dispute resolution, referrals, advice and representation.
Monitoring law-enforcement	The implementation of policies, regulations and laws is regularly monitored to assess the impact on Transgender Persons is largely done by civil society organisations. The assesments not robust and not regularly done.	The impact should be assesed regularly(2 years) and be robust to look at the relevant policies and laws.
Legal literacy ("Know your rights")	HRAPF UGANET have been doing legal literacy training for KP through Legal AIDS camps. However this is done on a small scale.	Scale up leagal literacy training through legal AIDS camps and Paralegal programs
Sensitization of law-makers and law-enforcement agents	Inadequate sensitization training regarding transgender persons for law-makers and law-enforcement officers. Indadequate resources for supporting the sensitisation trainings.	Mobilise lobby and allocate adequate resources for sensitization training regarding Transgender Persons for law-makers and law-enforcement officers.
Training for health care providers on human rights and medical ethics related to HIV	Inadequate sensitisation training on human rights and medical ethics, adapted to the country context, is conducted for health care providers.. Indadequate resources for supporting the sensitisation trainings.	Mobilise lobby and allocate adequate for sensitization training regarding sensitisation training on human rights and medical ethics, adapted to the country context, is conducted for health care providers
Reducing discrimination against women in the context of HIV	Programmes are partially implemented to address gender inequality and gender-based violence against Transgender Persons in the context of HIV. Inadequate resources and service package to implement programmes to address gender inequality and GBV against Transgender Persons in context of HIV. Transgender Persons have compounded stigma issues compared to other populations	Mobilise and lobby for resources to support the programms for stigma reduction compaigns amongst Transgender. Train health workers on reduction of stigma and Discrimination.
Safe spaces / drop-in centres	Safe spaces are very few and majorly around urban areas. Sustainability challenges of the Safe Spaces.	Increase coverage and develop and implement sustainability strategy for safe spaces.
Community committees	Committee meetings are irregular, and do not have national coverage due to inadequate resourrces and support.	Mobilise resources to support regular meetings and cational coverage.
Routine monitoring	Not all facilities are reporting regularly	Support Facilities to report regularly
Community-led monitoring for accountability	Community-led monitoring is not integrated into national monitoring platforms.	Finalise Integratgion of Community-led monitoring into national monitoring platforms.

Referral system tracking	Manual referral systems tools are present however operationalisation is challange,. Delayed updating directory, inadequate mapping of different stakeholders for services they provide, Feedback mechanism not functioning well. Stock outs of Recording and Reporting.	Strengthen referral system preferably making it electronic. Regular update of directory
Quality assessment	Client satisfactory survey done annually but is for the general population. Monitoring of program quality is not done systematically and not up to scale.	Develop program quality indicators, define how data is to be collected for the indicators, determine the tools and provide clarity on reporting mechanism.
Surveillance	Not done regularly and utilisation is not optimal. Passive surveillance is done at facilty level through program data.	Generate clear framework to define what needs to be done under surveillance(What,when,coverage). Mobilise funding to support active surveillance and set up a robust surveillance system.
Data for decision making	Not done regularly and utilisation is not optimal	Strengthen the national program for monitoring evaluation, ensure qualiry and use it fro information and share with people who need it for deceision making.
Unique Identifier Code for programme monitoring	There is a plan and structure to assign unique IDS and tools have been aligned to that.	MoH is in process to developing guidelines for assigning Unique IDs for EMR
Budget monitoring	National resources that support are not known due to the diversity of the support thus financial program performance monitoring is lacking. This is done at Partner level.	Harmonise finance and non financial program performance monitoring by involving all stakeholders to feed into it. The non financial program monitoring should include both quantitative and qualitative monitoring. Conduct impact cost benefit analysis for program monitoring.

Next Steps - Prisoners and other people in closed settings

Element that needs to be addressed	**Reason for scoring**	**Proposed actions (e.g. support required or corrective actions)**
National Key Populations (KP) strategy		
Accountability		
Technical working group	There is no TWG for prisoners, but there is a KP TWG at UAC where prisons are represented but not prisoners	Policy and Legal Reform
Stakeholder coordination	Limited resources for coordination of the stakeholders	Develop a financing strategy to mobilize more resources

Capacity building and technical assistance plan	Limited funding for capacity building and technical assistance	Develop a financing strategy to mobilize more resources
Sustainability plan and transition roadmap	Lack of political and leadership support at the prison level	Mobilization and advocacy for political will and leadership buy-in
Social contracting	No Social contracting mechanisms are available	NA
Targeting and planning		
Demographic assessment	Population size is known, but funding does not cater for all prisons	Develop a financing strategy to mobilize more resources
Epidemiological assessment	There is no seroprevalence estimate, non the determinants of risks for prisoners assessment is not regularly done	Conducting a sero prevalence Survey in all prisons
Needs assessment	Limited funds to conduct a needs assessment to identify gaps and access barriers in services for prisoners	Conducting a systematic needs assessment to identify gaps and access barriers in services for prisoners
Target setting	No Age- and gender-disaggregated targets because risk assessment is not done.	Conduct a risk assessment to determine Age- and gender-disaggregated targets
Implementation arrangement		
Maintain an access platform	No Clinics in some prisons	Establish clinics in all prisons
Management structure	The career progression plans are non-existent	Develop a career progression plan
Data flow	Data Review not done at regional and prison unit levels	Resource mobilization to conduct quarterly performance reviews at all levels
Peer outreach workers	Lack of funding for continuous training	Develop a financing strategy to mobilize more resources
Meaningful engagement of affected communities in leadership & coordination	NA	NA
Clinical interventions		
Condoms and lube	Have no access to condoms	
HIV testing services	HIV testing services are available for prisoners only upon Entry into prison. They are not tested when they are discharged.	
Pre-exposure prophylaxis	PrEP not available Oral PrEP is not available for prisoners at substantial risk of HIV infection	
Sexually transmitted infection prevention, screening and treatment	STI screening, testing and treatment are available for prisoners only upon Entry into prison	
Family planning and SRH	No family planning and other reproductive health services are available and accessible for all prisoners.	
Post-violence care	Post-violence services are accessible for all prisoners, such as support, counselling, PrEP, STI testing, and referral to comprehensive GBV.	

TB prevention, screening and treatment	Limited TB treatment facilities.	Establish clinics. Support outreach interventions. Civil society support to prisons, Human Resource capacity building support.
Viral hepatitis prevention, vaccination, screening and treatment	Done at limited sites	Support outreach interventions and scale up the provision of Hepatitis testing services. Civil society support to prisons, Human Resource capacity building support.
Drug and alcohol use screening and treatment	Limited to prisons with clinics	Establish clinics and support outreach interventions and scale up through Civil society and Implementing Partner support to prisons, Human Resource capacity building support. Policy reform to foster service integration
Mental health care	Human Resource Challenge	Civil society support prisons to support Human Resource capacity building and outreach interventions
Voluntary medical male circumcision	Limited Human Resources and supplies for universal coverage	Civil society support prisons to support Human Resource capacity building and outreach interventions
Behavioural interventions		
Social behaviour change communication (SBCC)	Insufficient funding	Civil society support for Human Resource capacity building and SBCC outreach interventions
Structural interventions		
Legal literacy ("Know your rights")	Not working well and is limited to a few facilities.	Building capacity of the service providers and prison leadership
Sensitization of lawmakers and law-enforcement agents	Previously not been a focus	Establish standard sensitization training and materials on human rights and medical ethics for lawmakers, law enforcement officers
Training for health care providers on human rights and medical ethics related to HIV	Not done due to lack of funds and Technical capacity	Conduct sensitization training on human rights and medical ethics for lawmakers, law enforcement officers
Reducing discrimination against women in the context of HIV	Limited Knowledge for officers and health workers regarding GBV	Establish sensitization training on GBV for prison officers and Health workers.
Programme monitoring		
Routine monitoring	Inadequate data utilization	Building capacity for data use at all levels in all prisons
Community-led monitoring for accountability	The community has not been given access to conduct quality improvement in the prisons setting	Advocate for sensitization programs on the importance of CLM in prisons
Referral system tracking	Not operationalized	Operationalization
Quality assessment	Limited to some facilities	The scale of CQI in all facilities
Surveillance	Limited funding to conduct funding	Advocate for funding for surveillance from both donors and government
Data for decision making	Data inaccuracy and limited HR	Capacity building and recruitment of more staff, Limited data infrastructure and logistics
Unique Identifier Code for programme monitoring	Not available	Advocacy for a Unique Identifier Code system to monitor programme performance.

Next Steps - People who inject drugs

Element that needs to be addressed	Reason for scoring	Proposed actions (e.g. support required or corrective actions)
Leadership and coordination		
National Key Populations (KP) strategy	PWID are included in the national KP strategy and overarching HIV prevention strategy. The strategy defines PWID, programme goals and objectives, tailored and evidence-based interventions, and an operational plan.	
Accountability	A lead department/ministry with solid leadership and authority is responsible for the success of the PWID programme.	
Technical working group	A Technical Working Group for PWID (or a KP TWG with PWID included) has been established at national and sub-national levels and has Terms of Reference, regular meetings, PWID representation, and activities aligned to the national KP strategy.	
Stakeholder coordination	Mechanisms are in place to ensure successful stakeholder coordination across all levels.	
Capacity building and technical assistance plan	A capacity building and technical assistance plan prioritize programme components and policy issues based on a gap assessment. It utilizes domestic and international technical experts and facilitates the capacity development of the PWID community.	
Sustainability plan and transition roadmap	A complete sustainability plan and transition roadmap are in place, which outlines the transition from donor-supported to domestically-supported interventions for PWID.	
Laws, policies and regulation		
Laws and policies	Laws and policies actively promote a successful programme for PWID by	

	facilitating access to stigma- and discrimination-free services.	
Guidelines	National guidelines define the package of interventions and services for PWID and support the successful implementation of the programme.	Development and Harmonization of PWIDS services implementation guidelines
Financing		
Costing	The national budget is informed by a costing exercise (average unit cost per PWID) for the standard package of PWID services.	Need for TA to cost PWIDs services
Budget planning	A well-managed budget planning process is in place, which links to national and subnational operational plans for the PWID programme.	Mobilization for resources from both government and other development partners
Resource mobilization and financing	There is sufficient funding available to address holistic programme needs and provide PWID's full package of services.	
Domestic resourcing	More than 50% of programme, human and financial resources are domestic.	Molization for resources from both government and other development partners
Social contracting	Social contracting mechanisms are developed and implemented with priority to PWID-led organizations.	
Programme implementation		
Targeting and planning		
Demographic assessment	Population size estimation and microplanning is completed regularly at local level and informs interventions needs, funding, and target setting.	Capacity building for local levels to conduct microplanning. Conduct microplanning at all levels. develop tools for microplanning. condcut regular population size estiamtion and microplanning
Epidemiological assessment	Seroprevalence estimates and assessments on the determinants of risk are available specifically for PWID and updated regularly (every 3-5 years).	Conduct a Population size estimation triangulation for all districts
Needs assessment	A needs assessment has been completed at the implementation and/or local level to identify gaps and access barriers for PWID service provision.	Conduct a countrywide needs assessment and Micro planning for PWDs

Target setting	Age- and gender-disaggregated targets for PWID have been clearly defined at national and sub-national level and are based on size estimation, risk assessment data, and consultation with implementers and PWID networks.	Stakeholder meeting for target setting
Implementation arrangement		
Maintain an access platform	limited by a lack of optimization resulting from operational issues in screening of PWID from the community. No QI systems, mentorships and microplanning	Establish QI systems, conduct mentorships and do microplanning at all levels
Management structure	Non- Existent	Establish a management structure with a clear Terms of Reference, supervision plan, career progression plans, and remuneration for all individuals on the program
Data flow	There is parralel reporting	Establishing a centralized M&E system.
Peer outreach workers	Lack of microplanning, and there is limited funding	Mobilization of funding
Meaningful engagement of affected communities in leadership & coordination	Working well	working well
Service delivery		
Accessible services	No community access points, interrupted service e.g for prisoners.	Establish community access points for PWDs
Acceptable services	Working well	Working well
Tailored / appropriate services	The package of services and delivery approaches is tailored to the specific needs of PWIDs in all diversities.	
Clinical Interventions		
Needle exchange and syringe programme (NSP)	NSPs have been established, are freely available without restrictions, and are integrated with access to other support and care services for PWID.	
Opioid substitution treatment	Opioid substitution therapy is freely offered and accessible to PWID.	
Condoms and lube	All PWID have access to condoms and lube at all times. Condom demonstrations are conducted regularly.	

HIV testing services	HIV testing services are available for PWID according to the WHO consolidated guidelines, with appropriate linkage to care and treatment for those testing HIV-positive and prevention services for those testing HIV-negative.	
Pre-exposure prophylaxis	Oral PrEP is available for PWID at substantial risk of HIV infection as part of a comprehensive combination prevention approach.	
Sexually transmitted infection prevention, screening and treatment	STI screening, testing and treatment is available for PWID according to national STI management guidelines.	
Family planning and SRH	Family planning and other reproductive health services are available and accessible for all PWID.	
Post-violence care	Post-violence services are accessible for all PWID such as support, counselling, PrEP, STI testing, and referral to comprehensive GBV.	
TB prevention, screening and treatment	TB prevention, screening and treatment is available for PWID, with appropriate antibiotic adherence support and linkage to HIV testing services for those testing positive.	
Viral hepatitis prevention, vaccination, screening and treatment	No national program	
Drug and alcohol use screening and treatment	Limited in scale	Scale up
Mental health care	Mental health care is accessible and consistently provided to PWID members living with HIV.	
Voluntary medical male circumcision	Available	
COVID-19	Challenges with infection control; space	Improve space and waiting areas; improve infection control facilities
Behavioural interventions		
Social behaviour change communication (SBCC)	IEC materials lacking	

Structural interventions		
Violence prevention and response	Absent	Legal and policy framework needs to be worked on
Stigma and discrimination reduction	Absent	
HIV-related legal services	Limited scale (UGANET), restricted to Kampala and nearby areas	Scale, legal and policy framework
Monitoring law-enforcement	absent	Neeed for more advocacy; stategic framework, policy framework needed
Legal literacy ("Know your rights")	Limited to civil society	scale, strategic framework needed
Sensitization of law-makers and law-enforcement agents	Limited efforts by civil society; advocacy manual in place but not implemented	scale, strategic framework needed
Training for health care providers on human rights and medical ethics related to HIV	absent; guidelines for mainstreaming in health sector are available	curriculum not available
Reducing discrimination against women in the context of HIV	absent	
Safe spaces / drop-in centres	present but few	scale
Community committees	absent but PWID CSOs somewhat play this role	set up
Programme monitoring		
Routine monitoring	indicators present but not comprehensive enough	
Community-led monitoring for accountability	CLM has not been operationalized PWIDs	Operationalize CLM at PWID service delivery points
Referral system tracking	System is there but HR limitations, e.g., individuals have to be escorted. Limited HR to enforce full scale of referral and linkage	Strengthen HR
Quality assessment	Data is collected on programme quality through well-defined indicators which incorporate feedback from PWID on services.	Establish CQI projects
Surveillance	Absent	
Data for decision making	A KP tracker exists but includes few indicators	Need to develop strategy, strategic plan, operational plan, and policy framework.

Unique Identifier Code for programme monitoring	Absent	
Budget monitoring	Absent	

Domestication of National Action Plan Activities

ACTION PLANS	Pillars of prevention	Current progress	Gaps	Milestones	Activities
1: Conduct a data-driven assessment of HIV prevention programme needs and barriers	KPs	• DICS assessment was done 2022 • Crane survey is underway and almost completed. • Revised the DIC guidelines and under dissemination in all Regions • Adopted and rolled out the integrated BIO-Behavioural Survey (IBBS) Lite Version Pilot completed and roll out ongoing • Developed Data tools to be integrated into HMIS A MOT and prevention analysis study is currently ongoing • Completed legal and policy environment assessment. • Completed the PMTCT impact assessment, UPHIA, CRANE survey in a few districts and IBBS Lite assessment in a few districts	• KP data is not disaggregated by KP categories, • Lack of an up-to-date analysis of epidemic patterns and trends at national and subnational levels for KPs • There is inconsistency in disaggregation of KP categories, • We lack current size estimates for KPs • There is no focused comprehensive evaluation of HIV prevention Programs • Lack of an integrated M&E plan for HIV prevention interventions. • The needs assessment for KPs has not been done	• Updated epidemic patterns and trends with disaggregation of standard • Key population categories at national and subnational level for key and priority populations • Size estimates of Key and Priority Populations • Focused comprehensive annual evaluations of HIV prevention Programs • An integrated M&E plan for HIV prevention interventions	• Finalise and disseminate the MOT and Prevention analysis study • Adopt the IBBS Lite and implement annually and compliment with Crane survey to do KP size estimate • Annual Prevention Symposium Feeding into the JAR • Engage TA to develop an integrated M&E plan for HIV Prevention Programs that feeds into the NSP M&E Plan • Capacity building of relevant stakeholders • Complete and Validate the PSAT • Convene the NPC to do the midterm review of the prevention thematic area of the NSP Conduct needs assessment

	ADOLESCENT BOYS AND MEN	• Analysis on epidemic patterns and trends at the national and subnational levels	• Country needs assessment not done. • Population size estimates based needs, vulnerabilities, and risks not done. • DHIS2 lacks finer age disaggregation- limited scale of the program • Lack of tailored programs ABM that covers the whole country. • Weak reporting systems for Behavioural and structural interventions (no tailored indicators). • There are no regular reviews for ABM program data • The needs assessment for ABM has not been done. Prevalence, comprehensive knowledge, condom use, behavioural indicators, GBV, Service access. -UPHIA, UDHS does not have up to date data since 2016. • GBV Data missing in clinical care. No nationally agreed upon Indicators & targets. No granular age disaggregation of data. No disaggregation of data in terms of diversity and vulnerability. • Lack of community data capture structures at national level. Incomplete	• Updated M&E framework to include comprehensive indicators for Adolescent boys and men • Focused comprehensive annual evaluations of HIV prevention Programs • An integrated M&E plan for HIV prevention interventions. • Develop a tailored ABM Program to cover the whole country • Strengthen data capture and utility, Incorporate data parameters i.e. - 1-Disease burden (Prevalence and Incidence), 2-Risk & Behaviour (Indicators on Level of Risk, Number of partners), • Comprehensive knowledge (Sero-Status) and 4-Access to Care/Service (capture data under CQI). • Finer Age desegregation, 2-3	• Finalise and disseminate the MOT and Prevention analysis study • Adopt the IBBS Lite and implement annually triangulating with the Crane survey for KP size Estimate • Annual Prevention Symposium Feeding into the JAR • Engage TA to develop an integrated M&E plan for HIV Prevention Programs that feeds into the NSP M&E Plan • Capacity building of relevant stakeholders • Complete and Validate the PSAT • Convene the NPC to do the midterm review of the prevention thematic area of the NSP • Conduct comprehensive needs assessment and stock taking exercises. • Conduct legal, policy and societal assessments on capacity and critical service needs

			comprehensive needs assessment for ABM (service done, awaiting behavioural).	year midterm review and 5 year review. • Complete comprehensive needs assessment (policy, legal, societal barriers and enablers to service access). • Complete population size estimates. Nationally agreed targets and indicators (highlight combination prevention package)"	
	ADOLESCENT GIRLS AND YOUNG WOMEN	• Availability of data for planning • Completed PMTCT Impact assessment UPHIA done DREAMS program data available • Ongoing Gender assessment for HIV response supported by Global fund Ongoing Gender barriers assessment in SRH and MNCH supported by UN women Ongoing Leaving no one behind assement supported by UN women YAPS MIS that tracks	• Insufficient coverage of the assessments Suboptimal programs like DREAMS that do not cover the whole country • Weak reporting systems for Behavioural and structural interventions • There are no regular reviews for AGYW program data • The needs assessment for AGYW has not been done. • Prevalence, comprehensive knowledge, condom use, behavioural indicators, GBV, Service access. - UPHIA, UDHS does not have up to date data since	• AGYW Program scaled up to cover the whole country AGYW take up leadership positions in societies. • Strengthen data capture and utility, Incorporate data parameters i.e. - 1-Disease burden (Prevalence and Incidence), 2-Risk & Behaviour (Indicators on • Level of Risk, Number of partners), 3-Comprehensive knowledge (Sero-Status) and 4-Access to Care/Service (capture data under CQI). 5-	• Finalise and disseminate the MOT and Prevention analysis study • Adopt the IBBS Lite and implement annually Annual Prevention Symposium Feeding into the JAR • Engage TA to develop an integrated M&E plan for HIV Prevention Programs that feeds into the NSP M&E Plan • Capacity building of relevant stakeholders • Complete and Validate the PSAT • Convene the NPC to do the midterm review of the prevention thematic area of the NSP

		progress of activities that YAPS do with AGYW	2016.-GBV Data missing in clinical care. • No nationally agreed upon Indicators & targets. • No granular age disaggregation of data. No disaggregation of data in terms of diversity and vulnerability. • Lack of community data capture structures at national level. • Incomplete comprehensive needs assessment for AGYWS (service done, awaiting behavioural).	Finer Age disaggregation, 2-3 year midterm review and 5 year review. • Complete comprehensive needs assessment (policy, legal, societal barriers and enablers to service access). • Complete population size estimates. Nationally agreed targets and indicators (highlight combination prevention package)	• Scale up Leadership and mentorship empowerment training for adolescent girls and young women • Conduct needs assessment
	ARV -BASED PREVENTION	• Complete and Availability of disaggregated data of PLHIV on ART • Availability of disaggregated data on PrEP • Availability of disaggregated data on PEP • Updated consolidated HIV • Prevention care and treatment guidelines 2022 • Availability of Data on Viral load • LEAR report and assessment is available • Stigma and discrimination guideline have been done- (dissemination	• Sub optimal coverage of ARV based prevention programs like PrEP • Yet to achieve the treatment and Viral load 95 targets • Inadequate delivery mechanism of third line ART to the beneficiaries in the community • No adequate supplies for ARVs and PrEP • No current size estimates for KP • PrEP Retention challenges • The Legal Assessment Survey conducted by UAC identified existing legal and policy barriers • Rapid and/routine assessments are done but not for all risk categories e.g. done for sex workers	• Scaled up coverage of ARV based prevention programs like PrEP • Robust supply chain for ART including 3rd line ART • A National resilient and optimal viral load coverage program	• Complete and Validate the PSAT • Scale up the ARV based prevention programs like PrEP • Perform Statistical modelling to get an estimate of the number of people in need of ARV based Prevention • Implement recommendations of the LEAR report to address the Legal, Policy and Societal Obstacle • Standardised assessments to include all subcategories review policies and laws to cater for excluded categories

		is limited to some levels and does not) Rapid and/routine assessments are done for specific risk categories • Multisectoral coordination at national level exists (not strong at subnational levels)	• Targets at subnational level do not include the gender and age bands • Not all groups have been engaged substantially like Prisoners, AGYW, Pregnant women. • Targets not set based on the need		e.g. MINORS under 18 years • Multi sectoral engagement in legal and policy review to cater for stigma and discrimination
	CONDOM PROGRAMMING	• An ongoing assessment for the availability and accessibility of condoms at the community user level, • The availability of an approved Condom programming strategy • An ongoing study on country-wide condom demand, utilization, distribution and disposal • Adopted CNET for condom quantification • An approved condom distribution guideline is currently available GIS mapping of hotspots for condom distribution • Availability of the Last Mile distribution approach Market surveillance and assessments by commercial IPs irregularly	• Insufficient & irregular coverage of the assessments • Conducted by Commercial Partners for their market projection not serving country interests • Limited commitment and prioritization from government to the TMA in terms of resources for market analysis, and programming activities e.g. demand creation and stigma attached to condom programming. • No coordinated mechanism available to objectively measure the proportion of appropriate outlets that carry condoms • Insufficient reporting • There no surveys that have been conducted to understand condom availability and peoples preferences	• Country needs (Who, where, when) for Lubricants determined • Market segmentation study conducted • Market surveillance study • A coordinated reporting mechanism established for condom programming • Comprehensive countrywide assessments conducted • Mainstreamed regular market surveillance and assessments conducted nationally and aligned to global guideline requirements	• Conducting a National Market Surveillance and comprehensive total market approach • Review & integrate condom data collection tools at all relevant PoC, Conduct a condom stock monitoring at the last mile • Establishing a coordinated reporting mechanism for condom programming • Conducting scientifically designed assessments to bring out a national picture of condom programming needs • Regular coverage of the assessments • Advocate for prioritization of TMA by government in terms

			• Complete and Validate the PSAT	• Suboptimal reporting by cost recovery and no data is reported from the commercial side. • No assessment has been done to understand the country needs for Lubricants. • No market segmentation studies have been done • No data on coverage of current demand creation interventions	• Distribution and behaviour user targets disaggregated for risk categories and groups up to subnational levels done • Finalised PSAT for condom programming • A comprehensive total market assessment for Condom Program completed • Condom distribution guidelines disseminated • Updated HMIS tools to include condom data in routine data collection • Available information on coverage of demand creation interventions	of resources for market analysis, and programming activities e.g. demand creation and stigma attached to condom programming. • Establish coordinated mechanism to objectively measure the proportion of appropriate outlets that carry condoms and operationalise regular reporting • Dissemination the guidelines on condom distribution • Suboptimal reporting by cost recovery and no data is reported from the commercial side. • Conduct needs assessment to understand the country needs for Lubricants. • Conduct market segmentation studies
2	**Adopt a precision prevention approach focused on the key and priority populations to develop**	KEY POPULATIONS	• The developed Equity plan is being implemented • KP tracker able to provide data for planning • DSD guidelines available	• The interventions are generalised and do not target to the different key population sub groups • Updated DSD guidelines are not yet rolled out to the subnational levels	• Updated National Prevention road map Updated and rolled out DSD guidelines • KP tracker is government owned	• Finalise and roll out DSD guidelines to the subnational levels • Transition the KP tracker to government and widen its scope to all facilities

	national HIV prevention goals aligned to the 2025 targets		• Presence of Revised DIC guidelines • Existence of National Prevention Roadmap • Existence Of KP programming Framework • Existence of MARPS priority action plan DSD tool kit for KPs is available • National and subnational KP size estimates last done in 2019 - Provide service package per age group. • estimates present National distribution and behavioural user targets	• KP tracker is donor funded and scope is limited to a few facilities • Targets for different subgroups are not yet set • **The equity plan is not disseminated to national and subnational levels** • The current national prevention roadmap does not captured all the typologies of the key and priority populations. • DSD Toolkit for KPs not yet updated and operationalised • The national KP size estimates are not updated • The MARPS Priority action plan is still in draft form • The KP programming framework is still in draft form • KP guidelines are still in draft form • The KP training manual 2018 yet to be updated • The KP peer training manual 2020 yet to be updated	• Targets for the different subgroups set • Equity plan disseminated to national and subnational levels • Updated DSD Tool Kit Updated National KP size estimate • Approved MARPS priority plan • Approved KP Programming Framework • Approved KP guidelines • Updated KP Training Manual • Updated KP Peer Training Manual	• Set Targets for different subgroups at national and subnational levels • Disseminate and popularize the equity plan to national and subnational levels • Update and disseminate the National HIV Prevention roadmap • Update disseminate and operationalise the DSD Toolkit for KPs • Update The national KP size estimates • Finalise and disseminate the MARPS Priority action plan • Finalise and disseminate KP programming framework • Finalise and disseminate KP guidelines • Update and operationalise the KP training manual • Update and operationalise the KP peer training manual
		ADOLESCENT BOYS AND MEN	No ABM programme currently	• Lack of targets and population size estimates per risk category (No/ mild, moderate, higher and KP).	• An integrated DSD sensitive Intervention package for	• Develop a tailored ABM Program to cover the whole country.

				• No granular targets to quantify subcategories according to risk • The package of interventions is still generalised • The appropriateness of the interventions are not tailored to the social cultural context (No analysis has been done of the social cultural contexts, needs and challenges in the different region and communities of ABM) • There are no National or Subnational targets for ABM programs for Precision Preventions • There is no Multisectoral ABM Guidelines the targets are not disaggregated for risk categories and groups. • No targets for the subnational levels	Precision prevention in place Target set for AGYW populations at national and subnational levels • Multisectoral ABM guidelines in place • Strengthened capacity of subnational units to collect data on social cultural drivers and use it in planning and implementation of AGWY response • Size estimation and mapping of ABM by risk Profile in place • Prevention goals and Targets Set for ABM in their Diversity • Granular national and subnational HIV prevention goals and targets for ABM in their • Diversity set based on detailed subnational and population specific data. • An updated prevention consensus on the social and structure determinants	• Using population size estimates, needs based assessments and risk profiling to develop targets and indicators. • Conduct a Size estimation and mapping of ABM by risk Profile. • Set Target for ABM populations at national and subnational levels • Set targets and goals for the different sub categories according to risk profile • Conduct evidence driven assessments. Generate consensus on the social and structure determinants and update the prevention road map "

		ADOLESCENT GIRLS AND YOUNG WOMEN		• Lack of targets and population size estimates per risk category (No/ mild, moderate, higher and KP). • No granular targets to quantify subcategories according to risk • The package of interventions is still generalised • The appropriateness of the interventions are not tailored to the social cultural context (No analysis has been done of the social cultural contexts, needs and challenges in the different region and communities of AGYW.) • There are no National or Subnational targets for AGYW Programs for Precision Preventions • There is no Multisectoral AGYW Guidelines	• An integrated DSD sensitive Intervention package for Precision prevention in place • Target set for AGYW populations at national and subnational levels • Multisectoral AGYW guidelines in place • Strengthened capacity of subnational units to collect data on social cultural drivers and use it in planning and implementation of AGWY response • Size estimation and mapping of AGYW by risk Profile in place *prevention goals and Targets Set for AGYW in their Diversity • Granular national and subnational HIV prevention goals and targets for AGYW in their Diversity set based on detailed subnational and population specific data	• Conduct a Size estimation and mapping of AGYW by risk Profile. • Set Target for AGYW populations at national and subnational levels • Set targets and goals for the different sub categories according to risk profile • Conduct evidence driven assessments Generate consensus on the social and structure determinants and update the prevention road map

					• An updated prevention consensus on the social and structure determinants	
		ARV -BASED PREVENTION	• Multi-Sectoral and Intersectoral coordination and engagement fora exits (lack a harmonised framework to track progress and feedback mechanisms, not representative of all stakeholders) • Population size estimates and gap analysis done (but not according to risk profiling by age area etc.) • National and subnational targets in place (microplanning and data use at subnational level lacking) • Guidelines on PrEP and PEP administration available for subnational involvement ()Dissemination needs to be strengthened	• Not all sector involved in coordination with other ministries/departments (e.g. finance, law enforcement, education, development, etc.) takes place • Limited scale-up of community safe spaces to reach AGYW in different community settings like barracks, universities • Inadequate linkage to preventive options (including PrEP) at all HIV testing points due to the absence of services at all testing points • Not all Facilities providing PrEP services are conveniently located geographically	• Strengthened coordination for all stakeholders and adopt new approaches • Harmonised M&E framework • Population size estimation based on risk profile and subcategories • National and sub national targets in place with harmonised progress monitoring mechanism • Disseminated guidelines for PrEP and PEP administration at all sub national levels • Strengthen community engagement and coordination	
		CONDOM PROGRAMMING	• National but no subnational targets for broad categories of priority populations	• The national comprehensive condom Programming strategy and implementation plan is generalised and does	• An integrated costed national comprehensive condom Programming	• Population size estimations with risk and perception profiling by

			• Existence of a National comprehensive condom Programming strategy and implementation plan • Existence of the Hot spot Mapping Guideline • Existence of an updated national condom distribution guidelines • DSD guidelines for Condoms in draft form. • Existence of an electronic monitoring application for condom distribution	not target to the different key population sub groups and is not costed. • No condom communication guidelines • Hot spot Mapping Guideline still in draft form • The updated national condom distribution guidelines yet to be rolled out country wide and operationalised • DSD guidelines for Condoms still in draft form *The Electronic monitoring application for condom distribution is not yet mainstreamed and added to the MoH server • Absence of SBCC strategy and robust demand creation programs for condoms • Absence of Social Marketing programs for condoms • Lack of domestic funding for Condoms • **Lack of an M&E Plan for Condom Programming**	strategy and implementation plan sensitive for Precision prevention for the different key population sub groups in place • Approved Hot spot Mapping Guideline • The updated national condom distribution guidelines rolled out country wide and operationalised • Approved DSD guidelines for Condoms • The Electronic monitoring application for condom distribution is mainstreamed at MoH and operationalised country wide • Finalised and operationalised SBCC strategy and robust demand creation programs for condoms effected • Presence of Social Marketing programs for condoms	subcategories in the priority populations. • Design an integrated costed national comprehensive condom Programming strategy and implementation plan sensitive for Precision prevention for the different key population sub groups in place • Finalise and operationalise the Hot spot Mapping Guideline • Roll out and Operationalise the updated national condom distribution guidelines • Finalise and Roll out communication, DSD guidelines for Condoms • Lobby for resources to mainstream at MoH and operationalise country wide the Electronic monitoring application for condom distribution • Finalise and operationalise SBCC strategy and robust demand creation

					• Availability of domestic funding for Condoms • **Finalised operationalised M&E Plan for Condom Programming** • District led innovations that support last mile distribution • Granular national and subnational condom(Access, use, Demand) targets based on detailed subnational and population specific data	programs for condoms effected • Establish a robust Social Marketing program for condoms that includes condom demand creation • Advocate and Lobby for domestic funding for Condoms • Finalise operationalise M&E Plan for Condom Programming • Capacity building for the Districts to take lead in innovations that support last mile distribution
3	**Define country investment needs for an adequately scaled HIV prevention response and ensure sustainable financing**	KEY POPULATIONS	• Existence of a costed Equity plan for addressing Human rights, equity and gender related barriers to access to HIV, Malaria and TB services by KPs • Existence of a costed MARPS priority action plan • A Draft costed National KP programming framework (Under development) • Adoption of integrated approach to service delivery for KP and PPs	• Integrated KP friendly services are not in all facilities • KP Programming is majorly donor funded • No policies about social contracting • No awareness about social contracting by key decision makers • The complementarity resources are not sufficient to reach the desired coverage optimally • Lack of uniformity in delivery of the recommended minimum care package by the implementers basing on		• Validation of the MARPS priority costed action plan • Strengthen coordination of partnerships with other agencies • Involvement of all sectors of society - governments, businesses, civil society organizations, communities and people living with HIV/AIDS at all levels in addressing to address KP programing challenges.

			• Availability of funds for KP Programming • There is complementarity of resources for a holistic HIV response • Rationalisation of partner support to minimise duplication and wastage • Presence of a coordinated mechanism for health development partner support • Existence of Facility and community drop in centers	their priorities and resources • Low coverage of KP friendly services • Low coverage of DIC (74 drop in centers the whole country, 19 in Kampala)		• Collaborating with different ministries, community organizations, and civil society organizations to assess capacities and the need for technical support, financial support for KP programming. • Increasing the scope of integrated, comprehensive interventions for key populations, such as drop-in facilities in community general and referral hospitals and outside the hospital environment. • Working with HIV Champions to disseminate Condom promotion messages and participate in educational and outreach initiatives, hand out IEC materials, use social media to reach out to others, and mobilize KPs for Condom promotion activities. • Enhance collaboration between communities associations of priority and key populations and all

						other partners in adopting an evidence-based HIV prevention agenda with a clear understanding of roles and responsibilities. • Leverage youth-led HIV prevention programs, such as the YAPS, to reach adolescents and young people with HIV Prevention initiatives.
		ADOLESCENT BOYS AND MEN	• Costed NSP with components of ABM Programming not based on risk profile • Self-coordinating entities and engagement structure across all sectors are in existence • UNAIDS developing a multisectoral financing mechanism	• No tailored program for ABM • Lack of costed strategic plan for ABM not aligned to risk profiles based on revised global targets, • No resource mobilisation plan for ABM. • Limited funding to the self-coordinating entities for coordination of ABM activities. • No legal and policy framework for social contracting.	• A Defined HIV prevention investment needs with components of ABM milestones aligned to risk profiles • Costed NSP with components of ABM milestones aligned to risk profiles respecting equity and efficiency with proportionate allocations for all essential components of a combination prevention response • Comprehensive Resource mobilisation plan developed with components for	• Gap analysis • Develop comprehensive HIV prevention costed plan with ABM components based on risk profile, equity and multisectoral approach and in line with global targets • Develop HIV Prevention resource mobilisation plan (e.g. AIDS trust, consolidated fund, sovereign fund) • Institute "basket budget" to Consolidate budgeting efforts with all self-coordinating entities • Multisectoral impact analysis of HIV

					ABM aligned to risk profiles based on the costing gaps • Completed Multisectoral impact analysis of HIV preventions strategies to control for inefficiencies and inform allocation of resources • Functional basket budget to consolidate budgeting efforts with self-coordinating entities with guidance to include components of AGYW aligned to risk profiles • Social contracting legal and Policy framework, guidelines developed • Implement social contracting • Operationalised AIDS trust fund. • Finalised, disseminated and operationalised Multisectoral financing mechanism with components of ABM milestones	preventions strategies to control for inefficiencies and inform allocation of resources • Develop social contracting legal and policy framework (guidelines) • Operationalise the multisectoral financing mechanism

					aligned to risk profiles	
		ADOLESCENT GIRLS AND YOUNG WOMEN	• Costed NSP with components of AGYW planning not based on risk profile • Self-coordinating entities and engagement structure across all sectors are in existence. • UNAIDS developing a multisectoral financing mechanism	• Lack of costed strategic plan for AGYWS not aligned to risk profiles based on revised global targets. • No resource mobilisation plan for AGYWs. • Limited funding to the self-coordinating entities for coordination of AGYWs activities • No legal and policy framework for social contracting.	• A Defined HIV prevention investment needs with components of AGYW milestones aligned to risk profiles • Costed NSP with components of AGYW milestones aligned to risk profiles respecting equity and efficiency with proportionate allocations for all essential components of a combination prevention response • Comprehensive Resource mobilisation plan developed with components for AGYW aligned to risk profiles based on the costing gaps • Completed Multisectoral impact analysis of HIV preventions strategies to control for inefficiencies and inform allocation of resources	• Gap analysis • Develop comprehensive HIV prevention costed plan with AGYW components based on risk profile, equity and multisectoral approach and in line with global targets • Develop HIV Prevention resource mobilisation plan (e.g. AIDS trust, consolidated fund, sovereign fund) • Institute "basket budget" to Consolidate budgeting efforts with all self-coordinating entities • Multisectoral impact analysis of HIV preventions strategies to control for inefficiencies and inform allocation of resources • Develop social contracting legal and policy framework (guidelines) • Operationalise the multisectoral financing mechanism

					• Functional basket budget to consolidate budgeting efforts with self-coordinating entities with guidance to include components of AGYW aligned to risk profiles • Social contracting legal and Policy framework, guidelines developed • Implement social contracting • Operationalised AIDS trust fund. • Finalised, disseminated and operationalised Multisectoral financing mechanism with components of AGYW milestones aligned to risk profiles	
		ARV -BASED PREVENTION	• Multisectoral Resource mobilisation plan (exists comprehensively lacks customisation for the 5 pillars) • Sustainability plan (UNAIDS developing a multisectoral financing mechanism)	• Unit cost of the intervention • Limited funding to the self-coordinating entities for coordination activities. • No legal and policy framework for social contracting.		• Develop an ARV-specific Resource mobilisation and sustainability plan • Developed a legal and policy framework for social contracting mechanisms for PrEP programming

			• Costed equity plan/strategy • Population size estimation according to risk profile and sub categories • CLM derived data for community ownership and adoption • Costed NSP with components of ARV Based prevention Programming not based on risk profile • Self-coordinating entities and engagement structure across all sectors are in existence • Integration strategy in place (not yet operationalised and disseminated to all levels)	• No country-specific financing target for ARV-based intervention • Insufficient domestic financing • PrEP budget is not integrated due to parallel funding		• Population size estimation according to risk profile and sub categories • Develop an investment case
		CONDOM PROGRAMMING	• Existence of the National comprehensive condom programming strategy and implementation plan • Existence of condom needs estimation tool • Existence of last mile distribution application • Availability Condom distribution reported and analysed from HMIS	• Lack of a costed condom programming strategy and implementation plan • Lack of an integrated condom financing strategy • The last mile distribution Application is still partner owned • Lack of regular analytics to inform on condom programming • Lack of a social marketing program • Limited scale of CLM not country wide	• Availability of a costed condom programming strategy and implementation plan • Estimates of condoms needed based on updated data in the CNET • Availability of an integrated condom financing strategy • Availability of quarterly analytics to inform condom programming	• Develop and operationalise a condom resource mobilisation strategy to address financial and human resource gaps • Conduct Total market research on targeted messaging and impact assessment done regularly • Develop and operationalise a resource mobilisation strategy

			• Ability to get information from CLM • Guidelines on SBCC for condom programming are being developed • Annual estimated need for Condoms is Procured • Developed a TMA plan • Ability to use multiple routes to distribute condoms • Condoms integrated in the other combination prevention pillars. • SBCC on condom programming in place but not targeted • Population size estimations done regularly	• Lack of a coordinated demand creation program • Lack of domestic financing for condom Procurement • Delayed operationalisation of the TMA plan. • SBCC messaging not targeted and not impact assessments on messaging • Symposiums on best practices on programming not done • Levies from commercial providers to support programming	• Availability of a social marketing condom program • Existence of CLM program that goes beyond facilities to cover community and implementing partner activities beyond commodities • Availability of a robust coordinated and operationalised demand creation program • Availability domestic financing for condom Programming • Condom TMA in operation • Total market research on targeted messaging and impact assessment done regularly symposiums on programme best practices	for condom programming sustainability • Targeted financing for all components of condom programming initiatives: Last mile distribution, SBCC, Demand creation, Stewardship, Commodities (Male condoms, Female condoms, Demonstration gadgets, Lubricants, Dispensers,) with a focus on key and priority populations. • Quarterly meetings to engage key Multisectoral stakeholders for coordination and collaboration in integrated condom Programming activities • MOH to procure and operationalise the last mile distribution Application • Finalise, validate and operationalise the costed condom programming strategy and implementation plan • Annually update the CNET

						• Hold quarterly data review meetings on condom programming • Adopt and operationalise a social marketing condom program • Scale up the CLM program to go beyond facilities to cover community and implementing partner activities beyond commodities and improve on the feedback mechanism. • Organise symposiums on best programme practices *impact assessments to inform programming • Levies on commercial profits to support programming
4	**Reinforce HIV Prevention leadership entities for multisectoral collaboration, oversight, and management of prevention responses and set up social**	KEY POPULATIONS	• Existence of a national KP steering committee which is a Multisectoral coordination committee with KP Led CSOs and other actors with Users represented • Existence of KP TWG in MoH which has inclusive	• Inadequate support to conduct business of the national KP steering committee which is a Multisectoral coordination committee • Inadequate support to conduct business of the TWG(Oversight and management of the HIV prevention response roles)		

	contracting mechanisms		representation (KPS and actors within KP Programming) • Existence of KP focal persons at district levels *Existence of Multisectoral response at UAC • Existence of Multisectoral KP PP framework • Representation of KP PP at CCM • Existence of leadership and coordination structures of KP led CSOS	• Insufficient support to the district KP focal persons to carry out their roles and responsibility for the HIV prevention response (Coordination and oversight) • Limited commitment of other sectors to fulfil their roles and responsibilities under the multisectoral approach on HIV response at all levels (National, and subnational levels) • The Multisectoral KP PP framework is yet to be rolled out countrywide		
		ADOLESCENT BOYS AND MEN	• NPC exists at national level but does not have ABM representation. • Male engagement strategy exists	• MoH ABM secretariat does not exists to provide oversight • Out dated male engagement strategy. • No Management- ABM focal person at MoH and UAC at national level; -No ABM focal persons exist at district up to facility level but not mainstreamed. • Multi-thematic quarterly performance reviews meetings. • No TWGs are multi-thematic in representation. • Private sector engagement framework exists not tailored for ABM.	• NPC incorporates ABM programming • Coordination entities of HIV Prevention for ABM at all levels from subnational structures mainstreamed to National level coordination structure • Representation of ABM in different HIV combination prevention programs nationally and sub nationally • Defined Private sector involvement	• Develop guidelines for selecting, coordinating and engaging sub national ABM oversight and management structures/entities. • Cascade multisectoral collaboration from national to all subnational and community levels. • Joint planning of the different TWGs for consolidated efforts. • Tailor to ABM and implement private sector engagement framework

				• No subnational ABM taskforce. • ABM structures are not mainstreamed to the government of Uganda coordination structure. • Strengthen subnational coordination of HIV prevention pillar with government leadership. • Limited engagement of the private sector in ABM interventions. • Limited coverage and Scope of the CSO interventions in ABM. • Limited funding and HR to the assigned led entity to provide multisectoral collaboration and planning for ABM.	in evidence-based HIV prevention agenda for ABM • Community led programming for ABM at all levels from subnational and national level • Programme Representation will be age based factoring in the boys and Men sub-categories • Updated and operationalised male engagement strategy	• Scale up and cascade to lower level the community led participation in ABM programming. • Fundraise for UAC • NPC incorporates ABM programming • Review and update the male engagement strategy aligned with Global standards
		ADOLESCENT GIRLS AND YOUNG WOMEN	• NPC & AGYW exist and are multisectoral-limited to national level • MoH AGYW secretariat exists to provide oversight • Management- AGYW focal person at MoH and UAC at national level; AGYW focal persons exist at district up to facility level but not mainstreamed. • Multi-thematic quarterly performance reviews meetings. TWGs are multi-	• No subnational AGYW taskforce. • AGYW structures are not mainstreamed to the government of Uganda coordination structure. • Strengthen subnational coordination of HIV prevention pillar with government leadership. • Limited engagement of the private sector in AGYW interventions. • Limited coverage and Scope of the CSO interventions in AGYWs. • Limited funding and HR to the assigned led entity to provide multisectoral	• Coordination entities of HIV Prevention for AGYW at all levels from subnational structures mainstreamed to National level coordination structure • Representation of AGYW in different HIV combination prevention programs nationally and sub nationally.	• Develop guidelines for selecting, coordinating and engaging sub national AGYW oversight and management structures/entities. • Cascade multisectoral collaboration from national to all subnational and community levels. • Joint planning of the different TWGs for consolidated efforts. • Tailor to AGYW and implement private sector

			thematic in representation. • Private sector engagement framework exists not tailored for AGYW. • CLM, shadow reporting for prevention, Community representation on NPC, JAR, TWG. • UAC leads cross-sectoral, joint planning and MGT of the intervention	collaboration and planning.	• Defined Private sector involvement in evidence-based HIV prevention agenda for AGYW • Community led programming for AGYW at all levels from subnational and national level	engagement framework • Scale up and cascade to lower level the community led participation in AGYW programming.
		ARV -BASED PREVENTION	• NPC & Prevention TWG exist and are multisectoral- limited to national level • MoH KP secretariat exists to provide oversight • Management- PrEP focal person at MoH and UAC at national level; PrEP focal persons exist at district up to facility level but not mainstreamed. • Multi-thematic quarterly performance reviews meetings. TWGs are multi-thematic in representation. • Private sector engagement framework exists not tailored for AGYW.	• No subnational task force. • Different population structures are not mainstreamed to the government of Uganda's coordination structure. • Weak subnational coordination of HIV prevention pillar with government leadership. • Limited engagement of the private sector in AGYW interventions. • Limited coverage and Scope of the CSO interventions. • Limited funding and HR to the assigned led entity to provide multisectoral collaboration and planning.	• Annual prevention symposiums preceding JAR • Coordination entities of HIV Prevention for PrEP at all levels from subnational structures mainstreamed to National level coordination structure • Representation of AGYW in different HIV combination prevention programs nationally and sub nationally • Defined Private sector involvement in evidence-based	• Organise Annual prevention symposiums prior to the JAR • Strengthen coordination structures from the sub-national level for PEP and PrEP programming. • Strengthening community led programming for PrEP at all levels from subnational and national level

			• CLM, shadow reporting for prevention, Community representation on NPC, JAR, TWG. • UAC leads cross-sectoral, joint planning and MGT of the intervention		HIV prevention agenda for PrEP • Community led programming for PrEP at all levels from subnational and national level • Coordination of PrEP programming at all subnational level	
5	**Strengthen and expand community-led HIV prevention services and set up social contracting mechanisms**	KEY POPULATIONS	• Existence of DICs in communities that provide HIV Prevention services • Sub-granting of KP CSOs and other Actors for HIV prevention services • Existence of community score card • Existence of CLM • Existence of leadership and coordination of KP led CSOS • Existence of Peer led HIV prevention mechanisms and services • Existence of linkage and referral mechanisms between the community and facilities *Existence of DIC guidelines that guide the establishment and operation of DICs • Existence of mechanisms to create	• Low coverage and inadequate funding of DICs in communities and facilities that provide HIV Prevention services • Few KP CSOs and other Actors are funded for HIV prevention services and these are majorly in urban areas around Kampala • The implementation of the community score card has not been scaled up • The CLM is still in pilot phase with low coverage and there no linkage between CLM and government reporting and feedback mechanisms • The leadership and coordination of KP led CSOs are majorly around Kampala and are multiple network leaderships • Inadequate facilitation of Peers and their support processes • These are majorly donor funded.		

			an enabling environment for KP and PPs in the community	• Inadequate Communication between Community and facility, Poor documentation, limited availability of essential KP services and commodities at the facilities • The DIC guidelines that guide the establishment and operation of DICs have not been rolled out country wide • Inadequate funding for community sensitisation meetings on KP PP Programming • Limited KP services available • Lack of harmonised KP PP community tools.		
		ADOLESCENT BOYS AND MEN		• No legal and policy framework for social contracting.	• Legal and policy Frameworks on social contracting mechanism with components of ABM developed and operationalised.	• Identify and empower community leadership to foster community initiatives and define HIV prevention priorities • Advocate and Develop legal and policy framework to conduct social contracting of services for KP &PP. • Develop guidelines for mgt, capacity building and technical assistance of community led

						organization engaged in social contracting. • Multisectoral resource mobilisation to fund community led organisation engaged in social contracting. conduct size estimation and needs assessment in order to set targets for increasing the proportion of HIV prevention services delivered by Community led organisation engaged in social contracting
		ADOLESCENT GIRLS AND YOUNG WOMEN		• No legal and policy framework for social contracting.	• Legal and policy Frameworks on social contracting mechanism with components of AGYW developed and operationalised.	• Identify and empower community leadership to foster community initiatives and define HIV prevention priories • Advocate and Develop legal and policy framework to conduct social contracting of services for KP &PP. • Develop guidelines for mgt, capacity building and technical assistance of community led

						organization engaged in social contracting. • Multisectoral resource mobilisation to fund community led organisation engaged in social contracting. conduct size estimation and needs assessment in order to set targets for increasing the proportion of HIV prevention services delivered by • Community led organisation engaged in social contracting
		ARV -BASED PREVENTION	• Existence of select PrEP and PEP sites limited to facilities • Sub granting of CSOs and other Actors for HIV prevention services • Existence of community score card • Existence of CLM • Existence of leadership and coordination of KP led CSOs • Existence of Peer led HIV prevention mechanisms and services	• No National and subnational targets for services delivered by Community-led organizations. • There is legal and policy obstacles to CLM organizations • Low coverage and inadequate funding in communities and facilities that provide HIV Prevention services • The implementation of the community scorecard has not been scaled up • The CLM is still in the pilot phase with low coverage and there is no		• Identify and empower community leadership to foster community initiatives and define HIV prevention priorities • Advocate and Develop legal and policy framework for social contracting mechanisms. • Develop guidelines for mgt, capacity building and technical assistance of community led

			• Existence of linkage and referral mechanisms between the community and facilities • Existence of PrEP and PEP guidelines that guide the establishment and operation of sites • Existence of mechanisms to create an enabling environment for ARV Based programming Limited government funds allocated to select PNFPs/CSOs	linkage between CLM and government reporting and feedback mechanisms • The leadership and coordination of CSOs are majorly around Kampala and are multiple network leadership • Inadequate facilitation of Peers and their support processes. These are majorly donor funded. • Inadequate Communication between Community and facility, Poor documentation, limited availability of essential KP services and commodities at the facilities • The guidelines that guide the establishment and operation of PrEP program have not been rolled out countrywide • Inadequate funding for community sensitisation meetings on KP PP Programming • Lack of harmonised KP PP community tools. • CSOs mapped and gap analysis on capacity and funding needs		organization engaged in social contracting. • Multisectoral resource mobilisation to fund community led organisation engaged in social contracting • Conduct size estimation and needs assessment in order to set targets for increasing the proportion of HIV prevention services delivered by Community led organisation engaged in social contracting. • Set national and subnational targets for increasing the proportion of HIV prevention services delivered by community led organisations, in line with commitments in the 2021 political Declaration on HIV and AIDS, and the Global AIDS strategy (2021-2026).
6	**Remove social and legal barriers to HIV prevention services for key**	KEY POPULATIONS	• Conducted an assessment of the legal environment for KPs,	• Criminalization laws, • Harassment from legal enforcement officers and the community,	• Law and policy reforms Reviews • Legal literacy training for KP	• Conduct high level dialogue and workshops with policy makers and key stakeholders on

	and priority populations		• National policy guidelines on ending HIV stigma and discrimination in place, • HIV prevention services in place, • Equity plan in place, • Drop in center guidelines are in place, • National stigma assessment	• Existence of both internal and external stigma and discrimination, • Knowledge gap at all levels, • Equity is still implemented at National level	service providers like police, prisons etc. at Preservice and in service level conducted • Implementation guidelines/SOPs developed for law enforcement officers. • IEC materials on stigma and discrimination developed and disseminated	laws and necessary reforms, • Conduct legal literacy training for KP service providers in all sectors. • Develop and disseminate implementation guidelines/SOPs developed for law enforcement officers. • Develop and disseminate IEC materials on stigma and discrimination. • Conduct stigma reduction campaign on all platforms e.g. media, community etc. • Develop advocacy tools, • Review the equity plan to address human rights barriers to accessing HIV prevention services for KPs • Training service providers at all levels, • Conduct stigma index assessments
		ADOLESCENT BOYS AND MEN	• Universal education allowing boys and girls to stay longer in school,	• No comprehensive HIV prevention needs assessment for ABYM	• Male-friendly services, • Needs assessment of the ABYM,	• Conduct advocacy campaigns targeting ABYM • Align the interventions for the

			• Stigma and discrimination guidelines in place, • Male engagement policy in place, • National male involvement strategy for prevention and response to GBV in place	• No equity in terms of boy empowerment and skilling. • Second chance for ABYM education not in place. • Parental guidelines not emphasising the boys. • No advocacy strategy and tool for ABYM. • No TWG for ABYM. • There is weak coordination for ABYM programming. • Societal toxic Masculinity norms	• Male engagement policy, • Information and messaging, • Gender norms and equality transformation	ABYM with those for the AGYW • Conduct a needs assessment to guide policy development of the ABYM HIV prevention, • Revise, disseminate, and monitor the male engagement policy. • Advocate for male-friendly services, • Capacity building on human rights, • Rollout the GBV reduction plan, • Scale up demand creation for the ABYM, • Increase access to information and targeted messaging using effective platforms, • dissemination of child protection policy, • transform gender norms and gender equality such as SASA and stepping stone
		ADOLESCENT GIRLS AND YOUNG WOMEN	• Stigma index studies have been conducted, • Stigma guidelines in place, • Enabling frameworks in place (GBV strategy, Education Plus Initiative,	• Weak Multisectoral coordination and meaningful community engagement. • Poor enforcement of laws, and policies that protect AGYW against Negative cultural	• TORs for the multisectoral coordination and community engagement developed • Revised Health Sector HIV	• Develop clear TORs for the multisectoral coordination and community engagement National multisectoral

			Sexuality education framework, Second chance for girls National guidelines in place for both formal and informal education), • National multisectoral coordination framework in place (2018-2022) for the Adolescent Girls only • Parenting guidelines under ministry of Gender • Health Sector HIV Prevention strategy for AGYW, 2020-2025 • Legal and policy environment assessment done- (not specific to the AGYW)	practices like child marriage • Stigma still exists in different sectors (against AGYWLHIV in school, pregnant teenagers) • Parental guidelines under Min. of Gender not widely disseminated, • The sexuality education framework has not yet been approved. • Health Sector HIV Prevention strategy for AGYW, 2020-2025 is based on age and not risk profile. • The National multisectoral Coordination framework for Adolescent Girls is outdated without being operationalized. • The Social Protection policy 2015 does not cater for all risk profiles (KPs) • Criminalizing and discriminative laws against AGYW who are KPs still exist which leads to systemic exclusion.	Prevention strategy for AGYW, developed based on risk profile • Social protection services by establishing programs (e.g. DREAMS) scaled up, • Parental guidelines disseminated and implemented • Revised sexuality education framework approved • Livelihood programs extended (e.g., under dreams) • An Updated and Operationalised National multisectoral framework for AG that factors in vulnerability and risk factors • A revised social protection policy that includes all KP/PP risk profiles in place • An inclusive environment for all the AGYW	• Revise the Health Sector HIV Prevention strategy for AGYW based on risk profile • Creation of enabling legal and policy environments for increased uptake of services, • Access to justice, gender equality and freedom from stigma and discrimination, • Demand creation, • Implementation of policies and guidelines,# • Scale-up of safe spaces, • Disseminate the parental guidelines at the community level, • Dissemination of child protection policy • Campaigns to minimize gender-based and partner violence IPV harmful gender norms and toxic masculinity. • Conduct consultative and advocacy dialogues/ meeting with religious and cultural leaders on the sexuality

						education framework • Review, Update, disseminate and operationalise the National multisectoral coordination framework for adolescent girls to cater for young women, and the risk profiles. • There is need to increase support for the child protection unit at all levels. Advocate for approval of the Sexuality education framework. Revise the health sector framework. • Revise the social protection policy to include all AGYW risk profiles like young KPs and PPs. • Advocate for an inclusive environment for all AGYW risk profiles.
		ARV -BASED PREVENTION	• Laws, policies and Guidelines in place to address stigma and discrimination • Equity plan in place limited at national level. • Multisectoral steering committee- provides	• Law and Policy contradict each other at implementation • Guidelines not disseminated specifically the PrEP • Capacity gaps for service provider	• Dissemination of guidelines, * Capacity building *Increased awareness	• Printing and dissemination of the guidelines, • Capacity building on ARV-Based service provision, • Demand generation for the different products

			shared leadership coordinating efforts to address barriers • Multisectoral engagements at national level e.g. on Human Right Day, Dialogue with statutory parliamentary committees (9) • Specific policies for PEP and PrEP disseminated. • Ongoing assessment for PrEP programming. • Acceptability studies done in different population groups • Judicial handbook in place, training of law enforcements nationally • Stigma index assessment done • Community led research (limited to PEPFAR areas via CLM) • Collaboration with Global HIV prevention Coalition	• Information gap on new ARV based prevention technologies • Existing policy only supports provision of PrEP from age 16. • There is legal and policy obstacles to CLM organizations • Equity is still implemented at National level		• Create awareness and demand • Support the creation of enabling legal and policy environment • Engage national policymakers and opinion leaders to participate in cross-country briefing on policy barriers. • FastTrack dissemination of the equity plan and another relevant policies to the sub national levels
7	**Promote integration of HIV prevention into essential related services to improve HIV outcomes**	KEY POPULATIONS	• National strategy for integration of SRH, HIV, GBV, TB, and nutrition exists • Guidelines for DSD developed • ART Consolidated guideline for KPs	• No costed implementation plan for the National strategy for integration of SRH, HIV, GBV, TB, and nutrition • Missed opportunity with routine outreach services	• Costed implementation plan developed for the National strategy for integration of SRH, HIV, GBV, TB, and nutrition	• Disseminate the client and health workers charter; • Capacity building for service providers communities and peers in integrated service delivery

			• Coordination meetings for KP programming • Multisectoral coordination mechanism exists • HMIS data collection tools capture KP data to some KP data • Integrated service package for KP exists • Dedicated clinics that are co-located within health facilities exist • Training manual exists for KP friendly service delivery	(health, education, agriculture • At the Health service delivery level prisoner, PWIDS, and other KPs miss out on medically assisted therapy. • Gender, and justice/health promotion services do not integrate HIV prevention messaging • There is vertical programming for HIV prevention • Lack of representation on the different coordination platforms • Targeted VMMC programming for KPs very limited. (Indicators on service not captured). • Low implementation of integrated services • Services are limited in scale for KP populations and for geographic areas • Commodity stock outs especially for STI drugs, condoms, lubricants, test kits for Hep C	• Revised training manual bringing out issues of service integration; complete the DSD took kit • Capacity building for health workers, communities and peers in integrated service delivery • Implement client and health workers rights charter; • Strengthened delivery of integrated services (HIV, GBV, TB, maternal, SRH, mental health) • Community service delivery strengthened • Commodity security strengthened	• Revise training manuals to bring out issues of service integration • Develop implementation plan for the national strategy on integration of services
		ADOLESCENT BOYS AND MEN	• MoH launched guidelines on integration of HIV, GBV,VMMC,HTS, SRHR services; • Country has a national HIV combination prevention strategy	• Limited implementation of combination HIV strategy and integration	• Implement combination strategy in an integrated manner and considering other epidemics and NCDs	• Scale up comprehensive integrated HIV prevention package for all sub-populations at risk of HIV. • One-stop centre for services; Service integration for the underserved

						population, including people who use drugs, people in prisons, refugees, displaced populations, truck drivers, and people in emergency and humanitarian contexts and prioritization of key populations in the differentiated service delivery model for HIV prevention response, • Expand VMMC services beyond PEPFAR funded districts. • Expand programs to address financial distress (cash for work) for AGYW, ABYM living with and at high risk of HIV. • Expand youth-friendly HIV prevention services to cover all districts, including in remand homes.
		ADOLESCENT GIRLS AND YOUNG WOMEN	• National strategy for integration of SRH/HIV/GBV response , Tuberculosis and Nutrition and TB (2021-2025) in place	• Limited implementation of National strategy for integration of SRH/HIV/GBV response, Tuberculosis and Nutrition, and TB • Solid Programming (FP, PrEP)	• Develop a cost implementation plan for the National strategy for integration of SRH/HIV/GBV response , Tuberculosis and Nutrition and TB	• Scale up the current innovative models such as DREAMS, YAPS, AGYW; • Incorporate health services, including mental health, psychological

			• Current antenatal doesn't discriminate on sero status • DREAMS programme is comprehensive with limited focus on ABM. • Combination prevention framework in place • Coordination at national level of different players in place (partner mapping and referral & linkages weak) • National strategy for integration of SRH, HIV, GBV, TB, and nutrition exists • Guidelines for DSD developed- (need to innovate for community based adolescent health service extensions) • ART Consolidated guideline for KPs • Coordination meetings for AGYW programming • Multisectoral coordination mechanism exists • HMIS data collection tools capture AGYW data (not all indicators and risk categories/profiles captured)	• Low staffing norms • Limited capacity of the service providers to offer integrated services • Limited scale-up of available integrated programs for AGYW and are also limited to donor funds (PEPFAR, GF) • Weak linkages and referral systems • Integrated service package available is not based on risk profile • Youth-friendly services are available but are generalized. • Limited resources (financial, infrastructure, and human resources) to support the operationalization of youth-friendly services • No costed implementation plan for the National Strategy for integration of SRH, HIV, GBV, TB, and nutrition • Service outreach program guidelines doesn't cater to AGYW needs • At the Health service delivery level prisoner, PWIDS, and other KPs miss out on medically assisted therapy. • Gender, and justice/health promotion services do not integrate HIV prevention messaging	• Roll out sexuality education framework for in and out of school young people; • Expand DSD models and integrate other HIV prevention services for the different categories; • Strengthen PMTCT services among AGYW mother • A strengthened coordination desk of all partners working AGYW empowerment mechanisms • An integrated services package for AGYW based on risk profile • Costed implementation plan developed for the National strategy for integration of SRH, HIV, GBV, TB, and nutrition • Revised training manual bringing out issues of service integration; complete the DSD took it	support, harm reduction, and STI testing and treatment to improve access to services for the most vulnerable groups to HIV prevention initiatives and community health; Integrate performance indicators for different programs, • Scale up and strengthen age appropriate PMTCT services e.g.; group ANC services, • Capacity building of local government to deliver, monitor the HIV prevention services for the AYP • Capacity building for communities and AGYW to demand and monitor and evaluate the quality of HIV prevention services, • Map partners implementing AGYW programs across the nation. • Strengthen coordination; Strengthen referral and linkage systems. • Develop an Integrated AGYW

			• Integrated service package for AGYW exists • Dedicated clinics that are co-located within health facilities (Adolescent clinics and flexi hours) and safe spaces in some partner supported areas exist (service package not based on need due to limited infrastructure and resources) *Training manual exists for AGYW friendly service delivery • Current guidelines for Support Supervision exist generally (not tailored to any subcategories)	• There is vertical programming for HIV prevention • Lack of representation on the different coordination platforms • Low implementation of integrated services • Services are limited in scale for KP populations and for geographic areas. • Commodity stock outs especially for STI drugs, condoms, lubricants, test kits for Hep C	• Capacity building for health workers, communities and peers in integrated service delivery • Implement client and health workers rights charter; • Strengthened delivery of integrated services (HIV, GBV, TB, maternal, SRH, mental health) • Community service delivery strengthened • Commodity security strengthened	package based on risk profiles. • Differentiate the services to the community. • Cost the implementation plan for the National strategy for integration of SRH, HIV, GBV, TB, and nutrition. • Develop AGYW specific guidelines for outreach services • At the Health service delivery level prisoner, PWIDS, and other KPs miss out on medically assisted therapy.
		ARV -BASED PREVENTION	• PrEP included into national HIV prevention package • PrEP included into the essential medicines and supplies list • PrEP procurement has been integrated into the national procurement system • PrEP communication plan exists- lacks new technologies and not yet disseminated to all levels	• Limited integration of PrEP into other services • PrEP new technologies not included in National Consolidated guidelines on integration of HIV, SRHR, GBV, Nutrition, and TB • PrEP is not available at all health facilities offering FP, STI, ANC, OPD services. • Integration strategy not implemented and don't include new technologies, lacks a unit costing for the interventions	• Scale up for PrEP integration into other services • PrEP included in integration guidelines *unit cost of the intervention	

				• PrEP communication plan lacks new technologies and not yet disseminated to all levels		
8	**Institute mechanisms for rapid introduction of new HIV prevention technologies and programme innovations**	KEY POPULATIONS	• Stakeholder engagements and consensus on new technologies • Policies have been revised to include new technologies (injectable PrEP, ring) • Demonstration projects for adoption of new technologies ongoing • Request for approval of injectable PrEP submitted to NDA • Readiness assessment for health facilities to deliver new PrEP products conducted	• Costing of service not yet done • Awareness, demand creation • Lack of targets	• Adoption of new HIV prevention technologies as part of combination prevention packages, e.g. antiretroviral drug-releasing vaginal rings or long-acting PrEP regimens. • Services costed • Needs assessment conducted	• Build capacity of all stakeholders (including community representatives, training institutions and professional bodies) to support and promote use of new technologies and approaches, • Strengthen district multisector accountability framework to include modern HIV prevention technology, e.g. during Baraza, • Demand creation for new technologies. • Scale up point of service delivery for new technologies (DSDs models), • Ensure availability of logistics and service standards (SOPs, guideline) for new technologies • Consensus meeting to agree on service provision targets for new prevention technologies • Conduct needs assessment

						• Advocate to have a communication plan that is updated with new PrEP technologies
		AGYW	• Stakeholder engagements and consensus on new technologies • Policies have been revised to include new technologies (injectable PrEP, ring) • Demonstration projects for adoption of new technologies ongoing • Request for approval of injectable PrEP submitted to NDA • SOPs for communicating PrEP (needs update for new technologies) • Readiness assessment for health facilities to deliver new PrEP products conducted • Implementation plan present • Communication plan for PrEP (limited to oral) • Logistics plan and guidelines in place- (Limited scale and scope)	• Costing of service not yet done • Awareness, demand creation • Lack of targets • PrEP communication plan doesn't include new technologies • Standard operating procedures doesn't include AGYW • Logistical plan is limited to scale and not up to date to cater for new technologies	• Adoption of new HIV prevention technologies as part of combination prevention packages, e.g. antiretroviral drug-releasing vaginal rings or long-acting PrEP regimens. • Services costed • Needs assessment conducted • An updated PrEP communication plan developed	• Build capacity of all stakeholders (including community representatives, training institutions and professional bodies) to support and promote use of new technologies and approaches, • Strengthen district multisector accountability framework to include modern HIV prevention technology, e.g. during Baraza • Demand creation for new technologies. • Scale up point of service delivery for new technologies (DSDs models). • Ensure availability of logistics and service standards (SOPs, guideline) for new technologies and communication • Consensus meeting to agree on service provision targets for new prevention technologies

						• Conduct needs assessment • Update guidelines to include new technologies • Mobilise resources for scale and updating of the Logistics and Communication plan
9	**Establish real-time prevention programme monitoring systems with regular reporting**	KEY POPULATIONS	• Indicators exist for reporting on KP service utilization • National centralized KP reporting system in place • Regular program implementation reviews • Data collection tools developed • Plan and structure to assign unique IDs and tools have been aligned accordingly	• Not all facilities are reporting regularly since KP tracker is not in all facilities • Inadequate utilization of data at source • No harmonized community tools	• KP tracker rolled out countrywide • Funded M&E plan • Community tools developed	• Periodic performance reviews and utilisation of data. • Adopt and implement the global scorecard for HIV prevention • Harmonize all tools and systems for HIV prevention to capture multisectoral HIV prevention response. • Collecting and disaggregating M&E data beyond age and sex to include other demographics • Conducting population size estimations to facilitate effective program planning, M&E, policy and advocacy for HIV prevention response, • Developing of an M&E multisectoral plan and budget for HIV prevention

						• Develop community tools • Roll out KP tracker countrywide
		AGYW	• Indicators exist for reporting on AGYW service utilization mainly on DREAMS (not comprehensive beyond PEPFAR) (Indicators not harmonised for all stakeholders) • Regular program implementation reviews at MOH secretariat (mainly on DREAMS hence limited scope) • Data collection tools developed (need to harmonise with centralised M&E Framework) • Subnational level service point focused identifiers in place (No National Unique Identifier code system in place) • Integration strategy in place to cater for efficiency and effectiveness of the service delivery (need for unit cost of service to inform costed plan)	• Not all facilities are reporting regularly since AGYW tracker is not in all facilities • Inadequate utilization of data at source • No harmonized community tools • Indicators only depict donor-funded programs like DREAMS • National centralized AGYW reporting system in not place • Scope of program implementation reviews is limited • No unit cost for AGYW has been developed	• KP tracker rolled out countrywide • A Harmonised and fully Funded M&E plan • Community tools developed • A national centralised AGYW reporting system with multisectoral lens the KPI • A developed M&E plan that tracks the 10 point programme • A cost unit for AGYW developed	• Periodic performance reviews and utilisation of data, • Adopt and implement the global scorecard for HIV prevention, • Harmonize all tools and systems for HIV prevention to capture multisectoral HIV prevention response, • Scale up the scope of the program implementation reviews. • Benchmark existing tools, develop and harmonise the data collection tools. • Develop an M&E plan that tracks progress of all the 10 points programme. *Define a unit cost for each service delivery package for AGWY • Collecting and disaggregating M&E data beyond age and sex to include other demographics. • Conducting population size

						estimations to facilitate effective program planning, M&E, policy and advocacy for HIV prevention response, • Developing of an M&E multisectoral plan and budget for HIV prevention • Develop community tools
10	**Strengthen accountability of all stakeholders for progress in HIV prevention**	KEY POPULATIONS	• Feedback meetings have been happening • Community-led HIV prevention monitoring is happening (community score cards) • Client satisfaction surveys done	• CLM not fully integrated into national monitoring platforms and not scaled • Community dialogues not done for HIV prevention and KP programming • Community scorecards not to scale. • NSP does not set specific objectives for sub categories of KPs. • Limited capacity for knowledge translation	• Mechanisms for multisectoral coordination and accountability for HIV prevention response strengthened • Routine performance review and accountability meetings e.g., JAR conducted • Evaluation studies conducted (e.g., MTR) • Capacity building for stakeholders in data utilization and knowledge translation	• Strengthen existing TWG at all levels of HIV response, • Monitor national and sub-national progress, • Develop an integrated M&E system for HIV prevention, • Update the performance indicators in line with the targets • ,Resource tracking mechanism for mobilisation, and allocation, utilisation and value for money (NASA) • Strengthen community system structures for accountability such as CLM (feedback loops), I-report • Harmonisation of resources based on existing gaps in HIV

						prevention programming, • Regularly update HIV prevention investment case for Uganda • Develop a Sustainability and transition plan • Conduct annual HIV prevention symposium • Invest in and build the capacity of CSOs coordination mechanisms and umbrella institutions for a coherent HIV prevention response, • Conduct regular cost-effective analysis for the HIV prevention response, • Harmonise the indicators for collecting data on AGWY and have an M&E framework
		ADOLESCENT GIRLS AND YOUNG WOMEN	• NPC meetings quarterly and annually with all stakeholders (need to strengthen operations and mobilise resources to widen scope) • Feedback meetings have been happening • Community-led HIV prevention monitoring is happening	• CLM not fully integrated into national monitoring platforms and not scaled up • Community dialogues not done for HIV prevention and AGYW programming • Community scorecards not to scale • NSP does not set specific objectives for subcategories of AGYWs	• Mechanisms for multisectoral coordination and accountability for HIV prevention response strengthened • Routine performance review and accountability meetings e.g., JAR conducted	• Strengthen existing TWG at all levels of HIV response • Monitor national and sub-national progress, • Develop an integrated M&E system for HIV prevention, • Update the performance

			(community score cards) • Client satisfaction surveys done • M&E framework in place (need to update, integrate and harmonise and include all indicators that track progress of the ten-point action plan) • Accountability for CSOs and scorecard in place (CLM limited in scope and scale to partner funding- need for comprehensive harmonisation and scale up to include all stakeholders) (CSO accountability plan for HIV prevention should be harmonised, scale up and actively tracked) • Multisectoral (NPC-UAC) and intersectoral Coordination (TWGs and Secretariats in MoH) & Joint AIDS Review mechanisms are in place (Need to be strengthened through a routine/regular Multi-Level gap analysis, harmonised M&E framework, institutionalised a human resource)	• Limited capacity for knowledge translation • Scorecard on ten-point action plan not in place • Inadequate resources for accountability resources. • Community dialogues on HIV prevention is not done • Weak accountability system for AGYW HIV prevention programming • Weak Multisectoral (NPC-UAC) and intersectoral Coordination (TWGs and Secretariats in MoH) & Joint AIDS Review mechanisms. • Multi-Level gap analysis not done • Harmonized M&E framework lacking • Institutionalized a human resource not available	• Evaluation studies conducted (e.g., MTR) • Capacity building for stakeholders in data utilization and knowledge translation • Strong accountability system for the AGYW	indicators in line with the targets • Resource tracking mechanism for mobilisation, and allocation, utilisation and value for money (NASA) • Strengthen community system structures for accountability such as CLM (feedback loops), I-report • Harmonisation of resources based on existing gaps in HIV prevention programming, • Regularly update HIV prevention investment case for Uganda, • Develop a Sustainability and transition plan, • Conduct annual HIV prevention symposium, • Invest in and build the capacity of CSOs coordination mechanisms and umbrella institutions for a coherent HIV prevention response, • Conduct regular cost-effective analysis for the HIV prevention response,

						• Harmonise the indicators for collecting data on AGWY and have an M&E framework • NPC meetings to track progress in implementing the main actions on a quarterly basis. Intentional and deliberate allocation of resources for accountability processes for optimal functionality and sustainability. • Integrate the 10 action points of roadmap in CLM and increase funding for CLM • Strengthen accountability mechanism on HIV prevention for AGYW
		ARV -BASED PREVENTION	• Quarterly progress reviews for PrEP happening at national level	• MTRs not being done for PrEP • Quarterly review at subnational level not happening	• Conducted MTR • Subnational quarterly reviews done	Conducting MTR Conducting quarterly reviews.