THE NATIONAL MARPS PRIORITY ACTION PLAN 2015/6-2016/2017 (DRAFT)

Uganda AIDS Commission

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FOREWORD

Uganda AIDS Commission (UAC), in collaboration with Ministry of Health and partners has facilitated the process of developing a National MARPS Priority Action Plan (2014/16) to operationalise the National MARPs Programming Framework (2014/16) but also enable rapid scale up of effective, efficient and harmonised national MARPS interventions. This Action Plan is aligned to the new National HIV&AIDS Strategic Plan (2015/16- 2019/20) Draft whose overall goal is; "Towards zero new infections, zero HIV/AIDS-related mortality and morbidity and zero discrimination"

The development process was guided by the National MARPS Steering Committee, Ministry of Health MARPs Technical Working Group and high representation from key stakeholders including UN agencies, CDC and USAID, implementing partners, MARPs Network and government line ministries. Uganda AIDS Commission and Ministry of Health are therefore indebted to the contributions made by all stakeholders setting MARPs National Priorities. We are equally indebted to the contributions and the financial support from UNFPA.

Particularly, we do recognize the following individuals whose technical input and commitment led to the priority setting of National MARPs Priorities: Dr. Zepher Karyabakabo, Dr. Peter Kyambadde, Dr. Peter Mudiope, Dr. Shaban Mugerwa, Dr. Elizabeth Namagala, Dr. Betty Atai, Dr. Geoffrey Mujisha, Ms Rosemary Kindyomunda, Dr. Stella Alamo, , Dr. Raymond Byaruhanga, Dr. Namuwenge Norah, Mr. Michael Muyonga, Dr. Brian Katungi, Mr. Sigirenda Simon, Flavia Kyomukama and staff of line ministries.

Lastly, I wish to congratulate all partners and national HIV stakeholders for their active participation in the development of this Action Plan but above all for their invaluable and continuous contribution to the fight against HIV and AIDS through MARPs Programming.

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1. INTRODUCTION AND BACKGROUND

1.1 Introduction

Uganda AIDS Commission (UAC), in collaboration with Ministry of Health and partners has facilitated the process of developing a MARPS National Priority Action Plan (2014/16) to operationalise the National MARPs Programming Framework (2014/16) but also enable rapid scale up of effective, efficient and harmonised national MARPS interventions. This Action Plan is aligned to the new National HIV&AIDS Strategic Plan (2015/16- 2019/20) whose overall goal is; "Towards zero new infections, zero HIV/AIDS-related mortality and morbidity and zero discrimination". This document acknowledges the importance of MARPS in the dynamics of the epidemic in the country and the need to mount an effective and sustainable response among these population groups.

1.2 Background

Uganda continues to experience a severe generalized HIV epidemic, increasing number of new HIV infections estimated at 140,000 with an approximate 1.6 million people living with HIV (MoH, 2014) and an increasing prevalence (6.4 to 7.3 per cent) among adults aged 15-49 years (AIS 2011). The Uganda NSP (2015/16 –2019/2) Draft identifies MARPs as a vulnerable group that bear a high burden of HIV compared to other populations and have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity. While MARPs contribute significantly to new infections, most programmes reaching them currently do not provide a comprehensive HIV prevention package yet there are limited defined partnerships and referral systems. Sub-optimal packages are compounded by limited knowledge about sizes, profiles and denominators of some MARPS to inform adequate planning, and to establish gaps and effects of the various programmes. Absence of commonly agreed harmonized MARPS specific strategies, indicators and reporting tools has affected proper planning and delivery of an effective and efficient response (UAC, 2014).

The National MARPS Programming Framework (UAC, 2014) therefore provides for the development of a National MARPS Action Plan with clear harmonized strategies and indicators to support scale up of efficient and effective interventions for all MARPs Subgroups aligned to the national priorities. The HIV Investment Case 2015-2025 defines several MARPs sub groups to include: fishing communities, Sex workers (SWs) and partners of sex workers, Men who have Sex with Men (MSM), uniformed services and truckers.

1.2.1 Fisher folk

The recent study on MARPS Size estimation (UAC, 2014) estimates an average of 2,000,000 fisher folk living in Uganda across the five large major lakes of Victoria, Kyoga, Albert, Edward, George and Kazinga Channel and 160 minor lakes and rivers including River Nile. The HIV Investment Case (2015-2025) estimates about 4,500,000 fishing community in Uganda. HIV prevalence among the fisher folk are almost 3-4 times higher than the national average and ranges between 23-35 per cent (Asiki et al., 2011; Seeley, Nakiyingi-Miiro, et al., 2012; Sigirenda et al., 2012, Opio et al., 2011). Major reasons for this high HIV prevalence and incidence in fishing communities is associated to; a booming sex work industry within fishing communities partly attributed to high income from fishing and preponderance to alcohol and drug abuse as

well as high mobility of fisher folk, high proportion of individuals with concurrent multiple sexual partnerships, and non-use of condoms during high risk sex. These populations suffer low access to prevention, treatment, care and support services.

1.2.2 Sex Workers (SW)

Sex workers include female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally[1]. Uganda AIDS Commission (UAC, 2014) **e**stimated over 54,549 sex workers in Uganda and the National HIV Investment Case (2015-2025) indicates an HIV prevalence of 35%. The high HIV risk among sex workers arises from high rates of unprotected sex, alcohol, drug use and non use of condoms. This is coupled to the discriminatory laws to sex work and the limited capacity to bargain for the right to social protections among others. These populations have low access to prevention, treatment, care and support services especially within hotspot catchments and face stigma accessing the rest of the existing services.

1.2.3 Truck Drivers

The MARP size estimation study (UAC, 2014) estimates over 31,588 Truckers to be living in Uganda at any given time of the year but the HIV Investment Case (2015-2025) indicates that there could be over 100,000 truckers in Uganda. HIV Prevalence rates among the truckers range between 25% to 32% (UAC, 2014). Recent studies indicate that rates of self reported STIs were annually up to 15% in both truck drivers and sex workers, and reported condom use was only 50-80%. Access to HIV prevention programs, treatment for HIV and STIs was limited, and there are few and seasonal programs offering HCT services for them (Morris 2007, IOM 2010, IGAD 2013).

1.2.4 Uniformed forces

Uganda AIDS Commission (UAC, 2014) estimates about 650,000 unformed forces living in Uganda but the national HIV Investment Case (2015-2025) estimates about 1 million uniformed forces (Army, Police, Reserved Force, Private Security etc.). HIV prevalence ranges between 10-18.2% (AIC 2007, MOT 2008, United Nations Office of Drug Control 2008, Jimrex Byamugisha 2009). The nature and characteristics of their profession that involves working at night, frequent and abrupt transfers, low salary scale, sex for favors, alcohol abuse and peer pressure expose them to risks of HIV infection. Direct combat related exposure; operation in high prevalence, conflict affected and hard to reach areas where delivery of preventive services is very difficult also affect uniformed services (Kusasira 2008a, Asingwire et al 2005).

1.2.5 Men having Sex with Men (MSM)

The Uganda Modes of Transmission Study (2008) estimated the contribution of MSM to incidence of HIV in Uganda to be 0.9% while the Crane survey (August 2013) showed an HIV prevalence of 13.7%, among the 3,000 study participants and 3% Syphilis prevalence among MSM in Kampala. The Crane Study (2010) estimates approximately 10,533 MSM in Uganda with 80% located in Kampala. Unprotected receptive anal sex predispose them to risk of HIV infection as well as multiple sex relationships between their spouse and fellow adult consenting males (Crane Survey 2013). Scale up of comprehensive HIV prevention services is constrained by national laws that criminalize sexual intercourse between consenting adults of the same sex.

[1] UNAIDS Guidance Note on HIV and Sex Work 2009 page 4

1.3 The Development Process of MARPS National Action Plan (2015/16-2019/20)

The National MARPS Programming Framework (UAC, 2014) provides for the development of MARPS National Action Plan with clear harmonized strategies and indicators to support effective scale up among stakeholders but also to align the MARPs Interventions to the National HIV&AIDS Strategic Plan 2015/16- 2019/20 (draft) and HIV Investment Case for 2015-2025 targets. The development process of MARPs National Action plan was therefore informed by the Uganda's HIV Investment Case (2015-2025), the National Multi-Sectoral MARPS Programming Framework (2014-2016) and the National HIV Strategic Plan, NSP (2015/16-2019/20 draft).

1.3.1 The Uganda's HIV Investment Case for 2015-2025

Uganda's HIV Investment Case for 2015-2025 aims at scaling up evidence based HIV interventions. The Investment Case aims to rapidly scale up selected combination prevention interventions in the first three years (between 2015-2018) and thereafter sustain the coverage at these recommended levels, in order to achieve the desired impact (averting 2,160,00 HIV infections and 570,000 deaths by 2025). The selected interventions include: 1) Anti Retroviral Therapy (ART) (80% coverage) with treatment irrespective of CD4 count for several MARPs; 2) eMTCT (95% coverage of ARVs among HIV infected pregnant women); 3) safe male circumcision (SMC) (80% coverage); 4) access to and use of condoms in high-risk sexual encounters (80%); 5) HIV testing and counseling (50%); and 6) behavior communication interventions focusing on the most affected populations including sex workers, MSM, fishing communities, truckers and uniformed personnel as well as young people in and out of school (*Uganda Investment Case 2014).*

1.3.2 The National Multi-Sectoral MARPS Programming Framework for 2014-2016

The programming framework defines a mechanism within which national MARPS programme priorities could be identified, addressed and implemented. It specifically highlights current gaps in MARPS response and proposes approaches to better address them by making the lead sectors more accountable while UAC better coordinating MARPS response. It also provides standards for some MARPs programming approaches including minimum requirements for measuring impact, tracking program progress, size estimation and profiling tools, as well as community engagement.

1.3.3 The National HIV Strategic Plan (NSP) for 2015/16-2019/20

The overall goal of the National Strategic Plan is towards zero new infections, zero HIV/AIDS related mortality and morbidity, and zero discrimination. The NSP therefore targets averting over 500,000 deaths and preventing 2 million infections by 2020 and projects a drop in new annual infections by 69% (from 134,562 in 2014 dropping to almost 60,000 by 2025). Specifically to this NSP, the Strategy proposes that to get on track, new targets need to be aimed at closing the access gaps to HIV treatment and prevention by setting new targets for 2020, which is the end year of this NSP. Accordingly, target 90-90-90—would enable 90% of people to know their HIV status, 90% of people who know their HIV status to access HIV treatment and 90% of people on HIV treatment to achieve viral suppression.

To achieve this, the NSP mid-term (2018) targets are 80% ART coverage, 50% HCT coverage, 50% condom coverage, 60% SMC coverage, 90% reduction in number of

sexual partners and support for those infected. Roll out of the 2013 treatment will ensure the test and treat approach for all key populations, discordant couples, HIV positive pregnant women, TB/HIV co-infected, and HIV positive children below 15 years. The NSP promotes scale-up of the combination prevention approach utilizing multi-sectoral HIV delivery systems. The draft NSP has four thematic service areas: Prevention, Care and Treatment, Social Support and protection, and systems strengthening, and is aligned to the Investment Case in terms of the selected interventions and targets.

1.3.4 Consultative meeting with MARPs Technical Working Group and HIV stakeholders

The methodology and approach used in the preparation of the NPAP was highly consultative and participatory with key stakeholders in the national HIV/AIDS response. The development process was guided by the National MARPs Steering Committee, Ministry of Health MARPs Technical Working Group and high representation from key stakeholders including UN agencies, CDC and USAID, implementing partners, MARPs Network and government line ministries.

1.3.5 The Purpose of National Priority Action Plan

In order to operationalize the NSP, HIV stakeholders have prepared a National MARPs Priority Action Plan (NMPAP) that elaborates priority activities for each of the agreed strategic actions that must be implemented by stakeholders and the targets to be achieved in each year of NSP.

The National Priority Action Plan will be used as:

- A guide for implementing partners: districts, sectors (public and private), CSOs, and FBOs in developing their annual plans and to align their operational plans in order to contribute to the achievement of NSP 2015/16-2019/20 goals and targets.
- A guide to align international support to national priorities;
- An instrument to assist with mobilization and allocation of resources to the national response;
- An instrument for Uganda AIDS Commission and partners to monitor implementation of the national MARPS response.

2. OUTCOMES, STRATEGIC OBJECTIVES AND ACTIONS

2.1 Outcome 1: Increased Adoption of Safer Sexual Behaviours and Reduction in Risky Behaviors (NSP Thematic area 1, Objective 1)

The National HIV Investment Case (2015-2025) and the National Multi-Sectoral MARPS Programming Framework (2014-2016) call for cost effective, evidence based approaches for adoption of safer sexual behaviors and reduction of risk behavior among the key populations. National and sub-national level stakeholders will implement programs with efforts to modify risky sexual behaviors among MARPS that are driving the epidemic.

2.1.1 Indicators and targets of outcome1:

The behavior change and reduction in risks taking targets based on the following corresponding indicators are as follows:

- Comprehensive HIV knowledge among MARPs increased from 47 to 70%
- Consistent Condom use among MARPS during risky sexual encounter increased to 90%

2.1.1.1 Strategies and priority actions for outcome 1

Shifts in high risk sexual behavior among the Most at-risk populations (MARPS) will require effective strategies tailored to each MARP sub-category based on know behavior traits and development of approaches, involving coordinated multi- channel communication (mass media, community mobilization, working with MARPS peers, and simultaneously addressing the socio-cultural and structural context that underpin the behaviors). The strategies and priority actions for adoption of safer sexual behavior and reduction of risky behavior among MARPs in the next phase of HIV prevention will be as follows:

Outcome	Key actions to be performed	Time Frame	Lead agency and Other partners
Outcome 1: Increased Adoption of Safer Sexual Behaviors and Reduction in Risky Behaviors (linked to NSP **Thematic area 1, Objective 1)**	– Conduct a study to establish and document risky sexual behaviors among MARPs sub-categories and associated causal factors	FY 2015	**UAC,** MOH
	– Develop and translate IEC/BCC messages and materials tailored to known risk sexual behaviors for each MARP sub-category	FY2015	**MOH,** MoGLSD, UAC
	– Capacity building of stakeholders on effective HIV Prevention interventions for MARPs, IEC/BCC guidelines , approaches and service delivery tools	FY 2015	**UAC,** MOH, Line Ministries
	– Disseminate IEC/BCC messages and materials to the key populations using a dynamic mix of mass media, interpersonal, small group	FY 2015	**UAC**, MOH, Line Ministries, IPs

	dialogue and peer -to peer network campaigns		
	– Support hotspot mobilization for key populations to go for HIV prevention services utilizing peer to peer approach	FY 2015-17	**UAC,** MOH, Line Ministries, IPs
	– Disseminate national policies and guidelines including drug and alcohol use	FY 2015	**UAC,** MOH, IPs
	– Regularly review the IEC/BCC programs of various stakeholders to inform better programming	FY 2015-17	**UAC,** MoH, District teams, IPs

2.2 Outcome 2: Increased Coverage, Quality and Utilization of HIV prevention services

Most programmes reaching MARPs currently do not provide a comprehensive HIV prevention package yet there are limited defined partnerships and referral systems to ensure that MARPs receive the complete package in a convenient manner. Under this action plan, a combination HIV prevention package and delivery of a core packed of evidence-based interventions that will be scaled up to achieve critical levels of coverage. The Biomedical interventions will be augmented with a strong IEC/BCC utilizing multi-channels models but largely embracing an interpersonal, peer to peer and small group dialogue approach. A strong livelihood and psychosocial component will be intergraded in this program addressing poverty among MARPs and reduction of vulnerability. Addressing the quality of care service gaps remains core in MARPs programming.

2.2.1 Indicators and targets of outcome 2[2]

- The proportion of MARPS who know their HIV sero-status increased to 90%
- Increase coverage of ART for MARPs to 90%
- Increase utilization of STI screening and treatment services for MARPS to 90%

2.2.1.1 Strategies and Priority Actions:

The main strategies for addressing the biomedical drivers of the epidemic in the next phase of HIV prevention in the country are summarized in the table below:

Outcome	Key actions to be performed	Time Frame	Lead agency and Other partners
Outcome 2: Increased Coverage, and Utilization of HIV prevention	– Conduct a service mapping of national HIV prevention services for all MARP sub-categories to identify service gaps and utilization[3]	FY 2015	**UAC,** MoH, IPs
	– Map out all MARPS hot s pots to guide effective implementation of MARPS comprehensive programs	FY 2015	**UAC,** MoH, IPs,
	– Commission studies for establishing size estimate, operational research and	FY 2015/16	**UAC,** MoH, IPs

[2] There was a strong recommendation at MOH meeting to include eMTCT and SRH, PEP among MARPs

[3] Mapping of services will precede a review of current mapping exercises among MARPs to establish where they have been done as per MARPs Category, methodology and close the gaps where they exist

services (Linked to NSP Thematic area 1, Objective 2 and Thematic Area 3)	undertaking national MARPs survey delineated from AIDs Indicator surveys		
	– Develop scale up plans for a minimum HIV prevention package for MARPS to fill identified gaps to achieve critical coverage	FY 2015/16	**UAC,** MoH, IPs
	– Develop, review and update policies, technical guidelines and standards for delivery of the core HIV prevention services among MARPs including updates to definitions, current categories of MARPS in Uganda and protocols	FY 2015/16	**UAC,** MoH, IPs
	– Provide the minimum package of HIV prevention services to all MARPs categories by utilizing innovative approaches like boat, moonlight testing, Test and treat, peer to peer and accrediting more health facilities in hotspot zones	FY2015-18	**MoH, UAC,** Line Ministries, IPs
	– Develop and disseminate facility-level protocols for delivering friendly services to MARPs	FY 2015/16	**MoH, UAC,** Line Ministries, IPs
	– Train health care givers countrywide to provide friendly comprehensive MARPs services for all sub-categories including SGBV	FY 2015/16	**MoH, UAC,** IPs
	– Institute and implement pilot projects for minimum HIV prevention package for MARPs in Selected hot spot areas with rigorous impact evaluation and documentation of Best practices (hot spot programming)	FY 2016	**MoH,** UAC, Line Ministries, IPs
	– Set up outreach or dedicated clinics for hard-to-reach population groups e.g. STI services for sex workers, moonlight clinics for truckers, wellness centres for truckers, mobile clinics for fisher folk etc	FY 2016/17	**MoH**, UAC, Line ministries, IPs
	– Expand condom distribution outlets for MARPs in the mapped hot spots including lodges, beaches, bars, hotels, etc to ensure that there are condoms all the time[4]	FY 2015	**MoH**, UAC, Line ministries, IPs
	– Ensure uninterrupted supply of commodities for MARPs services throughout the year	FY2015-017	**MoH**, UAC, Line ministries, IPs
	– Integrate a full range of FP services for prevention of unwanted pregnancies among MARPs, safer conception and access to eMTCT services	FY2015-017	**MoH**, UAC, Line ministries, IPs

[4] The condom distribution plan will be aligned to the national Condom distribution strategy(MOH)

	– Expand provision of services for timely management SGBV among MARPs sub-groups using the standard package	FY 2015-17	**UAC,** MOH, Line ministries, IPs
	– Train service providers and MARP peers on psychosocial support using peer-to peer approach	FY 2015/17	**UAC,** MoGLSD, IPs
	– Conduct a needs and capacity assessment on MARPs to engage in IGAs, and appropriate IGAs for each category		**UAC,** MoGLSD, IPs
	– Use the needs assessment to scale up a comprehensive livelihood component for MARP sub-categories to reduce vulnerability	FY 2015/17	**UAC,** IPs
	– Train and support IGA MARP beneficiaries in essential business management skills including bulk marketing	FY 2015/17	**UAC,** IPs
	– Document Cash transfers best practices and scale them up among MARPs	FY 2015/17	**UAC/MoGLSD,** IPs

2.3 Outcome 3: Strengthened Sustainable enabling environment that mitigates Underlying Factors Driving the HIV Epidemic

The key drivers of the epidemic currently comprise of harmful cultural norms, beliefs and practices; gender disparities, discriminatory laws and violation of their rights, wealth and poverty, HIV-related stigma and discrimination, poor governance and accountability, inequitable targeting of existing HIV services and weak leadership and coordination of HIV response especially at the local government level. The MARPs Action plan seeks to influence these factors that increase risk and vulnerability to HIV infection among MARP Sub-categories.

2.3.1 Indicators and Targets:

The major indicators and targets of change in these drivers over the next five years include:

- Improved legislative and policy framework that promotes HIV prevention for most-at risk populations.
- Sexual and Gender-Based Violence among MARPs reduced
- Survivors of SGBV seeking help from service organizations increased (Establish baseline targets)
- Stigma and discrimination reduced as seen from MARPs freely accessing and utilizing HIV preventive services
- Strengthened capacity of MARPs network organizations and group

2.3.1.1 Strategies and Priority Actions:

The strategies and priority actions to influence change in factors that increase risk vulnerability to HIV infection are as follows:

Outcome	Key actions to be performed	Time Frame	Lead agency and Other partners

Outcome 3: Strengthened Sustainable enabling environment that mitigates Underlying Factors Driving the HIV Epidemic (Linked to NSP Thematic area 1, Objective 3)	– Undertake research on socio-cultural factors that hinder sexual behavior change and encourage risky sexual behaviors	FY 2015/16	**UAC,** MoGLSD and Research Institutions
	– Research the causes and manifestation of SGBV in different MARPs sub-groups and design and implement appropriate interventions based	FY 2016/17	**MoGLSD,** UAC, Research Institutions
	– Support IPs, CSOs, communities to design and implement MARPs context specific interventions that address harmful socio-cultural and gender norms (e.g. group sex etc)	FY 2015-18	**MoGLSD,** UAC, Research Institutions
	– Analysis of existing, policies, legislation, programs and advocate for the amendment of laws that restrict provision of HIV prevention services to some MARP groups	FY 2016/18	**UAC, Justice Law and Order sector** MoGLSD, MOH, and IPs/CSOs, , MoJ
	– Conduct advocacy campaigns on policies and laws that affect the health rights of MARPs	FY 2015/18	**UAC, IPs**
	– Sensitize and educate the law enforcement officers on public health vs laws.	FY 2015/17	**UAC,** MoJ, MoGLSD, and IPs/CSOs
	– Sensitize and educate MARP groups on their health rights and responsibilities vs laws.	FY 2015/17	**UAC,** MoJ, MoGLSD, and IPs/CSOs, HRC
	– Lobby government and development partners to increase resources for delivery of services to all MARPs groups	FY 2015/17	**UAC,** MoH, MoGLSD, IPs, Districts MoIA, MoD
	– Conduct ethnographic studies to profile MARPs including structural factors affecting the population groups	FY 2015/16	**UAC,** MoH, MoGLSD, IPs, Districts MoIA, MoD
	– Develop a plan of action to address the structural factors that – disproportionately affect MARPs	FY 2015/16	**UAC,** MoH, MoGLSD, IPs, line ministries
	– Engage, sensitize and educate the religious, cultural and political leaders on health rights and response for MARPs	FY 2015/16	**UAC,** MoGLSD, IPs, line ministries
	– Develop advocacy materials for engaging religious, cultural and political leaders on health rights and response for MARPs	FY 2015/16	**UAC,** MoGLSD, IPs, line ministries

2.4 Outcome 4: Achieving a more Coordinated MARPS HIV Prevention response at all levels

Improving leadership and coordination of MARPS national response is key to meeting the goal and targets that have been set in the NSP. Currently, although the national coordination mechanisms exist under a multi-sectoral approach, they are dysfunctional especially at sub national level and especially led by civil society. Nationally, there is no planning and monitoring framework to guide MARPS HIV combination prevention

response and most of the implementing partners track different indicators with different tools at national and district levels. At the same time, different funding sources targeting similar activities in the same geographical areas are not well coordinated. The lack of convergence of such funds at agreed minimum administration units e.g. sector and districts level, affects synergy building for expanded coverage and focus on common results. Therefore, NMAP is needed especially in mobilization and allocation of resources based on clear targets but also in monitoring the implementation of the national MARPs responses by UAC and partners to realise and efficient, effective and up to scale national response.

2.4.1 Indicators and targets:

- All districts having functional MARP networks by 2017
- Number of districts with HIV plans that integrate MARPs programs aligned to the National MARPs Planning Framework (2014-16) and Action Plan (2015-17).
- A National coordination index for MARPS national HIV response increased (Baseline targets to be established)

2.4.1.1 Strategies and Priority Actions:

The main strategies and priority actions for addressing the emerging gaps in the leadership and coordination of HIV prevention at all levels include the following:

Outcome	Key actions to be performed	Time Frame	Lead agency and Other partners
Outcome 4: Achieving a more Coordinated MARPS HIV Prevention response at all levels	– A harmonized results-based framework for monitoring and holding different sectors, structures and IPs accountable implemented	FY 2015/17	**UAC,** MoLG, LG
	– Review the existing coordination structures at district and community levels and establish if they are convenient in coordinating MARPs response at community level	FY 2015/17	**UAC,** MoLG, LG
	– Work with the partners to establish functional MARPs coordination structures at sub-national levels (hot spots)	FY 2015/17	**UAC,** MoLG, LG
	– Strengthen the MARPs steering committee, review its terms of reference and expand its mandate	FY 2015/17	**UAC,** MoH
	– Set up MARPs coordination desk at UAC and MOH	FY 2015/17	**UAC,** MoH
	– Strengthen the MARPs coordination network at national level	FY 2015/17	**UAC,** MoH
	– Copt members from the Justice law and order sector on te MARPs steering committee	FY 2015/17	**UAC,** MoH
	– Hold national coordination dialogue with stakeholders (religious leaders, cultural leaders, political leaders, IPs MARPs communities to discuss the national MARPs response		
	– Adopt tools for monitoring MARPs services	FY 2015/17	**MOH, UAC**

	– Coordinate resource allocation and use among IPS targeting MARPS at national, district and community levels	FY 2015/18	**UAC,** MoH, MoGLSD, IPs, Districts MoIA, MoD, CSOs
	– Develop a joint planning and monitoring framework to guide MARPS HIV response	FY 2015/16	**UAC,** MoH, MoGLSD, IPs, Districts MoIA, MoD
	– Develop a reporting system, and guidelines for regular collection and compilation of data on community services for MARPS	FY 2015/16	**MoH**, UAC**,** , MoGLSD, IPs, Districts MoIA, MoD

2.5 Outcome 5: Strengthened Information Systems, tracking and reporting on MARPS national response

In Uganda, absence of harmonized reporting tools and programming frameworks among actors at national, sector and district and hotspot levels affect effective tracking and reporting for MARPS national response. Yet without appropriate programme data, it is difficult to establish the extent of program coverage, resource gaps but also holding respective leadership accountable for action or inaction for some MARP groups.

Uganda AIDS Commission and Ministry of health and partners will review the existing national and sectoral tools to establish if these tools capture all the needed national MARPS indicators (biomedical, Behavioral, socio-economic/structural) or are comprehensive but also establish the inherent gaps across national actors. The review exercise will lead to harmonization of existing tools (government, implementing partners), revisions of such tools, revisiting national tracking mechanisms including tracking systems and a national consensus of such agreed tools through a partner consultation process. Monitoring and Evaluation efforts will continue to be based on the existing M&E, and surveillance systems, procedures and mechanisms but evaluated and strengthened to respond to MARPs Needs. In addition, information systems of major IPs such as MEEPP will also be harnessed. Uganda AIDS Commission through its National HIV Prevention Committee and Directorate of Planning and monitoring will provide oversight to multi-sectoral monitoring and evaluation. However, working very closely with and strengthening horizontal linkages with sector information systems to capture timely data is necessary.

2.5.1 Indicators and Targets:

The major targets and indicators of change in these drivers over the next five years include:

- Harmonized tools for data capture on all MARPs programs adopted and utilized by IPs Strengthened reporting systems to track coverage, outputs, and utilization of HIV Prevention programs for the different MARP sub-categories
- Two annual and one mid-term reports of HIV prevention programs comparing achievements against targets for MARPs produced
- National MARPs sub-groups sizes, profiles and HIV burden determined by 2017
- Special surveys and studies done on MARPs for tracking HIV prevention outcomes conducted every 2 years and data disseminated to stakeholders
- A mechanism for regular tracking of HIV Prevention Resources for MARPs instituted by 2017

2.5.1.1 Strategies and Priority Actions:

The strategies and priority actions to influence change in factors that increase risk vulnerability to HIV infection are as follows:

Outcome	Key actions to be performed	Time Frame	Lead agency and Other partners
Outcome 5: Strengthened Information Systems, tracking and reporting on MARPS national response	– Review data variables that are captured by IPs, Government and recommend additional variables required for effective tracking additional HIV prevention Indicators for MARPs	FY 2015	**UAC**, MoH, IPs
	– Work with the Resource Centre in MoH on new additional variables that can be captured in the electronic version of the HMIS	FY 2015	**UAC**, MoH, IPs
	– Establish horizontal reporting linkages with sector Management information systems to track MARPs response	FY 2015	**UAC,** Sectors
	– Assess sector M&E systems and recommend appropriate strengthening measures to track MARPs response	FY 2015	**UAC,** Sectors
	– Develop a reporting system, and guidelines for regular collection and compilation of data on MARPs services at community/hot spot levels	FY 2015	**UAC,** Sectors, IPs
	– Compilation and analysis of HIV prevention M&E data and production of quarterly and annual HIV prevention Reports	FY 2015-17	**UAC, MOH,** Sectors, IPs
	– Establish or strengthen a one stop centre or knowledge hub for HIV prevention information for MARPs, and similar centres at community and hotspot level	FY 2015-17	**UAC, MOH,** Sectors, IPs
	– Establish linkages and reporting relationships with IPs, research institutions and research coordination entities	FY 2015-17	**UAC, MOH,** Sectors, IPs
	– Periodic evaluation of HIV prevention interventions for MARPs, service delivery approaches, models and sharing of best practices and lessons learned to inform better programming	FY 2015-17	UAC, NPC, IPs, Research Institutions
	– Regular dissemination of information, brainstorming sessions, debates, data use workshops etc	FY 2015/18	**Lead: UAC,** MoH, IPs, line ministries
	– Institute data triangulation to generate consensus HIV service report for MARPs		

3. Institutional Support to Action Plan implementation

The Implementation of the priority activities for MARPs HIV prevention outlined in this Action Plan will be undertaken by various stakeholders working together under the

auspices of the multi-sectoral approach. Uganda AIDS Commission and Ministry of Health will provide leadership and guidance for effective implementation of the action plan by the implementing partners. UAC and Ministry of health will further support lead sectors to review their existing implementation plans and align them to the national MARPs Programming Framework (2014/16 and Action Plan (2015/17)[5].

3.1 Role of the Uganda AIDS Commission

Uganda AIDS Commission (UAC) will continue with its oversight role of nation-wide efforts in HIV prevention for MARPs. This will include coordination of policy development, planning, resource mobilization and allocation, as well as monitoring and reporting on progress on implementation of MARPs National Interventions. UAC will further support sectors and districts to develop/align their annual plans to the national MARPs Programming Framework (2014/16 and Action Plan (2015/17) and collate the plans and progress reports to compile annual progress reports on HIV prevention to be shared with stakeholders through various fora including the Joints AIDS Programme Review (JAR). UAC through its NPC will from time-to-time hold stakeholder meetings on HIV prevention to monitor implementation reports, identify gaps and draw the attention of stakeholders.

3.2 Role of the Ministry of Health

The MoH is central to the implementation of MARPs Priority Action Plan 2015-17. It will be responsible for coordination and technical guidance of the public health response and sex work settings. The MoH will also be responsible for quantification, procurement, rationalization, supply chain management of commodities for MARPs HIV prevention, overseeing integration of MARPs services in the health sector and tracking implementation of HIV prevention in districts and other implementing partners. The MoH will be expected to develop MARPs specific annual plans as well as compilation of regular progress reports from the health sector on implementation of MARPs activities.

3.3 Roles of Other Line Ministries

All sectors in MARPs programming will be required to review their policies, plans and align them to the national MARPs Programming Framework (2014/16 and Action Plan (2015/17. The sector plans will be harmonized plans at sectoral levels through consultative processes with all IPs/CSOs supporting sectoral specific the HIV responses. Deliberate efforts to support planning functions of sub-national entities as well as tracking implementation of HIV prevention endeavours within respective sectors should be undertaken. To facilitate this MARPs coordination role, it is necessary that each line ministry identify a responsible desk officer to coordinate MARPs HIV prevention in the sector, and be accountable for compilation of quarterly progress reports on HIV prevention in the sector. The reports will outline progress being made in meeting the targets of MARPs National Priority Action Plan. These reports will be shared with UAC and other stakeholders periodically to contribute to and inform national MARPs better and coordinated programming.

[5] The National MARPs Programming Framework (UAC, 2014-16) provides for priority actions and strategies for each sub- sector to utilize in programming based on nationally identified gaps in wide national consultative forums (December 2014 to January 2015).

3.4 Role of Districts and Local Governments:

Since district and local governments are responsible for service delivery, UAC, MoH and line Ministries will work with district teams to develop integrated annual multi-sectoral work plans that mainstream HIV prevention interventions for MARPs within the existing programs. The plans will be aligned to the national MARPs Programming Framework (2014/16 and Action Plan (2015/17) but incorporate all activities of all IPs operating in the district, including activities funded from national, local and external sources.

After developing a harmonized district/urban plans, Districts and municipal councils will also be responsible for coordination of various IPs irrespective of source of funding, and ensure that linkages and referral mechanisms between IPs and other district entities are established and functional in order to offer the complete package of HIV prevention services for MARPs. Districts and Municipal Councils also will be required to indentify a lead officer and department that will be responsible for coordination and compilation of regular progress reports on implementation of MARPs Activities as well as support formation and functionality of MARPs Networks. Rationalization of implementation of MARPs response at district level will be a joint activities with IPs based on a common plan, joint reviews on progress but the district/municipal council will take lead in compilation and reporting to respective line ministries and UAC.

Furthermore, districts and local government will be required to mobilize local resources to support MARPs HIV/AIDS prevention, care and treatment as one measure of ensuring sustainability of HIV prevention endeavours.

3.5 Role of Implementing Partners, NGOs, CBOs:

In line with the multi-sectoral approach, IPs, NGOs, CBOs, research and academic institutions, private sector entities, etc at all levels will also play significant roles in MARPs national HIV prevention in order to realize the set targets and priorities. It is evident that many partners implement HIV activities within line ministries and sectors and therefore coordination of the entities will be critical to ensure delivery of a complete package of HIV prevention services to communities and individuals. Development partners and Bilaterals supporting MARPs response will be coordinated through UAC and MOH line departments.

At sector level, the specific roles will be in line with their mandates and comparative advantage. For example, NGOs are often more efficient in reaching at Hotspot level, as well as supporting community led interventions. Therefore, all stakeholders will be required to harmonize their plans with the district plan and to provide regular reports to districts and line ministries so that they can be incorporated in district-wide and national reports of HIV prevention.

4. Financing the National MARPs Action Plan

Uganda AIDS Commission, Ministry of Health and Districts will use the plans of action for mobilization of resources to support program implementation. Existing partners that have been implementing programs targeting MARPs will be mobilized to contribute to common national, district plans and support activities within their mandate.

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ANNEX 1: 2014 WHO Comprehensive Package for key populations

HIV prevention

- The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).
- Among men who have sex with men, pre-exposure prophylaxis (PrEP) is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package.
- Where sero discordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.
- Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
- Voluntary medical male circumcision (VMMC) is recommended as an additional important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision.

Harm reduction

- All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes.
- All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy in keeping with WHO guidance.
- All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.
- People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.

HIV testing and counseling (HTC)

- 10. Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and **counseling** for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and **counseling**.

HIV treatment and care

- Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.
- All pregnant women from key populations should have the same access to services for prevention of mother-to child transmission of HIV (PMTCT) and follow the same recommendations as women in other populations.
- *Prevention and management of co-infections and co-morbidities*
- Key populations should have the same access to tuberculosis prevention, screening and treatment services as other populations at risk of or living with HIV.
- Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.
- Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-**counseling** for HIV and depression to appropriate medical therapies.

Sexual and reproductive health

- Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.
- People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.

- Abortion laws and services should protect the health and human rights of all women, including those from key populations.
- It is important to offer cervical cancer screening to all women from key populations, as indicated in the WHO 2013 cervical cancer screening guidelines.
- It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as indicated by WHO guidelines, as women from other populations.

Critical Enablers

- Laws, policies and practices should be reviewed and revised where necessary, and countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and non-conforming gender identity and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.
- Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
- Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
- Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations.
- Violence against people from key populations should be prevented and addressed in partnership with key population led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

ANNEX 2: LIST OF PARTICPANTS

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Field Code Changed

Field Code Changed

ANNEX 3: MARPS INDICATORS IN HOTSPOT PROGRAMMING

Table Indicators that can be used to track HIV response at District and community Level

1	Programme Coverage Indicators	Definition
1.1.	Estimated MARPs in area of work/district or community.	**Definition:** Total estimate of MARPs in the specific geographical coverage area derived from mapping or size estimation studies. This figure should be static for the reporting year. The figure also serves as the denominator. **Denominator:** No. of MARPS estimated in a given geographical coverage area **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
1.2.	Number of MARPs planned to be covered as per the district plan or IP service contract	Total number of MARPs targeted to be covered in the intervention geographical area as per district plan or service contract with a funding or support agency. **Denominator:** Number of MARPs targeted to be covered in the intervention geographical area **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
1.3.	Number of sites/ hotspots through which MARPs operate in the intervention geographical area to guide scale up of programs (hotspot programming).	Total estimated number of sites/spots through which the estimated MARPs (1.1) operate. This figure could be derived from the district[6]/ project's own mapping/estimation **Denominator:** Number of sites/spots through which the estimated MARPs operate. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
1.4	Number of sites/spots through which MARPs operate planned to be covered in the intervention geographical area	Total number of MARPs sites/hotspots targeted to be covered in the intervention geographical area as per the district plan or contract with a funding or support agency **Denominator:** Number of MARPs sites/hotspots targeted to be covered in the intervention geographical area in a given time **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
2	**Outreach**	
2.1	Number of individual MARPs contacted at least once in the	Total number of individual MARPs met by the district or project outreach team at least once through field outreach or project services in the reporting quarter. The contacts at the outreach level can be 1-1 contact or group contact at

[6] Districts rarely carry out mapping exercises to locate services for MARPS or establish sizes. It is important that any mapping exercise or size estimation in a given area involves the district to own them and target them as part of planned outreaches

	reporting quarter	community level. **Denominator:** Number of individual MARPs met by the district or project outreach team at least once through field outreach or project services in the reporting quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
2.2	Number of new individual MARPs contacted for the first time in the project during the reporting quarter	Total number of new individual MARPs contacted for the first time by the district/ project outreach team through field outreach or services in the reporting quarter. The contacts at the outreach level can be 1-1 contact or group contact at community level. **Denominator:** Number of new individual MARPs contacted for the first time by the district/ project outreach team through field outreach or services in the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
2.3	Number of group meeting/ events conducted with MARPs during the reporting quarter	Total number of group meetings or events conducted with MARPs during the reporting quarter. **Denominator:** Number of group meetings or events conducted with MARPs during the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
2.4	Number of MARPs who participated in the group meetings during the reporting quarter	Total number of individual MARPs who attended group meetings or events during the reporting quarter. **Denominator:** Number of individual MARPs who attended group meetings or events during the reporting quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3	**Services**	
3.1	Number of individual MARPs received risk reduction counseling at least once during the reporting quarter	Total number of individual MARPs who received risk reduction counseling at least once during the reporting quarter (not cumulative counseling sessions held) **Denominator:** Number of individual MARPs who received risk reduction counseling at least once during the reporting quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.2.	Number of individual MARPs counseled and tested for HIV during the reporting Quarter	Cumulative number of individual MARPs counseled and tested for HIV during the reporting Quarter **Denominator:** Number of individual MARPs counseled and tested for HIV during the reporting Quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)

3.3	Number of individual MARPs tested HIV positive during the reporting quarter	Cumulative number of individual MARPs who tested HIV positive during the reporting Quarter **Denominator:** Cumulative Number of individual MARPs who tested HIV positive during the reporting Quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.4	Number of MARPs enrolled in care during the reporting quarter	Cumulative number of individual MARPs enrolled in HIV care (e.g. cotrimoxazole prophylaxis) during the reporting Quarter. **Denominator:** Cumulative number of individual MARPs enrolled in HIV care during the reporting Quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.5	Number of individual MARPs initiated on ART in the reporting Quarter	Cumulative number of individual MARPs initiated on ART in the reporting Quarter **Denominator:** Cumulative number of individual MARPs initiated on ART in the reporting Quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.6	Number of Individual MARPs visited in a health facility during the reporting Quarter	Total number of individual MARPs who visited a health facility/ clinic supported by the Project / linked with the project for STI Screening during the reporting quarter **Denominator:** Number of individual MARPs who visited a health facility/ clinic supported by the Project / linked with the project for STI Screening during the reporting quarter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.7	Number of individual MARPs treated for STIs during the reporting quarter	Total number of individual MARPs treated for STIs during the reporting quarter. Individuals are counted once irrespective of number of STIs diagnosed with and treated for. **Denominator:** Number of individual MARPs treated for STIs during the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.8	Number of individual MARPs provided with Post Exposure Prophylaxis	Total number of individual MARPs who reported to be exposed to HIV and provided with post-exposure prophylaxis (PEP) within 72 hours of exposure during the reporting quarter. Individuals are counted once irrespective of number of PEP episodes attended to. **Denominator:** Number of individual MARPs who reported to be exposed to HIV and provided with post-exposure prophylaxis (PEP) within 72 hours of exposure during the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)

3.9	Number of MSM treated for STIs during the reporting quarter	Total number of individual MSM treated for STIs during the reporting quarter. Individuals are counted once irrespective of number of times treated **Denominator:** Number of individual MSM treated for STIs during the reporting quarter. Individuals are counted once irrespective of number of times treated **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.10	Number of health camps organized for the bridge populations in the reporting quarter	Total number of health camps organized for the bridge populations in the reporting quarter. The health camps may include provision of HIV-related as well as other general health services **Denominator:** Number of health camps organized for the bridge populations in the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
3.11	Number of individual members of the bridge populations who utilized the health camps in the reporting quarter	Total number of individual members of the bridge populations who attended and utilized the health camps in the reporting quarter. **Denominator:** Number of individual members of the bridge populations who attended and utilized the health camps in the reporting quarter. **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)
5	**Structural Interventions/Enabling Environment**	
5.1	Number of advocacy workshops/ meeting conducted with key stakeholders during the reporting quarter	Total number of advocacy workshops/ meetings conducted with key stakeholders (e.g. law enforcement agencies, religious leaders, local administration, entertainment establishments owners, etc) to promote an enabling environment for MARPs during the reporting quarter **Denominator:** Number of advocacy workshops/ meetings conducted with key stakeholders to promote an enabling environment for MARPs during the reporting quarter. **Disaggregation**: Stakeholder type (e.g. law enforcement agencies, religious leaders, local administration, entertainment establishments owners, etc)
5.2	Number of participants at the Advocacy workshops/ meeting conducted with key stakeholders during the reporting quarter	Total number of participants at the advocacy workshops/ meetings conducted with key stakeholders (e.g. law enforcement agencies, religious leaders, local administration, entertainment establishments owners, etc) to promote an enabling environment for MARPs during the reporting quarter **Denominator:** Number of participants at the advocacy workshops/ meetings conducted with key stakeholders to promote an enabling environment for MARPs during the reporting quarter

5.3	Number of incidents of violence reported against the MARPs during the quarter	Violence includes any incident faced by the MARPs like extortion, abuse, arrest / detention by police, beating by gangs, rapes, beating by clients and partners targeted at MARPs. Report all cases for the reporting quarter **Denominator:** Number of incidents of violence reported against the MARPs during the quarter **Disaggregation**: Age, sex, type (CSW, MSM, IDUs etc.)
5.4	Number of incidents of violence addressed during the quarter	**Definition:** Addressing of cases means that peers and/or project staff met with affected community members within 24 hours to register a complaint with the police or other legal / mutually agreeable channel against perpetrators of violence and arranged for appropriate help. The case does not have to be necessarily resolved to be counted in this indicator as a solution may take time. **Denominator:** Number of incidents of violence addressed during the quarter **Disaggregation**: Age, sex, type (CSW, MSM, IDUs etc.)
6	**Infrastructure and human resources**	
6.1	Number of Project supported health facility	Total number of service delivery points or health facilities (GOV, Private, NGO, or FBO) supported by the project/ or linked with the project as a referral centre to offer services for MARPS within a defined geographical region **Denominator:** Number of service delivery points or health facilities supported by the project/ or linked with the project as a referral centre to offer services for MARPS within a defined geographical region **Disaggregation**: Type (GOV, Private, NGO, or FBO etc)
6.2	Number of project owned Drop In Centres	Total number of active Drop In Service Centers (Safe spaces for MARPs) established / owned by the project to offer services to MARPS **Denominator:** Number of active Drop In Service Centers (Safe spaces for MARPs) established to offer services to MARPS **Disaggregation**: Type (GOV. owned Private owned, NGO, or FBO etc)
6.3	Number of active Outreach Workers	Total number of outreach workers hired and engaged by the project for the purposes of conducting outreaches for MARPS in a designated project area during the reporting period **Denominator** Number of outreach workers hired and engaged by the project for the purposes of conducting outreaches for MARPS in a designated project area during the reporting period **Disaggregation**: Type (e.g. peer educator, outreach staff etc) , cadre etc
6.4	Number of Active Peer Educators	Individuals from MARPs community that have been hired to provide outreach services in the reporting period. These

		individuals work with the project on a regular basis, collect data related to their activities, and may be paid an honorarium. **Denominator** Number of Individuals from MARPs community that have been hired to provide outreach services in the reporting period **Disaggregation**: Type (e.g. peer educator, outreach staff etc) , cadre etc
4	**Commodities**	
4.1	Number of individual MARPs who received a condom (Male/Female) directly from the programme/project during the reporting quarter	Total number of individual MARPs who received a condom (male of female) directly from a peer educator, outreach staff, or a MARPs-friendly health facility, Drop-in-Centres) during the reporting quarter **Denominator:** Number of individual MARPs who received condoms (male of female) a during the reporting quarter **Disaggregation**: Type of MARP recipient, Source of condoms (e.g. peer educator, outreach staff, or a MARPs-friendly health facility, Drop-in-Centres) etc
4.2	Number of male condoms distributed by the outreach staff during the reporting quarter	Total number of male condoms distributed by the outreach staff directly to the MARPs (through Peer Educators, Prevention staff, Outreach workers, MARPs-friendly facilities, Drop-in-Centres, etc) during the reporting Quarter **Denominator:** Number of individual MARPs who received only male condoms a during the reporting quarter **Disaggregation**: Type of MARP recipient, Source of condoms (e.g. peer educator, outreach staff, or a MARPs-friendly health facility, Drop-in-Centres) etc
4.3	Number of female condoms distributed by the outreach staff during the reporting quarter	Total number of female condoms distributed by the outreach staff directly to the MARPs (through Peer Educators, Prevention staff, Outreach workers, Clinics, Drop-in-Centres, etc) during the reporting Quarter **Denominator:** Number of individual MARPs who received only female condoms a during the reporting quarter **Disaggregation**: Type of MARP recipient, Source of condoms (e.g. peer educator, outreach staff, or a MARPs-friendly health facility, Drop-in-Centres) etc
4.4	Number of condoms distributed through condom outlets during the reporting quarter	Total number of free condoms distributed indirectly to the MARPs through channels other than outreach staff (e.g. through condom dispensers, unmanned/ manned condom outlets etc.) during the reporting quarter **Denominator:** Number of individual MARPs who received condoms during the reporting quarter through channels other than outreach staff **Disaggregation**: Type of MARP recipient, Source of condoms (through condom dispensers, unmanned/ manned condom outlets etc)

Annex 4: Results and Performance Indicators' Matrix for MARPS[7]

Performance Indicator	Indicator Definition	Baseline	Annual Targets			Data Source and methods	Frequency of data collection	Responsibility
			2015	2016	2017			
NPS Result Area 1 : Community-based peer education and outreach for MARPS								
Sexual and other Behavioral Risk Prevention								
1.1.1 No. of MARPS reached with HIV Prevention programs	No. of MARPS reached HIV Prevention programs **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: 2,000,000 (UAC, 2014) Only 76,710 (4%) reached with services (PEPFAR Report October 2013 to March 2014	2,000,000[8]	2,060,000	2,120,000	UAC, 2014 PEPFAR Program reports 2013/2014	Annually	**UAC, MOH, IPs**
		Sex workers: 54,549 (UAC, 2014) Only 15,059 (27%) reached with services (PEPFAR Report October 2013 to March 2014	54,549[9]	56,185	57,871	UAC, 2014 PEPFAR Program reports 2013/2014	Annually	**UAC, MOH, IPs**
		Truckers: 31,588 (UAC, 2014) Only 15,917 (50%) reached with services (PEPFAR Report October 2013 to March 2014	31,588[10]	32,536	33,483	UAC, 2014 PEPFAR Program reports 2013/2014	Annually	**UAC, MOH, IPs**

[7] All MARPs indicators under this matrix target up to 90% in the FY2015/2017. This position was reached at through all the consultative meetings for the development of this Action plan (UAC/MOH and stakeholders). This was irrespective of the baselines to be established and the short term 2 years period. For all Converge, access and utilization data, there was a need for a survey to establish program coverage, access and utilization to calculate the real denominators in FY 2015/16

[8] This is the estimated Fisher folk population (UAC, 2014) assumed to increase by 3% annually

[9] Sex workers s; Ibid

[10] Truckers; Ibid

		MSM: 10848 MSM (Crane Survey 2009/10) Only 429 (4%) reached with services (PEPFAR Report October 2013 to March 2014	10848[11]	11174	11509	Crane Survey (2009/10) PEPFAR Program reports 2013/2014	Annually	**UAC, MOH, IPs**
		Uniformed services: 650,000 (UAC, 2014) Only 9334 (1.4%) reached with services (PEPFAR Report October 2013 to March 2014	650,000	659,100	668,200	Crane Survey (2009/10) PEPFAR Program reports 2013/2014	Annually	**UAC, MOH, IPs**
1.1.2 No. of MARPS reached with BCC/IEC interventions based on evidence and/or minimum standards	No. of MARPS reached with individual and/or small group level interventions that are based on evidence **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: (TBD)	50%	60%	70%	MOH Reports	Annually	**MOH**
		Sex workers: (TBD)	50%	60%	70%	MOH Reports	Annually	**MOH**
		Truckers: TBD	50%	60%	70%	MOH Reports	Annually	**MOH**
		MSM: TBD	50%	60%	70%	MOH Reports	Annually	**MOH**
		Uniformed services: **Police:** estimated 40,000 UPF (UAC, 2014)[12]. Only 19,869 (49.%) reached with services (UPF Progress Report FY 2013/2014) **Prisons:** estimated 40,000 UPS (UAC, 2014)[13]. Only 18,341	50%	60%	70%	MOH Reports UPF Progress Report FY (2013/2014), UPS Progress Report (FY 2012-14)	Annually	**MOH**

[11] MSM; Ibid

[12] The Uganda Police Force of 40,000 excludes the policy programming factor that includes a 5 member element per family

[13] The Uganda Prisons Force of 40,000 excludes the policy programming factor that includes a 5 member element per family

		(49%) reached with services (UPS Progress Report FY 2012-14) UPDF: (TBD)						
1.1.3 Percentage of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen (Av. 40%) Men: 41% Women: 38%	40%	60%	70%	A study on forty six fishing communities of the Lake Victoria Basin August 2010 (n =911)	Annually	**UAC**
		Sex workers: (TBD)	TBD	80%	90%	MARP Surveys	2 years	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	MARP Surveys	2 years	**UAC, MOH IPs**
		MSM: TBD	TBD	80%	90%	MARP Surveys	2 years	**MOH, UAC, IPs**
		Uniformed services: TBD	TBD	80%	90%	MARP Surveys	2 years	**UAC, MOH IPs**
1.1.4 No. of MARPS that have used a condom in a risky sexual encounter in the last 3 months	No. of MARPS that have used a condom in a risky sexual encounter **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: (Av. 44%) Women: 41% Men: 47%	44%	60%	80%	Lake Victoria Basin Commission (2010). n=911	2 years	**UAC/MOH**
		Sex workers: 66%	66%	80%	90%	CRANE 1 study in greater Kampala – 2008/09 (n=947)	2 years	**UAC/MOH**
		Truckers: TBD	TBD	80%	90%	MARP Surveys	2 years	**UAC, MOH IPs**
		MSM: Casual partner -43% Steady Partner – 50%	40%	80%	80%	CRANE study in greater Kampala – 2008/09 (n=306)	2 years	**UAC/MOH**
		Uniformed services: TBD	TBD					
1.2 Risk reduction Counseling, Testing, Care and support								
1.2.1 No of MARPS who test for HIV and receive their test results	No. of MARPS who test for HIV and received their test results	Fishermen (Av. 70%) Men: 62% Women: 77%	70%	80%	90%	A study on forty six fishing communities of the Lake Victoria Basin August 2010 (n =911)	Annually	**UAC/MOH**

	Disaggregation: Age; sex; test result and type of HCT provided	Sex workers: Ever tested – 54%	54%	80%	90%	CRANE study in greater Kampala – 2008/09 (n=947)	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	MARP Surveys	Annually	**MOH, UAC, IPs**
		MSM: Ever tested – 44%	44%	80%	90%	CRANE study in greater Kampala – 2008/09 (n=947)	Annually	**MOH, UAC, IPs**
		Uniformed services: **Police:** estimated 40,000 UPF (UAC, 2014)[14] Only 24, 986 (62%) reached with HCT services (UPF Progress Report FY 2013/2014) Police: TBD UPDF: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.2 No. of MARPS who tested HIV+	No. of MARPS who test HIV + and received their test results **Disaggregation**: Age; sex; test result and type of HCT provided	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Sex workers: 34.2%	34.2%	60%	80%	CRANE study in greater Kampala – 2008/09 (n=947)	Annually	**MOH, , UAC, IPS**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		MSM: 13.2%	13.2%	70%	90%	CRANE study in greater Kampala – 2008/09 (n=947)	Annually	**MOH, IPS**
		Uniformed services: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.3 No. of HIV+ MARPS assessed for	MARPS assessed for ART eligibility	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs	Annually	**MOH, UAC, IPs**

[14] The Uganda Police Force of 40,000 excludes the policy programming factor that includes a 5 member element per family

ART eligibility through either clinical staging or CD4 testing	**Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)					services surveys		
		Sex workers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		MSM: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Uniformed services: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.4 No. of HIV+ MARPS enrolled into HIV care and support services	HIV+ MARPS newly enrolled into HIV care and support services **Disaggregation**: Age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Sex workers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		MSM: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Uniformed services: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.5 No. of HIV+ MARPS reached with a minimum package of prevention with positives (PwP) interventions	MARPS reached with a minimum package of PwP interventions **Disaggregation**: Service location (hot spot, clinical, community), age, sex, type (CSW, truckers,	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Sex workers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**

	fisher folk etc.)	MSM: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Uniformed services: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.6 No. of HIV+ MARPS who were screened for TB in HIV care settings	**Numerator**: HIV+ MARPS who were screened for TB **Denominator**: All HIV+ MARPS recorded in HCT Register **Disaggregation**: age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Sex workers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		MSM: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
1.2.7 No of HIV+ MARPS in HIV care or treatment who started TB treatment	**Numerator**: HIV+ MARPS started on TB treatment **Denominator**: All HIV+ MARPS recorded in HCT Register **Disaggregation**: age, sex, type (CSW, truckers, fisher folk etc.)	Fishermen: (TBD)	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Sex workers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Truckers: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		MSM: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**
		Uniformed services: TBD	TBD	80%	90%	Coverage, access, utilization of MARPs services surveys	Annually	**MOH, UAC, IPs**

1.2.8 Percent of laboratories in MARPS targeted outlets/health facility with a satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program for CD4	**Numerator**: Laboratories in target MARPS service outlets/facility with satisfactory EQA/PT for CD4 measurement **Denominator**: All laboratories in target districts providing HIV/AIDS-related testing services	TBD	TBD	80%	90%	Service Mapping Surveys	Annually	**MOH, UAC, IPs**
1.2.9 No. of staff trained in MARPS service outlets/ facilities in logistics and supply chain management of HIV&AIDS-related commodities	Staff trained in logistics and supply chain management of HIV/AIDS-related commodities	TBD	TBD	80%	90%	Service Mapping Surveys	Annually	**MOH, UAC, IPs**
1.2.10 Percent of service outlets/ facilities providing MARPS services that do not report stock-outs of essential HIV/AIDS-related commodities	**Numerator**: Service outlets/ facilities providing MARPS services that do not report stock-outs **Denominator**: All service outlets/health facilities in target districts		TBD	80%	90%	Service Mapping Surveys	Annually	**MOH, UAC, IPs**
1.2.11 No. of service outlets/ health facilities providing MARPS services that are utilizing the web-based	service outlets/ health facilities providing MARPS services that are utilizing the web-based HMIS	TBD	TBD	80%	90%	Service Mapping Surveys	Annually	**MOH, UAC, IPs**

HMIS reporting mechanism in according with national guidelines	reporting mechanisms							
1.2.12 No. of Service outlets/ facilities providing MARPS services that have improved their timeliness and quality of reporting in HMIS and other MoH registers	Service outlets/ facilities providing MARPS services that have improved their timeliness and quality of reporting in HMIS in a district	TBD	TBD	80%	90%	Service Mapping Surveys	Annually	**MOH, UAC, IPs**
1.2.13 No. of staff trained in routine monitoring and evaluation of MARPS programs in accordance with national guidelines	**Staff trained in routine monitoring and evaluation of MARPS programs in accordance with national guidelines**	**TBD**	**TBD**	**80%**	**90%**	**Service Mapping Surveys**	**Annually**	**MOH, UAC, IPs**