

Integrating Paediatric HIV in Uganda's Primary Health Care

An international learning visit on Uganda's integration experiences, 15-18 June 2026

Photo: Ezekiel Mutete CHAU, June 2026



Introduction and background

On 20th of January 2025 the United States Government issued an official announcement that the United States Presidential Emergency Plan for AIDS Relief (PEPFAR) would cease to fund the global HIV response and an immediate stop work order followed, sending thousands of medical staff home, interrupting ARV for people living with HIV while leaving PEPFAR-funded ART unused on the shelves, until a waiver for life saving treatment¹ came mid-February 2025.

The USG Stop Work Order in January 2025 shocked Uganda's HIV response and health sector to the core. To fill the immediate gaps, Uganda reallocated domestic resources to support HIV commodities and consulted with civil society organisations and on-going programmes to find practical solutions for ARV distribution and, transport of lab tests. In February 2025 the Uganda Ministry of Health issued a directive to all hospitals to integrate specialised HIV services into the regular health services, through a staged integration for which soon a practical manual was shared.

In June 2026, 15 months into the HIV integration process, a learning visit to the Ministry of Health in Uganda was organised with four Paediatric Breakthrough Programme partners from Nigeria (SFH), Tanzania (ACC), Uganda (PATA, CHAU) and Mozambique (N'weti), **to understand and learn from the integration process in Uganda, especially what it means for children living with HIV, their community and the Breakthrough programme 2026-2029.**

¹ The waiver applied to approved HIV care and treatment, HTS, PMTCT, laboratory and supply chain functions.

Part 1: Uganda's first response to SWO

Recognizing the UGX 480 billion shortfall [for Jan- June 2025] caused by the SWO, the Uganda Ministry of Finance responded first with providing domestic resources for a six months emergency fund for 2025 and then committed UGX 50 billion annually to procure essential HIV commodities such as antiretroviral drugs and laboratory supplies. After the initial confusion and rush for medication it became soon evident that most Paediatric HIV services were fully donor funded and the Uganda HIV budget didn't have a separate budget line for paediatrics. **Uganda's available funding for HIV dropped with 70%** from UGX 1,564 billion (2024/2025) to UGX 500 billion (2025/2026) per year. Uganda aims to increase domestic funding for to UGX 500-700 billion for 2026/2027 and increase in the overall strategic health budget² and the HIV budget (slightly) for 2026³, maintaining free health services throughout Uganda. Additionally, the Uganda AIDS Commission advocated for increasing the HIV mainstreaming allocation from 0.1% to 0.5% of the local government budgets, potentially generating an extra UGX 200 billion to close the resource gap.

While initially the Ministry of Health and CSOs worked together closely to respond, **also CSO programmes were affected** and staff was laid off, projects closed overnight and community outreach services stopped, as these were largely PEPFAR funded.

Districts remained with inadequate staffing levels (Dr. Kawooya DHO Mityana, District Meeting 17/07/2026).

By June 2026, MoH proposes a HIV trust funds and small levies to support long-term financing and reviving the UAC Basket Fund to mobilize local and donor resources. A five year G2G MoU was signed in 2026 between the Uganda and US Government (USG). As mentioned above, paediatric HIV services do not have a separate budget, but are funded through MCH/ PMTCT, child health, TB/HIV, laboratory, pharmacy and district health platforms. MoH now provides more guidance on the utilization of existing PHC funds for integrated services.

"At national level budget we are at 5 (on a scale of 1-10)."

– Dr. Elenor Paediatric HIV focal point
MoH, June 2026

Uganda lost an estimated 15,000 staff members including community health workers, facility staff and data clerks. This impaired the data on paediatric HIV from November 2025 onwards, halted community outreach and disrupted health coordination mechanisms.

The immediate drop in funding visibly affected health services in Mityana district. Fortunately they feel supported in paediatric HIV services by CHAU and Baylor College of Medicine Children's Foundation.

Health staff at Pongwe Health Center reduced from 10 to 5 staff, losing counsellors, data clerks and others. There is only one health worker providing services and to work with Village Health Teams (VHT). VHTs cannot test, unless under the authority of the health worker.

² Uganda's national budget for the 2025/26 financial year, presented and approved on 12th June 2025, totals UGX 72.136 trillion, with a strong focus on health and human capital development. The health sector received UGX 5.87 trillion, marking a 99% increase from the UGX 2.95 trillion allocated in the 2024/25 budget. This sharp rise is aimed at offsetting donor reductions and addressing growing health service demands. For HIV/AIDS services, UGX 1 trillion was allocated through the Global Fund to support treatment for HIV, TB, and malaria. This contributes to sustaining Uganda's annual HIV response typically costing UGX 1.9 trillion, with 60% previously funded by donors by boosting domestic investment in essential services.

³ In the national budget for FY 2023/2024, UGX 16.6 billion was allocated to HIV/AIDS programme. For FY 2024/2025, the government slightly increased its HIV/AIDS budget to UGX 16.719 billion.

The VHT noticed a significant reduction in attendance by adolescents, as they fear to mix with other patients.

At Mityana District Hospital, the ANC and PNC departments currently integrate all services for children. 'The ART and Chronic disease office saw a slight drop in October to December 2025 from TX-CURR 5784 to 4987, which we follow up since January 2026. HIV clients dropped out, but we talked to them.' (Nurse at ART distribution centre at Mityana District Hospital 17 June 2026) There is only one counsellor who can attend all clients in the hospital now. The teenage centre has one nurse since April 2026 providing holistic care, supported by others occasionally and making use of the general lab. There are long waiting lines, which is challenging for adolescents, especially if they have to line up again later at the lab.

For adults living with HIV the process is different, sometimes positive feedback is received by the medical staff.

"There was fear of integrating HIV clients with other clients however with continuous awareness and sensitisation the clients received it positively minimising stigma. We sensitised the clients what was coming on board, fear for being stigmatised was one of the worries."

– Medical staff at Mityana hospital, June 2026)

"Routine testing is a must for pregnant mother and we encourage voluntary testing and couple testing. High risk mothers are screened periodically. MCH knows what happens at delivery, high risk mothers are followed up. There is routine testing of the mother as children do get infected during breast feeding during labour."

– Medical staff at Mityana hospital, June 2026)

For the hospital staff the news on integration initially created fear and resistance as staff are not (yet) trained in all services they now need to provide. They received training for five days (on the job)

and they formed new teams for counselling/ mental health, data management, clinical work, nursing, lab and an admin team.

"We didn't let the problem overtake us, with 4 we were prepared to take over [the work] from 10 [nurses]. From 5 clinicians to 3 and from 4 doctors only 2 remained, 5 HWs working Monday to Friday. After one month we saw advantages of this one-stop-clinic, as clients responded positive. We evaluate patients, investigate, diagnose, prescribe, refer. It helped to reduce costs per clients, who need only one visit to address all health issues."

– Nurse at Mityana District Hospital, group discussion 17 June 2026)

We identify more HIV patients with hypertension since it is integrated in chronic care. In general the district is understaffed, with only 30% of staff in place, which strongly differs from city-based health facilities like Kisenye.

First responses from other countries to SWO, as indicated by Aidsfonds partner organisations

Nigeria provided free ART for 1,7 million people (€3,5m), through private sector production and signed an MOU with USG. Nigeria has an estimated 67,000 children living with HIV.

In Tanzania all OVC programmes closed and about 1500 staff lost their job. The government committed to a budget for (free) ART, MSD supplies and absorbed (registered) health workers to ensure continuity of care.

In Mozambique Previously 66% of HIV funding was PEPFAR supported (\$355.5m). The country signed an MOU on HIV and Malaria for \$1,8 billion with the US government in December 2025.

Part 2: Uganda's integration model(s)

The integrated service delivery strategy was developed in quarter 4 of 2024, to improve access, efficiency, quality and continuity of health care services. Integration was already embedded in the health sector plans (NDP IV, NSP 2025-2030, Essential Healthcare Package 2024). An executive order was sent in March 2025 to the directors of district health offices and all health facilities, followed by a practical guide in April 2025, based on the **OPD model and the Chronic Care integration model**. See also table 1 for progress on integration. A national coordination body (NACI⁴) and integration task force are coordinating the policy process. A maturity matrix (grading integration levels) was initiated. With essential health services being integrated in 83% of health settings (60% mixed OPD, 23% chronic care outpatient) and 76% of critical health staff recruited and stock

distribution aligned, MoH now focusses on institutionalisation, strengthening the national strategy and health care package roadmap and phased approach.

MoH monitors **client satisfaction** (reduced cues/visits), **health outcomes** (improved adherence and timely referrals) and **system efficiency** (workflow, reporting). An e-learning curriculum on all diseases for health staff is available, supporting the on-job training and mentorship. An SOP for chronic care processes is in development, promoting differentiated services based on age and continuous quality improvements (CQI), harmonise data and reporting systems. MoH works on a national evaluation and research protocol and an SOP/service models for the poorly performing community systems integration. (Dr. Cordelia Katureebe Mboijana, National Coordinator for HIV Care and Treatment at the Uganda Ministry of Health's AIDS Control Program)

⁴ National Advisory Committee on Integration

“Integration, it has improved linkage between the various levels/departments, laboratory ANC, if a patient is identified from ANC and the patient requires certain attention, they are easily linked to the laboratory or mental health services it has improved coordination and linkage.

When integration came in all things were merged and operating on daily basis thus workload increased. A lot of clinical health workers became burnt out ie what you saw at the adolescent clinic, you cannot call on a health worker from Maternity to support of which it's also understaffed. The aspect of human resource services has to continue moving. But if we have no funds, can we stop? No until when solution is got, hence [during] integration people have to move on.”

Mono Dennis Senior Health Educator Mityana District
(Interview 17 June 2026)

Paediatric HIV services are integrated in (1) MNCH services including ANC, PMTCT, immunization, child health and family planning and (2) outpatient services including all OPD consultations, TB, nutrition and counselling services. Service integration in lower health facilities focusses on providing multiple (comprehensive) health services through a single point of contact during a client visit. In general hospitals (level V) the focus is on the chronic care model for outpatient and in-patient services, including maternity ward and delivery units, paediatric and adolescent clinics, community drug distribution points and viral load monitoring and patient follow up. Differentiated services are based on age e.g. adjusted days for children, adolescents or young mothers. (Mityana District Health Officer Dr. Kawooya Vincent)

Community health system integration is still pending

Community Health Services Integration was not mentioned in the first directive, but added as a key step in the practical guide. This includes village health teams (VHT) who already support linkage, retention and community ART distribution and who will engage in the newly developed client satisfaction surveys. It also includes community health workers (CHW) who operate at facility level, and CHEW⁵ and VHTs who work at parish level. Each parish has about 4-12 villages and each village has 2 VHT members, who report to the CHWs at the facility. The health inspectors and clinic assistants coordinate closely with the village health teams.

Community systems were mostly funded by PEPFAR and many community health workers are no longer supported. The community and its level I health structures are not (yet) receiving the support and information to align with the integration process. The Ministry of Health is currently mapping all community health (extension) workers and only 20% of districts have

trained CHEWs. Under MOU with USG a total amount of 15 million US\$ is reserved for training, recruitment, communication and referral networks. At national level training is planned for CHEW, who will receive a 6 months comprehensive training and for VHT, who will receive a 2-day training on data entry. The Young Adolescent Peer Educators (YAPs) model is strongly affected by the funding cuts as they are not part of the national health system. The MoH plans to absorb some YAPS as CHEWs for adolescents and support their transport. Furthermore the eCHIS Community Health Information System is being rolled out. All district M&E officers have been trained in 2026 on the integration of the EMR/DHIS2 data systems. They in turn need to train clinics assistants and district statisticians this year. (Juliet, M&E MOH)

Integration in Nigeria and Mozambique

Nigeria integrated PMTCT in maternal/child health services (estimated 39,898 clients PMTCT). While integration guidelines are developed at national level, decisions on implementation are at State level.

In Mozambique's integration process started sixteen years ago on technical level at health facilities (MCH/PMTCT, child health like immunization, nutrition, laboratory, community health actors), the current focus is on financial integration, workforce, community and accountability. Tanzania had integration guidelines ready in December 2024.

⁵ The MoH will change the title of all CHW the CHEW

Table 1: Government of Uganda Health Services Integration plan versus developments in 2025 and 2026

KEY INTEGRATION Seps/plans from the circular/report	PROGRESS March 25	PROGRESS March 26	CHALLENGES june 2026
01 . LEADERSHIP AND GOVERNANCE			
At national, regional, district and health facility level ⁶ for Integration of HIV, AIDS, TB into Chronic Disease or OPD services	> First directive including integration plan to all facilities > Leadership scored low, especially at HF IV > 37% still stand-alone clinics in March 2025 (phased approach)	> 83% of health settings integrated services (60% mixed OPD, 23% chronic care model) > 30% a mixed system > An SOP for chronic diseases in development	> Only 54% have Internal supervision and 25% lacked work plans for integration and standalone clinics still exist > Next is institutionalisation in core systems, which is RRH⁷ led > Mityana indicated it increased district-led planning
02 . HEALTH FINANCING			
Utilization of PHC funding for Disease prevention outreach for immunization, FP, nutrition awareness to improve community coverage	> PHC funds can be used for HR, integrated outreach, lab sample transportation, mobile data use for results > Districts to increase funding from 0,1 to 0.5%	> Guidance for efficient use of PHC funds for integration in districts with budget for AIDS/Malaria > 83.4% of facilities using PHC funds for Integration	> Domestic funding at 5 out of 10 > Still heavy reliance on partner funding and sustainability concerns > Pooled financing not implemented
03 . HUMAN RESOURCES FOR HEALTH (was donor dependent)			
Training and orientation of health workers (CME) on integrated service delivery and HIV/TB/HepB Prioritizing recruitment of critical staff (qualified DHO)	> A modular training programme on integration was developed for health workers > 62% trained on integration and 48% on HIV/AIDS > 52% of clinical officers are in place	> E-learning curriculum available covering all diseases and multi-screening for any child contact with facility > 35,000 health workers trained on-site > Assessed terminated staff > 76% of critical staff is currently in place	> Very Low staffing levels at most facilities (Mityana district 30%) > Limited domestic financing for CHWs > Lack of guidelines on HRH optimization > Overloaded and burden of internet/power outing and double data entry
04 . SERVICE DELIVERY PROGRESS			
Includes care pathways, screening, appointment tracking and quality improvement plans Client satisfaction and feedback mechanisms (QR-code system, language accessibility, reviews)	> Practical guide issued for aligning services, workflows, clinic space and coordination for integrated care	> 90% facilities screen multiple chronic conditions > ART Coverage 92.8% > VLS 95% > TB treatment success rate (TSR) 92.5% > Treatment rates for NCDs still low -27.7% > Adoption of DSD models in HIV for other chronic conditions	> OPD congestion, space constraints, stigma for ARVs, parallel IPC elements for TB > Gaps in QIP (achievement 40%) > Active QI projects 28% > Routine client feedback use at 41% > Client satisfaction low at 43% > Paediatric HIV patients drop > Youth drop out due to stigma, privacy concerns at pharmacy windows
05. COMMUNITY HEALTH SYSTEMS			
CSO alliances, budget CHW, VHT, PLWA, health care workers engagement, peer support groups Was mostly donor funded but through IPs and CSOs Community tracking collapsed	> Least performing so far, 71% of facilities provided integrated community outreach services > Only 40% worked with CHW for patient follow up/adherence > 56% had patient support groups > 46% of clinics of facilities provide community-based tracking for chronic disease patients	> National VHT/CHW policy and Policy for community health systems strengthening under development > RRH revived CDDP Integrated community outreaches (HTN/DM/HIV/MNH) > HF: 71% provide integrated outreach services in some areas > CHWs are oriented and patient support groups are active	> CHW supervision weak, VHT/CHW allowances inconsistent > Low linkage and referrals (56%) > 46% track patients beyond HIV > Community data not integrated into HMIS > Limited community screening tools > VHTs were not yet assessed and informed of the integration process. > CHW will be trained for six months, VHT for a couple of days

6 National level: Policy, funding, strategic leadership, partnership. Regional/district level: coordination, accountability, performance, multistakeholder forums and collaboration mechanisms. Facility level: leadership, patient centred, decentralised decision making, accountability and performance measurement systems.
 7 RRH are level II public healthcare facilities managed directly by the Ministry of Health. They provide specialized clinical services (such as surgery, paediatrics, and obstetrics) and act as mentors for district hospitals.

KEY INTEGRATION

Seps/plans from the circular/report

PROGRESS

March 25

PROGRESS

March 26

CHALLENGES

June 2026

06. SUPPLY CHAIN AND MEDICINE MANAGEMENT

Includes laboratory supplies, managing stocks, expiry, dispensing, redistribution within/to other districts
Management of medical equipment (redistribute, repair, dispose)

> **50% of facilities had an interrupted supply of essential medicines for HIV, TB, Hepatitis, Malaria, MCH and NCDs**

> Stock distribution is currently aligned
> HF: 87% have active Medicine & Therapeutic Committees (MTC) with Regular forecasting and ordering
> Good facility-district coordination
> **Facilities maintaining 1 stock card per drug policy**

> **50% of facilities experiencing supply interruptions**
> NCD medicines frequently out of stock
> Weak emergency stock mechanisms

07. HMIS, M&E, RESEARCH

From Electronic Medical Records (EMR) data system to DHIS2, staff training, analysis, alignment with eCHIS reporting system
Strengthening Death notification and Reporting Sentinel learning sites (48 sites going to 80 from July)

> **69% of facilities had an electronic or manual HMIS system used for documenting integrated services**
> Data for HIV is often managed separately using Uganda EMR, while other services rely on paper-based HMIS tools
> Data staff left

> 69% facility have functional data system, use integration indicators in DHIS2.
> DQA on-going
> National research and evaluation protocol
> **Efficiency studies by different actors**

> Parallel data entry burden, compatibility challenges EMR, eAFYA, DHIS2
> Only 31% have Health Info Exchange beyond HIV
> Internet outages, power issues, Limited computers/tablets for data entry

08. LABORATORY AND DIAGNOSTICS

(Testing) guidelines, lab result reporting and referral systems to reduce TAT, quality control and supplies
Sample transport (spokes to hubs, coordination by DNHLS), Waste management

> 96% of facilities had clients who tested HIV positive linked for other testing services
> 85% had a functional EMR system
> 62% of health facilities possessed a functional e-inventory management system

> 96% link HIV+ clients to other testing
> Laboratory staff trained on integrated testing protocol
> Multi-disease testing capacity (HIV VL, HbA1c, lipid profiles, TB GeneXpert)

> **Limited lab personnel trained in integrated protocols. Sample referral system fragmented**
> Laboratory information systems don't communicate with EMRs
> Quality control reagents stockouts

OVERALL RESULTS

(HIV integration study findings⁸)

- > More holistic, person-centred care in one-stop service model reduced movement
- > Overall reduced HIV-related stigma in OPD
- > Improved privacy and confidentiality for PLHIV
- > Comprehensive quality of care improvements (QIP)

GAPS

(HIV integration study findings)

- > Overcrowding at integrated service points, with longer patient waiting times
- > Perceived risk of disease transmission
- > Increased workload for health workers
- > Stigma at dispensing points (packaging) and resistance from adolescent/young PLHIV

NEXT STEPS 2026/2027

(NACI presentation Dr. Cordelia, see footnote 7)

- > **Roll out National SoPs on Integration.** Scale mentorship programme and support supervision to remaining facilities (156 of ~1,500 total facilities assessed) and to low-performing districts with targeted mentorship, strengthen QI/work improvement teams from the current 18-38% to 80% in 2026 and scale successful innovations like Patient-led procurement groups, weekly online CMEs, integrated outreaches
- > **Priority for staff is the digital systems integration** and harmonized reporting templates (reduce parallel data entry burden), fast-track data roadmap for inter-operability of e-Afya and EMR. Institutionalize monthly data reviews linking process indicators to outcome indicators (retention, VL suppression, NCD control)
- > **HRH recruitment for critical cadres** (Consultants 88% gap, MOs 65%, Nurses 55%) + partner HR absorption plan Functional teams at 80% facilities
- > **Sustainability planning for technology, power, infrastructure** (address dependency on partner support)
- > **Paediatric and adolescent HIV** Expand integration to paediatric services (developmental clinics, neonatal care) and specialized services (OAT)
- > **Need for harmonised reporting system**, routine performance dashboard for paediatrics in DHIS2 and alignment of patient tools and KPI for national M&E framework. Alignment with Integrated Community Health Service Delivery package, eCHIS reporting system. Develop and disseminate integrated IEC materials (rename ART Clinic → Chronic Care Clinic)
- > **Establish Sentinel Sites** as centres of learning on Integration

⁸ MakSPH | 254 facilities | Global Fund / TASO funded | Two models: Integrated Mixed OPD & Chronic Care OPD

Part 3: The effect for children and adolescents living with HIV

The end of PEPFAR funding strongly affected community services, as they were not considered as essential lifesaving interventions. Funding for peer educators, mentor mothers, lay counsellors, orphans and vulnerable children, outreach programmes and community based organisations ended, as USAID offices closed. The effects of this are felt in the facilities, as paediatric and youth clients drop out.

During conversations with the National MoH, the Mityana district offices, the health facilities and the VHTs, concerns were raised for paediatric HIV, as numbers dropped and the alert was raised for how this is affecting adolescents as they fear stigma to access services from one integrated central point.

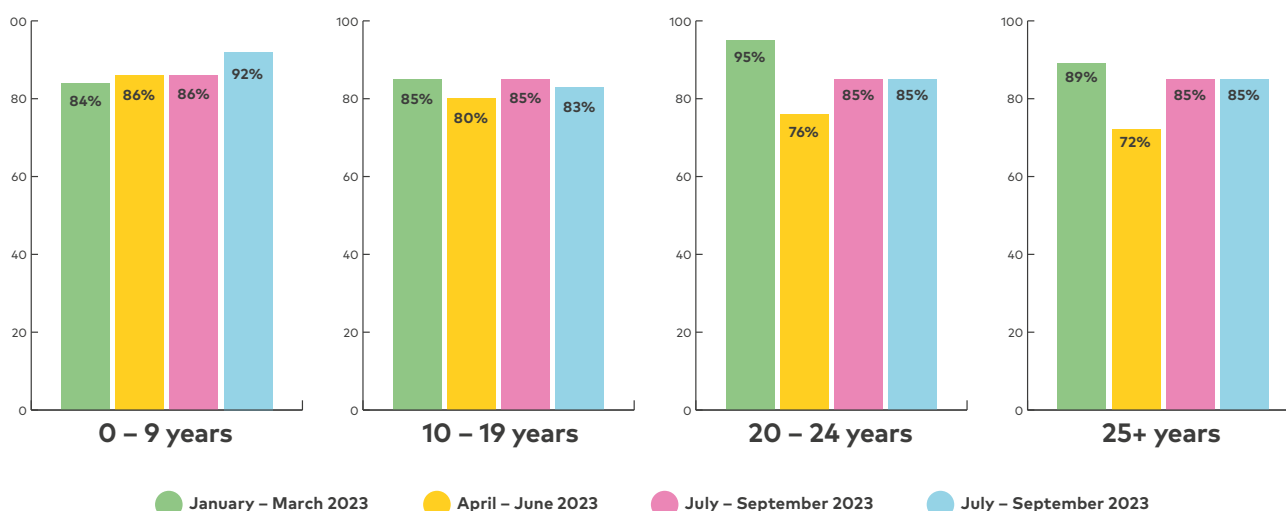
Dr. Elenor Paediatric HIV focal point Ministry of Health presented The status of national paediatric and adolescent HIV programme (data till March 2026). In 2024

there were 36,648 new infections among children. In Uganda only 54% of children with HIV are on treatment (Higher rates among 0-9 years, 4200 in total). Out of all adolescents living with HIV 88% know their status, 75% are on ARV and adolescent VLS rate is 54%⁹. Only 59% of adolescents is linked to prevention. A 20% drop at mother-baby care point, drop out of care, zero convert, we lose them at the 3rd test. Case finding during ANC is good, but timeliness is problematic, with cascading 72% negative, we miss 28% in testing. Risk based identification triggers 73% ART clients. Furthermore there are gaps in adolescent friendly services, VLS challenges for 20-24 years old and the 0-9 years ART coverage is low.

The data on this slide shows that in 2025 the ART retention rates dropped in December 2025, compared to quarter 1 2025.

⁹ Presentation Dr. Elenor, population with % based on all adolescents living with HIV

ART Retention Rates Trends – 12 Months Post ART Initiation



Retention rates are generally lower across all age groups. This trajectory is evident across the previous quarters

High **entry points for paediatric case identification** are OPD, TB and nutrition services, we also missed opportunities (results Munyonye Campaign) for children below 12 months (80%) including 40% not delivered in health setting, limited adolescent services. We need to map high risk sub populations (VLS challenge among 20-24 year old), provide easy-peasy pill boxes, rebrand peer-to-peer model in a community service delivery package (pharmacy refill at night, challenges with VHT on confidentiality) combined with digital solutions.

We strive to have a dashboard for paediatric HIV data for analysis in DHIS2.

In 2024 the Uganda government launched the national Munyonye (Find the child) HIV testing campaign for mothers and babies, identifying over 6000 children living with HIV of whom 80% were below 12 months of age and 80% had a clinic-based delivery. Health services are free in Uganda, however families of young mothers, with poor economic status and high levels of GBV were over-represented in the previously unidentified group. (Dr. Elenor Paediatric HIV focal point Ministry of Health).

Dr. Kawooya Vincent, District Health Officer Mityana, indicated the high risk of children living with HIV being lost to follow up (LTFU) and that the psychosocial support services for adolescents and caregivers [to counter this] reduced. This is mainly due to the reduced partner supported community outreach and reduced community follow up of CLHIV, reduced funding for community peers, linkage facilitators and CHW. The possibilities to shift tasks is minimal, considering the increased workload among existing (remaining) health workers). He also mentioned a positive effects of

the integration strategy, as it increased district led planning and ownership of HIV services, reduced parallel programmes.

The medical staff at the ART clinic in Mityana district hospital indicated '70-80% of adults found their way back to ARV services and follow up messaging continues, but this is different for children and adolescents'. She noticed missed appointments among paediatric and adolescent clients. Adolescents fear/experience high levels of stigma and have major privacy concerns. They face long waiting times, as staff are face with a high workload. She indicated counselling is easier to access, but only few counsellors remained and she fears quality of counselling as disclosure is an issue). LTFU tracing in community is an issue for facilities.

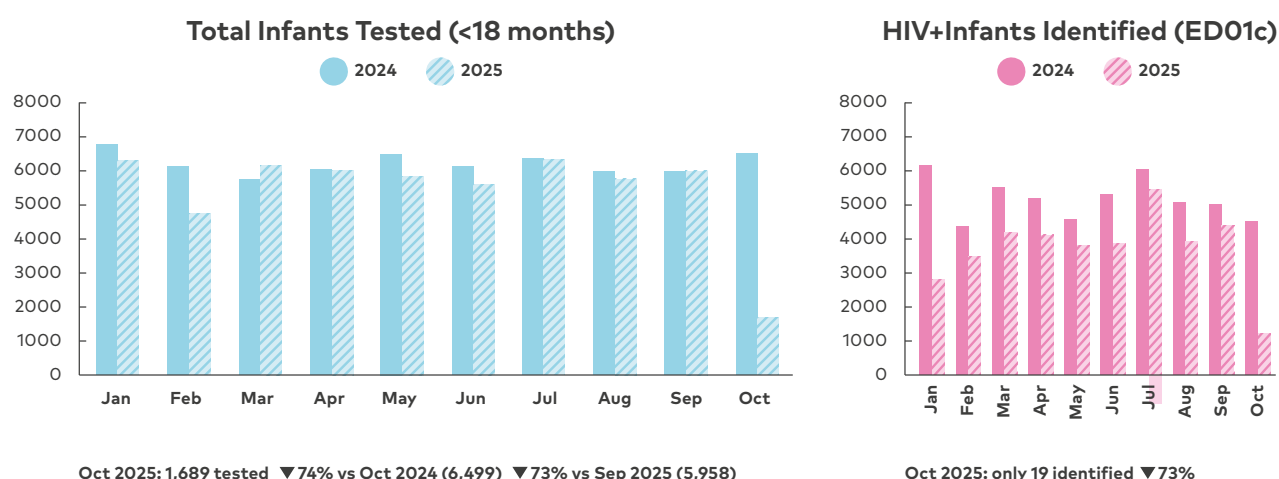
The VHT members also confirmed the privacy concerns and that stigma among adolescents is higher, fear for mixing with other patients. They indicated that Prevention work dropped strongly.

In October 2025 the data showed a serious drop (70%) in infant HIV testing¹⁰. Distribution of ARV prophylaxes dropped from 14,500 (Q1, 2025) to 1000 (Q2, 2026). Reduced availability of ARV, condoms and tests while adolescent friendly services show significant gaps (CHAU presentation, 15 June 2026).

However due to a lack of recent data/evidence comparing 2024 with 2025 it is difficult to raise the alarm (yet). Also the funding gaps might be less visible to the Ministry of Health and not considered in new budget processes, as funds were previously channelled through CSOs.

¹⁰ 2026 Zakumumpa et al. [The sustainability of public health programs following donor transition: A comparative case study of HIV services and maternal and newborn care in Uganda – PubMed](#)

Table 2 Presentation CHAU, June 2026
Paediatric HIV: Early Infant Diagnosis (EID) – service Volumes & Utilization



July 2025 – last normal month / Stop-work order consistent with late Q2/earlt Q3 205

Data on 2025 for quarter 4 is missing and clinics struggle with data entry. This mainly relates to the parallel data system, poor internet and workload, as filling in forms in duplicate takes time which they prefer to use for helping clients instead. At Health Facilities many data clerks left (as they were USG funded) but there currently is an info assistant and one data clerk is stationed at district level. Community information is provided through a long list of indicators by VHT/CHEW. This needs alignment with DHIS2 system (which has data organised at individual level (not disease level). Not all clinics have digital records, but hardcopy records are also needed for verification. Some clinics submit reports to sub district level who enters it in Uganda's Chronic care register/acute care register.

The effect for children in Nigeria, Tanzania, Mozambique

Nigeria: New paediatric HIV infections identified dropped from 6,882 in 2024 to 3,881 in 2025 (SFH)

Tanzania has 1.7m people LHIV, including 60,000 children, 66% ART and 5000 new infections among children annually. MTCT 3-4%. There is currently no focus on community identification, follow up, prevention. (ACC)

In **Mozambique**, there was a strong drop in viral load testing in February 2025, which shows risk signals. (N'weti)

Part 4: Lessons from Ministry of Health Uganda

The Ugandan integration process was **well prepared** and with full **national level leadership** in all key areas of the Integration process including Governance and Leadership, Health financing, Workforce Training & Recruitment, Service Delivery, Data Systems, Supply Chain Alignment and a clear Community Strategy.

The **coordination** by NACI was crucial as they oversee the multi-sectoral Integration Task Force, ensuring strategic alignment among the MoH, the Office of the Prime Minister, and development partners to prevent duplication of efforts. In February 2025, immediately there was a **clear strategy, a directive and a practical guide** for integration into routine outpatient and chronic care services at regional, district and lower-level health facilities. However domestic financing is impaired by donor dependency and national debt servicing.

The **main challenges are in human resources and digital data systems**, which are both closely linked to core aspects of service provision, distribution of medicine, monitoring, quality improvements, supply chain, laboratory services etc. Several hospital staff mentioned the need for clear data and communication/information,

e.g. on job-security and in support of reorganising teams, training, online learning and SOPs. The data system urgently needs streamlining as current issues require staff to capture a lot of info per patient (3 systems). The response of children and young people living with HIV and their caregivers avoiding services are a clear sign that immediate action is required, especially in support of CHW, VHTs and peer-to-peer (mentor mothers, young peer educators, PLHIV). Challenges with data on paediatric HIV care and adolescents do not support the monitoring of it.

The current integration process works for most people living with HIV, but for some sub populations it works less, like paediatric and adolescent clients. There is need for more emphasis on **capacity building of service providers with paediatrics and adolescent case-based curriculum**. Also, NACI (integration committee) requires input for this framework to ensure better integration. It is not one-size-fit-all. Support ministries of health with the development of SOPs and community integrated service models, especially referrals, linkage and follow up. (Dr. Patrick Mandola Team lead HIV Care and Treatment children, adolescents and adults).

“The integration process is about the health systems and the people of Uganda closely interacting.”

VHT member, Mityana, June 2026

Part 5: Key lessons learnt during the visit

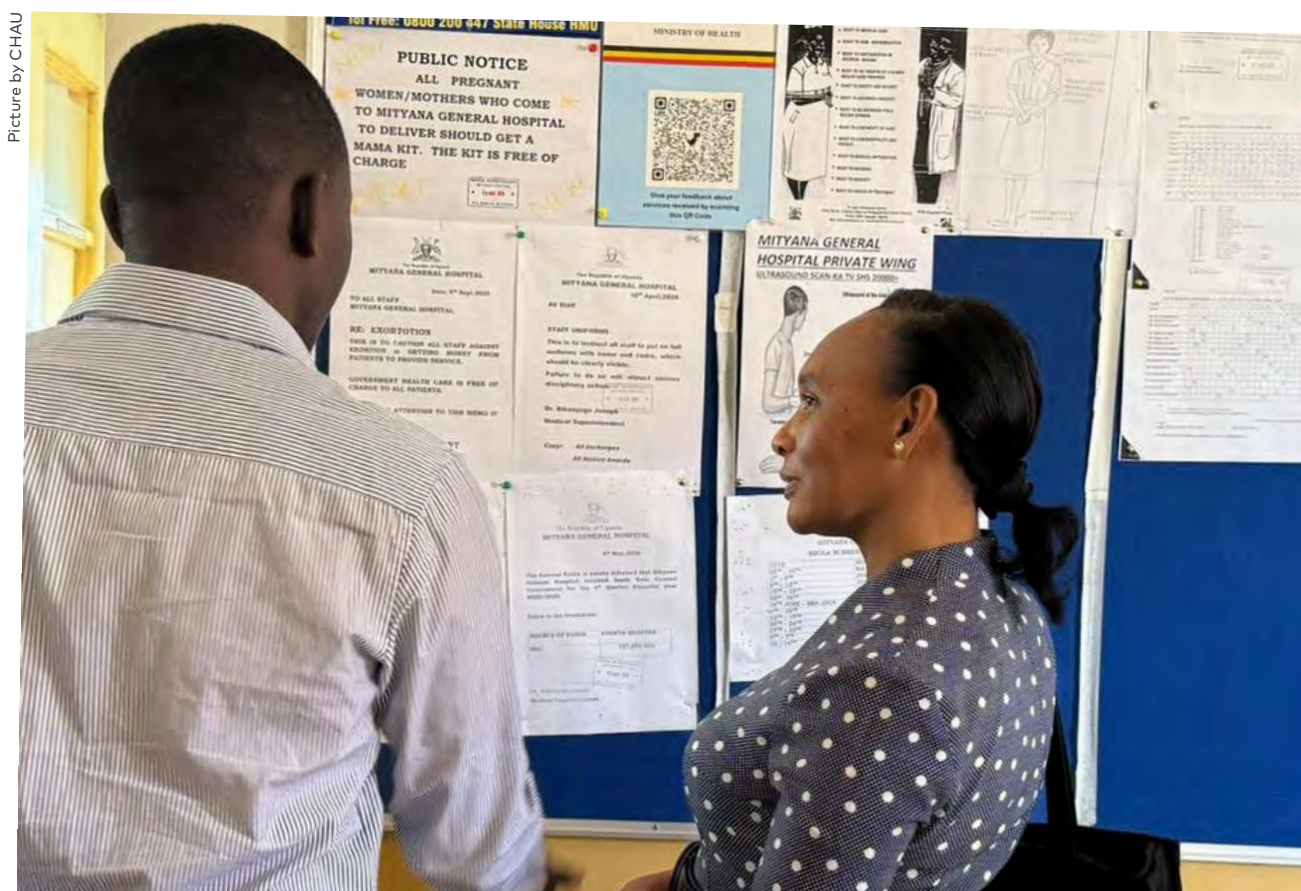
Key lessons were learnt on leadership and governance, as evidenced by the following responses from international guests.

Aisha Dadi (SFH Nigeria) 15/07/2026, Kampala: "It [MoH Uganda integration plan on HIV services] is intentionality, purposeful and has a roadmap framework, HR, service delivery. **MoH really took ownership!** It is not siloed but embedded in chronic/acute streams. Integration is a holistic package, mainstream at the driver's seat. That we can do the same in regions [in Nigeria], how interventions can develop, while you have other regions [in Uganda] with other challenges. I wish my government officers [involved in paediatric HIV and Breakthrough programme] were here." Nigeria has the highest availability of commodities but has not yet pushed to have a circular on integration like Uganda, it is important for the country, government to at least initiate and have that Circular provided which initiates and introduces

integration. There is a need to have advocacy programs getting the leaders to understand integration at national level hence the roadmap.

Manuel Saboneta (N'weti Mozambique) 15/07/2026, Kampala: "Why Mozambique [integration efforts] didn't work out [because of] challenges with adolescent facilities. **Recognition by government [of Uganda] that paediatric and adolescents need more, they are left out by integration.** They [MoH Uganda] acknowledge weaknesses and are concerned for adolescents. What stood out for me besides coordination was that it is interesting to see how it [village health teams] works here and how it can be used for Mozambique."

Pendo Maiseli (ACC Tanzania) in conversation with staff from Mityana General Hospital (June 2026).



Picture by CHAU

Pendo Maiseli (ACC Tanzania) 15/07/2026, Kampala: **"How integration is well organised, government ownership and commitment, plan, framework, M&E everything is clear, including taskforce committee!** It is different in Tanzania; HIV is integrated with other programs like the management of HIV, STIs and Viral Hepatitis.. 'We have guides for integration of HIV with specific programs. However, there is no independent documented plan to guide integration. I will follow up further to see how it goes from the national level to facilities, and who is involved."

Joselyne Mbawadde (former staff NAFOPHANU Uganda) 15/07/2026, Kampala: **"Uganda picked very fast, historically it was integrated but (different streams of) funding separated disease approaches.** Blessing to go back to integration, I am happy the government (of Uganda) recognises challenges on children and adolescents when integration is implemented. The policy is guided by evidence base. Makerere University follows up with research. On paper all is well, but the gaps [is] on orientation of people living with HIV, the community, which the government does not realise – reporting brought it out. We shall have one reporting system, easy for CHW and HC staff."

Vivian (CHAU Uganda): [what stood out was] "the totality and involvement from the top to bottom, lessons, the curriculum which CHAU uses next week is really helpful ... health care workers are being oriented. Not everyone is on board."

Ezekiel (CHAU): **"Initially CSO's felt threatened,** were against integration, we need to go back to clinics, they worked, crisis management of human resources, **but you have to remove dependency** [on donors], more privacy on care and at [hospital] pharmacy, the way to go is confidentiality."

"In Nigeria, not only did PEPFAR funding stop for trained HIV specialist medical staff, laboratory staff, data clerks and communities, the funding for the coming five years is channelled through government accounts. Also a high level of domestic funding is required and funding modalities for community work are not clear. This is a major concern for many CSOs."

Aisha Dadi, SFH, June 2026

With thanks

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Sources/annexes

The sustainability of public health programs following donor transition: A comparative case study of HIV services and maternal and newborn care in Uganda – PubMed



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