Uganda Country Updates

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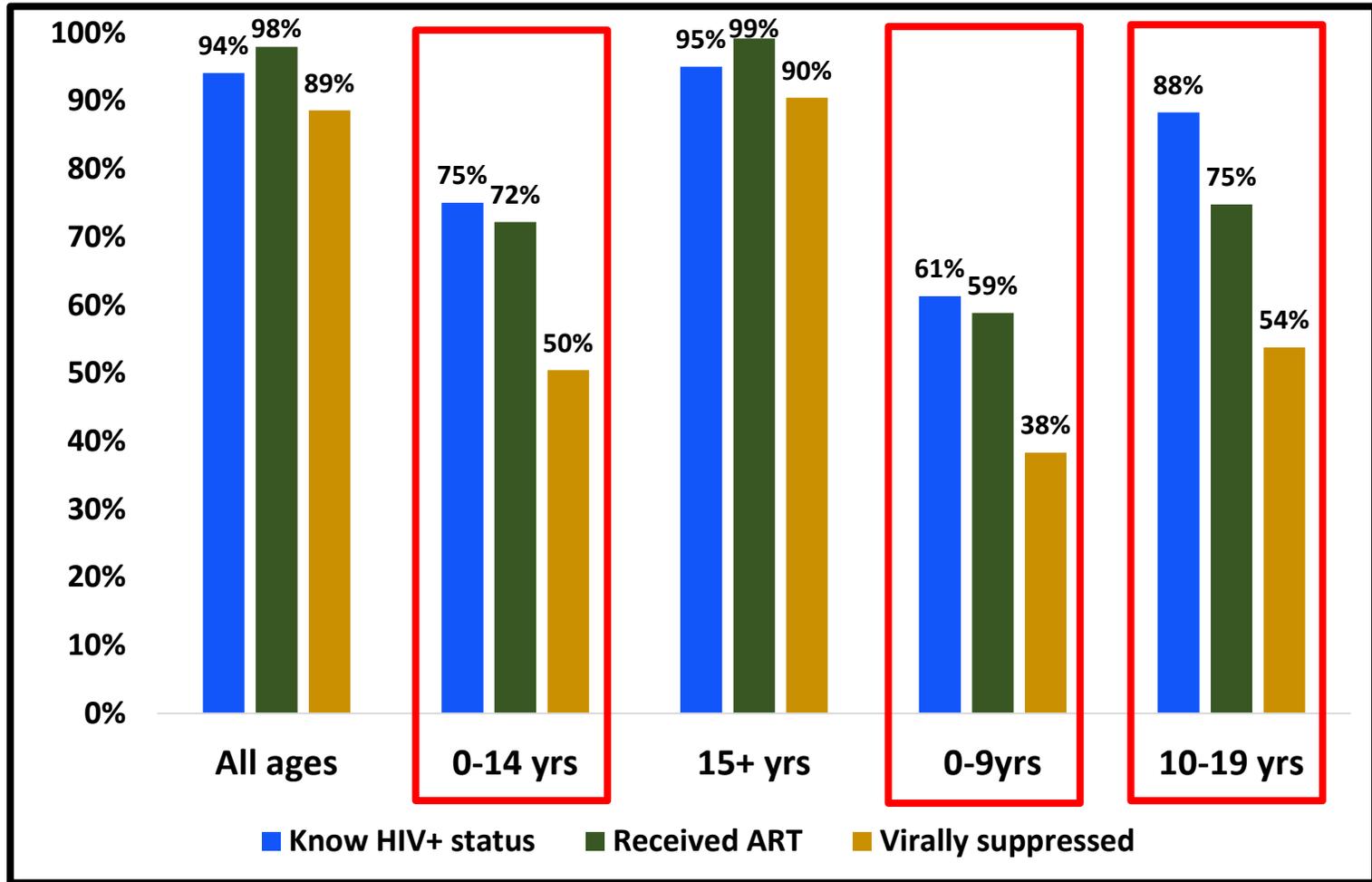**Program Manager - STD/AIDS Program**

Presentation Outline

- Country Epidemic Overview

- Funding Shifts and Programmatic Realignment

- Summary of Prioritized HIV Services and System Adaptations

- M&E System Adaptations, Key Indicator Trends and Implications

- Community Engagement
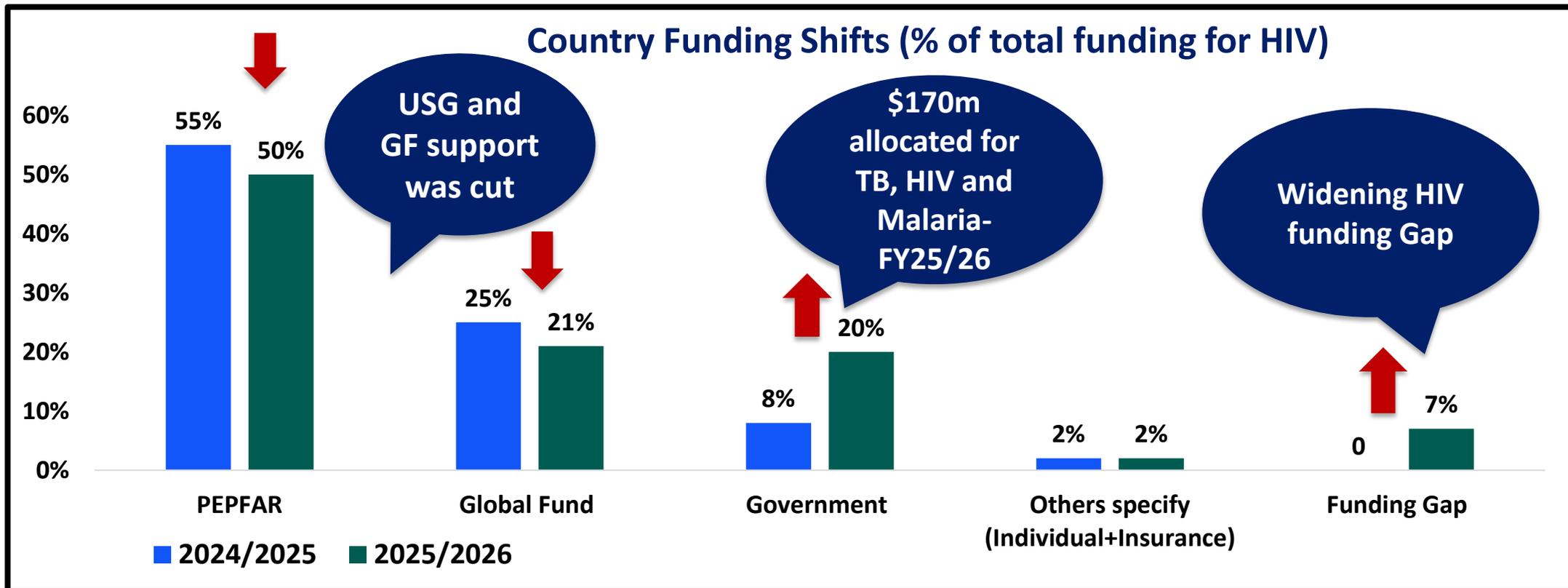
- Lessons Learnt

- Next Steps

Uganda HIV Snapshot, 2024:

- 1.53M PLHIV; **prevalence** 5.5% (Women 6.9%, Men 4.2%); Children 0–14: 0.4% (~70k)

- **New infections:** 36,648 (2024) down from 100k in 2010

- **AIDS deaths:** 20,335 (2024) down from 55k in 2010

- Infections exceed deaths hence epidemic control not yet achieved

- **Cascade:** 94% know status → 98% on ART → 89% virally suppressed

Chart: 95-95-95 Cascade by age group

Legend: ■ Know HIV+ status ■ Received ART ■ Virally suppressed

Category	Know HIV+ status	Received ART	Virally suppressed
All ages	94%	98%	89%
0-14 yrs	75%	72%	50%
15+ yrs	95%	99%	90%
0-9yrs	61%	59%	38%
10-19 yrs	88%	75%	54%

HIV Burden

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Funding Shifts

Country Funding Shifts (% of total funding for HIV)

Chart data:

Category	2024/2025	2025/2026
PEPFAR	55%	50%
Global Fund	25%	21%
Government	8%	20%
Others specify (Individual+Insurance)	2%	2%
Funding Gap	0	7%

Callouts: "USG and GF support was cut"; "$170m allocated for TB, HIV and Malaria- FY25/26"; "Widening HIV funding Gap"

- HIV global fund budget reduced by 12.5% (from $245 to $215)
- Government of Uganda (GoU) stepping up funding $13m in 2024 to $32m in 2025 ($15m received, $17m in pipeline)
- PEPFAR funding is reducing but overall budget support from PEPFAR expected after MOU signing
- There is a proposal to FURTHER increase GoU funding-discussions now at interministerial level
- Coping mechanisms include task sharing of GoU health workers to cover the HRH gap

Programmatic Realignment in Response to Funding Shifts (Oct 2024 – Mar 2025)

- **HRH and workforce:** GoU has mobilized $9.5m to absorb about 6,000 health workers laid off by PEPFAR, into mainstream service

- **Health information systems (EMR)**: Currently building an integrated GoU led EMR (EAFYA)

- **Commodities and financing**: GOU committed USD 13m for FY25/26 to procure/stock essential commodities

- **Service integration and community health:** Health facilities directed to allocate primary health care (PHC) funds for integration and reinforce community health activities

- **Bridge funding to maintain critical services:** PEPFAR 6-month bridge (Oct 2025–Mar 2026) to support MOH/GoU transition; VMMC, AGYW, medically-assisted therapy (MAT) to be sustained via MOH/GoU capacity-building.

- Services for **populations at risk** will be provided by Global Fund and GoU

National Prioritized Prevention and Testing Services

Prevention Services

Component	Intervention	UG
Infant prophylaxis	Infant PEP HR 0–6w	Not applicable
Infant prophylaxis	Infant PEP HR 6–12w	Keep (No Change)
Infant prophylaxis	Infant PEP LR	Keep (No Change)
PEP	Facility PEP (guidelines)	Keep (No Change)
PEP	Community PEP (GBV/KP)	Keep (Modify)
Condoms	Facility condoms/lube	Keep (Modify)
Condoms	KP condom points	Keep (Modify)
Condoms	Community condom points	Keep (Modify)
PrEP continuation	Facility PrEP KP 3MMD/6m	Drop
PrEP continuation	Facility PrEP PBFW 3MMD/6m	Keep (No Change)
PrEP continuation	Facility PrEP others 3MMD/6m	Drop
PrEP continuation	Annual PrEP review	Keep (No Change)
PrEP continuation	PrEP review 6-monthly	Drop
PrEP continuation	Facility PrEP DSD-indiv	Keep (No Change)
PrEP continuation	Out-facility PrEP DSD	Keep (No Change)
PrEP continuation	Virtual PrEP refills	Keep (No Change)
PrEP continuation	Adherence/risk counselling	Drop
PrEP continuation	Continue DVR PrEP	Keep (Modify)
PrEP continuation	Continue LAI PrEP	Keep (No Change)
PrEP initiation (& re-initiation)	Start PrEP PBFW self-ID	Keep (No Change)
PrEP initiation (& re-initiation)	Start PrEP PBFW at-risk	Keep (No Change)
PrEP initiation (& re-initiation)	Start PrEP KP	Keep (No Change)
PrEP initiation (& re-initiation)	Start PrEP AGYW self-ID	Drop
PrEP initiation (& re-initiation)	Start PrEP others self-ID	Not applicable
PrEP initiation (& re-initiation)	Test post-start 1–3m	Keep (No Change)
PrEP initiation (& re-initiation)	PrEP demand creation	Keep (Modify)
PrEP initiation (& re-initiation)	Continue DVR PrEP	Keep (No Change)
PrEP initiation (& re-initiation)	Continue LAI PrEP	Keep (Modify)
PrEP initiation (& re-initiation)	PrEP start education	Keep (No Change)
Harm reduction for people who inject drugs	Facility-first NSP+naloxone	Drop
Harm reduction for people who inject drugs	Community NSP+naloxone	Drop
Harm reduction for people who inject drugs	Continue OAMT refills (PWID)	Keep (No Change)
Harm reduction for people who inject drugs	Initiate/continue OAMT (PWID)	Keep (No Change)
VMMC	Targeted VMMC scale-up	Keep (Modify)

Testing Services

Component	Intervention	UG
Blood products	Blood product screening	Keep (No Change)
Facility-based	Symptomatic testing (entry)	Keep (No Change)
Facility-based	ANC first test	Keep (No Change)
Facility-based	ANC late retest	Keep (No Change)
Facility-based	Postnatal PBFW 6-monthly	Keep (No Change)
Facility-based	HEI 6w/6-9-18m EPI	Keep (No Change)
Facility-based	HEI birth test	Drop
Facility-based	TB clients (newly diagnosed)	Keep (No Change)
Facility-based	TB clients (presumptive TB)	Keep (No Change)
Facility-based	STI clients (new STI)	Keep (No Change)
Facility-based	Hep B/C (new)	Keep (No Change)
Facility-based	Inpatient (new admission)	Keep (Modify)
Facility-based	Children in malnutrition clinics	Keep (No Change)
Facility-based	EPI child post-screen	Keep (No Change)
Facility-based	FP initiation clients	Keep (Modify)
Facility-based	FP <25 init+annual	Drop
Facility-based	FP init+biennial+change	Drop
Facility-based	FP init+annual	Drop
Facility-based	Self-initiated HIVST (annual)	Keep (No Change)
Facility-based	VCT/HIVST any frequency	Keep (Modify)
Facility-based	PrEP users 1m+6m	Keep (No Change)
Facility-based	PrEP users 1m+3m	Keep (No Change)
Facility-based	VMMC clients	Drop
Network-based (including facility/virtual and community-based)	PN EPN +HIVST/FBT	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN APN +FBT (virtual)	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN APN +community test	Keep (No Change)
Network-based (including facility/virtual and community-based)	Female index: child FBT/HIVST	Keep (No Change)
Network-based (including facility/virtual and community-based)	Female index: child CBT	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN EPN +HIVST (VL>1000)	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN EPN +HIVST FP/ANC<25	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN EPN +HIVST (FP/ANC)	Keep (No Change)
Network-based (including facility/virtual and community-based)	KP SNT +HIVST	Keep (No Change)
Network-based (including facility/virtual and community-based)	AGYW SNT +HIVST	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN EPN +HIVST (95s STI-neg)	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN EPN +HIVST (STI-neg)	Keep (No Change)
Network-based (including facility/virtual and community-based)	PN APN +FBT (STI-neg)	Keep (No Change)

Testing Services

Component	Intervention	UG
Community-based (virtual and in-person)	CB HIVST points >15	Keep (No Change)
Community-based (virtual and in-person)	CB HIVST points 95-gap	Keep (No Change)
Community-based (virtual and in-person)	CB HIVST points KP	Keep (No Change)
Community-based (virtual and in-person)	HIVST digital outreach	Keep (No Change)
Community-based (virtual and in-person)	KP high-volume outreach	Keep (No Change)
Community-based (virtual and in-person)	KP all outreach sites	Keep (No Change)
Community-based (virtual and in-person)	AGYW targeted outreach	Keep (No Change)
Community-based (virtual and in-person)	Men targeted outreach	Keep (No Change)
Community-based (virtual and in-person)	Men workplace testing	Keep (No Change)
Community-based (virtual and in-person)	Children targeted outreach	Keep (No Change)
Community-based (virtual and in-person)	Prisoners: On entry/discharge	Keep (No Change)
Community-based (virtual and in-person)	Prisoners entry/annual	Keep (No Change)
Community-based (virtual and in-person)	ABYM targeted outreach	Keep (No Change)
Recency testing	Recency testing	Drop

Legend:
- Keep (No Change)
- Keep (Modify)
- Drop
- Not applicable
- Missing Data

- VMMC has been fully integrated into PHC
- Guidelines for PrEP and PEP are being updated to be provided to Populations at risk
- Recency testing has been dropped
- Family Planning is deprioritized with alternative funding still provided at smaller scale
- HIV-exposed infants (HEI) birth testing is deprioritized
- Deprioritized some studies

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National Prioritized Treatment Services

Component	Intervention	UG
ART continuity	Uninterrupted ART for all	
	MMD 3–6 months	
	Annual clinical review	
	Enroll less-intensive DSD	
	Maintain facility DSD-indiv	
	Maintain community DSD-indiv KP	
	Maintain client-managed groups	
	Maintain adolescent groups (HCW)	
	Maintain community DSD-indiv	(green modify)
	Maintain DSD groups (HCW)	
	Active transfer same-day 3MMD	(grey)
Continuity OI prophylaxis	CTX adults S3/4/CD4<350	(grey)
	CTX adults high-risk	(grey)
	CTX for HIV/TB	
	CTX for CLHIV	
	CTX for HEI	
	Fluconazole secondary proph	
ART initiation (and re-initiation)	Initiate <5 years	
	Initiate PBFW	
	Initiate symptomatic/AHD	
	Initiate all positives	
	Initiate stage3/4 or CD4 low	
	Initiate stage1/2 (CD4 high)	
Viral load monitoring	VL for suspected failure	
	Repeat VL at 3m	
	First VL by 6m	
	First VL (no prior)	
	Pregnant: VL at ANC/3m	
	Pregnant: VL 34–36w	
	Breastfeeding: VL 3m+6mly	
	LLV: repeat VL 3m	(grey)
	VL annually if suppressed	
	VL q2–3y post-2x	(grey)
	Resistance test per guidelines	

Component	Intervention	UG
OI management	TB Xpert for symptomatic	
	TB treatment	
	TPT per regimen	
	CRAG for symptomatic	
	Cryptococcal treatment	
AHD package	LAM S3/4 seriously ill	
	CRAG S3/4 IPD	
	CD4 S3/4 new or >90d	
	CD4 S1/2 new or >90d	
	LAM S1/2 CD4<200	
	CRAG S1/2 CD4<200	
	Fluconazole pre-emptive	
Integration	PAP smear never-screened	
	HPV screen never-screened	(green modify)
	Hypertension integration	
	Diabetes integration	
	Family planning integration	
	VIAC annually WLHIV	
Tracking and tracing	Confirm contacts each visit	
	Phone trace abnormal labs	(red drop)
	Phone trace high-risk	
	Phone trace >28d missed	
	Home trace abnormal labs	
	Home trace high-risk	
	Home trace >28d missed	
Psychosocial support/ Counselling	ART start literacy	
	Adherence assessment visits	
	VL and DSD prep	
	EAC for high VL	
	Child disclosure support	
	MH screening at start	
	MH screening high VL	
	MH screening all visits	

- Majority of services are to be maintained with a few modifications

- GoU is looking for alternative funding to cater for funding shortfalls

- Selected IPs with adequate funding are providing the pharmacy model, however plans are underway to scale up, through GoU funding

(dark green)	Keep (No Change)
(green)	Keep (Modify)
(red)	Drop
(grey)	Not applicable

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National Prioritized HIV Services-Rationale

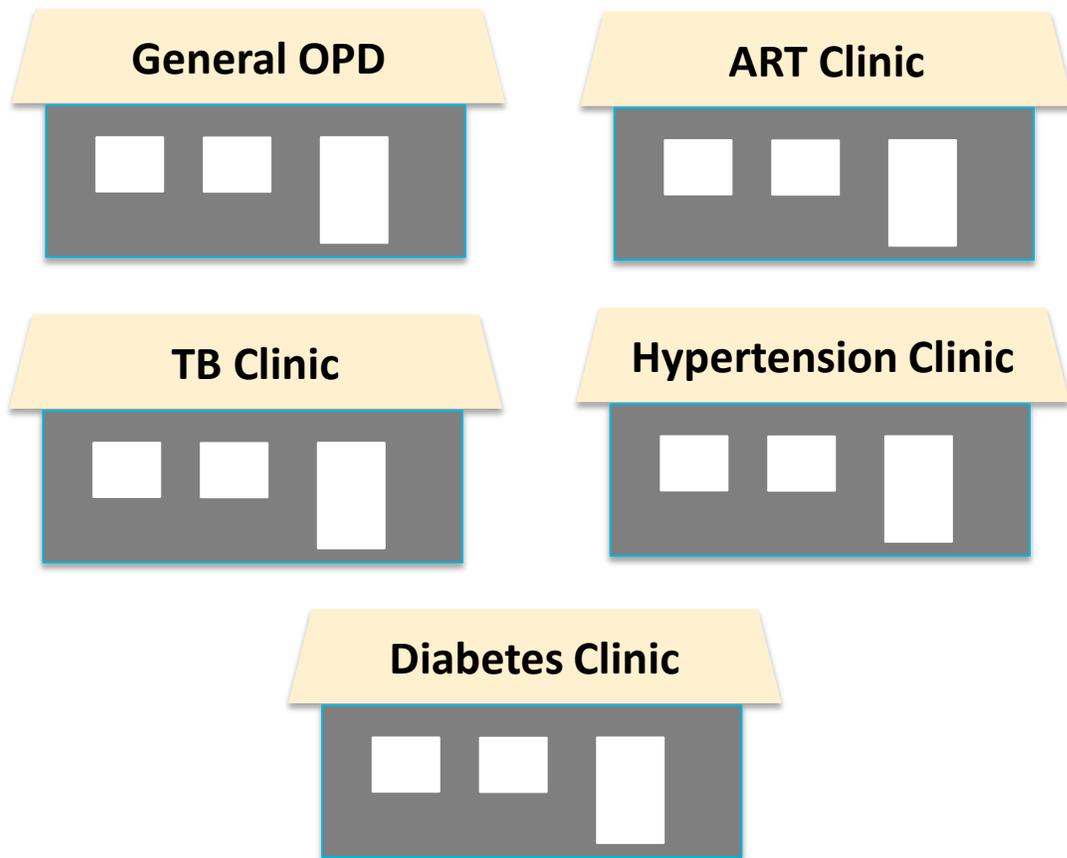**Priotization was based on several factors:**

- **Current epidemic context and future projections**
  - 4 Spectrum/Naomi modelled scenarios project Uganda's progress toward epidemic control to 2030 and 2035
  - Scenarios assess impact of different scale-up levels on new infections, AIDS-related deaths, and costs
  - Aim: guide prioritization and investment decisions under Health Sector Strategic Plan (HSSP) 2025–2030
- **Resource envelope**
  - Global Fund had already provided indicative planning figures
  - MOH negotiations with GoU for increased allocation of funds to bridge HRH and services delivery gaps
- **Implementation feasibility**
  - Easy to implement services were prioritized based on the prevailing circumstances: e.g., VMMC has been integrated into existing routine PHC services

Uganda has Aligned Priorities to the National Integration Model which Consists of 10 Standards, Focusing on Systems and Services

Standard	Description
Standard 1	**Leaders and managers must ensure they develop an action plan** for service integration
Standard 2	Health facility managers must **reorganize clinics** to support integrated service delivery to manage Acute and Chronic Disease conditions
	Implementation Procedure 1: Reorganize / establish clinic space
	Implementation Procedure 2: Conduct comprehensive Patient-Centered Clinical Assessment & Care
	Implementation Procedure 3: Implement service delivery approaches for efficiency & quality of care
Standard 3	Pharmacy in-charges must ensure **uninterrupted supply of essential medicines and diagnostics**
Standard 4	Functionalize the **National Integrated HMIS**
Standard 5	Prioritize **Human Resource Optimization**
Standard 6	Integrate **Laboratory Systems, Networks, and Diagnostic Services**
Standard 7	Deliver integrated **Community Health Services**
Standard 8	Utilization of **Primary Health Care (PHC)** resources
Standard 9	**Waste management**
Standard 10	**Equipment maintenance**

Service Delivery Models for Integration in Uganda

Before

General OPD

ART Clinic

TB Clinic

Hypertension Clinic

Diabetes Clinic

After

Lower-Level small health units and some Higher-Level units

Integrated Mixed OPD
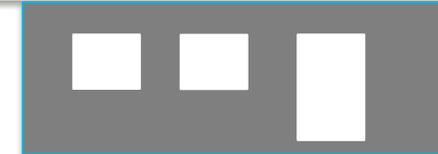
Or

General OPD (Acute Care)

Chronic Care OPD

Higher Level Facilities with space and infrastructure

Linkage / Referral to Specialist Services as needed by patient

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Quality Assessments Adaptation

- HIV Quality Assessment is an integral part of routine service delivery.

- Quality is assessed and supported during quarterly mentorships.

- Health services mentorship is conducted at regional, district, and facility levels.

- A unified data repository exists and provides visuals highlighting compliance, performance gaps, action plans, and trends over time to support decision-making.
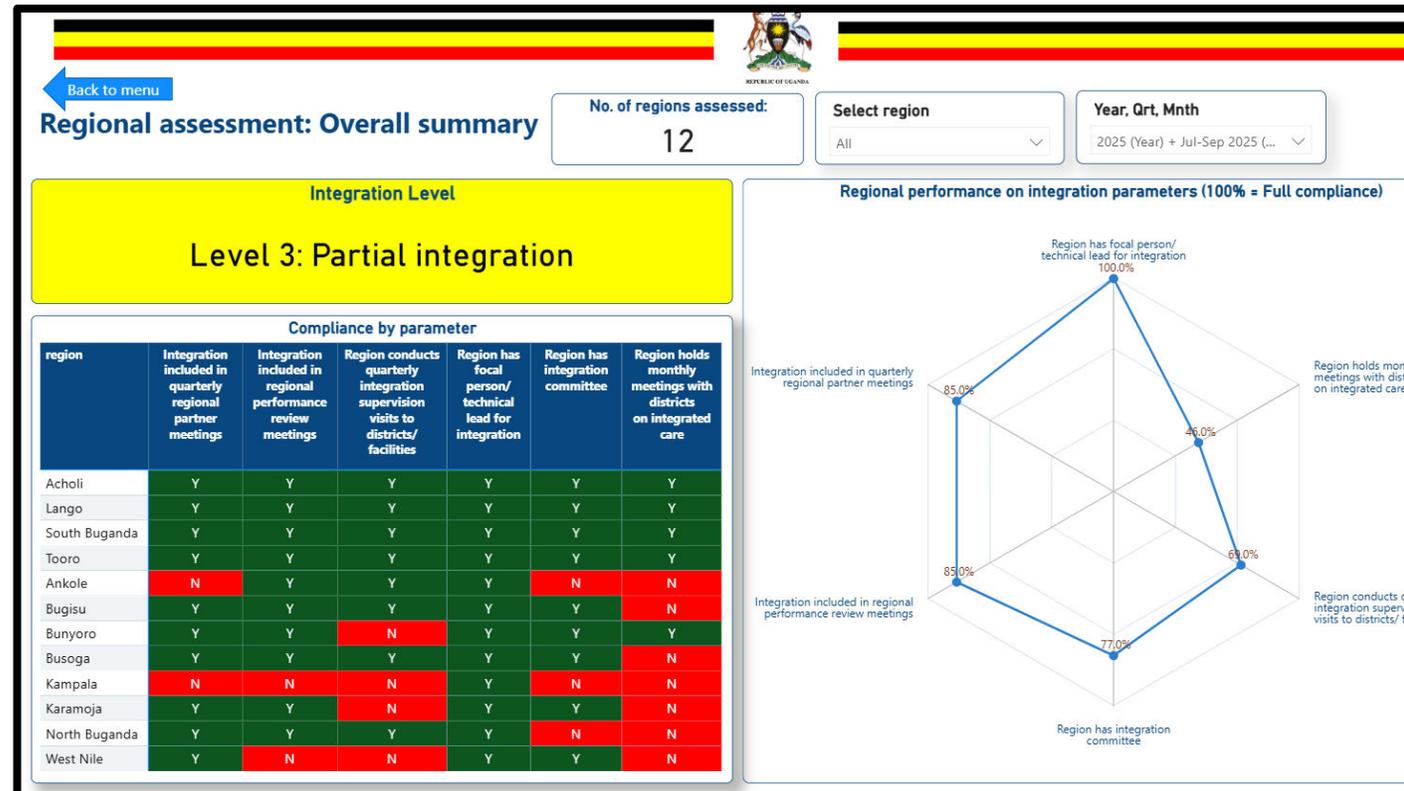
System Adaptations to Support Priorities

- HIV sustainability road map is in development and currently being costed

- HIV strategic plan and HIV Sector strategic plans have been developed and aligned to the roadmap

- HIV National Policy is under review after 15 years and is also aligned to the sustainability roadmap

- Prioritization information is being used to develop targets and cost estimates for the next 5 years

M&E Indicator Prioritization

Indicator Prioritisation by External Funding Scenario			Uganda
#	Program Area	Indicator	50%
1	VTP	Ist ANC attendance	
2		Ist ANC testing	
3		1st ANC HIV+	
4		1st ANC Known HIV+	
5		HEI 1st EID	
6		HEI outcome	
7		HEI ARV prophylaxis	
8	HTS	HTS_TST	
9		HTS_POS	
10		HTS_TST by modality	
11		HTS_POS by modality	
12	ART	TX_NEW	
13		TX_NEW by CD4 count	
14		TX_CURR by MMD	
15		Interuption in Treatment [IIT]	
16		AIDS-related mortality	
17	VL	VL results received	
18		VL results <1,000 C/ml	
19	TB	TB diagnosis	
20		Initiated on TPT	
21		Completed TPT	
22	HIV Prevention	PrEP_NEW	
23		Received PrEP	
24		Received PEP	
25		Received condoms	

Legend:
- **Keep (No Change)** (dark green)
- **Keep (Modify)** (light green)
- **Drop** (red)

Numbers reported Active on ART Oct-24-Sept 25

Y-axis: 1,380,000 – 1,520,000
X-axis: Oct to Dec 2024 | Jan to Mar 2025 | Apr to Jun 2025 | Jul to Sep 2025

- All indicators were prioritized for monitoring
- The total accredited health facilities expected to be reporting on ART indicators is 2,240
- Numbers reported active on ART declined for the quarter Jan – Mar 25 , declined further Apr – Jun 25 and have now started stabilizing back to normal
- **Timeliness of reporting has improved**: 91% in Jan to 95% in Sep 2025

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M&E Systems Assessment Over Time

Domain	Functionality	Stop Work (Feb 2025) - Post Stop Work (May and Sept 2025)		
		Uganda		
		Feb-25	May-25	Sep-25
Data collection	M&E Tools Availability	🟨	🟨	🟥
	Data Quality and Completeness	🟥	🟨	🟨
	Community Based Monitoring	🟥	🟨	🟨
	Retention Monitoring and Follow Up	🟥	🟨	🟩
	Commodity Tracking Systems	🟥	🟨	🟩
Databases, reporting, and use	HMIS reporting	🟥	🟨	🟩
	EMR Functionality	🟥	🟨	🟨
	Site Level Monitoring and Supervision	🟥	🟨	🟩
	Data Dissemination and Data Use	🟥	🟨	🟩
HRH capacity	M&E HRH Capacity	🟥	🟨	🟨
	Supervision and Mentorship for HRH	🟨	🟨	🟨
	Capacity Building for M&E Staff	🟥	🟨	🟨

Key- Impact			
None	Partial	High	No data
🟩	🟨	🟥	⬜

- Since February, 40%+ of facilities without EMR lost patient monitoring tools, lowering report quality.

- Replenishment paused due to funding cuts (printing was donor-funded).

- Jan 25 lay-offs hit Data Clerks; ~40% returned on short-term basis around May 25.

- M&E staff (Officers/Specialists) from IPs were also laid off in Jan 25 and not yet replaced.

- EMR systems were not updated from Jan 25 to May 25, impacting data quality.

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Quarterly HIV testing Trends and Implications
[Data Source: National Aggregate HMIS Data from Jan. 2024 to Sept. 2025]

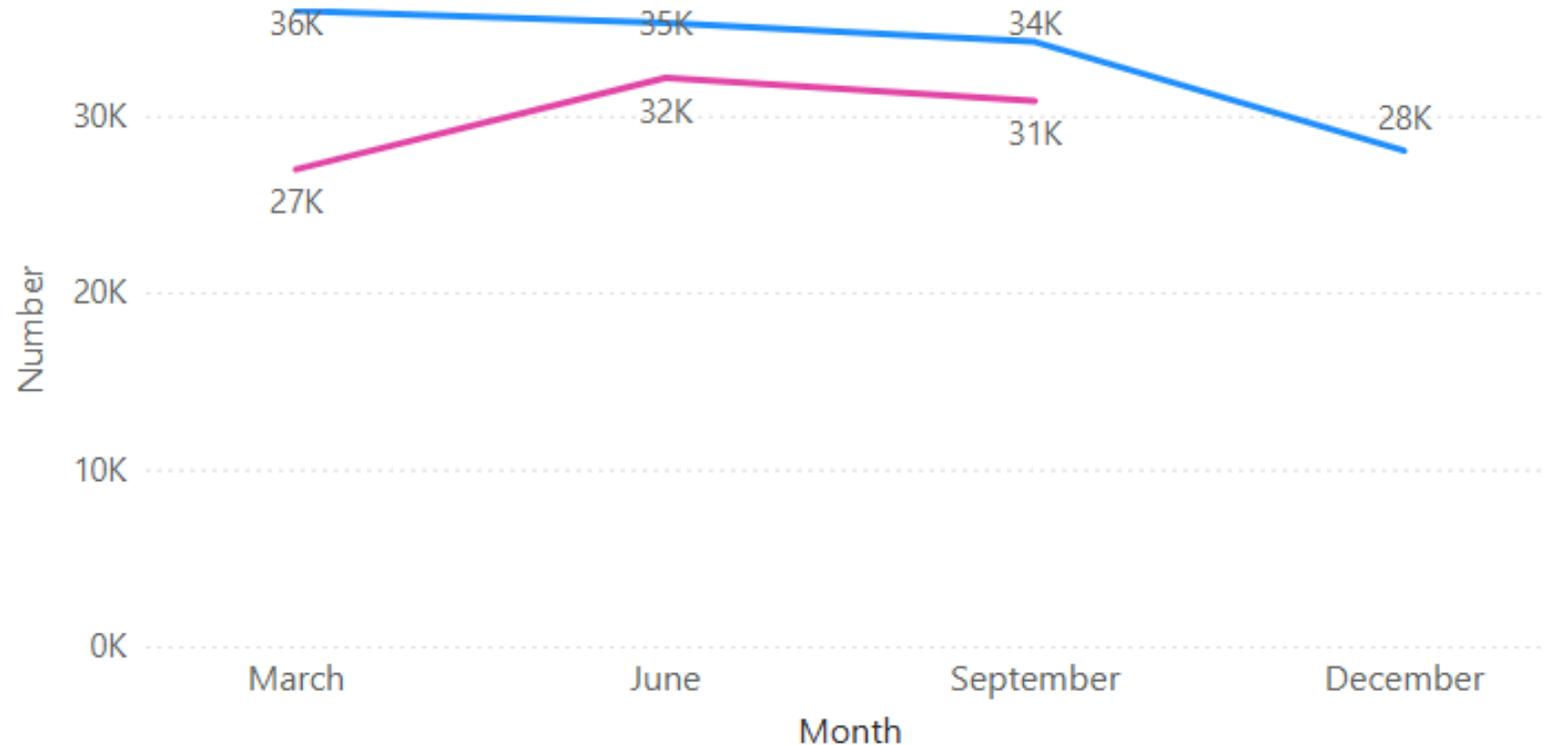**HIV Tested by Month and Year**

Year ● 2024 ● 2025
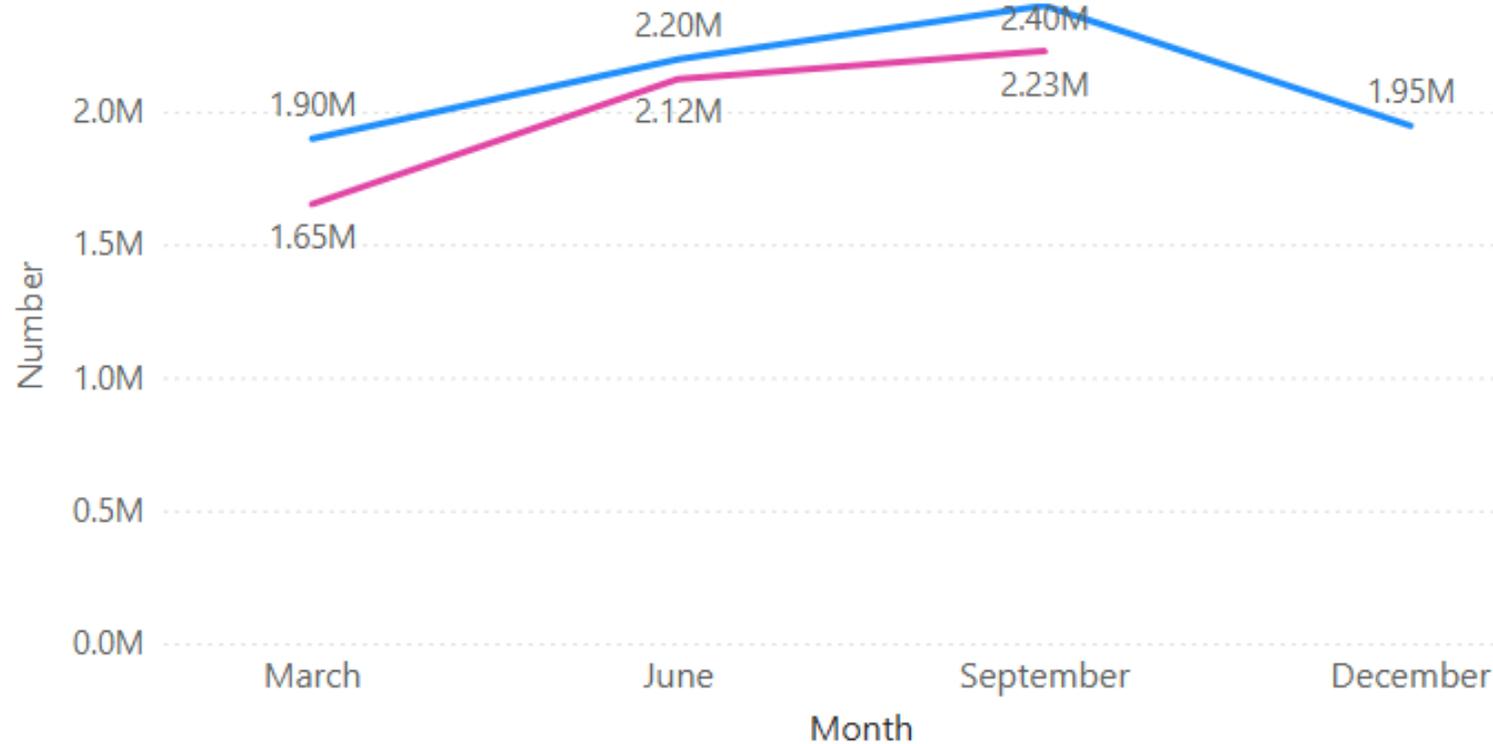
- Low HIV Testing coverage due to interrupted community testing, and occasional stock out of testing commodities
- Slow recovery in testing coverage due to task sharing, and improved supply of HTS commodities
- MOH plans to implement network-based testing services to accelerate testing coverage

Trends in Quarterly HIV Positives Identified and Implications

[Data Source: National Aggregate HMIS Data from Jan. 2024 to Sept. 2025]



Tested HIV Positive by Month and Year

Year ● 2024 ● 2025

- Fewer numbers identified due to interrupted community testing, and occasional stock out of testing commodities

- Slow recovery in testing coverage due to task sharing, and improved supply of HTS commodities

Trends in TB Diagnosis (Samples collected by Quarter/Year) and Implications

[Data Source: National Aggregate HMIS Data from Jan. 2024 to Sept. 2025]

TB Samples Collected by Month and Year

Year ● 2024 ● 2025
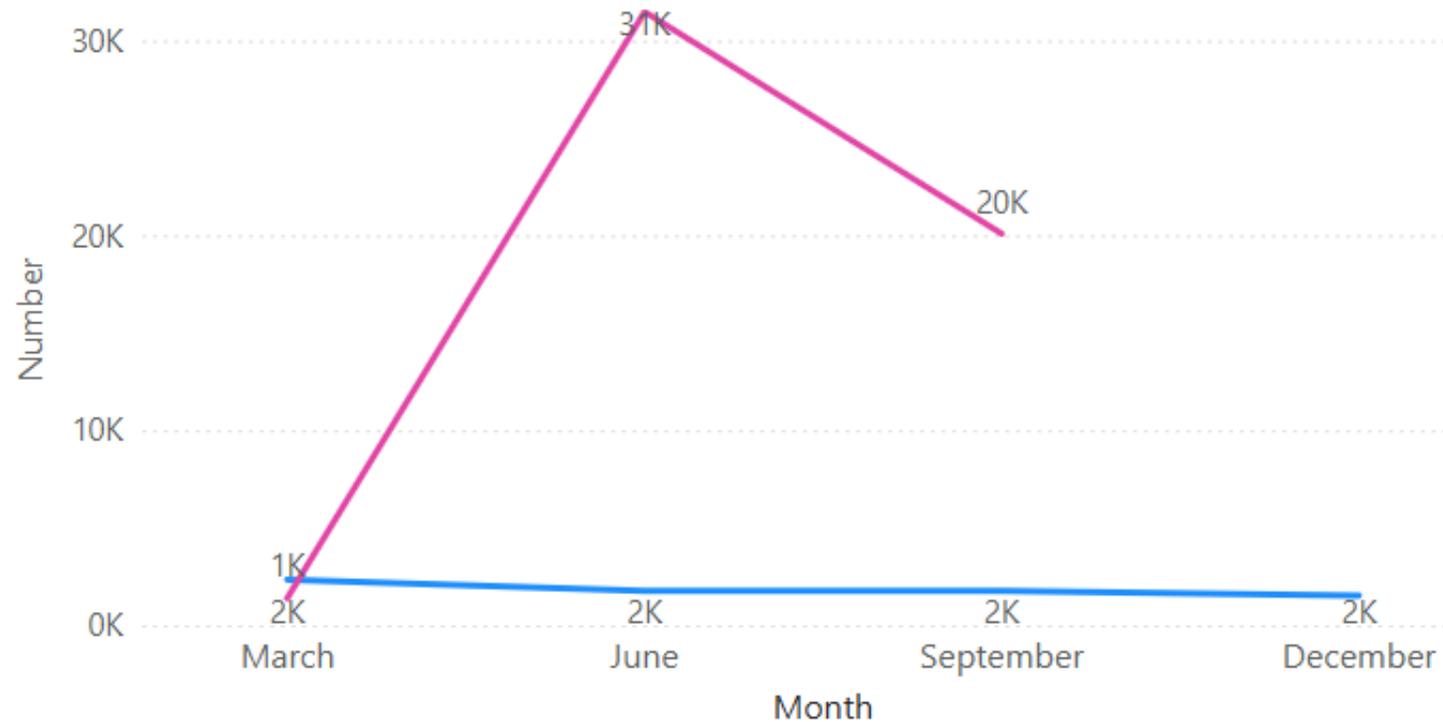
- Astronomical rise in TB sample collection between Mar-Jun due to:
  - Setting surge for TB detection and testing
- A decline in sample collection between Jun-Sep is due to attainment of backlog targets

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Trends in Quarterly TPT Initiation Trends and Implications

[Data Source: National Aggregate HMIS Data from Jan. 2024 to Sept. 2025]

Initiated on TPT by Month and Year

Year ● 2024 ● 2025
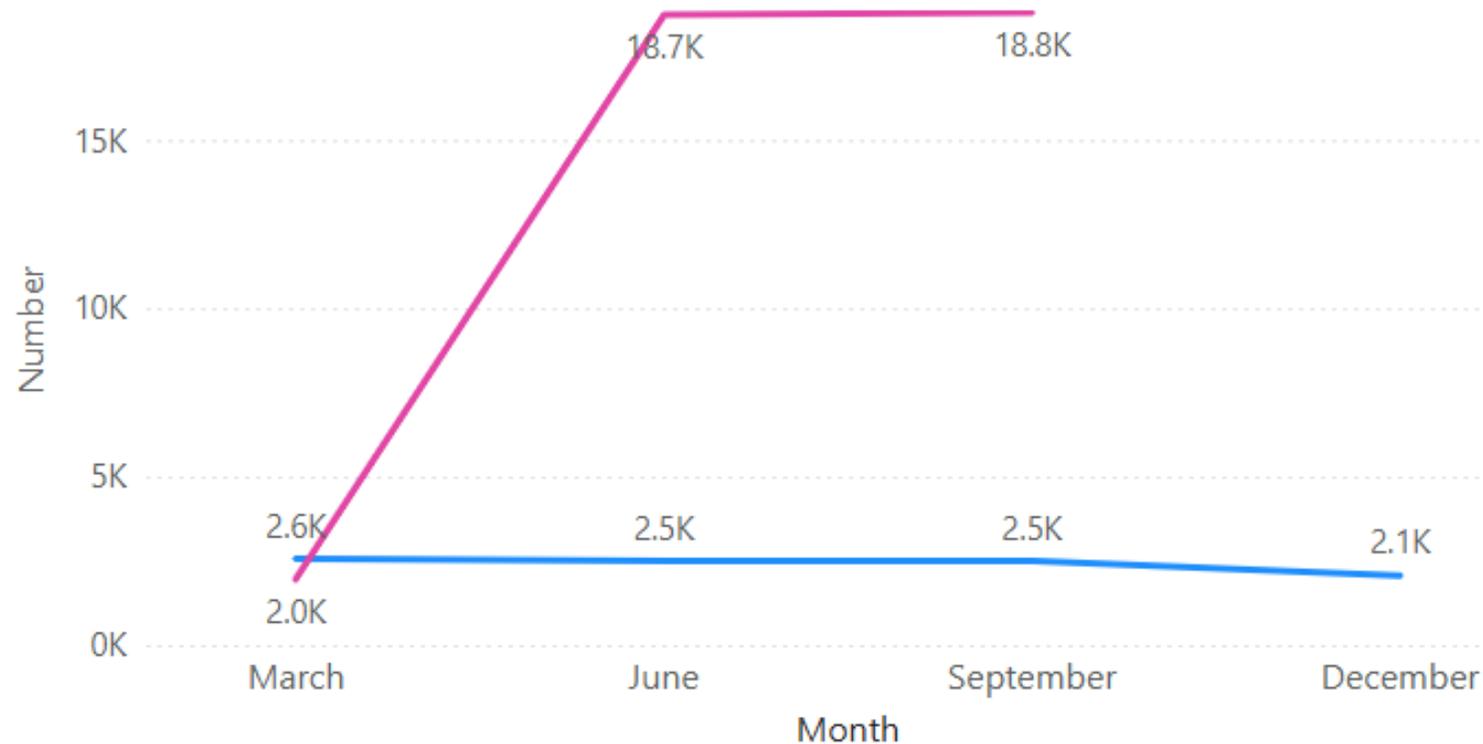
- Astronomical rise in TPT initiation between Mar-Jun due to:
  o Introduction of a waiver following SWO
  o Resumption of IPT rapid scale up
- TPT initiation levelled between June-Sep because facilities have been allocated regular TPT targets

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Community Engagement – 1

Challenges

- Closure/merging of standalone clinics → stigma, low privacy, poor acceptance
- Reduced DSD/MMD → longer travel, missed appointments, rising LTFU & non-suppression
- Weakened community systems (NAFOPHANU, expert pts, district forums) due to cuts
- Limited involvement in M&E due to costs & poor HMIS capture of community

Achievements

- Community/RoC represented in national & Global Fund processes
- Weekly PLHIV/CSO meetings identify gaps & engage duty bearers, incl. stock-outs
- CSOs joined national integration mentorship & documented rights/person-centered issues
- CLM active; work with MOH/UAC/partners to keep referrals & linkages

Community Engagement – 2

Lessons Learnt

- Integration must be explained to recipients, not only providers
- Cutting DSD/MMD quickly hurts retention & viral suppression
- Community systems collapse fast when unfunded; rebuilding is slow
- Meaningful participation needs funding & integrated community/disability data

Next Steps

- Re-resource community/PLHIV structures (NAFOPHANU, expert pts, district forums)
- Rollout community integration education & fix stigma/privacy in merged clinics
- Restore/protect DSD & reliable MMD/supply chains for priority groups
- Integrate community MIS with national HMIS & fund community M&E participation

Ask: Re-invest in community/CSO platforms, protect DSD and MMD, and fund community led monitoring activities

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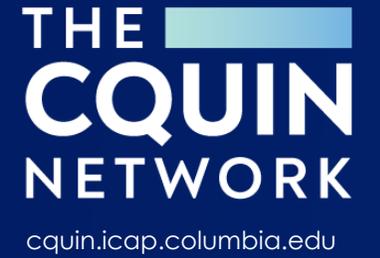
Challenges and Lessons Learnt

Challenges

- Structural and space challenges for integrated health care especially in lower-level facilities (HCIVs and HCIIIs)

- Under staffing in most health facilities

- Stigma among HIV clients arising from integration of services

- Poor attitude of a few staff towards integration despite the training

- Data capture challenges due to unintegrated systems i.e. eAFYA and EMR

Lessons Learnt

- Strong governance and leadership structures are critical buy-in for integration of health services (DHOs, HUMCs and Boards)

- Availability of regional and district-based trainers enhanced mentorships and monitoring of integration within the districts

- Uganda clinical guidelines are a useful resource for integrated management of health conditions

- Task shifting is an opportunity to sustain integration

Next Steps

- Strengthen leadership and governance structures at regional, district facility level
- Lobby for resources to support:
    - integration, including training and infrastructure re-modelling
    - community led services
- Lobby government for improvement of staffing structures
- Improve supervision and clinical mentorship to improve quality of service delivery in facilities
- Expedite integration of EMR systems to improve data capture
- Prioritize implementation of community differentiated service approach for stable HTN and DM patients as it is with HIV clients (CCLAD and CRPDDP).
- Consider improvement in health infrastructure and space
- Reflect of the potential for return and continuation of donor funding