Uganda

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

Program Description:

Uganda remains one of the poorest countries in the world, with a per capita income of $420 per year, a life expectancy at birth of 52 years, and a fertility rate of 6.7 children per woman. Despite this, the country has had considerable success in reducing the prevalence of HIV/AIDS from about 14 percent in the early 1990s to the current level of about 6.2 percent. However, the decline in prevalence has reversed over the past five years. Sexual transmission accounts for 81 percent of all new infections, followed by mother to child transmission at 18 percent. Approximately 1.1 million Ugandans are HIV positive, of which about 120,000 are children under the age of 15. With a rapidly growing population and stable or rising incidence, the number of people needing care and treatment will grow. With an estimated 135,000 new infections a year, and 61,000 HIV/AIDS related deaths, the national burden of HIV/AIDS will rise along with the resulting unmet need for care and treatment.

Since 2003, PEPFAR has supported Uganda in its response to the HIV/AIDS epidemic, aligning U.S. Government (USG) efforts with Uganda's National Strategic Plan (NSP). In close collaboration with the Government of Uganda (GOU), PEPFAR supports the national HIV response across all HIV program areas, including prevention, care, treatment, laboratory services, health systems strengthening, and strategic information. PEPFAR has allocated over $1 billion of funding to Uganda, with a significant increase from $20 million in 2004 to greater than $280 million in 2010. PEPFAR currently contributes over 85 percent of the national HIV/AIDS response budget.

In March 2009, PEPFAR provided life-saving antiretroviral therapy (ART) for 153,000 HIV-infected Ugandans. By September 2010, this number will grow to 172,000, and should continue to grow at this modest rate. But in the coming years the number of patients in need of antiretroviral treatment will increase dramatically. In mid-2009, over 320,000 HIV-positive Ugandans needed ART but only 60 percent received treatment (80 percent through PEPFAR support). All 1.1 million HIV-positive Ugandans will eventually need treatment, less those who die first, as will the 135,000 people who were newly infected this year. As long as the number of new infections exceeds the number who die the number needing treatment will continue to grow.

While the USG is committed to continuing treatment for those individuals already enrolled on antiretroviral drugs, future PEPFAR funding for HIV programs is not expected to increase. As a result, PEPFAR cannot continue to fund the scale-up of antiretroviral treatment that Uganda will need. We will encourage the GOU to identify additional funding to meet this need, which will grow in the months and years to come. The USG will continue to assist the GOU in support of these efforts.

The current shortage of antiretroviral drugs is one indicator of the weak leadership and commitment to health shown by the GOU. During the next year, the Government will develop a new national development plan, health strategy, and HIV/AIDS strategy. These are opportunities for the GOU to show stronger leadership and to build better relationships with its development partners. If successful, this would provide the context in which to participate in global initiatives such as the Partnership Framework, the Global Health Initiative, the International Health Partnership, and the Global Fund's National Strategy Applications. The PEPFAR team in Uganda will encourage this partnership with the GOU.

Emergency Plan funding will be focused on the following programmatic areas to achieve the 3-12-12

targets:

Prevention: $XXXX (Will be added by OGAC)

Uganda's NSP highlights HIV prevention as a cornerstone of HIV/AIDS programming. The changing pattern of people affected by the HIV/AIDS epidemic and the rise in new infections have compelled the country to change its strategy while maintaining approaches that have proved effective in reducing the impact of the epidemic.

The most common means of HIV transmission in Uganda remains through unprotected sex. Over 37 percent of all new HIV infections are attributable to multiple sexual partnerships, 35 percent to discordant monogamous partnerships, and 9 percent from commercial sex work. High-risk sexual behaviors and biomedical transmissions account for the remainder of the new transmissions. Therefore, in FY 2010 the USG will develop sexual prevention programming around, 'personalized risk', to highlight self-perception of risk and enable individuals to identify strategies that mitigate or avoid their higher risk sexual behavior. Comprehensive programs will focus on identified high prevalence areas and groups, will address the social and gender norms that underlie risky sexual behavior, and will increase access to reproductive health education and services.

Although the peak age for HIV prevalence has shifted to the adult ages, adolescents and young people are still a major focus for prevention activities. In FY 2010, the USG will continue to support the national program of comprehensive life skills education for young people (e.g., delay of sexual debut, secondary abstinence, partner reduction, and HIV testing) and a campaign to raise HIV awareness, including the risks cross-generational and transactional sex.

While the national condom policy has provided an enabling environment, condom use is still hampered by shortages and stock outs, limited targeting to most at risk populations (MARPs) and low levels of condom use in long-term relationships. The USG will support procurement, quality testing, and logistics management of approximately 40 million condoms for free distribution in the public sector and through social marketing.

HIV counseling and testing (HCT) is an entry point for prevention education, based on knowledge of HIV status, as well as an entry point for HIV care and treatment for those who test positively. Two million people will be tested at 2,450 sites and the quality of HCT services will be strengthened to raise awareness of HIV status, enhance prevention and optimize entry into care and treatment. Technical guidelines for running post-test clubs will be reviewed and networks of people living with HIV/AIDS will be used to scale up the integration of positive prevention in community and facility based programs. Specifically, PEPFAR will increase access to HCT services for couples and for MARPs; scale-up HCT services in public health facilities; expand HCT services in work places; strengthen the integration of HCT services with sexual prevention, male circumcision, TB services, and care and treatment; and strengthen quality service provision through improved HCT commodities and supplies systems, quality assurance, and training.

About 18 percent of all new HIV infections are due to transmission from mother to child. In 2010, the USG will improve antenatal ART services, scale up combination therapy and improve adherence support, strengthen early infant diagnosis and linkages to pediatric care and treatment, and improve the nutritional status of pregnant women, infants, and young children. Primary prevention and preventing unwanted pregnancies, two of the four PMTCT elements, will receive special attention in FY 2010.

The USG will work to address sexual norms among MARPs since they are still a key driver of the epidemic. In FY 2010, we will work to reduce their number of sexual partners and increase their condom use; involve MARPs in delivery of messages and services to their peers; and scale up prevention

interventions for truck drivers, the military, and commercial sex workers and their partners. To improve access to these communities we will work with a network of organizations that was recently launched to coordinate services, information sharing, and referrals for MARPs.

Biomedical prevention programming has been very effective in Uganda, though continued support is required to maintain the quality of services. The USG will support the completion and implementation of the national blood transfusion safety strategic plan, activities to improve blood donations, safety through a centralized testing system and to promote appropriate use of blood. Although the centrally funded injection safety project ended in 2009, the USG will continue to support the Ministry of Health (MOH) to strengthen injection safety practices and sustain gains made in the past.

Research in Uganda and elsewhere showed that medical male circumcision (MMC) is an effective prevention measure and many health facilities have reported an increase in the number requests for MMC. In absence of a national policy and strategy, however, USG supported projects remain cautious. We expect that the MOH will release a national MMC policy by the end of 2009, clarifying national goals in this area and the responsibilities of clinical staff and managers. In FY 2010, a gradual scale-up of services will take place in several districts following staff training, infrastructure improvement, and a media campaign. The Ugandan People's Defense Force will increase the number of its fully equipped MMC sites from four to six.

Care: $XXXX (Will be added by OGAC)

Demand for care is high following the national HIV counseling and testing (HCT) scale-up. Over a million individuals had an HIV test in FY 2009 and the USG plans to target a further two million in FY 2010. In order to meet this demand, care services will be rationalized; service duplication will be reduced; and district-based USG projects will work in close partnership with the district health management teams to use all resources more efficiently. Community and home-based models have gained importance due to their cost-effectiveness and the fact that care for stable patients need not be provided in facilities. However, only few providers can offer the full range of services, thus coordination and establishment of referral networks to co-manage clients are essential.

Uganda has made progress towards providing HIV care, treatment, and support to people living with HIV/AIDS (PLWAs). By the end of March 2009, 360,000 PLWAs were receiving care supported by PEPFAR-funded partners. The USG will continue to strengthen linkages among services such as counseling and testing, PMTCT, early infant diagnosis, and orphan care. By identifying HIV-positive individuals early, they can be started on care activities to keep them healthy and postpone the time when they will need antiretroviral treatment.

The integration of HIV and TB activities are vital to achieving success in combating these diseases. In FY 2010, the USG will improve the linkage to HCT and HIV care and treatment in TB sites as well as strengthen routine TB screening and treatment in HIV/AIDS sites. TB laboratory services will be strengthened within the systematic support to the laboratory network. It will also strengthen TB infection control (IC) in health facilities by supporting training in TB IC and help them develop TB IC plans. The USG will also strengthen the surveillance and management of multi-drug resistant TB and help complete the national TB Drug Resistance Survey.

Early infant diagnosis (EID) of HIV infection has become an integral component in the relationship between PMTCT and pediatric care. Early infant diagnosis and follow-up is critical to the early initiation of life-saving ART for all HIV-infected infants. EID can also be used to monitor PMTCT programs to see if they are as effective as they can be. For example, data from the national program show that vertical transmission can be reduced to 8 percent, a level that can serve as a benchmark for all PMTCT sites. In FY 2010, the USG will reduce the turn-a-round time for EID results through improved coordination of labs

and clinics to allow for better follow-up of exposed children born to HIV-positive mothers. Emphasis will be put on continued capacity building for pediatric health care staff through training, mentorship, and supervision and on building the capacity of community care groups such as PLWHA networks, religious leaders, and volunteers to assist with pediatric care. Increased nutritional assessments, counseling, and supplementation to eligible children and their families are also important aspects of care.

The USG will extend Prevention with Positives (PwP) programs to HIV-infected adolescents to help them understand the implications of being HIV-positive, the need for adherence to ARV drug therapy, individual responsibility in HIV prevention, and the use of condoms and family planning services. Emphasis will be put on integrating confidential care within broad-based youth programs to minimize stigma.

Of Uganda's 32 million people, 50 percent are under the age of 15. About 2.5 million of these children are orphans, and of these, 1.2 million have lost a parent to AIDS. Many of these orphaned and non-orphaned children live in child-headed households, receive less nutrition, education, and health care than other children receive, and are victims of violence, exploitation, trafficking, dispossession from land and other assets, discrimination and other abuses. Many are HIV-positive themselves.

PEPFAR has supported a number of programs for vulnerable orphans and other children, which have significantly contributed to the scaling up of OVC services in Uganda. These interventions have focused on supporting a strong family and community response; improving service delivery systems and institutions; and implementing a broad portfolio of both proven interventions and innovative activities at the community and facility levels. A lesson learned is that programs need to be sensitive to unplanned negative social effects on children who are stigmatized as "OVCs" and the need to provide a comprehensive social protection system for vulnerable children.

Treatment: $XXXX (Will be added by OGAC)

In March 2009, an estimated 153,000 patients were receiving ART with PEPFAR support. This represents almost 80 percent of all patients then on treatment in the country. However, the number of people needing ART is approximately 323,000 (MOH estimate), so only about 60 percent of those in need of ART are receiving it. Challenges for providing greater treatment coverage include human resources, lab infrastructure, and the logistics system. Inadequate GOU procurement of ARVs in 2009, due to limited Global Fund disbursement and MOH procurement problems, led to near-stockouts in the MOH system and resulting strains for PEPFAR supported sites.

Of the estimated 1.1 million people living with HIV/AIDS in Uganda, about 120,000 are children below 15 years of age. Without ART, 50 percent of HIV-infected infants will die before their second birthday and 75 percent before their fifth birthday. In June 2009, only 16,500 were on ART, 39 percent of the estimated 42,000 children in need of treatment. This shows a continued need to focus efforts on raising pediatric ART coverage to levels commensurate with the adult coverage.

The shortage of health workers with skills in pediatric treatment remains a major challenge. Children require more physician time and therefore suffer most from understaffing. Because of these staffing shortages, fewer accredited ART sites provide pediatric HIV/AIDS treatment. The technical expertise needed for pediatric treatment prevents facility managers from shifting care to lower-level staff, a method that is used to reduce the impact of staff shortages in adult treatment. The USG will continue to strengthen the MOH's pediatric ART committee so that it can provide better leadership; continue to support the expansion of the pediatric mentoring program using regional pediatricians and experts; and expand the delivery of pediatric services through PEPFAR partners.

In 2009, the USG supported the MOH in undertaking the first national ARV quantification study to enable it to plan and mobilize resources to meet ARV requirements in the period 2009-2014. In 2010, the USG

will provide technical support to strengthen the MOH's forecasting and procurement capability and support roll-out of the national three-year procurement plan to enable the government to develop the capacity for long-range planning, thereby preventing ARV stock-outs and emergency procurements.

Although laboratory services are truly crosscutting, no single MOH department is responsible for laboratory services and as a result, management, coordination, and supervision are poorly defined. Against this backdrop, the USG has made progress in addressing both systems management and service delivery. The National Health Laboratory Services Policy was launched in September 2009 and a draft Laboratory Strategic Plan has been completed. Thirty-six laboratories will be renovated and management training will prepare staff for the WHO accreditation scheme targeting 50 laboratories. The USG will also support the MOH to define standards for equipment and ensure there is capacity for maintenance and servicing, important sustainability issues.

Other: $XXXX (Will be added by OGAC)

Building sustainable health systems is a critical aspect of the next five years of PEPFAR support. The change in scope of the Health Systems Strengthening technical area and renewed focus on this area has contributed to a 50 percent rise in funding allocation that will focus largely in the areas of human resources for health (HRH); health management information systems (HMIS) and support for evidence-based planning; improving governance and leadership; and supply chain management.

In FY 2010, the USG will support the operationalization of the HRH Strategic Plan and GOU capacity for planning, policy, management, and monitoring of HRH. PEPFAR will also support the development and implementation of a national training plan, the strengthening of indigenous training institutions and the strengthening of pre- and in-service education for the public health sector. The USG will continue its support for the national retention and motivation strategy, and continue to provide technical assistance to districts to improve the efficiency of their recruitment efforts. USG will also support line ministries and professional councils to develop a task-shifting plan.

In FY 2010, Uganda’s second HIV/AIDS Sero-Behavioral Survey will be started with PEPFAR support, updating information from the 2004-2005 survey. Following a successful implementation of a pilot activity to operationalize the Uganda AIDS Commission's multi-sectoral Performance Monitoring and Management Plan (PMMP) at the district level, the USG plans to support a follow-on activity to demonstrate the actual data flow in five districts. The USG will continue to support the Ministry of Health's "Vision 2012" plan for its HMIS. USG will work with MOH to develop a national strategic surveillance plan for HIV/AIDS, and will continue to support the implementation of ANC sentinel surveillance, surveillance of most at-risk populations and surveillance of early warning indicators of resistance to HIV/AIDS and TB drugs and the extent of multidrug resistant TB.

PEPFAR support will expand upon the progress made over the past five years by addressing the financial, legal and regulatory issues affecting the national supply chain system and providing substantial support for the first time to local governments to improve their performance in procuring, managing, and distributing health commodities. In FY 2010, the USG will work with key stakeholders to develop a master supply chain management implementation plan.

Management and operations funds will support the in-country personnel needed for Department of Defense, Department of State, HHS/Centers for Disease Control, Peace Corps, and USAID. Funds will ensure program monitoring and accountability, ensure USG policy and technical leadership within the Uganda national response, and cover compensation, logistics, and office and administrative costs.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The USG continues to work collaboratively with the UN system, bilateral, and multilateral partners in supporting the Uganda AIDS Commission (UAC) on the implementation of the three ones (i.e., one national plan - the National Strategic Plan, one national M&E system, and one coordinating authority) in the response to HIV/AIDS in Uganda. USG agencies are members of the AIDS Development Partner and Health Development Partner groups and attend the Global Fund Country Coordinating Mechanism meetings.

USG will continue to support the Government of Uganda to reorganize governance structures and implementation arrangements for the management of the Global Fund resources. At the Mission level the USG will balance its commitment to improving governance in Uganda with its commitment to improving public health as it deals with Global Fund issues.

Program Contact: PEPFAR Coordinator, Michael Strong

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						

Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
Becton Dickinson (BD)		Becton Dickinson			To implement quality improvements in the lab system, managers are needed at all levels. In line with national

					plans, BD will train central managers & “preceptor resident mentors”. Aside from improved training skills, mentors require the ability to influence & manage change, plan training & lab projects & utilize communication & teamwork skills. Quality management skills will also improve their ability to coach lab techs & managers. We will extend Project Management training to include leadership, training & coaching skills, communication, & team-building skills for CPHL leaders & national mentors in support of SLMTA. As part of lab Quality Systems Management improvement, BD will teach quality management concepts based upon ISO 15189

					standards for building lab systems, including but not limited to internal auditing for compliance, EQA development, & management oversight. We propose to extend this training through a training-of-trainers course to national mentors who will support national implementation of SLMTA.
HHS/CDC/Becton Dickinson (Oct 07-Sept 08)		TBD			Delete
HHS/CDC/Becton Dickinson (Oct 08 - Sept 09)		TBD			Delete
HHS/CDC/Becton Dickinson (Oct 09-Jun 10)		TBD			Delete
OGAC-BD Laboratory Strengthening					Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Africa Affordable Medicines(AAM)	7188:HIPS (Health Initiatives in the Private Sector)	Africa Affordable Medicines			Africa Affordable Medicines is a privately owned entity in Uganda whose main goal is to bring affordable, quality, essential

					medicines and medical supplies closer to the end users wherever they may be in Uganda. AAM operates a franchise pharmacy model and currently has 5 pharmacies distributed in the various regions of the country. These pharmacies provide both retail and wholesale services. In 2011, HIPS has partnered with AAM to support the scale up of franchise pharmacies in the country. This is aimed at expanding this model that is valuable for the private health sector. HIPS partner clinics and other clinics can benefit from AAMs network of pharmacies that are in all regions of the country, through access to high quality essential health commodities in a timely and cost effective manner.

					So far, 2 HIPS partners namely McLeod Russell Uganda and Kinyara are benefiting from this partnership.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Airtel Uganda	7188:HIPS (Health Initiatives in the Private Sector)	Airtel Uganda			Airtel Uganda is one of the major Telecommunications company in Uganda and in the East African region. In August 2011, HIPS signed a Memorandum of Understanding with Airtel to implement a mobile phone referral network program that will facilitate referrals and information seeking in selected HIPS partner communities. Having been successfully piloted in 3 HIPS partner companies in 2010, this program is now being expanded to 9 HIPS partners i.e. Tullow Oil, Hima Cement, Kinyara Sugar, Kakira, Wagagai, Mpanga Tea, Mabale, New

					Forests company and Rwenzori commodities. HIPS and Airtel cost shared purchase of 332 mobile handsets, which have been handed to selected peer educators and company clinics. 1 mobile handset has been given to the Aids Treatment Information Center (ATIC) in Mulago – the national referral center. The medical personnel call this center when they are faced with challenges on HIV/AIDS treatment and care. Airtel has enabled a Closed User Group platform (CUG) and zero rated calls for these handsets. The program will be running for 12 months. This partnership demonstrates the value that cellular phone technology can bring to the

					health sector.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Ankole Coffee Processors		TBD			Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Bead for Life	7188:HIPS (Health Initiatives in the Private Sector)	Bead for Life	19,994	47,329	Bead for Life is an organization that improves the livelihoods of vulnerable women by engaging them in various entrepreneurship activities and helping them find markets for their products. Bead for Life is currently working with over 800 women who care for over 1000 OVC in Lira & Otuke districts and are involved in the production of Shea butter oil. The organization provides the women with technical assistance to improve the quality of their oil products and then link them to markets where they can sell their

					products. HIPS has been working with Bead for Life since 2009 to provide OVC care and support services in Lira and Otuke through a matching grants program. This comprehensive program includes support in education, health, child protection, economic strengthening and psychosocial support for OVC and OVC households. In 2011, 467 OVC have been served, four of these OVC are HIV positive and are receiving care and treatment.
USAID/Health Initiatives for the Private Sector Project (HIPS)/BM Group of companies	7188:HIPS (Health Initiatives in the Private Sector)	BM Group of Companies			BM Group of Companies Services is an established private limited company engaged in the manufacture of quality steel products with its operations currently located in South

					Western Uganda. The company has 300 employees and another 26,600 people in its catchment area. In FY 2011, HIPS together with its local partner Federation of Uganda Employers (FUE) signed an MOU with BM Steel. REDACTED. BM Steel will recruit the necessary personnel while HIPS will provide basic start up equipment and supplies to the clinic. HIPS will also sponsor medical personnel for trainings. Peer education trainings for the company employees have been scheduled for September this year.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Buikwe Dairy Development	7188:HIPS (Health Initiatives in the Private Sector)	Buikwe Dairy Development Cooperative Society			Buikwe Diary Development Cooperative Society/International Needs Network is an organization that

Cooperative Society					Provides support to the neglected children and addresses cases of child labor on Buvuma Islands, Kiyindi landing sites, sugar plantations, tea estates and other hard to reach areas in Buikwe district. In 2011, HIPS partnered with Buikwe Dairy Development Cooperative society to implement an OVC program. HIPS has built the capacity of 40 OVC caretakers for the company in OVC care and support. The trained caretakers provide the psychosocial support, conduct home and school visits to assess children's needs at the home and at school and conduct referrals. So far, 165 OVC have been served, including18 who are HIV positive. The HIV

					positive are receiving treatment care & support.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Caring Hands	7188:HIPS (Health Initiatives in the Private Sector)	Caring Hands	13,545	15,805	Caring Hands is an organization made up of volunteers who assist neighborhoods of Kampala families living in poverty, giving them new hope for the future. Their goal is to break the cycle of poverty in families in the community. HIPS has been working with Caring Hands since 2009 to implement an OVC matching grants program. Caring Hands & HIPS have been delivering comprehensive care and support services to OVC in the Nakawa division through socio-economic activities using a family centered approach. This comprehensive OVC program includes support in education, child protection, nutrition,

					economic strengthening and psychosocial support for OVC and OVC households. Through this program, 171 OVC have so far been supported. Thirteen of these OVC are HIV positive and are receiving care and treatment. Caring Hands has also started a large sports and recreation program for these OVC.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Centenary Bank Limited (CERUDEB)		TBD			Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Cornerstone Foundation	7188:HIPS (Health Initiatives in the Private Sector)	Cornerstone Foundation	16,091	23,030	Cornerstone Development is an NGO that is directed towards helping underprivileged children with a special focus on youth leadership development. The organization was established in

					Uganda in 1988 to help in the rebuilding and development of the nation as it was emerging from a very turbulent past. HIPS has partnered with Cornerstone Development since 2009 to implement an OVC matching grants program. This program intends to reach out to 600 OVC. This comprehensive OVC program includes support in education, child protection, health, nutrition, economic strengthening and psychosocial support for OVC and OVC households. In 2011, HIPS has continued to put a lot of emphasis on economic strengthening of OVC households. HIPS and Cornerstone have built the capacity of OVC caregivers by

					supporting socio-economic strengthening in OVC households. The self sustaining Village Savings Loan Associations (VSLAs) is one of the programs that HIPS has facilitated to enhance OVC Caregivers' capacity to provide care and support to OVCs. Members are able to save and borrow money from these associations so as to set up income generating activities. At Cornerstone, 7 VSLAs have been formed. This program has so far benefited 592 OVC; Two of these are HIV positive and are receiving care & support. HIPS and Cornerstone are also implementing the schools program and through this program, 1,122 students have been reached with abstinence

					messages.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Dominion Uganda Limited (DUL)	7188:HIPS (Health Initiatives in the Private Sector)	Dominion Uganda Limited (DUL)			Dominion Petroleum is an Oil exploring company operating in Rukungiri. Dominion Uganda Limited signed a Production Sharing Agreement with the Government of the Republic of Uganda which grants it exclusive rights to explore for petroleum in the south-west of Uganda. HIPS together with its local partner Federation of Uganda Employers (FUE) and Dominion signed an MOU in 2010 to implement health programs for community members in Bwambara sub county, Dominions' area of operation. These activities include training of community volunteers as peer educators, conducting community health

					fairs, distributing IEC materials & health commodities and working with a nearby private clinic to enable surrounding community members access treatment services. Bwambara comprises mainly fishing communities – a high risk group. FUE leads in implementation of activities at Dominion. To date, more than 4,000 ITN's have been distributed to community members &1 community health fair event in which 215 people accessed VCT services has been conducted. All those that turned out positive were referred to the nearby government health facility, Bwambara health unit for care and treatment. 70

					Community members have also been trained as peer educators. Furthermore, a policy has been drafted for Dominions employees. Also, Dominion has provided basic equipment and supplies to the health facility.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)		TBD	REDACTED	REDACTED	Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Eskom	7188:HIPS (Health Initiatives in the Private Sector)	Eskom			Eskom Limited is the electricity generating company in the country. The company is located in Njeru town with a catchment population of 35,000. In 2009, HIPS together with its local partner Uganda Manufacturers association (UMA) partnered with

					Eskom to increase utilization of health services by Eskom's employees, dependants and the surrounding community members. HIPS and UMA assisted Eskom to develop their HIV/AIDS workplace policy. This policy was disseminated through a policy launch/health fair event. In 2011, HIPS, UMA and Eskom have continued to strengthen these programs. HIPS together with UMA have conducted 2 employee health fair events. Refresher trainings have also been conducted for all the 28 peer educators. HIPS and Eskom are also implementing the Text to Change SMS messaging program. Furthermore, HIPS is assisting Eskom

					to come up with tailor made information education communication materials that will be distributed to the company employees and community members. HIPS has further supported medical trainings for IAA Jinja. Eskom staff access their treatment services from this clinic. This clinic currently takes care of 12 clients on ART and 15 on palliative care.
USAID/Health Initiatives for the Private Sector Project (HIPS)/EVOKCOM	7188:HIPS (Health Initiatives in the Private Sector)	EVOCKOM/Ngora Development Association			EVOKCOM Limited is a company that is registered to promote socio-economic empowerment of youth in Uganda through hire purchase business to build the capacity of youth in business enterprises, trading in general merchandise, hire purchase, conduct microfinance &

					research and training in business skills. EVOKCOM works in the districts of Gulu, Kampala, Mukono, Kumi and Ngora. HIPS partnered with EVOKCOM to support OVC interventions among child headed households and vulnerable children in Teso region. The program aims to provide education, socio-economic strengthening, health care and psychosocial support to 200 OVC.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Farmers Center (U) Limited (FACE)	7188:HIPS (Health Initiatives in the Private Sector)	Farmers Center Uganda Limited			Farmers Center (U) Ltd (FACE) is a registered limited liability company in operation since 2005 with its main office in Lira district. FACE is motivated to work with rural communities and low income e earners to uplift and enhance sustainable agricultural

					practices and other integrated rural development initiatives that build on farmers' knowledge and general livelihood. HIPS and FACE have been partnering since 2009 to provide comprehensive service delivery and support services to OVC selected from among farming groups in 12 sub counties in lango sub region. The program encompasses support in education, health, socio-economic strengthening, nutrition, child protection and care & support. This partnership has so far benefited 246 OVC. 14 of these OVC are HIV positive and are in care and treatment. HIPS and FACE have built the capacity of OVC

					caregivers by supporting socio-economic strengthening in OVC households. The self sustaining Village Savings Loan Associations (VSLAs) is one of the programs that HIPS has facilitated to enhance OVC Caregivers' capacity to provide care and support to OVCs. Members are able to save and borrow money from these associations so as to set up income generating activities. At FACE, 11 VSLAs have been formed.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Fiduga Flowers	7188:HIPS (Health Initiatives in the Private Sector)	Fiduga Ltd.			HIPS together with local partner association Federation of Uganda Employers (FUE) approached Fiduga in 2010 to scale up the company's prevention and treatment programs. A Memorandum of Understanding (MOU) was signed

					between Fiduga, HIPS and FUE. Activities in the MOU included developing & launching an HIV/AIDS workplace policy, training employees & community members as peer educators, conducting health fair events, and partitioning the clinic. In 2011, HIPS & FUE have assisted Fiduga to develop and launch the company's HIV/AIDS workplace policy. HIPS & FUE have also conducted peer education trainings for 33 employees. In addition Fiduga and HIPS have co-sponsored a health fair event in which 476 community members accessed VCT services. All those that were HIV positive were referred to the company clinic. This

					clinic currently supports 6 clients on ART and palliative care. Also, 372, people have accessed VCT from the clinic this year. HIPS has further supported the clinic with basic medical supplies and commodities as well as medical trainings for the medical staff. The clinic has also been supported to conduct Long Term Family Planning (LTFP) methods.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Group 4 Security		TBD			Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Hima Cement	7188:HIPS (Health Initiatives in the Private Sector)	Hima Cement	32,535	117,927	Hima Cement is owned by the French multinational Lafarge & is located in Kasese district, south west of Uganda. Hima has 1,042 employees and is in a catchment of 40,000 people. HIPS has partnered with Hima

					since 2007 to expand the range of health services at the company to include HIV/AIDS, TB, malaria & RH/FP. In 2011, HIPS has transitioned management of prevention activities at the company to its local partner Federation of Uganda Employers (FUE). HIPS/FUE and Hima have cosponsored 2 trainings for 41 Peer educators and oriented these Peer educators into small discussion groups. The company now has 119 peer educators. Also, 1 health fair targeted towards the most at risk group, the truck drivers has been conducted. Through the Good Life at School (GLAS) program, student peer educators in selected schools have been trained.

					HIPS has also engaged Hima to provide to students treatment for Sexually Transmitted Infections (STIs). HIPS has further boosted Safe Male Circumcision (SMC) and Reproductive Health/Family Planning (RH/FP) services through provision of basic equipment and supplies & on the job mentorship for clinic staff. Also, 1 Integrated community outreach has been conducted. HIPS and Hima Cement are also sponsoring the mobile phone referral network program to facilitate referrals and information sharing in Hima's community. HIPS & Hima are implementing the PMI-funded IPT malaria program in which 202 pregnant

					women have benefited. The Hima clinic which HIPS supports currently takes care of 227 patients on ART and 351 on palliative care. Hima & HIPS have also supported 782 people access VCT services this year. Also, 4 TB patients are currently receiving TB treatment through Directly Observed Therapy (DOT). HIPS is also working with National TB and Leprosy program(NTLP) to improve case follow up for TB patients in the community of Hima. 2 follow up visits have been conducted by HIPS and NTLP to ensure treatment success and quality of care.
USAID/Health Initiatives for the Private Sector Project (HIPS)/HIPS and Ugarose Flowers Limited		TBD			Delete

USAID/Health Initiatives for the Private Sector Project (HIPS)/James Finlay (Uganda) Limited	7188:HIPS (Health Initiatives in the Private Sector)	McLeod Russel (U)Ltd	58,163	121,805	Since 2007, HIPS has partnered with McLeod Russell Uganda (MRU) - formerly James Finlay's to implement workplace and community health programs for its 5,000 employees and over 60,000 community members in the company's 6 tea estates. In 2011, HIPS together with its local partner Federation of Uganda Employers (FUE) & MRU have co-sponsored refresher trainings for 278 peer educators & new trainings for 32 peer educators - bringing the total number of peer educators at the company to 310. Also, MRU & HIPS/FUE have conducted 5 health fairs in which over 1,439 people have accessed VCT and 2,603 have been

					sensitized. Furthermore, HIPS has facilitated accreditation of 1 more company clinic for ART, bringing the total of accredited company clinics to 6. As a result of these clinics' accreditation, 345 people are currently receiving palliative care and 285 are on ART. MRU & HIPS have also scaled up Safe Male Circumcision (SMC) services amongst its predominantly male population to include SMC camps. HIPS has further sponsored medical staff for trainings in SMC and Long-Term Family Planning (LTFP). HIPS has also provided basic SMC & LTFP equipment and supplies to MRU. HIPS & MRU are implementing the PMI-funded IPT

					malaria program in which over 800 pregnant women have so far benefited.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Jomo fruit company	7188:HIPS (Health Initiatives in the Private Sector)	Jomo Fruit Processing Company			Jomo Fruit Company is a local fruit processing company established and registered in 2007 by Kumi organic farmers. Jomo works with 60 farmers' groups comprised of widows and vulnerable women households as well as child headed households. Jomo provides training and technical support to the fruit farmers while at the same time buys the fruits from these farmers for re-sell and juice processing. Jomo sells its juice on the local market in Tororo, Kumi, Malaba, Soroti and Kampala. Jomo works with Action for Behavioral

					Change, a local NGO that provides HIV/AIDS, and OVC care and support services in the regions of Tororo, Kumi, Ngora and Atutur. Since 2010, HIPS has been working with Jomo Fruit Company to implement an OVC program targeting OVC care takers in Kumi, Tororo and Ngora region. This comprehensive program includes support in education, child protection, nutrition, economic strengthening and psychosocial support for OVC and OVC households. So far, 162 OVC have been served, 13 of whom are HIV positive. Also, HIPS has built the capacity of 40 OVC caretakers to provide support to these OVC.
USAID/Health Initiatives for the	7188:HIPS (Health	Kakira Sugar Works	60,712	61,803	Kakira Sugar Works is one of the

Private Sector Project (HIPS)/Kakira Sugar Works	Initiatives in the Private Sector)				companies under the "Madhvani Group of Companies" umbrella. Since 2008, HIPS has engaged Kakira to carry out a comprehensive health program that includes HIV/AIDS, TB & malaria prevention & treatment, and promotion of Reproductive Health/Family Planning services amongst Kakira's 7,500 employees & 25,000 community members. In 2011, HIPS has continued to work with Kakira in expanding the health programs; Long Term Family Planning (LTFP) and Safe Male Circumcision (SMC) services received a boost with basic equipment & supplies being provided to facilitate the two services, clinic staffs have

					also been trained. The community prevention programs such as community outreaches, schools program, men only seminars, and pre recorded community radio discussions have also been scaled up. The Kakira health facility currently supports 250 patients on ART and 255 on palliative care. Also, 5 TB patients are currently receiving TB treatment through Directly Observed Therapy (DOT). Another 1,735 people have accessed VCT services this year. HIPS is also working with National TB and Leprosy program(NTLP) to improve case follow up for TB patients in the community of Kakira. 2 follow up visits have been conducted by HIPS

					and NTLP to ensure treatment success and quality of care. Kakira re-launched the “Text to Change” SMS massaging program among the employees and community members & this time around, the program was extended to the out growers. Kakira & HIPS have also continued to support the OVC & PMI IPT2 malaria program and 549 OVC & 406 pregnant women have been served respectively. In addition, Kakira’s trainers of trainers conducted refresher trainings for the 129 already trained peer educators, demonstrating that this program will be sustained beyond HIPS. HIPS has transitioned management of prevention activities of Kakira to its local

					partner Uganda Manufacturers Association to further enhance the sustainability of the programs.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Kasese Cobalt Company Limited (KCCL)/International Medical Foundation	7188:HIPS (Health Initiatives in the Private Sector)	Kasese Cobalt Company Limited	25,137	27,967	Kasese Cobalt Company Limited (KCCL) is a cobalt mining company in south western Uganda owned by a European private equity group. KCCL has 275 employees and a catchment population of 8,500. In 2007, HIPS engaged KCCL to expand the KCCL/IMF (International Medical Foundation) implemented HIV/AIDS workplace program beyond the company to cater for the health needs of 3 neighboring fishing communities of Hamukungu, Kahendero & Muhokya. In 2011, HIPS has expanded the programs at KCCL to include Integrated

					outreaches in which Safe Male Circumcision (SMC) & Long Term Family Planning (LTFP) services are offered to the community. 1 SMC camp has been done in which 68 men have been circumcised and 6 integrated outreaches have been done in which 274 people have accessed FP methods for the first time. Also, HIPS has strengthened KCCL's capacity to provide these services at the company clinic. Medical staffs have been trained and basic equipment & supplies have been provided. The KCCL clinic currently has 143 people on ART & 201 on palliative care. Another 555 people have accessed VCT services this year. Also, 7 people are currently receiving

					TB treatment through Directly Observed Therapy (DOT). HIPS is also working with National TB and Leprosy program (NTLP) to improve case follow up for TB patients. 2 follow up visits have been conducted by HIPS & NTLP. KCCL is also implementing the PMI IPT malaria program in which 383 women have benefited. KCCL has also continued to support other prevention programs such as the community radio discussions, men only seminars & the Good Life At School (GLAS) program. Also, KCCL's trainers of trainers conducted refresher trainings for peer educators, an affirmation that this program will be sustained after HIPS. HIPS together with local

					partner Federation of Uganda Employers (FUE), IMF& KCCL also revised the expired partnership Memorandum of Understanding & agreed to extend it for another 12 months.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Kinyara Sugar Works	7188:HIPS (Health Initiatives in the Private Sector)	Kinyara Sugar Works	50,482	62,999	Kinyara Sugar is a sugar cane processing factory based in Masindi, western Uganda. HIPS has been working with Kinyara since 2007 to augment Kinyara's existing HIV/AIDS workplace program to include TB, Malaria and RH/FP services among its 6,000 employees and 50,000 community members. In 2011, HIPS has expanded the community health programs at Kinyara to include Integrated outreach events in which Safe Male Circumcision (SMC)

					and Long Term Family Planning(LTFP) services are offered to community members. 5 events have been conducted this year. Also, HIPS has strengthened Kinyara's capacity to provide these services at the company clinic. Medical staffs have been sponsored for trainings in SMC & LTFP and basic equipment and supplies have been provided to facilitate initial procedures. The Kinyara clinic that HIPS supports is currently providing 95 people with ART while 133 are on palliative care. Another 3,717 people accessed VCT services this year. Also, 8 TB patients are currently receiving TB treatment through Directly Observed Therapy

					(DOT). HIPS is also working with National TB and Leprosy program(NTLP) to improve case follow up for TB patients in the community of Kinyara. 2 follow up visits have been conducted by HIPS and NTLP to ensure treatment success and quality of care. Furthermore, HIPS & Kinyara have revised the OVC matching grants program in which 248 OVC have been served, 17 of these are HIV positive and are receiving care & treatment. In addition, the “Text to Change” SMS messaging program was renewed for another 12 months. HIPS and Kinyara are also sponsoring the mobile phone referral network program to facilitate referrals and information sharing in Kinyara’s

					communities. Kinyara is also implementing the PMI IPT malaria program in which 850 pregnant women have benefited. Furthermore, HIPS has transitioned management of the prevention activities at Kinyara to its local partner Uganda Manufacturers Association (UMA). This is reflected in the revised MOU that was signed between Kinyara, HIPS and UMA.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Liberty Development Trust clinic	7188:HIPS (Health Initiatives in the Private Sector)	Liberty Development Trust clinic	9,719	9,932	Liberty Development is a local NGO that was started up in 1996 to support former employees of the national Internal Security Organization (ISO) with health services. It is surrounded by a community of more than 66,000 people. HIPS has partnered with Liberty since

					2008 to extend health services for this community. Liberty works closely with the Kitante Medical Center, a Kampala based clinic which HIPS has supported. Basic equipment, supplies and commodities have been provided to this clinic. Also, medical staff have been sponsored for various medical trainings. The clinic currently manages 362 clients on ART & 597 on palliative care. Another 989 people have accessed VCT services this year. Six people are currently receiving TB treatment through Directly Observed Therapy (DOT). HIPS is also working with the National TB & Leprosy program (NTLP) to improve case follow up for TB patients. Two

					follow up visits have been conducted by HIPS & NTLP. HIPS and Liberty also support the PMI IPT malaria program in which 300 pregnant women within the Kitante community have been served. The clinic has also been supported by HIPS to provide integrated health services to include TB and Reproductive Health/Family Planning (RH/FP).
USAID/Health Initiatives for the Private Sector Project (HIPS)/Luwero Industries Limited	7188:HIPS (Health Initiatives in the Private Sector)	Luwero Industries Ltd.			Luwero Industries Limited is a Manufacturing medium sized company based in Nakasongola district with 400 employees. The company is surrounded by a predominantly fishing community of about 6,700 people. HIPS has partnered with Luwero industries since 2007 to augment the company's workplace health

					program that was only focused on HIV/AIDS to include TB, Malaria and RH/FP services. To date, 29 Peer educators have been trained and retrained to sensitize their peers in these key areas. HIPS has also assisted Luwero Industries to develop the HIV/AIDS policy for its employees. The company has a clinic which is open to the community & both employees and community members access free treatment from this clinic. This clinic is currently supporting 69 clients on ART and 22 on palliative care. Another 108 people have accessed VCT this year. The company clinic has been supported to receive basic equipment and supplies such

					as family planning products. Furthermore, HIPS has also supported medical staff from this clinic to receive various medical trainings to enable them provide quality services.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Mpanga Tea Estate	7188:HIPS (Health Initiatives in the Private Sector)	Mpanga Tea Estate			Mpanga tea factory is located 12kms from Fort portal town in Kabarole district. The factory was licensed to start operations in 1971 as a government entity however; the government offered it to the local community in 1995. The company has1,927 employees & a catchment of 28,700 people. HIPS together with its local partner Uganda Manufacturers Association (UMA) started to work with Mpanga in 2010 to implement work place programs for employees &

					community members. Mpanga has been assisted to develop an HIV/AIDS work place. This policy was launched through a health fair event in which 406 accessed VCT services. HIPS has also trained 33 community members as peer educators. HIPS has further supported upgrading of the company clinic to provide integrated health services. The company refurbished the clinic and hired more medical staff while HIPS provided basic laboratory equipment & supplies and sponsored the new clinic staff for various trainings at Mildmay. This clinic now offers free integrated health services to employees and

					community members. HIPS has further facilitated accreditation of this facility for ART services. 299 people have accessed VCT services this year. The clinic is currently supporting 10 patients on palliative care. HIPS and Mpanga are also implementing the mobile referral network program that will facilitate critical information access and referrals in the community. Mpanga is also implementing the IPT program and so far, more than 60 mothers have benefited.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Mpongo Fisheries Limited	7188:HIPS (Health Initiatives in the Private Sector)	Mpongo Fisheries Limited	32,926	32,683	Mpongo Limited is a fish processing company located in Masaka. It is a subsidiary of the "Four Ways Group" of companies. The company has a catchment population of 16,000

					people. Mpongo completes a value chain that entails buying fish from local fishermen, processing it and then transporting it to various distribution centers across the country for export. HIPS has been partnering with Mpongo since 2009. The company supports Lambu Health Center in the community. HIPS facilitated Ministry of health accreditation of this health facility to enable it provide ART services. Currently, the clinic is serving 19 patients on ART and 27 on palliative care. Another 205 people have accessed VCT services this year. In addition, Mpongo & HIPS are sponsoring the PMI IPT malaria program and so far, 356 pregnant mothers have benefited.

					HIPS & Mpongo are also implementing the OVC matching grants program in which 256 OVC have been supported in the areas of health, education, social economic strengthening and psychosocial support. Among these are 18 HIV positive OVC who are being provided with care and support. OVC care givers have also been assissted to form Village Savings Loan Associations(VSLAs) from which they make savings & borrow and can be able to start up income generating activities. HIPS has also continued to support Safe Male Circumcision(SMC) & Long Term Family Planning(LTFP), basic equipment and supplies have been provided to the

					clinic to facilitate these procedures.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Music Life Skills and Destitute Alleviation(MLISADA)	7188:HIPS (Health Initiatives in the Private Sector)	Music, Life Skills, and Destitution Alleviation			Music Life Skills and Destitute Alleviation (MLISADA) is largely a self supportive organization that is being directed by former street children. For the last 15 years, MLISADA uses music, dance and football to lure children off the streets and places them in a reception center at the MLISADA home. HIPS has partnered with MLISADA since 2009 to lure off the streets these OVC through music and life skills including soccer and provide them with comprehensive care and support services. This comprehensive program includes support in health, education, nutrition, socio-economic strengthening and psychosocial

					support for OVC. So far, HIPS and MLISADA have supported 179 OVC, 2 of these are HIV positive and are receiving care & treatment.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Nile Breweries	7188:HIPS (Health Initiatives in the Private Sector)	Nile Breweries	82,568	105,195	Nile Breweries Limited (NBL) is located in Jinja, Eastern Uganda. It is a subsidiary of the South African Breweries Miller Group (SABMiller). NBL has 400 employees and 35,000 people in its catchment. HIPS has been working with NBL since 2007 to extend its work place health program to its supply chain that includes 10,000 small scale sorghum farmers, 300 long distance truck drivers and 1,000 hospitality workers. In 2011, HIPS and NBL concluded the Home Based counseling and testing program that

					was piloted in 2010. The 12 month program has seen 4,400 people receive HCT services; all 175 who tested positive are on Septrin prophylaxis, 32 of the 175 HIV positive are receiving ART. HIPS & NBL also support another 41 clients on ART through two NBL supported clinics. In addition, another 225 people have received HCT services in these clinics this year. Furthermore, HIPS & NBL support the palliative care program at St. Francis, a community health facility that provides HIV/AIDS treatment to community members. HIPS has sponsored NBL medical staff for various medical trainings & has provided basic supplies to the

					clinics. HIPS & NBL are also implementing the PMI-funded IPT malaria program in which 1,995 pregnant women have benefited. At NBL, HIPS has facilitated transition of prevention activities to its local partners Federation of Uganda Employers (FUE) and Uganda Manufactures Association (UMA). UMA manages the community activities while FUE manages the employees' activities. FUE has so far conducted 1 health fair event while UMA has scheduled peer education trainings for September.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Rakai Community Health Development (RCHD) Project	7188:HIPS (Health Initiatives in the Private Sector)	Rakai Community Health Development Project	6,276	6,348	Rakai Community Development Health (RCDH) project was established in 1999 to respond to the alarming health crisis and high HIV/AIDS

					prevalence within Rakai district. The project is operating in a community of 5,600 people. HIPS partnered with RCHD in 2008 to implement the PMI IPT malaria program to mitigate the impact of malaria amongst pregnant women in the district. Through this partnership, more than 688 pregnant women have been supported to receive Intermittent Presumptive Treatment for malaria. HIPS has further assisted one of the private clinics' within the project's community to acquire ART accreditation to enable community members access ART services. This clinic currently provides ART to 19 clients & palliative care to 40 clients. Another 273 people have accessed VCT

					services this year. HIPS has trained clinic staff from this clinic in various training programs at Mildmay. In addition to this, HIPS has supported integration of services in this clinic, for example the clinic now offers safe male circumcision services and long term family planning services. HIPS has supported the clinic with basic equipment and supplies to facilitate these services.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Regional Lorry Drivers and Transporters Association (RLDTA)	7188:HIPS (Health Initiatives in the Private Sector)	Regional Lorry Drivers & Transporters Association			Regional Lorry Drivers and Transporters Association (RLDTA) is an association for lorry/truck drivers and transporters that started operations in February 2010. RLDTA works with over 10,000 lorry drivers, 443 of whom are direct

					association members. In 2011, HIPS/FUE and RLDTA signed an MOU to implement health programs geared towards improving the lives of these Lorry drivers. So far, 20 lorry drivers have been trained as peer educators to reach out to their peers with behavior change information. HIPS has also assisted the association to draft an HIV/AIDS policy. HIPS has further negotiated an arrangement with Touch Namuwongo to assist the lorry drivers access highly subsidized safe male circumcision services at the hospital.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Roofings Limited		TBD	REDACTED	REDACTED	Delete

USAID/Health Initiatives for the Private Sector Project (HIPS)/Royal Van Zanten Flowers (RVZ)/International Medical Foundation	7188:HIPS (Health Initiatives in the Private Sector)	Royal Van Zanten Flowers	20,592	23,089	RVZ is a flower exporting medium sized company based in Mukono district with 500 employees, surrounded by a community of about 7,000 people. HIPS has been partnering with RVZ since 2008 to expand RVZ's employee HIV/AIDS program to cover dependants and surrounding community members under a Memorandum of Understanding between RVZ, IMF (International Medical Foundation) and HIPS. In 2011, HIPS has continued to consolidate the programs at RVZ. HIPS has provided various trainings to the company clinic medical personnel so they continue providing quality services to company employees and community members. HIPS has

					also provided equipment & supplies to this clinic. Currently the clinic supports 185 community clients on palliative care and 35 on ART. Another 413 people have accessed VCT services this year. The clinic also offers Long Term Family Planning (LTFP) methods. In addition, HIPS & RVZ implement a community based palliative care program in Kyetume for those that are HIV positive. Also, HIPS has transitioned management of prevention activities of RVZ to its local partner Federation of Uganda Employers to enhance the sustainability of programs; 30 peer educators have been trained & a health fair event in which 238

					community members accessed HCT has been conducted.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Rwenzori Commodities	7188:HIPS (Health Initiatives in the Private Sector)	Rwenzori Commodities	15,171	19,039	Rwenzori Commodities is a tea exporting company located in western Uganda. It is one of the many companies owned by 'Mukwano Group of Companies'. Rwenzori spans 4 tea estates that have a total catchment population of over 29,000 people. HIPS has been partnering with Rwenzori Commodities since 2009 to implement prevention and treatment programs for its 5,822 employees and community members. In 2011, HIPS has continued to strengthen the programs at Rwenzori commodities. HIPS has provided basic equipment and

					medical supplies to the 3 company clinics. Also medical personnel in these clinics have been sponsored for various medical trainings so that they continue providing quality and integrated health services to employees and community members. The clinics currently support 102 HIV positive clients on palliative care and those that require treatment are referred to the nearby government health facility. Also, 315 people have accessed VCT services this year. Services at the clinics have been integrated to include Long Term Family Planning (LTFP). Two people are currently receiving TB treatment through Directly Observed Therapy

					(DOT). HIPS is also working with National TB and Leprosy program (NTLP) to improve case follow up for TB patients. 2 follow up visits have been conducted by HIPS & NTLP. HIPS together with its local partner Federation of Ugandan Employers have trained 33 new peer educators, bringing the total number of trained peer educators to 106. HIPS and Rwenzori Commodities are also implementing the mobile phone referral network program in Buzirasagama estate; this program will facilitate communication and timely referrals in the community of Buzirasagama.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Shell		TBD			Delete

Uganda Limited					
USAID/Health Initiatives for the Private Sector Project (HIPS)/Southern Range Nyanza Limited (SRNL)	7188:HIPS (Health Initiatives in the Private Sector)	Southern Range Nyanza Limited	15,571	15,751	Southern Range Nyanza Limited (SRNL), formerly NYTIL Uganda, is a textile processing and paper milling company located in Jinja district. HIPS together with its local partner Uganda Manufacturing Association (UMA) approached SRNL in 2009 to carry out a comprehensive health program for the company's 1,500 employees & 35,000 community members in its catchment area. A Memorandum of Understanding to implement both prevention and treatment programs was signed between UMA, HIPS and SRNL. The company refurbished its clinic; HIPS provided basic equipment and sponsored medical personnel for

					various training programs. In 2011, SRNL and HIPS/UMA have strengthened the current programs at the company. Refresher trainings for 26 peer educators have been conducted. A community health fair event has been planned for September. The company clinic currently takes care of 11 patients on palliative care and 1 patient on ART. Another 130 people have accessed VCT services this year. In addition, HIPS & UMA have worked with SRNL to integrate more health services like Reproductive Health/Family Planning (RH/FP) for the predominantly female staff. HIPS has trained clinical staff in long-term family planning

					services and has provided basic FP commodities and supplies.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Sugar Corporation of Uganda	7188:HIPS (Health Initiatives in the Private Sector)	Sugar Corporation of Uganda			Sugar Corporation of Uganda (SCOUL) is a sugar cane processing factory based in Buikwe District, Central Uganda. HIPS started working with SCOUL in early 2008 to expand SCOUL's existing HIV/AIDS workplace program to include TB, Malaria and RH/FP services and extend these services to SCOUL's 6,000 employees and 30,000 community members and dependants. In 2011, Having realized the benefits of partnering with HIPS, SCOUL accepted to increase their contribution towards health programs & formalize the partnership through signing of an MOU

					& a costed menu of services. HIPS has provided basic equipment and supplies to SCOUL including Safe Male Circumcision (SMC) & Long Term Family Planning (LTFP) equipment; medical personnel from the clinic have also been sponsored for training in SMC & LTFP. SCOUL is also engaged in the PMI IPT2 malaria program in which 200 pregnant women have benefited. The SCOUL health facility is currently providing ARVs to 27 clients while 58 clients are on palliative care. Another 546 people have accessed VCT services this year. Also, 150 community volunteers have been trained as peer educators. HIPS has transitioned

					management of prevention activities at SCOUL to its local partner Uganda Manufacturers Association (UMA).
USAID/Health Initiatives for the Private Sector Project (HIPS)/TBD 1	7188:HIPS (Health Initiatives in the Private Sector)	TBD			TBD
USAID/Health Initiatives for the Private Sector Project (HIPS)/TBD 2	7188:HIPS (Health Initiatives in the Private Sector)	TBD			TBD
USAID/Health Initiatives for the Private Sector Project (HIPS)/TBD 3	7188:HIPS (Health Initiatives in the Private Sector)	TBD			TBD
USAID/Health Initiatives for the Private Sector Project (HIPS)/The New Forests Company (NFC)	7188:HIPS (Health Initiatives in the Private Sector)	The New Forests Company	6,365	6,387	The New Forests Company is involved with promoting tree planting in 4 districts in Uganda. The company buys tree seedlings from over 700 out growers in the rural districts of Kiboga, Mubende, Mityana and Bugiri. These 4 communities

					comprise a catchment population of more than 10,000 people. HIPS together with its local partner Federation of Uganda Employers(FUE), has partnered with NFC since 2009 to ensure that the out growers working with the company have access to health services in the areas of HIV/AIDS, TB, Malaria and RH/FP. HIPS & FUE have assisted NFC draft an HIV/AIDS workplace policy. REDACTED. HIPS provided basic equipment to each of these facilities and sponsored medical personnel from these clinics for various training programs to enable them provide quality services. HIPS has also facilitated the Ministry of Health to accredit these

					clinics. During this year, 156 people have accessed VCT services from the clinics. All the HIV positives are currently being referred to the nearby government health facilities until the company is administratively ready to start treating these patients at their facilities. In addition, 106 community members have trained by HIPS/FUS as peer educators. HIPS and NFC are also implementing the Mobile Referral network program to facilitate critical information access and referrals within the communities of NFC.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Toro And Mityana Tea Company(TAMTECO)	7188:HIPS (Health Initiatives in the Private Sector)	Toro and Mityana Tea Company			Toro And Mityana Tea Company (TAMTECO) is a tea growing and exporting company with 7,000 employees and

					25,700 people in its catchment area. HIPS has been working with TAMTECO since 2008 to implement work place programs for the company's employees and community members. In 2011, TAMTECO agreed to increase their contribution towards the health programs and as a result, the partnership was formalized through an MOU and a costed menu of services which was signed between TAMTECO & HIPS together with its local partner Uganda Manufacturers Association (UMA). HIPS has assisted TAMTECO in developing an HIV/AIDS workplace policy for its employees, this was followed by peer education trainings

					for 129 company employees and community volunteers. HIPS has also provided support to the 2 company clinics that includes provision of basic health supplies, facilitating accreditation of the clinics for ART and sponsoring medical personnel for various training programs. The 2 TAMTECO clinics currently provide ART to 130 clients and palliative care to 135 clients. Another 292 people have received VCT services this year. HIPS has also facilitated one of the clinics to receive TB accreditation. Currently 4 TB patients are receiving TB treatment through Directly Observed Therapy (DOT). HIPS is also working with National TB and

					Leprosy program (NTLP) to improve case follow up for TB patients. 2 follow up visits have been conducted by HIPS and NTLP The clinics' services have further been expanded to include Long Term Family Planning services.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Tororo Cement Industries	7188:HIPS (Health Initiatives in the Private Sector)	Tororo Cement Industries	18,912	20,292	Tororo Cement is a company based in Eastern Uganda with 500 employees & a catchment population of 42,100. HIPS together with its local partner Uganda Manufacturers Association (UMA), has partnered with Tororo Cement since 2009, to expand the scope of the company's HIV/AIDS workplace program to include TB, Malaria & RH/FP services. HIPS and UMA helped Tororo develop an HIV/AIDS workplace

					policy and train peer educators on HIV/AIDS, TB, Malaria & RH/FP. HIPS has further worked with Tororo Cement to extend this comprehensive workplace health program along the company's supply chain that comprises the quarry workers, the truck drivers who ferry limestone to the factory & the distribution centers where the cement is sold. In 2011, HIPS has continued to engage Tororo Cement in the PMI IPT malaria program which has served 304 Pregnant women. Through the company clinic, 57 people have accessed VCT services and all those who test HIV positive are referred to the nearby government health facility for care and treatment. Tororo

					Cement financially supports this government health facility. Tororo has also cost shared with HIPS to distribute 1,047 long lasting insecticide treated mosquito nets. HIPS has engaged the District in discussions to strengthen referral mechanisms of HIV positive and TB patients from the Tororo Cement company clinic.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Tullow Oil	7188:HIPS (Health Initiatives in the Private Sector)	Tullow Oil	67,130	193,282	Tullow Oil is an oil exploration company based in Hoima & Bullisa districts. HIPS has partnered with Tullow since 2008 to extend health services among Tullow's 200 employees and 60,000 community members. HIPS has assisted Tullow set up 4 VCT & FP service centers and 1 maternity clinic that has been expanded to provide

					primary care services. HIPS facilitated Ministry of Health accreditation for ART and TB of the clinic. To date, more than 40 clients are receiving ARVs and 69 are receiving palliative care through this clinic. Also, HIPS & Tullow are implementing the PMI-funded IPT malaria program in which 927 pregnant women have so far benefited. HIPS and Tullow have sponsored training of 339 volunteers as peer educators; these reach out to their peers with health messages. Also, 6 health fair events have been conducted in which 6,229 people have been sensitized & 2,803 accessed VCT. HIPS has expanded the programs at Tullow to include men only seminars, community dramas

					& pre-recorded community radio discussions. HIPS & Tullow are utilizing technology to facilitate referrals and promote communication through the mobile phone referral network program. As part of sustainability efforts, HIPS has shifted management of prevention activities at Tullow to Uganda Manufacturers Association.
USAID/Health Initiatives for the Private Sector Project (HIPS)/UGACOF Coffee		TBD	REDACTED	REDACTED	Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Uganda Baati	7188:HIPS (Health Initiatives in the Private Sector)	Uganda Baati	10,040	10,177	Uganda Baati is building material manufacturing company located in Kampala. It is part of a larger group of companies that produces iron sheets and steel products for the whole East Africa region. The

					company has 400 employees and over 14,000 people within its catchment area. HIPS together with its local partner Uganda Manufacturers Association (UMA) have been working with Uganda Baati since 2009 to co-sponsor activities that include developing an HIV/AIDS workplace policy, supporting the health facility receive accreditation for HIV/AIDS & TB, train peer educators & carry out health fair events. Uganda Baati has a clinic that is open to the community. In 2011, HIPS & UMA have continued to work with Uganda Baati to strengthen and expand the current programs; HIPS has provided basic equipment & has trained the medical personnel in various

					programs. HIPS, UMA & Uganda Baati have co-sponsored training of 24 peer educators. 1 health fair event has also been conducted in which the company HIV/AIDS work place policy that HIPS & UMA assisted in developing was launched. During the health fair, 227 community members accessed free HCT. The clinic provides care and support to 10 HIV positive people who receive their ARVs from the nearby government health facility. Another 61 people Have accessed VCT services this year. Uganda Baati has also procured health commodities such as bed nets, family planning supplies etc that it distributes to its employees. HIPS & Uganda

					Baati have recently implemented the PMI IPT malaria program in which 20 mothers have so far benefited.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Uganda Clays		TBD	REDACTED	REDACTED	Delete - duplicate
USAID/Health Initiatives for the Private Sector Project (HIPS)/Uganda Clays/Uganda Clays	7188:HIPS (Health Initiatives in the Private Sector)	Uganda Clays			Uganda Clays is the leading producer of roofing tiles in the country. The company is located in Kajjansi town, Wakiso District and has a catchment population of 19,000 people. HIPS together with its local partner Uganda Manufactures Association (UMA) has partnered with Uganda Clays since 2008 to increase utilization of health services by Uganda Clays' employees & surrounding community members. HIPS & UMA have assisted

					Clays to draft their HIV/AIDS workplace policy & disseminate it through a policy launch/health fair event. Uganda Clays & HIPS have replicated the comprehensive health programs established at Kajjansi in their new branch in Mbale. This new branch was commissioned through a health fair event which was attended by H.E The President of Uganda. So far, 104 employees have been trained as peer educators & 2 Health Fair events have been conducted. Uganda Clays has also purchased more than 1500 bed nets that have been distributed to company employees. HIPS has also facilitated various trainings for the clinics medical staff to enable them

					ably handle the expanded range of services. The clinic provides integrated services and is currently providing palliative care services to 39 clients. The HIV positive patients that need ARVs are referred to Mildmay, an HIV/AIDS treatment center. Another 130 people have accessed VCT services this year.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Uganda Crane Creameries Cooperative Union (UCCU)	7188:HIPS (Health Initiatives in the Private Sector)	Uganda Crane Creameries Cooperative Union (UCCCU)			Uganda Crane Creameries Cooperative Union (UCCCU) is an association that brings together dairy farmers in western Uganda. The Association has a presence in 10 districts i.e. Mbarara, Ibanda, Kamwenge, Kiruhura, Isingiro, Bushenyi, Ntungamo, Rukungiri, Kanungu and Kabale. UCCCU has 88 direct employees

					and 13,600 Dairy farmers across the 10 districts. HIPS together with its local partner Uganda Manufacturers Association (UMA) has partnered with UCCCU since 2010. A Memorandum of Understanding was signed to implement both prevention and treatment programs among the dairy farmers; some of the activities agreed upon include carrying out peer education training, workplace policy development, conducting health fairs and setting up a clinic. The workplace policy has been developed & launched. 2 health fair events have also been held during which 300 people received VCT services. All those that turned out positive were referred to the

					nearby government facility which the company has a working arrangement with to access care & treatment. UCCCU is finalizing setting up of the clinic which will provide treatment services to its members and the community. The treatment activities are hinged on completion of the clinic which is anticipated for early 2012.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Uganda Telecom Limited (UTL)		TBD			Delete
USAID/Health Initiatives for the Private Sector Project (HIPS)/Wagagai Flowers Limited	7188:HIPS (Health Initiatives in the Private Sector)	Wagagai Flowers	27,972	32,795	Wagagai Limited is a flower exporting company with a work force of 1,700 employees and 15,700 people in its catchment area. In 2008, HIPS partnered with Wagagai to expand the health programs

					the company was providing to its employees to include community members. The company set up a clinic which provides integrated health services and is open to community members. In 2011, HIPS has continued to work with Wagagai to support both prevention & treatment programs at the company. Long Term Family Planning (LTFP) & Safe Medical Circumcision (SMC) services received a boost with basic equipment and supplies being provided to facilitate the two services, clinic staffs have also been trained. So far, 50 SMC and 47 LTFP procedures have been done at the clinic. The Wagagai clinic is currently taking care of 104 patients on ARVS & another

					155 on palliative care. Another 1,063 people have accessed VCT services this year. Also, 8 patients are currently receiving TB treatment through Directly Observed Therapy (DOT). HIPS is also working with National TB and Leprosy program(NTLP) to improve case follow up for TB patients in the community of Wagagai. 2 follow up visits have been conducted by HIPS and NTLP to ensure treatment success and quality of care. Furthermore, HIPS & Wagagai are implementing the mobile phone referral network program to facilitate referrals and communication. HIPS has also transitioned management of prevention activities at Wagagai to its

					local partner, Federation of Uganda Employers (FUE). FUE has so far conducted refresher trainings for the peer educators. A health fair event for Wagagai has been scheduled.
USAID/Health Initiatives for the Private Sector Project (HIPS)/Xclusive Cuttings Flowers	7188:HIPS (Health Initiatives in the Private Sector)	Xclusive Cuttings Flowers	17,877	18,302	Xclusive Cuttings is a Dutch owned flower farm located in Gayaza, Wakiso district. Xclusive has over 200 employees and 10,000 people living within its catchment area. In FY 2009, HIPS & its local partner Federation of Uganda Employers (FUE) signed an MOU with Xclusive to co-sponsor integrated health activities within their community. These activities include; developing & launching an HIV/AIDS workplace policy, training employees as peer educators,

					conducting community health fair events, and constructing a new clinic to enable the employees & community members access treatment services. In 2011, HIPS has facilitated MOH accreditation of this clinic to provide ART and TB treatment services. In total, 84 People have received VCT services this year. The clinic is in the process of recalling all the 7 HIV positives who were previously referred to Mulago before the clinic was accredited. HIPS is also supporting the clinic to expand on the range of services at the clinic to include Long Term Family Planning & Safe Male Circumcision services. Basic equipment and supplies have been

					given to the facility and medical staff have been trained. Besides this, HIPS & Xclusive Cuttings are implementing the PMI IPT malaria program among the predominantly female staff. In addition, the company clinic now conducts community outreach events; these take place at least once a week. HIPS, FUE & Xclusive Cuttings further renewed the partnership MOU that had expired. Other activities such as refresher trainings for peer educators and a health fair event are slated to take place in late September 2011.
Wellness Center for Health Care Workers		Becton Dickinson, International Council of Nurses (ICN)	450,000	800,000	Project ending

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
ANC Surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation
Cohort-based HIV drug resistance surveillance	HIV Drug Resistance	Other	Planning
Early warning indicator survey	HIV Drug Resistance	Other	Implementation
Epsilon estimation study	Recent HIV Infections	Other	Planning
Estimating MARP sizes	Population size estimates	Other	Development
Fishing community HIV survey	Population-based Behavioral Surveys	Mobile Populations	Planning
Global Health Survey	Other	General Population	Planning
HMIS based MCH surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Other	Planning
Piloting PMTCT-based HIV surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Development
Prison survey	Sentinel Surveillance (e.g. ANC Surveys)	Other	Development
TB drug resistance survey	Other	Other	Implementation
The Crane Survey - bio-behavioral HIV-related surveillance in Uganda	Population-based Behavioral Surveys	Other	Implementation
Uganda AIDS Indicator Survey	Population-based Behavioral Surveys	General Population	Data Review
Uganda Demographic and Health Survey	Population-based Behavioral Surveys	General Population	Data Review
VCT-based surveillance of HIV acquisition	Recent HIV Infections	General Population	Implementation

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			6,209,978		**6,209,978**
HHS/CDC		8,040,000	101,948,927		**109,988,927**
HHS/HRSA	6,264,675		11,686,175		**17,950,850**
PC			343,700		**343,700**
State			389,580		**389,580**
State/AF			401,000		**401,000**
State/PRM			283,345		**283,345**
USAID	370,000		141,021,833		**141,391,833**
Total	**6,634,675**	**8,040,000**	**262,284,538**	**0**	**276,959,213**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	DOD	HHS/CDC	HHS/HRSA	PC	State/AF	USAID	AllOther	
CIRC		1,924,400	3,158,620				2,321,167		**7,404,187**
HBHC		540,000	7,577,065	296,000		175,000	12,509,616		**21,097,681**
HKID		350,000	1,494,000	300,000		226,000	22,775,778	52,191	**25,197,969**
HLAB		400,000	10,890,874	600,000			1,910,020		**13,800,894**
HMBL			3,218,000						**3,218,000**
HMIN		50,000	200,000				752,500		**1,002,500**
HTXD			19,255,000	7,661,937			18,522,721		**45,439,658**
HTXS		666,820	9,300,000	6,255,941			11,973,565		**28,196,326**
HVAB		188,000	984,948	500,000			13,259,846	29,949	**14,962,743**
HVCT		427,000	9,767,395	150,000			6,425,310	47,408	**16,817,113**
HVMS	389,580	377,866	13,795,039		343,700		8,096,610		**23,002,795**

HVOP		425,000	1,832,779				11,155,657	24,506	**13,437,942**
HVSI		273,000	3,364,150				8,253,882		**11,891,032**
HVTB		98,987	4,703,778	98,987			4,142,715	69,291	**9,113,758**
MTCT		100,000	8,718,546	450,000			5,582,000	60,000	**14,910,546**
OHSS			5,359,772				6,740,672		**12,100,444**
PDCS		222,200	2,678,961	74,000			2,540,653		**5,515,814**
PDTX		166,705	3,690,000	1,563,985			4,429,121		**9,849,811**
	389,580	**6,209,978**	**109,988,927**	**17,950,850**	**343,700**	**401,000**	**141,391,833**	**283,345**	**276,959,213**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets
REDACTED.

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	21,097,681	
HTXS	28,196,326	
Total Technical Area Planned Funding:	**49,294,007**	**0**

Summary:
Context and background

Uganda has made progress towards providing HIV care, treatment, and support to people living with HIV/AIDS (PLWAs). Care and support includes activities enhancing quality of life of PLWAs, from diagnosis through end-of-life. Services vary in scope, coverage, and quality, and may be delivered at facilities, communities, or homes. Community and home-based models have gained prominence due to their cost-effectiveness and the fact that care for stable patients need not be provided in facilities. However, only few providers can offer the full range of services, thus coordination and establishment of referral networks to co-manage clients are essential.

By the end of March 2009 (SAPR), 357,108 PLWAs were receiving care against a FY09 target of 389,747. Over 80% of PLWAs in care receive co-trimoxazole, and more than 250,000 PLWAs have received a Basic Care Package (BCP) in the past 5 years. The BCP is a minimum set of evidence-based interventions for HIV-infected persons comprising of co-trimoxazole for opportunistic infection (OI) prophylaxis, insecticide treated bed nets (ITNs), a safe water vessel, water purification solution, information on Prevention with Positives (PwP) written in local languages, and condoms as appropriate. Uganda receives free fluconazole from Pfizer for treatment of cryptococcal meningitis, a common OI among PLWAs. TB diagnosis and treatment supplies are distributed by the National TB and Leprosy Program (NTLP) through Global Fund (GF) support.

By June 2009, 193,746 (60% of eligible) were receiving ART nationally, a significant increase from 40% in June 2008. PEPFAR contributed 153,024 to the national total by March 2009. The national target for ART is 203,000 PLWA by September 2009 while that of PEPFAR is 164,397. Children comprise 8.5% of national ART recipients against a target of 15%. The proportion of HAART-eligible HIV-infected pregnant women receiving treatment is low, only 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009. The number of people needing ART is approximately 322,819 at a CD4 threshold of 250 cells/mm3. Using the WHO recommended CD4 threshold of 350, however, only about 25% of the estimated 724,000 eligible are receiving it (Spectrum model). By March 2009 (SAPR), 323 PEPFAR supported sites were providing ART services out of a national total of 364. Adherence to ART remains over 90% and over 97% of all clients are on first-line ART regimens. Retention on ART, however, remains a challenge with a loss- to-follow-up rate of about 30% (MOH AIDS Control Program (MOH-ACP)).

Accomplishments since last COP

Improved BCP coverage: The number of PLWAs receiving the Basic Care Package (BCP) increased to over 80%. While the 2007 Uganda Service Provision Assessment (USPA) Survey revealed co-trimoxazole stock-outs in up to 44% of facilities, logistics management improved in the following year with almost no site reporting stock-out.

Improved ART coverage: An additional 22,187 individuals were supported directly by PEPFAR to receive ART, an increase of 17% from 130,837 to 153,024 in the 6 months ending March 2009. PEPFAR supports over 80% of national ART recipients and procures ARVs for over 50%. USG supported the roll-out of the 2008 revised national treatment policy changing CD4 eligibility threshold for ART initiation from CD4<200 to <250 for adults, and CD4<350 for TB patients and pregnant females, plus all infected infants under 1 year. Apart from PEPFAR, contributors for the ART program included the Clinton Foundation HIV/AIDS Initiative (CHAI) that donated pediatric and adult second line ARVs and diagnostic reagents (CD4 and DNA-PCR), and Government of Uganda (GOU) which allocated up to $30 million in FY08/9 to procure ARV drugs and antimalarials from Quality Chemicals, a local pharmaceutical manufacturing firm.

Rationalization: With increasing demand for services and limited resources, the USG spearheaded efforts to improve efficiency in service delivery. One major challenge was duplication: 50% of all ART sites had two or more implementing partners (MOH-ACP, 2008). Among PEPFAR-supported sites, 32 ART sites (10%) received support from more than one partner. This resulted in reporting duplication, inaccurate supplies quantification, and inefficiency. There is ongoing dialogue between MOH, other donors, and providers on strategies to achieve rationalization. Ongoing and future cost-efficiency studies will help identify best practices to be replicated by implementers for more efficient use of resources.

M&E: The MOH-ACP revised the care and support data collection tools for improved patient tracking and enhanced linkages. PEPFAR partners have increasingly adopted these MOH tools to minimize parallel and uncoordinated reporting. An evaluation of the first year of implementation of the National HIV & AIDS Strategic Plan 2007/8 - 2011/12 (NSP) was conducted, findings disseminated, and priority actions summarized in the National Priority Action Plan 2008/09-2009/10 (NPAP).

Challenges facing the Care and Treatment Program

1. Poor leadership and coordination: There is inadequate GOU leadership, resource allocation and ownership of the program. This results in inadequate coordination of HIV care and treatment services at all levels resulting into duplication of services and reporting as well as challenges in quantification of supplies and poor integration of services.

2. Inadequate funding for comprehensive care and treatment: Demand for care and treatment is high following national HCT scale-up; over a million individuals had an HIV test in the past year. The health infrastructure (human resource, laboratories, space, and supply chain) requires support. The NPAP recommended accelerated ART scale-up, with over 50,000 to initiate ART annually. However available funds are inadequate as GF is unpredictable and GOU support limited. The USG therefore needs to be prepared to manage stakeholder expectations given previous performance. There is high unmet demand for nutritional support, home based care, and palliative end-of life care due to resource constraints.

3. Monitoring and Evaluation: Data gaps exist at several levels. The total number of PLWAs, and numbers in care and receiving the different services, is often unavailable or inconsistent due to weak and fragmented M&E systems at program, facility, district and national levels.

4. Weak linkages: Weak linkages between the different care and treatment services (e.g., TB, PMTCT, and pediatric care) lead to missed opportunities. For example, in the year ending June 2009, only 21% of pregnant women requiring HAART received it, and only 17% of HIV exposed infants had DNA-PCR for early infant diagnosis (EID).

5. Weak PwP interventions: Reproductive health needs for PLWAs in care are not fully addressed with resultant unplanned pregnancies and HIV transmission to spouses and infants. The national PwP package is also yet to be clearly defined and adopted.

6. Inequitable access to care and treatment: Underserved populations include rural populations, high prevalence groups like uniformed forces, fishing communities, and commercial sex workers. Most districts have no special strategies to target provision of ART and care to these populations.

Goals and strategies for the coming year

1. Rationalize care and treatment services: There is need for improved coordination of services at all levels (USG, MOH, districts, facility). A number of strategies will be employed in FY10:

a. Reduce duplication: The USG will focus on mapping care and treatment services by partner and program area and work with the MOH to minimize overlap and maximize efficiencies, especially as new funding agreements are tendered in FY10.

b. District support: USG will advocate for support to district-based programs that work in close partnership with the district health management team. This will promote integration and improve alignment in planning, implementation and monitoring of services in the district. USG district support will include conducting situational analyses to guide prioritization of implemented activities, mainstreaming HIV/AIDS into district plans, aligning reporting with national requirements, improving data quality, availability and utilization, and improving technical supportive supervision for ongoing activities.

c. Integrated comprehensive service delivery: The USG will support programs that focus on comprehensive services covering the continuum of HIV prevention, care, treatment, and support components. Services maybe clinical or non-clinical and cover HCT, PMTCT, ART, OI care, pediatric care, adult care, pain management, PwP, and RH/FP.

d. Ongoing and future cost-efficiency best practices: These include (1) switch from branded to generic ARV drugs; (2) task shifting to alleviate staffing shortages; and (3) replication of innovative care models such as the 'family care' model, nurse only/pharmacy only visits for stable patients on ART, and community ARV drug distribution points. A committee established by the care and treatment partners will work in partnership with the MOH and USG to reach consensus on rationalization principles and strategies, with the aim of improving coordination and maximizing efficiencies. The committee will review clinical, laboratory, and procurement protocols to identify opportunities for improved efficiencies.

2. Human Capacity Development: In response to staffing shortage, and in an attempt to build a sustainable workforce, USG will expand its support for human resources for health. This is addressed in detail under the Health System Strengthening and Human Resources for Health technical area. Support will be provided for pre-service and in service training of various cadres of health providers.

3. Basic Care Package and Prevention with Positives (PwP): USG will continue to focus on providing the BCP to all identified HIV-positive clients including pregnant women attending PMTCT programs. Increased support to National Medical Stores (NMS), Joint Medical Stores (JMS) and the BCP program, will ensure improved storage, distribution and delivery to clients in active care. Social marketing strategies through the private sector will help widen the client base. 'Positive Prevention' approaches to be promoted will include provider-initiated family-based HCT, supported HIV status disclosure, and counseling on PMTCT, FP, and STI management.

4. Strengthen PMTCT Follow-up: Care and treatment of HIV-positive pregnant women and post-natal

follow-up of mother-infant pairs will be strengthened. USG will support partners to implement a family-centered approach to providing care for mothers, infants, and household members. This will also foster male involvement.

5. Linkages, referral mechanisms and systems:

a. A key focus of this year is to strengthen referral mechanisms and linkages between facility, home-based care, OVC care and other support services. As facilities reach capacity, clinically stable patients will be referred to lower level facilities and community-based care points. Network Support Agents will play an increasing role in ensuring that referral linkages between health facilities and the community happen. They will track patients, provide adherence counseling, at-home services, and support caregivers. This approach will be scaled up to cover more districts. Distribution of BCP through community based PLWA groups and networks will be explored. Community networks, currently being strengthened by most of the care and treatment partners, will provide social support including: (1) food security interventions, income generating activities and sustainable livelihood strategies; (2) community mobilization and promotion of awareness of HIV/AIDS prevention, HCT, care and treatment; and (3) stigma reduction. Significant aspects of this program will be achieved by leveraging non-PEPFAR resources.

b. Linkages between care and treatment services and the laboratory system will be strengthened in FY10 to achieve regular monitoring of both pre-ART and ART patients in accordance with national guidelines. The capacity of regional referral laboratories and designated district laboratories in both the public and private sector has been built to act as hubs for providing diagnostics. Referral networks between lower health center laboratories and the hubs will be strengthened and a mapping exercise will be done to ensure national coverage. More emphasis will be put on patients under care but not yet enrolled on ART, and on TB/HIV co-infected patients and HIV+ pregnant women, as these often are not monitored. This will increase the number of TB/HIV co-infected patients and HIV+ pregnant women on ART.

6. Monitoring, reporting, and quality improvement: USG will focus on improving program monitoring and reporting by supporting partners to comply with national reporting requirements and to analyze and utilize program data at source. USG will continue to enhance the quality of facility-based HIV care and treatment through the activities of the HIVQUAL and HCI projects, which build capacity for quality improvement. These QI efforts will be extended to PMTCT, HCT, and other interventions.

7. Increasing Coverage: In FY10 the PEPFAR program will support about 411,000 PLWAs in care and about 30,000 will be newly initiated on HAART.

8. Resource mobilization: Although rationalization efforts will realize savings through improved efficiencies, more structured long-term funding frameworks are required to support the national care and treatment program. Following the 2009 five-year ART costing study for the national HIV care and treatment program, results will be shared with stakeholders with the goal of identifying additional funding sources as USG funding is unlikely to increase. These include the MOH, other GOU sectors, the Uganda AIDS Commission, donors, and implementers. The team will review terms of USG engagement with the Global Fund (GF) and determine the technical assistance needs to improve GF support to Uganda. Previously, GF experienced delays in fund disbursement with resultant interruption in services delivery.

Costing of care and treatment programs

ART Costing: The USG conducted a costing study for HIV treatment programs in Uganda (pre-ART and ART) for a five year period using the PEPFAR ART Costing Project Model. The MOH, in partnership with the Supply Chain Management Systems (SCMS) project, also carried out national four-year (2009-12) ARV drug quantification to determine country needs. The results are being utilized to ensure more

realistic and efficient targeting, resource allocation and tracking in future. This will also assist GOU/MOH and stakeholders mobilize required resources for care and treatment given the current funding situation.

Staffing
In FY10, approximately 71 USG FTE will work in this technical area.

Technical Area: ARV Drugs

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	45,439,658	
Total Technical Area Planned Funding:	**45,439,658**	**0**

Summary:
Context and background

The procurement of antiretroviral drugs (ARVs) is a critical component of USG support to the Uganda Ministry of Health's (MOH) national program. By September 2009, an estimated 126,000 patients were receiving their ARV drugs with PEPFAR funding. This represents approximately 60% of all patients currently on treatment in the country. USG support is particularly critical given the relatively low levels and unreliability of funding from the Global Fund (GF) and Government of Uganda (GOU) for ARV procurement. In the last two years PEPFAR allocated $80 million for ARV drugs, the Clinton Foundation $28 million, and the GF $2.2 million. The GOU allocated $12 million for procurement through the new local manufacturer, Quality Chemicals, and its parent company Cipla (India).

USG resources, through the Supply Chain Management (SCMS) project, supported the MOH's AIDS Control Program (MOH-ACP) to undertake the first national ARV quantification that would enable the GOU to plan and mobilize resources to meet ARV requirements in the period 2009-2014. The Procurement and Supply Management Plan (PSM) for the Round 7 HIV/AIDS GF grant was successfully submitted and in July 2009, the GF announced a resumption of "normal" funding to Uganda with the release of an initial $4.25 million to procure urgently needed ARVs. The GF grant has approved a total of $33.9 million for ARV procurement over the next two years. The GOU has allocated approximately $15 million in the next fiscal year to buy ARVs from Quality Chemicals, which is proceeding with obtaining WHO certification. It is hoped that over the coming years the disbursements from both funding streams are stabilized to enable the USG and national program to better plan procurements and eliminate the past problems with stock outs of adult first line regimens. This is particularly important as Clinton Foundation donations of adult second line and pediatric treatment are phased out.

Accomplishments and challenges since last COP

During this time there were periodic shortages of GOU supplies and delays in GF ARV procurement. In support of the national ART program, fifteen USG partners procured and provided uninterrupted supplies of ARVs for treatment of adults and children in MOH and NGO hospitals and health centers around the country, providing a lifeline for these thousands of patients in the face of these stock-outs.

Concerted efforts to rationalize services and seek efficiencies in the program are underway. A USG team participated in workshops on the cost of ART scale-up, members of the PEPFAR treatment technical working group (Elliot Raizes and Laura Porter) visited Uganda, and a rapid ART costing exercise to project national ARV and non-ARV costs for the next five years was undertaken. In FY08, 76 percent of ARV drugs procured through PEPFAR were generic, up from only 44 percent in FY07. Significant savings

have since been realized as a result of FDA's initial approval for generic TDF+FTC (Truvada) and because of individual program reviews to ensure procurement of best value generics and formulations where possible. Other examples include consolidating more partners under SCMS for procurement and negotiating reductions in cost with product manufacturers and local entities that provide storage and distribution services.

Product Selection

The 2008 National ART Treatment Guidelines recommended regimens are:

Adult 1st line:
Preferred AZT/3TC + NVP, AZT/3TC + EFV
Alternative 1 TDF/FTC + NVP, TDF/FTC + EFV
Alternative 2 d4T/3TC + NVP, d4T/3TC + EFV

Adult 2nd line:
Preferred ABC/ddI + LPV/r, TDF+3TC or FTC+ LPV/r
Alternative 1 ZDV+ddI + LPV/r, ABC/ddI + LPV/r, AZT+3TC + LPV/r
Alternative 2 ABC/ddI + LPV/r, TDF+3TC or FTC+ LPV/r

Pediatric 1st line:
Preferred d4T/3TC + NVP, d4T/3TC + EFV
Alternative 1 AZT/3TC + NVP, AZT/3TC + EFV
Alternative 2 ABC/3TC + NVP, AZT/3TC/ABC

Pediatric 2nd line:
Preferred ABC/ddI + LPV/r, TDF+3TC or FTC+ LPV/r
Alternative 1 ABC/ddI + LPV/r, TDF+3TC or FTC + LPV/r
Alternative 2 ABC/ddI + LPV/r, ZDV+ddI + LPV/r

In compliance MOH treatment guidelines, USG partners have increased use of TDF-based regimens and almost all have switched to generic TDF+3TC ($13.25/month) instead of Truvada ($26.25/month) for first line treatment. The MOH has had challenges in the coordination and communication of the revised national treatment guidelines and policy changes. For example, the MOH recommended phasing out d4T while there was more than one year supply in stock at the National Medical Stores (NMS) and then had to reverse the policy because of central level stock outs of alternative ARVs.

The 2008 National ARV Quantification showed that many ARV regimens and formulations were in use for ART in the country, with PEPFAR-supported programs having the widest variety of them. Among PEPFAR partners, two programs used 1 to 5 different regimens, five partners uses 6 to 10 regimens, four used 11 to 15 regimens, and three used more than 20 different regimens. The use of multiple regimens was partly attributed to the maturity level of a program and ART research studies using unique regimens but as not necessarily in line with the national treatment guidelines. Partners also used many ARV drug formulations within a given regimen, e.g., triple FDCs, dual fixed dose with another medicine, and individual single medicines. Some partners also procured the same adult second line and pediatric ARVs that the Clinton Foundation donated a full supply of to the national program. These issues will be addressed in the coming year.

Forecasting/Quantification

National treatment targets call for a continuation of Uganda's rapid scale-up of care and treatment services with differing scenarios of the pace of scale-up. The National Strategic Plan 2007/8-2011/12 has

a target of 240,000 on ART by 2012 while the 2008 MOH national quantification exercise projected requirements for a target of 406,500 on ART by 2012 (at a cost of $100 million for ARVs alone). Whatever the scenario considerable resources will be required to further extend coverage of ART as well as maintaining current patients on treatment and scale-up must be consistent with the national service capacity and available financial resources.

The MOH plans for ART expansion have not occurred as rapidly as expected primarily because of limitations in service delivery capacity and supply chain capacity to finance, procure, and manage greater volumes of ARV drugs. Overly ambitious projections of the scale-up of pediatric treatment and data inaccuracies has led to overstocks at NMS of some pediatric drugs, procured by the Clinton Foundation, which will expire before they can be used.

ARV forecasting and supply planning has been complicated because of uncertainty in delivery of GF and MOH supplies and the inability to accurately validate patient numbers in MOH sites, particularly when sites are shared by more than one partner. In times of MOH ARV shortages, health workers over-report patient numbers to ensure they have a buffer stock and/or shift MOH patients to USG-procured drugs, either permanently or on a temporary basis. To overcome these problems some PEPFAR partners have been planning for their patient numbers plus an additional percentage to accommodate MOH patients; this may reduce treatment interruptions but it also can lead to stock imbalances (over-stocks).

PEPFAR partners supported by SCMS quantify their ARV requirements using the same software and morbidity-based methodology as the MOH, which is based on classification of the patient data by line of therapy, regimen used, actual drugs used and the projected number of patients expected to receive treatment or services within the forecast period. The software program "Pipeline" is used to plan the quantities and timing of shipments to maintain appropriate stock levels.

Procurement

ARV procurement for the national program is handled through several channels: the MOH procures directly from Quality Chemicals with GOU funds; a third party procurement agent is used for GF ARV procurements funded by GF; and the USG uses several approaches (described below). NMS, which has a GOU mandate to procure, store and deliver all essential medicines and health supplies for the MOH, has not yet been used to procure ARV drugs. Under the GF Round 7 HIV/AIDS grant agreement, NMS capacity will be assessed and areas strengthened as needed so that ARV procurements can be eventually conducted through NMS.

Importation, Warehousing and Distribution

All health commodities imported into the country, including donated products, must have a verification certificate from the National Drug Authority (NDA), for which it levies a fee of 2% (FOB value). Although the MOH has requested the Ministry of Finance to provide funds to cover these costs on donated products, these funds have yet to materialize and donors continue to pay them. No other significant issues have been identified regarding freight/forwarding and importation of ARV drugs.

NMS and Joint Medical Stores (JMS, a joint venture of the Protestant and Catholic Medical Bureaus) warehouse and distribute all ARVs for the national program. Most PEPFAR partners also use JMS because they are well established and show good performance (which is due in part to the support received by SCMS in reorganizing their warehousing operations and implementing a new warehouse management information system). Partners have an agreement with JMS to provide warehousing, picking, packing and distribution to individual ART sites. The agreement includes provision of adequate storage conditions including cold-chain, quality inspections and documentation of goods received, monthly reports on opening stock balances, issues, losses and stock adjustments are issued and or

expiries are reported on a monthly basis. Six PEPFAR partners have a similar agreement with Medical Access Uganda Limited. Medical Access was established under the UNAIDS Drug Access Initiative as a not-for-profit company to procure drugs at reduced cost from participating pharmaceutical companies and to sell the products to accredited facilities.

Logistics Management Information System

The national program uses a Logistics Management Information System (LMIS) that gathers data on ARV inventory levels, patient numbers, and numbers of expected new patients on a bi-monthly basis at all reporting sites. At the central level the system tracks inventory based on the issues data; logistics data are then compiled and used to distribute supplies to each site. The national LMIS faces challenges with reporting. On average only 67 percent of facilities submit their bimonthly reports; if facilities do not report they do not get resupplied causing stock-outs. The problem is due in part to understaffing at facilities. The same LMIS is used by SCMS-supported partners but they report to JMS. All ART sites have been trained and report regularly and supervisors provide support.

Goals and strategies for the coming year

1. In 2010, in support of the national program, the USG will continue to rationalize product selection by working with PEPFAR partners and procurement agents to standardize procurement of medicines and formulations across programs so that they are in closer alignment with MOH treatment guidelines and achieve the best value for money, i.e., generic drugs and fixed dose combinations. Programs that will procure adult second line ARVs previously supplied by Clinton Foundation (which ends its support for these products in December 2009) will procure those same medicines and formulations at equivalent prices where possible to ensure continuity in drug treatment and cost savings.

2. The USG will provide technical support to strengthen the Government of Uganda's forecasting and procurement capability and support roll-out of the national three-year procurement plan to enable the government to develop and maintain the capacity for long-range planning, thereby preventing ARV stock-outs and emergency procurements. PEPFAR partners will continue to receive technical assistance in quantifying and updating their annual ARV procurement requirements from SCMS and Medical Access. (USG support to strengthen the national supply chain is covered in the Health Systems Strengthening technical area narrative.)

3. In FY10, $45 million is requested for ARV drug procurement. These funds will enable the program to procure all of the ARV drugs needed to treat the 126,000 currently enrolled PEPFAR patients for a 15-month period. The funds will also be used to enroll about 30,000 new patients for whom treatment can be maintained over the coming years.

These projections take into account expected flat-lined budgets, the need for a buffer stock, and the need to absorb the full costs of adult and pediatric drugs previously provided by Clinton Foundation. This level of scale-up is made possible through realization of cost savings, e.g., fall in drug costs and cheaper generics, and the use of carry-over FY08 and FY09 ARV drug funds. The Clinton Foundation will continue to procure and import pediatric first and second line ARVs for the national program, including PEPFAR partners, through December 2010.

Between 20-25% of the $38 million budget ($7.6-$9.5 million) will pay for handling fees including freight and insurance, the 2% NDA verification fee, warehousing and distribution costs (5-10%) and procurement service fees (e.g. , the SCMS fee of 5% of CIF). Where applicable, costs for in-country procurement personnel are also included in the ARV drug budget. In FY10, all but one PEPFAR partner, Catholic Relief Services (CRS), will use the services of SCMS (7 partners) or Medical Access (6 partners) to procure their ARV supplies. CRS will continue to procure its own ARV drugs directly from suppliers.

4. The USG, in collaboration with the GF and other donors, will provide technical support to strengthen the national forecasting and procurement capability and the roll-out of the national three-year procurement plan for essential medicines and health supplies to enable the government to develop and maintain the capacity for long-range planning. Technical and other support will also be provided to improve the security, efficiency and cost-effectiveness of NMS warehousing and distribution systems with the ultimate aim of integrating ARVs fully into the national warehousing and distribution system. USG will also continue to dialogue with the GOU to honor their commitment to pay in-country fees and levies for donated health commodities.

Staffing

In FY10 approximately 2 USG FTE will work in this technical area.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	7,404,187	
HMBL	3,218,000	
HMIN	1,002,500	
Total Technical Area Planned Funding:	**11,624,687**	**0**

Summary:
Blood safety

Context and background

The Blood Safety Program is implemented by the Uganda Blood Transfusion Service (UBTS), a semi-autonomous institution under the Ministry of Health (MOH) and the Uganda Red Cross Society (URCS), a charitable, not for profit organization. About 100,000 patients receive blood or blood products annually at 160 major facilities in the country. Nearly half of the recipients of blood or blood products in Uganda are pediatric, a quarter are obstetric, and the rest are medical and surgical patients.

The Government of Uganda (GOU) is committed to ensuring elimination of HIV transmission through blood transfusion. The blood safety objective in the National HIV & AIDS Strategic Plan 2007/8 - 2011/12 (NSP) is to maintain 100% blood transfusion safety. Key goals of the blood safety program include: 1) retention of low-risk, voluntary, non-remunerated repeat blood donors; 2) care referrals for HIV-positive donors; 3) collection, testing, storage and distribution of blood products; 4) staff training; 5) quality assurance; and 6) monitoring and evaluation. The program has developed national blood transfusion safety policies and strategies. The USG supports infrastructure, transport, supplies and equipment to ensure that program goals are met.

The program, however, is challenged to meet the increasing demand for blood and blood products mainly due to a rapidly growing population and upgrading of lower health facilities to Health Center IVs and hospitals. Currently the UBTS program meets only 85% of the country's blood transfusion needs. Blood transfusion needs are expected to grow by 20% annually to reach an estimated 200,000 units of blood in FY10.

Accomplishments since last COP

Community mobilization and education for donor recruitment was jointly implemented by the UBTS and URCS. These institutions have built a countrywide blood recruitment network in communities, schools and workplaces. Access to and regular communication with individuals and communities has greatly improved with the recruitment of additional staff and the purchase of vehicles for program field activities. The program has worked collaboratively with URCS and the blood safety technical assistance group, Sanquin Consulting Services (SCS), to improve blood donor selection and counseling.

Compared to new donors, repeat donors have a lower HIV sero-prevalence. Repeat donors currently represent 58% of all donors. Recruitment and retention of voluntary, non-remunerated HIV-negative donors through URCS supported blood donor clubs is particularly vital for running a successful blood safety program. This has been enhanced through increased use of electronic and print media, mobile phone text messages, and scheduled visits by counselors.

Quality assurance activities that insure maintenance of high standards for blood collection, testing, storage, and distribution are critical to the program's strategy. UBTS tests all transfusion blood for HIV and other transfusion-transmitted infections (TTI) (e.g., hepatitis B and C and syphilis) at the seven regional blood banks. Related quality assurance manuals have been completed, along with staff training and supervision.

CDC/Uganda has provided technical assistance for strengthening the Management Information System (MIS) for the program. Data reporting forms have been revised to enable the program to generate MIS reports for all vital activities on daily, weekly, and monthly basis. Computerization of laboratory equipment is now in progress.

Inadequate infrastructure and space at the regional blood banks and the national referral laboratory remain a major challenge to the expansion of the program. REDACTED.

In FY09, varying approaches were used to train all cadres of program staff in the country in line with the national blood safety training program. In collaboration with SCS, a Masters Degree training program in Management of Transfusion Medicine for regional blood bank directors continued to be offered in the Netherlands. Additionally, UBTS and SCS worked to finalize blood safety course modules for adoption in pre-service curricula of medical training institutions, with the aim of fostering appropriate clinical use of blood and blood products in the long term. The program continues to conduct regular continuing medical education seminars with clinical staff at major teaching hospitals along with support for formation of, and regular interactions with, hospital transfusion committees.

Goals and strategies for the coming year

In FY10, the USG will support the completion of the UBTS strategic plan and the implementation of pertinent sections of the plan in line with PEPFAR goals and objectives. The USG will continue to support activities to improve blood donations from regular voluntary non-remunerated donors; to ensure safety through a centralized testing system by the UBTS; and to promote appropriate use of blood and blood components among the main beneficiaries.

Although not the main focus of the program, thousands of potential and repeat donors benefit from the HIV and TTI prevention counseling and referral to HIV prevention and care services. In particular, the USG will support UBTS to foster linkages with other HIV prevention activities through integration of prevention education in donor recruitment activities.

To avoid the overdependence on a sole funding source, UBTS will be supported to diversify its funding base by soliciting additional funds from other international development and funding agencies. The USG will also continue to support UBTS efforts to develop and maintain the capacity for a robust program monitoring and evaluation system, and its use of results for ongoing improvement of program performance.

Medical Male Circumcision

Context and background

Trials conducted in South Africa, Kenya and Uganda from 2005 to 2007 demonstrated that adult medical male circumcision (MMC) reduced the acquisition of HIV by 50-60%. WHO and UNAIDS approved MMC as an efficacious HIV prevention intervention. The NSP recognizes the need to integrate MMC in the comprehensive package of HIV prevention services in line with a comprehensive ABC approach.

About 25% of adults in Uganda are circumcised for religious cultural, customary and health reasons. Many districts would like to provide MMC services but lack adequate equipment, supplies and skilled human resources. Since 2007, USG has supported Rakai Health Sciences Program (HSP) to provide voluntary MMC services and train health workers including medical officers, theatre nurses and counselors. The program provides resource material to all trainees and surgical kits for clinicians and medical officers. USG will continue to support the MOH and partners strengthen system for integration of MMC services, including finalizing the MMC policy and implementation guidelines, media campaign, training curricula, infrastructure improvement and procurement of equipment and supplies.

Accomplishment since last COP

With USG support, Rakai HSP has trained 120 health workers, including surgeons, theatre nurses and counselors for various programs. REDACTED. Post-training follow-up and mentoring has been strengthened by developing a protocol for supportive supervision and the procurement of two field vehicles. USG has also supported the Makerere University Walter Reed Project (MUWRP) to pilot a large MMC service delivery program in Kayunga District Hospital. REDACTED. It worked with the District Health Office to develop IEC materials and implement a robust media campaign. By March 2009 (SAPR), close to 300 adults and adolescents had received MMC services, with only three minor adverse events reported. Lessons from the program in Kayunga will be documented and used to inform development of technical guidelines for introducing MMC services in other districts. In preparation for scaling-up MMC services, many USG supported programs have sent their staff for training at Rakai HSP. REDACTED.

Goals and strategies for the coming year

1. Increasing coverage for voluntary MMC services
In FY10, the USG will support implementing partners to integrate MMC service into their comprehensive package of HIV/AIDS services. USG has prioritized MMC scale up to start in districts with high HIV prevalence. Service provision will primarily target adults and adolescent men in the general population and high-risk groups. Many health facilities have reported an increase in the number requests for MMC surgeries for children and adults. In FY10, USG will support MOH and partners to respond to this need by supporting staff training, infrastructure improvement and media campaigns. In addition to promoting facility-based MMC services, USG will support mobile outreach services especially for the hard to reach areas. The US DOD will support UPDF to increase the number of fully equipped MMC sites for the military from four to six.

2. Training of MMC service providers
A number of implementing partners have set MMC targets for adults and children. To achieve these

targets and ensure safe MMC services, the MOH has to quickly finalize training guidelines and rapidly roll out service provider training for various cadres of providers. USG will continue to support the Rakai HSP to continue training health workers for various programs and work with MOH to establish other MMC training centers to meet the increasing demand for service provider training. Program that have successfully implemented MMC service provision in the public sector, like MUWRP, will provide technical placement and mentoring support to those initiating program activities for the first time

3. Integrating MMC with VCT and prevention programs
The USG will promote MMC for HIV-negative men within VCT settings. We will integrate MMC education to all male VCT clients in the door-to-door HCT programs and support all facilities offering MMC services in the prioritized districts to provide comprehensive prevention package. Implementing partners will ensure an efficient referral system and linkages to other services such as STI services, HIV care and treatment, within each facility offering MMC.

Injection safety

Context and background
Medical injections are estimated to account for 0.1% of the total number of new infections in Uganda (MoT). Although this mode of transmission is not a major driver of the HIV/AIDS epidemic in Uganda, medical transmissions deserves continued attention because of their potential for spreading HIV and other infections to patients and health care workers. Additionally, a high use of injections has been documented in Uganda (3 per person per year), which also raises the important issue of prevention of unnecessary injections and decreasing associated risks.

The main goals of the injection safety programs are to prevent the transmission of HIV and other blood borne pathogens by reducing the number of unsafe and unnecessary injections. This risk can be reduced drastically by establishing and implementing national policies for rational and safe use of injections. This can be done through a comprehensive injection safety strategy of capacity building and training of health workers, strengthening injection safety commodities supply and management systems, applying behavior change communication strategies aimed at communities and health care providers, and improving health care waste management.

Accomplishments since last COP

Through Track 1 funding, USG supported the Making Medical Injections Safer (MMIS) project to assist the MOH in preventing medical transmission of HIV through rapid reduction of unsafe and unnecessary injections. The key strategies for the program were improving service provider skills; behavior change and communication aimed at reducing unnecessary injections; improving the logistics system to ensure full supply of injection commodities; and improving health care waste management. Consistent with the MOH plans of introducing syringes with re-use prevention features nationwide, USG supported the scale-up of interventions in twenty-five districts.

USG has supported a comprehensive approach to injection safety to strengthen national systems including policy development, and support to the MOH supervision of injection safety by health care providers.

FY09 was the last year during which the centrally funded MMIS project was operational globally and in Uganda. USG will continue to support MOH to strengthen injection safety practices and sustain gains from MMIS project, through field funds.
Staffing

In FY10, approximately 2 USG FTE will work in this technical area.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	16,817,113	
Total Technical Area Planned Funding:	**16,817,113**	**0**

Summary:
Context and Background

HIV counseling and testing (HCT) is an important intervention for raising awareness of HIV status, promoting behavior change, and diagnosing HIV infection. HIV counseling and testing is also an entry point for universal access to HIV prevention, care, and treatment. The objectives of the national HCT program are to identify those in need of HIV care and treatment, and to provide specific prevention education, including stay-negative messages and counseling based on knowledge of HIV status, with special emphasis on most-at-risk populations (MARPs) identified from the Uganda HIV Prevention Response and Modes of Transmission Analysis (UAC 2009). High-risk categories include discordant couples, commercial sex workers (CSWs) and their partners, transportation workers, the uniformed services, and fishing communities. In alignment with the National HCT policy and strategic priorities, PEPFAR in Uganda supports a mix of HCT approaches including: 1) Voluntary Counseling and Testing (VCT) with outreach; 2) Provider Initiated HIV Counseling and Testing (PICT); and 3) Home-Based HIV Counseling and Testing (HBHCT).

Expanded HCT service provision has been facilitated by an enabling GOU HCT Policy that allows use of multiple HCT approaches, task-shifting to lay counselors and use of serial rapid HIV testing algorithms.

Despite these achievements, significant challenges remain including inadequate health workforce, weak logistics management system for procurement and distribution of HIV test kits and related supplies, and poor coordination among implementing partners.

Accomplishments since last COP

In FY09, PEPFAR HCT activities aimed at increased access to quality HCT with specific emphasis on couples and high-risk groups, expanded PICT service provision at district hospitals and lower level health facilities, and expanded HCT for family members of clients in care and treatment. Between October 2008 and March 2009 (SAPR), 885,339 individuals received HCT services from USG supported site (56% of annual target) through 2,225 service outlets. Overall, there has been increased access to HCT with a five-fold increase in the number of clients receiving HCT services from 308,730 clients served in FY04 to 1,613,728 in FY08.

In addition, progress has been made in mitigating the bottlenecks that hamper universal access to HCT. These include efforts to address the quantity and quality of health workforce through recruitment of new health workers by the GOU and training of existing staff to provide quality services, harmonizing the logistics management system for procurement and distribution of HIV test kits and related supplies, and improving coordination among implementing partners to reduce overlaps.

Goals and strategies for the coming year

In FY10 USG will support the provision of HCT services to 2,099,201 individuals (a 32% increase over the

FY09 target) through 2,450 outlets (a 10% increase in number of sites). Quality HCT service provision will be expanded to raise awareness of HIV status, enhance prevention and optimize entry into care and treatment.

Specifically PEPFAR partners will: 1) increase access to HCT services for couples; 2) increase access to HCT services for MARPs; 3) scale-up HCT services in public health facilities; 4) expand HCT services in work places; 5) strengthen integration of HCT services with sexual prevention, medical male circumcision, TB services, and care and treatment; 6) strengthen quality service provision through improved HCT commodities and supplies systems, quality assurance and training of service providers.

The USG will support targeted HIV testing programs that promote “Know Your Status”, targeting married and cohabiting couples. A couple communication and HCT strategy has been designed through a participatory process to reach at least 5,000 couples within 12 months. Service providers will receive refresher training for couples counseling to be able to support the needs for couples with special emphasis on discordant couples.

High prevalence communities in northern and central Uganda will be reached through several strategies including district and regional home-based HCT reaching 100% of households. VCT with outreach activities will be provided to specific MARP communities, including fishing communities, CSWs and their clients, and truckers. Service provider skills will be strengthened to enhance post-test counseling with emphasis on HIV status disclosure and partner testing, referral linkages to care, treatment, and follow up, within facilities and communities will be emphasized for all those testing HIV-positive. For those testing HIV-negative, risk avoidance/reduction counseling and linkages to post-test clubs (PTCs) and prevention programs will be made.

Through comprehensive district based programs, PICT will be scaled up to cover all regional and district hospitals and more lower level health facilities so that more patients seeking care in public and private health facilities have access to HCT and the opportunity to know their HIV status. This will be done within the context of strengthening GOU health systems for sustainability and ownership of HCT services.

Care and treatment partners will be supported to strengthen their outreach to family members of clients in care and treatment through facility-based referral and targeted home-based approaches. In family-based HCT, index HIV-positive clients serve as entry points to members of entire households, including spouses and children. Family based HCT is beneficial in supporting disclosure of HIV status, obtaining support for discordant couples and promoting adherence. Care and treatment partners will continue to support quality post-test counseling and referral to post-test clubs to enhance care and on-going support for those diagnosed with HIV infection.

The USG utilizes an integrated approach to promote HCT services. Community mobilization is integrated into all prevention, care, and treatment programs. Integration of HCT services will be strengthened for other core program areas including TB/HIV, male circumcision, prevention, care and treatment through training of service providers in integration of services, improved monitoring of clients, ensuring adequate supplies and effective referral and linkages within and between service delivery sites. HCT for OVCs and the use of pediatric clients as an entry points to households will be strengthened to enhance family-based care and support.

Procuring and distributing test kits and related medical supplies is largely the mandate of the MOH's National Medical Stores (NMS). Most public health facilities receive their test kits through the NMS system, while Joint Medical Stores (JMS, a joint venture of the Protestant and Catholic Medical Bureaus) manages supplies for NGO sites. The Global Fund, UNICEF, Clinton Foundation and other donors pool their donations, with 80% going to NMS and 20% to JMS. In prior years, inadequate funding for HCT supplies, limited data for forecasting national needs, and limited NMS capacity to procure and distribute

HCT commodities to public health facilities, led to national and facility-level stock outs. In FY10, a newly-awarded project, "Securing Ugandans' Right to Essential Medicines" (SURE), will continue to strengthen supply chain management of all HIV/AIDS commodities, including HCT supplies, by working with key stakeholders (including MOH, the Central Public Health Lab, NMS, JMS, and other donors) to develop a master implementation plan to strengthen the entire supply chain, including policy, regulatory and financing reforms; technical revisions to integrate and modernize supply chain management for all essential medicines and health supplies; and capacity building at all levels in priority functions such as procurement, quantification, warehousing, distribution, and information management. In its first year of operation, to avoid disruptions in supply, SURE will continue to maintain the existing supply chain information management system for HCT and other laboratory commodities while carrying out the systems and options analyses to identify feasible, cost-effective ways to improve supply chain management performance at central and district levels. Through direct funding to National Medical Stores, the USG will increase support for procurement of HCT commodities to meet the increasing demand generated by expanded HCT programs.

In FY10, the USG will continue to support task shifting through the training and use of lay counselors, including people living with HIV/AIDS (PLWHAs), to bridge the human resource gap. The MOH will develop guidelines and protocols that define the working relationship between the public health facility health workers and the PLWHA networks in the revised HCT policy.

In FY10, the USG will contribute to the participatory process of strengthening the national MOH HCT policy committee, called "CT 17". In addition, the USG will support the HCT policy review process to accommodate the changing HCT environment including the key areas of evaluation of HCT algorithms, repeat testing for individuals testing HIV-negative, and counseling and referral for MARPs, and HIV counseling and testing in male circumcision service delivery.

In FY10, quality assurance, supportive supervision, equity considerations, and rationalization of HCT service provision by district and site will be enhanced through comprehensive district or region based projects to avoid duplication of services. Implementing partners will be supported to strengthen reporting requirements to satisfy monitoring and program improvement. New technologies will be used for Quality Control/Assurance, including a move from dry blood spots to dried tube specimens for transporting samples.

Over the next five years, the USG will work with national stakeholders to increase equitable and rational provision of high quality HCT services with enhanced targeting and support for couples and MARPs; increased regulation and private sector involvement in HCT service provision; improved HCT policy dissemination; increased operational research and increased GOU ownership of HCT programs.

Staffing

In FY10, approximately 5 USG FTE will work in this technical area.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	12,100,444	
Total Technical Area Planned Funding:	**12,100,444**	**0**

Summary:

Overarching approach to HSS

PEPFAR funds for focused interventions in Health Systems Strengthening are largely in the areas of human resources for health (HRH), health information systems (HIS), governance /leadership (G/L) and supply chain management (SCM), with less emphasis in the area of health finance (HF). HRH and HIS efforts are described under the HRH and SI Technical Area Narratives. Both L/G and HF also receive substantial support through non-PEPFAR USG and non-USG donor mechanisms which have greater competitive advantage. USG also tries to maximize intentional spillovers of non-HSS focused activities to strengthen health systems (HS), as described as other activities or implementation approaches in other technical areas. Finally, the USG team actively leverages efforts to strengthen all national systems that impact on health through relevant national coordinating and technical bodies, such as the Health Policy Advisory Committee, Uganda AIDS Commission, Health Development Partners and AIDS Development Partners.

In FY09, the USG received technical assistance from headquarters and outside consultants for HSS; this included a HS assessment workshop. Because of the large number of HSS related assessments that have been (and continue to be) conducted in Uganda, the USG team decided against conducting its own full HS assessment. Instead, a HS desk review and stakeholder analysis were conducted. The priority recommendations coming from the various existing HS assessments underpin key GOU national strategic development plans that guide the activities of PEPFAR and other USG programs in the areas of health and education, economic growth, and the promotion of democracy and governance.

The position of the GOU is that donors should strengthen and utilize national systems in providing support to the health sector. In the last five years, PEPFAR has played a vital role in improving the health of HIV-infected and affected Ugandans and strengthening HIV/AIDS service delivery and other supporting systems. Key stakeholders interviewed in early 2009, however, held differing opinions on how PEPFAR has impacted on health systems. The concern of many was that the positive impact in HIV/AIDS was realized at the expense of building an integrated health system and that most of the investments may not be sustainable beyond current funding. The complex task of understanding the past and future system wide effects of PEPFAR is the focus of multiple current and planned studies.

The largest barrier to USG HSS and sustainability efforts is extremely weak host government leadership and commitment at the central level, and inefficient administrative and fiduciary mechanisms. As a result, USG HSS efforts have increasingly focused on building line ministry and district level management and administrative capacity to better own their programs, integrating service delivery and associated systems (e.g., commodity procurement, infrastructure development, clinical training, laboratory capacity strengthening, and strategic information) initiatives with host government systems, and building the capacity of civil society and the private sector to engage all levels of government to improve the health system. The upcoming presidential elections scheduled for March 2011 have introduced another complex consideration in planning HSS efforts.

Description of HSS areas

Governance/Leadership

PEPFAR support is focused on improving effectiveness of the national and local governments in planning and managing health resources for HIV/AIDS and increasing civil society and private sector capacity and involvement in the provision of quality HIV/AIDS treatment, care and prevention services. At the national level, USG will continue to provide the MOH with financial and technical support for the development and dissemination of policies, standards and technical guidelines that are instrumental to the delivery of quality health services. Also in FY10, implementation of prevention, care and treatment service delivery programs will increasingly move away from direct NGO implementation to NGO support for

implementation by district governments and other host government entities, through mechanisms such as conditional subgrants. This implementation approach would be based on work plans developed by District Health Offices: use of a single district work plan will ensure that district-based programs active in districts are not duplicative. Two USG PEPFAR partners whose mechanisms are ending in FY09, EGPAF and PREFA, have successfully applied this model for PMTCT and pediatric care and treatment services.

Support will also continue to the GOU and civil society to ensure that Global Fund (GF) Round 7 HIV/AIDS funds for non-governmental partners are channeled through the Civil Society Fund (CSF) to ensure equitable access to AIDS grants by local district and community based organizations. USG provides support to CSF partners to build their financial and technical management capacity to effectively implement their activities. Continued roll-out of the government's HIV/AIDS workplace policy in the private sector will be supported through assistance to mid-to-large size employers to establish and or improve workplace policies, with a particular focus on supporting the delivery of prevention programs and improving access to critical care and treatment programs for employees, their families and respective communities. The Makerere University School of Public Health fellowship program will also continue to train public health professionals in leadership and management skills.

The commitment of local governments to improving and sustaining health services is hindered by poor governance, complacency, low remuneration levels, lack of training, lack of supervision, and leadership and management deficiencies. To strengthen the decentralized system of financing and governance, USG efforts will continue to support improved district-based HIV/AIDS planning, management, implementation and monitoring through key political and technical HIV/AIDS structures. Key outcomes will be improved management, implementation and coordination of resources and service delivery at the district and sub-county level.

Examples of focused interventions for G/L include improving capacity of civil society organizations (CSO) to accountably manage and implement HIV activities, increasing ART accreditation of private sector health facilities, and improving local government capacity to plan and manage HIV/AIDS services. An example of an intentional spillover for G/L is the use of an implementation strategy for service delivery programs, which is fully integrated with host government health systems. Targeted leveraging in G/L occurs through other USG support to other USG/USAID activities that aim more widely to improve the quality and integrity of governance through programs that strengthen Parliament and civil society, encourage open public debate about key issues of governance, and strengthen institutions and systems that combat endemic corruption.

PEPFAR mechanisms supporting G/L include: Ministry of Health, Central Public Health Laboratory, FMA/CSF (TBD/TMA/CSF), HIPS (Private Sector), MUSPH, NUMAT (JSI), multiple TBD prevention, care and treatment mechanisms, STAR-East, STAR-East Central, and STAR-South West

Supply Chain Management

PEPFAR support will expand upon the progress made over the past five years by addressing the financial, legal and regulatory issues impacting on the national supply chain system and providing substantial support for the first time to local governments to improve their performance in procuring, managing, and distributing health commodities. To contribute to the overall goal of ensuring that Uganda's population has access to adequate quantities of good quality Essential Medicines and Health Supplies (EMHS), the newly-awarded project-- Securing Ugandans' Right to Essential Medicines (SURE)-- will work with all key stakeholders during FY10 to develop a master supply chain management implementation plan. The consultative process includes an initial Policy Options Analysis (POA) to identify specific reforms needed in policies affecting the supply chain (e.g., financing and cash flow, product selection, procurement, distribution, HR, three-year rolling procurement plan) and define the specific changes needed to remove roadblocks, determine the feasibility of proposed changes, and obtain

necessary commitments for change. The POA combines political mapping, indicator-based measurement of system performance and analysis of operating costs and efficiency of the supply chain. The outcome will be stakeholder consensus and memoranda of understanding with key GOU agencies and donor partners that clearly define each relevant agency's role, responsibilities, milestones and timelines which correspond with the master implementation plan.

Also in FY10, SURE will gather information on district-level baseline indicators and design and pilot an integrated supply chain and logistics management information system in selected districts. The integrated supply chain model will feature cost-effective innovative solutions to minimize stock-outs and leakage and stronger linkages between the central level, the district, health sub-districts, and facilities. NMS will also receive support to improve procurement practices, central warehousing, transport and distribution. During this initial process SURE will ensure that existing services and programs, such as logistics data reporting for HIV/AIDS commodities, will be maintained with no disruptions.

For capacity building, a key focus will be on developing standard operating procedures for supply chain functions, including financial management and procurement. In FY10, GOU/MOH stakeholders will be trained on quantification procedures and NMS and MOH managers at central level will receive training on financial management and leadership and management. For later capacity building activities, SURE will develop and implement appropriate curricula for pre and in-service training in priority areas such as procurement management and organizational management and strategic planning for senior managers in the MOH and NMS.

The overall aim of the USG support is to leave a functional supply chain at central and district levels with the necessary tools, approaches, skills, and coordinating mechanisms that will allow the GOU to maintain and expand on these investments. This support also has linkages with HF (improving financial management skills, flow of funds) and G/L (improving legal and regulatory environment, management and leadership skills, and procurement practices).

The GOU, with GF Round 9 funds if approved, proposes additional support to improve distribution by procuring additional trucks for NMS, including one dedicated to ARV drug distribution. REDACTED. The GOU has also proposed to use World Bank funds to support roll-out of the same district-level interventions being implemented by SURE in 45 districts.

PEPFAR mechanisms supporting SCM: SURE, NMS

Health Finance

The focus of PEPFAR support in HF is to strengthen local government capability in financial management and fiscal accountability and effectiveness by providing performance-based grants and technical assistance. By putting financial resources and support as close to implementers and beneficiaries as possible, the USG's district-based service delivery and technical assistance partners aim to have more effective allocation of resources, increased accountability and more sustainable results. Under the new TBD grant mechanisms, initial funds will target HIV/AIDS and other health activities but support for other USG initiatives in democracy and governance, expanded support to Northern Uganda, economic growth and agriculture may be included, generating spill over effects in health systems strengthening and impact. Mechanisms which provide subgrants to districts, regional referral hospitals, or other government service delivery institutions will use a performance-based financing process to adjust subgrant amounts on a regular basis. Capacity at the district and health facility level is also being built to improve planning and systematic demand (the 'pull' system) for health-related commodities and resources which are supposed to be made available from central sources.

While there have been discussions about more sophisticated national HF schemes, such as health

system wide performance-based financing at the facility level or social health insurance schemes, host government capacity and commitment to these complex schemes is inadequate for their development in the near future.

Donor partners (UNAIDS, UNDP, WHO, DFID, WB) provide technical and financial assistance in the areas of national development planning, macro-economic environmental reform, sector budget support and mainstreaming. One key aim shared by all donors is to increase the GOU budget allocation to health (currently 9.6% of GDP), despite the fact that GOU has not made progress in this indicator during PEPFAR I. Tracking and planning of health resources and health service costs is support by other USG mechanisms through regular national health account assessments and cost modeling of specific health services, such as ART, HCT and PMTCT.

PEPFAR mechanisms supporting HF include: Multiple TBD district-based prevention, care and treatment mechanisms, NUMAT, STAR-East, STAR-East Central, STAR-South West, TBD/Strengthening Decentralization for Sustainability (SDS).

Staffing

In FY10, approximately 15 USG FTE will work in this technical area.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	13,800,894	
Total Technical Area Planned Funding:	**13,800,894**	**0**

Summary:
Context and Background

The Health Sector Strategic Plan II includes strategies to strengthen lab systems in support of the Uganda National Minimum Health Care Package. Despite efforts by stakeholders over the past 5 years, little progress was made in developing a National Health Laboratory Services Policy (NHLSP) until recently. Lab services are available from Health Center (HC) levels III and IV, through district, general and regional hospitals to national reference hospitals. The Central Public Health Laboratory (CPHL) coordinates training, quality assurance (QA) and logistics in addition to its function as a national reference lab. There are lab services at 12 Regional Referral Hospitals. Each group of districts has one referral hospital, 4-5 HC IVs and 5-10 HC IIIs. There are also private not-for-profit and private for-profit hospitals and clinics.

HIV rapid testing (RT) is offered at most health facilities and ART is available at more than 300 sites. USG is the major provider of support to the lab sector. No single MOH department is responsible for lab services and as a result, management, coordination and supervision are poorly defined. CPHL was provided with new premises and additional staff to address these shortfalls. District Health Offices (DHO) exist in all Districts but there is no regional administrative authority.

Before PEPFAR, lower-level health facilities were upgraded, often without labs. In FY07 and FY08, PEPFAR funding was allocated to renovate 17 HC IV labs, 19 District Hospital labs, 5 blood banks and the National Tuberculosis Reference Laboratory (NTRL) training lab. Six of the 12 regional hospitals now have access to functional, quality-assured laboratories.

Recruiting and retaining qualified staff in the districts is a major hurdle. To address this issue PEPFAR supports training schools, bursaries for field attachments, grants for tutors and sponsors uncertified staff to upgrade. HIV RT training of 2,000 providers was completed with follow-up assessment and refresher training. Training in dried blood spot (DBS) collection for the Early Infant Diagnosis (EID) program was merged with HIV RT training at 150 sites. The OGAC-Becton Dickinson (BD) partnership trained 64 sites in lab quality management using CD4+ external quality assurance (EQA) as a model system at the first 2 of 6 workshops. BD also provided TA to NTRL to conduct training in the TB specimen referral system as well as two regional trainings using the WHO/CDC/IUATLD Acid-Fast Bacilli (AFB) Direct Smear Microscopy training package. The CPHL Training Coordination Unit conducted the first of three workshops piloting the 'Job-Task-Based' training approach. Adequate numbers of staff to support scale-up of testing have been trained but attendance and retention remain major constraints.

Equipment for health facilities is largely procured using Global Fund resources but many labs lack essential, basic equipment while in others equipment is poorly maintained or there is no skilled operator; this is because no maintenance agreements or training were included in the procurement process. MOH has a Medical Equipment Maintenance Department but it is poorly resourced and staff lack the appropriate skills. Of 45 instruments procured in 2007 less than 50% are still functional. PEPFAR has procured equipment for more than 140 labs.

Lab commodities are procured through National Medical stores (NMS) but despite PEPFAR support, inventory and procurement systems remain inadequate. A credit line was established in 2005 to procure and distribute lab commodities through NMS and Joint Medical Stores (JMS) to meet 40% of the basic commodity needs of more than 1,000 facilities. For HIV RTs and accessories, funded separately under other budget codes, the figure is nearer 100% yet stock-outs continue. In an independent survey, the primary reason for a client not receiving a test result was test kit unavailability.

District Laboratory Focal Persons (DLFP) oversee lab services at the district level and are assisted by CPHL and the MOH QA Department, working with quality of care initiatives and EQA programs for HIV, TB and malaria. An assessment tool is used to evaluate lab services, management and QA, and SOPs for all levels of lab testing and quality management have been distributed. Record keeping in labs is poor and little attempt has been made to standardize lab record management. Supportive supervision is conducted quarterly at each of 1,002 labs, while EQA for CD4+ was conducted at 64 labs. During assessment visits, capacity for CD4+, hematology and chemistries, and the geographical location of the lab were captured using GPS.

Proficiency Testing (PT) schemes for HIV-related infections were scaled up to cover more than 400 laboratories nationwide. CPHL has accumulated a vast amount of data but it is under-utilized, due to IT staffing shortages. Most labs manage information manually and it is not utilized effectively for reporting and planning. Management of data at the national level is crucial for coordination of activities and staffing at CPHL was increased to analyze data, forecast needs and plan activities. A feasibility study, started in 2007, on the use of mobile telephony for data information sharing is still on-going.

The existing regulatory system for the lab sector remains weak. The Allied Health Professionals' Council, for example, mandated to register all lab practitioners and labs, is under-resourced and consequently many labs and their staff operate without proper registration. Nationally, there are no indicators or systems to assess lab performance; PEPFAR, however, has a system in place for monitoring and reporting the activities of all IPs. Health lab services are grossly under-funded both centrally and in the Districts – the little that is available from Primary Health Care funds is often misdirected.

Accomplishments since last COP

Against this background of challenges, USG has made significant progress in addressing both systems management and service delivery. Members of the Laboratory Technical and Advisory Committee (LTAC) were joined by the Foundation for Innovative New Diagnostics (FIND) to finalize the NHLSP which was launched in September 2009. The draft National Health Laboratory Strategic Plan to implement the NHLSP has been developed and PEPFAR has been instrumental in developing both. A Senior Technical Advisor (TA) to support MOH in developing an effective management structure to provide advocacy, stewardship and coordination of lab services was recently posted. A new Division of Laboratory Services will be created at MOH and the TA will be assigned to work there.

REDACTED.

PEPFAR continued to support technician training schools and to provide scholarships, training grants for tutors and a range of refresher courses in basic technologies, maintenance and lab management. BD has trained 94 staff at 84 sites in lab management. National HIV RT training has reached 1,700 but with high staff turnover and deficiencies identified in QC and PT exercises, re-training will need to be maintained. Training in DBS collection for the EID Program has expanded to nearly 400 sites but two problems have been highlighted; only 37% of HIV-exposed infants are tested for HIV, and only 48% of them ever received results; turnaround times for results are sometimes in excess of 40 days.

CPHL working with NTRL continued to roll out the AFB microscopy training package reaching 90 lab staff. BD has been providing TA to NTRL for the TB specimen referral system. TB microscopy sites in Kampala were mapped and the data is being analyzed in an attempt to improve the performance of the referral system. Mapping is being extended to the rest of Uganda. ArcGIS software is used to analyze data in an attempt to improve coverage of the country and surveillance for TB drug resistance (TBDR). In the reporting period 703 labs had 2 rounds of support supervision while a further 140 were visited once.

Lab equipment procurement is unregulated; the MOH Procurement Unit needs to define national standards and specifications and ensure there is sustainable, in-country capacity to maintain equipment. The NMS credit line for lab commodities has not been successful; commodities have not been ordered in good time and supplies have ‘gone missing’ during delivery. PEPFAR through CDC provided trucks to distribute lab supplies to the district stores but the supplies may wait there several months before collection. SCMS provided support to NMS in re-organizing warehouse operations, implementing a new warehouse and financial MIS’ and in procuring vehicle tracking devices. Despite these inputs from USG, the performance of NMS has been disappointing. The SCMS project is being replaced by ‘Securing Ugandan’s Right to Essential Medicines’ (SURE), which should have a wider mandate over NMS.

Uganda has no comprehensive QA plan to ensure the quality of lab testing. Different labs have developed IQA/EQA systems of their own with mixed success. CPHL coordinates the National External Quality Assessment Scheme (NEQAS) program and has now mapped the 84 sites with CD4+ capacity; the locations are being compared with care and treatment sites in order to identify gaps in the availability of CD4+ capacity. The HIV/AIDS Reference and Quality Assurance Laboratory (HRL) at UVRI participated in QA training at 400 sites and distributed 2,835 HIV PT panels to 476 public and private sites, providing refresher training where required. Improved performance is expected from HRL under new management and with the introduction of PT using dried tube specimens (DTS). QA for AFB smear microscopy continues with PEPFAR support and reached 250 labs. Specimens from TB patients not responding to therapy are forwarded to NTRL for resistance testing. The EID program reached over 403 sites and 36,000 DBS were sent to specialized labs for DNA PCR, the latter participating in an EQA scheme run by GAP/CDC. The EID program, however, is underfunded and the demand is high resulting in poor turnaround times. HIV drug resistance (HIVDR) activities have only recently been funded but the HIVDR lab is accredited and part of an international EQA scheme. Labs performing viral load (VL) measurements are part of international accreditation schemes that conduct EQA regularly. A systematic review of lab data management was carried out by CPHL with the goal of standardizing data collection, management

and reporting at low and mid-level laboratories and to introduce computers for records retention. Unfortunately, data-handling capacity at CPHL has decreased with the closing of the SCMS project.

Goals and strategies for the coming year

The NHLSP was launched in September 2009 and a draft of the Strategic Plan has been completed. The Policy, strategies for implementation and the goals for COP10 are fully aligned. PEPFAR has recently posted a senior lab systems policy advisor to work with top management at the MOH; duties include completing the 5-year strategic plan, guiding the re-establishment of a Division of Laboratory Services, advocating for the lab sector, liaising with the PEPFAR lab TWG and IPs and integrating IP lab strengthening activities into the national plan. The advisor will be a member of the LTAC and will provide TA to CPHL as it assumes a new role within MOH. REDACTED. To promote ownership and sustainability, the Advisor will encourage IPs to support the DHO with funding and technical assistance while rationalizing the number of IPs operating in any one district.

REDACTED. Training for lower-level health facilities will continue as before. BD will move into phase two of the project; 9 Ugandan trainers have been trained using the TOT curriculum offered by BD to teach the lab quality management curriculum 'Workshop in a Box' that will ensure sustainability of the project and facilitate regionalization of the training. The task-based approach to management training will be used to prepare for implementation of the WHO lab accreditation scheme targeting 50 labs in 10 districts for special attention and mentoring of staff. Technicians in charge of labs will undergo 2 weeks of sensitization and exposure to quality management at the CAP-accredited CDC lab. Re-training of lab staff will continue as HIV testing is expanded to reach 3,500 providers and new testing algorithms will be validated. The AFB training package will continue to be rolled-out targeting 1,600 lab staff. GIS/GPS mapping of the country to identify ART service gaps will be initiated. A new RFA has been posted that supports capacity building at 11 regional referral hospitals. PEPFAR will support MOH to define national standards for equipment and ensure there is capacity for maintenance and servicing. Strengthening of the national supply chain management systems under SURE, to include lab commodities, is described in the Health Sector Strengthening activity narrative. EQA for CD4+ counting is established under the coordination unit at CPHL and this program will be expanded to include hematology and serum chemistries. An assessment on the performance of the EQA program for HIV RT was carried out and recommendations made that will be implemented in FY10. The EID service will be reorganized to make more efficient use of the extant capacity for HIV DNA PCR and provided with additional funding to address the UNITAID phase-out in 2010. CPHL assessed the way lab data is managed at lower-level facilities and CDC IT and MOH Resource Center teams are developing standardized data recording procedures that can be computerized at the facility. Technologies for real-time transfer of data are being explored and a simplified list of performance indicators to monitor lab services is being defined. Threshold and EWI surveys for HIVDR will be conducted by the HIVDR coordination unit at UVRI. The CDC lab at UVRI works closely with MOH and PEPFAR IPs to ensure coordination and provides human, material and financial resources to plug gaps as they are identified.

Staffing

In FY10, approximately 34 USG FTE will work in this technical area.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	23,002,725	
Total Technical Area Planned	**23,002,725**	**0**

Funding:		

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	25,197,969	
Total Technical Area Planned Funding:	**25,197,969**	**0**

Summary:
Context and background

Uganda is one of the countries in sub-Saharan Africa that has been devastated by HIV/AIDS, malaria and tuberculosis. The three major diseases have led to a huge population of orphans and other vulnerable children. Children are also considered vulnerable if they live in child-headed households or on streets; if they have psychosocial or physical problems; if they are neglected, disabled, or under severe child labor; or are affected by conflict, war or natural disasters. As of 2009, out of an estimated population of 32 million people, there are 17.2 million children less than 18 years, 56 percent of the total population. Approximately 7.5 million of them, including orphans, are considered most vulnerable. According to the Uganda Population and Housing Census (UPHC) 2002, the Uganda Demographic Health Survey (UDHS) 2006 and Uganda National Household Survey (UNHS) 2005/6, more than 3 million children in Uganda live below the poverty line and are therefore vulnerable. Preliminary data from the OVC situational analysis (UBOS; October 2009) indicate that nationwide 14.6% (2.43 million) of children are orphans, 46% of whom are orphaned by AIDS. Paternal orphans are the most common form of orphanhood, 1.38 million children (8.2% of all children), while 509,575 (3.2%) and 535,759 (3.1%) children have lost only their mother or both parents respectively. There are an equal number of male and female orphans with the highest proportion being in the 15-17 year old age group. Regarding age and gender, the study shows that the most vulnerable age group is 15 to 17 years (65.5%). There is no significant gender difference in the vulnerability of children, males 50.6% and females 51.5%. In addition to poverty and orphanhood, other major causes of vulnerability include disability; being a married child; affected by HIV or other diseases; child labor; child or elderly heading household; or lacking basics and psychosocial support.

PEPFAR has initiated and supported a number of OVC programs which have significantly contributed to the scaling up of OVC services in Uganda. The interventions have focused on supporting a strong family and community response; improving service delivery systems and institutions; and implementing a broad portfolio of both proven interventions and innovative activities at community and facility level. Within the multi-sector and integrated approach, USG agencies have been supporting a number of partners in their effort to scale up OVC interventions within the HIV/AIDS response. There are many USG partners providing direct services delivery at community and facility level as well as partners that build capacity and systems of government, civil society and private sector. A portion of OVC funds have been utilized by pediatric care partners to provide or refer their infected and affected children and their families to receive community-based OVC services according to the families needs. Such services include school fees support, economic strengthening, nutrition and food security and over 60,000 OVC have been reached through this channel. In partnership with other donors, USAID established a sustainable civil society funding and granting mechanism through which donors (USAID, DANIDA, Irish Aid, and DFID) fund Civil Society Organizations (CSOs) to provide OVC services. Between its start in FY08 and March 2009, 48

sub-grants have been awarded reaching over 50,000 OVC with comprehensive care.

In addition to the bilateral programs, USG agencies oversee the implementation of several centrally-funded and regionally-initiated OVC programs. The Track 1 Orphans and Vulnerable Children awards have been an integral part of PEPFAR's OVC response in Uganda. These started in 2004 and are ending in June 2010. Comprehensive and compassionate care services previously implemented by Track 1 mechanisms will be continued in FY10 through a competitive process. In addition, OGAC introduced the New Partners Initiative (NPI) in 2007 with the aim of expanding and scaling up access to HIV/AIDS and OVC services. PEPFAR/Uganda also participates in a regional HIV/AIDS program initiated by USAID/East Africa offering care and OVC services to communities along the transport corridor. All these central and regional mechanisms have given PEPFAR/Uganda an opportunity to reach out to over 250,000 children with comprehensive care and support for access to education, health, food and nutrition, protection, psychosocial and livelihood services. Despite the progress made partly by these key initiatives, the response to date does not match the magnitude of the need. Coverage, reach and impact of services to the most vulnerable children and their households remain insufficient. The Uganda HIV/AIDS Sero-behavioral Survey 2004-2005 (UHSBS) found that only 23% of OVC lived in households that received any kind of external support.

During the last five years, national level activities focused on developing policies and guidelines, and initiated rollout of service delivery and quality standards tools, through Technical Support Organizations (TSOs), at the district level. The OVC Core Program Areas emphasized in the National Strategic Program Plan of Interventions (NSPPI) for Orphans and Other Vulnerable Children in Uganda are sustaining livelihoods (socio-economic security, food security and nutrition, care and support, and mitigation of the impact of conflict); linking essential social sectors (education, psychosocial support, and health); strengthening legal and policy frameworks (child protection and legal support); and enhancing the capacity to deliver (strengthening capacity and resource mobilization).

The services provided to OVCs are family based, targeted to their identified needs and mostly offered by a network of service providers. The TSOs work in close partnership with district local government (DLG) and civil society organizations (CSOs) to develop a comprehensive OVC response. They also provide technical backstopping to the Ministry of Gender, Labor, and Social Development (MGLSD)through rolling out of policies, guidelines, standards, tools, systems and approaches for OVC program management; strengthening the capacity of district local governments and CSOs to plan, coordinate, manage, monitor, evaluate and strengthen OVC service provision at district and lower levels; and providing technical oversight and supportive supervision for OVC programs nationwide, including those funded through the central level granting mechanism.

Recent accomplishments

During the past two years of the TSO approach, the MGLSD achieved significant results in over ninety districts including preparation of district maps and inventories of service providers in each of the OVC Core Programme Area; analysis of district OVC service coverage gaps; development of district and lower levels strategic and operational plans for strengthening OVC service provision; establishment of district multi-sector OVC coordination mechanisms; familiarization of districts and CSOs with national level policies, strategies, standards and tools; and development of M&E and supportive supervision tools for districts, sub-counties and CSOs; strengthening capacity of DLGs and CSOs to use systems, standards and strategies. These teams supported the functionality of the multi-sector coordination mechanism, rolling out of the OVC program M&E and MIS systems, OVC services quality standards, management and technical tools and provided support supervision to OVC programs. With this approach, the MGLSD has shown successful leadership and technical support provided to all 90 district local governments for improved OVC service provision.

Nonetheless, in its endeavor to contribute to the roll out of the OVC response, the MGLSD continues to face the following critical gaps and challenges:
1. Coordination mechanism at national and local government levels needs continued strengthening;
2. Implementation of district OVC strategic and annual plans remains largely unfunded;
3. Inadequate resource allocations to implement OVC plans at all levels;
4. Inadequate management of the OVC information system with functional data bases at national and district level; and
5. Limited quality of care in OVC programs and inadequate implementation of standard tools to measure quality of care improvement.

Goals and strategies for the coming year

In FY10, USG will continue to support the MGLSD to build its capacity to provide strategic direction, coordination and monitoring of Uganda's response to OVC, from the national to the district level. In this partnership, USG will enhance the capacity of the MGLSD to lead, manage, coordinate and strengthen programs and services for OVC, and support the MGLSD to develop a new plan (NSPPI-2) for the period 2009/2010-2014/15. A comprehensive National Monitoring and Evaluation Plan for the NSPPI-2 and a functional web-based Management Information System will also be developed. In addition, the MGLSD will continue rolling out the OVC response to all districts and lower level local governments. USG will support this initiative through an activity that will provide technical assistance to local governments and civil society organizations to deliver high quality, comprehensive care and scaled-up services for OVC. Continued funding to TSOs will enable them to support districts in preparation of strategic plans and annual work plans to improve quality of district response. This assistance will foster increased capacity to lead, plan, manage and implement a decentralized OVC response and ensure OVC quality and comprehensive care.

Working through Project SEARCH, the Population Council and the Uganda Bureau of Statistics conducted the national OVC situational analysis with the objective of establishing the current magnitude of OVC needs and use the evidence obtained to revise the national OVC strategic plan to effectively inform programming for the next five years 2009-2014. In FY10/11 emphasis will be on facilitating the provision of comprehensive care with focus on quality of care improvement using a family based care approach; continuing to promote linkages between facility and community based OVC service providers; ensuring that all OVC receive care in line with the national strategic plan; providing technical assistance and sharing high impact and successful models of service delivery such as block grants for scaling up education support to OVC. In addition, USG support will be linked to PLWHA networks to increase access to care for HIV-positive children and leverage private sector resources through Corporate Social Responsibility (CSR) approaches to support OVC programs. The USG also intends to strengthen the socio-economic security of the OVC households through market access models (micro-enterprise), strengthen the civil society grants mechanism to reach the underserved OVC living in hard to reach communities and build capacity of civil society and faith-based institutions for expanded quality OVC service delivery and integrate HIV prevention for OVC. A national and district based OVC MIS to monitor and measure quality improvement will be established. USG Peace Corp volunteers will continue to support and serve OVC through strengthening of community based organization systems.

Staffing

In FY10, approximately 4 USG FTE will work in this technical area.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount

PDCS	5,515,814	
PDTX	9,849,811	
Total Technical Area Planned Funding:	**15,365,625**	**0**

Summary:
Context and background

Of the estimated 1,100,000 people living with HIV/AIDS (PLWA) in Uganda, about 120,000 are children below 15 years of age. Infant mortality among children born to HIV-infected and uninfected mothers is estimated at 209 and 98 per 1,000 births respectively. Without ART, 50% of HIV-infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). In June 2009 an estimated 42,140 children were in need of treatment, 13% of all those in need. Of those children, 16,495 (39% of eligible) were on ART, representing 8.5% of the total 193,746 on ART.

The primary mode of transmission of HIV to Ugandan children is mother-to-child-transmission (MTCT), accounting for over 95% of HIV infections in children under 12 years, and 18% of the 135,000 new HIV infections annually. Factors contributing to high MTCT rates and levels include: 1) high total fertility rate (6.7 children per woman); 2) high HIV prevalence among pregnant women; 3) limited access to PMTCT interventions; 4) use of less effective antiretroviral therapy (ART) regimens for PMTCT; and 5) lack of affordable safe infant feeding options resulting in HIV transmission through breast-feeding.

The Uganda National HIV & AIDS Strategic Plan 2007/8 - 2011/12 (NSP) recognized children as an underserved population and advocated for improved support.

In 2006, the MOH established the Early Infant Diagnosis (EID) program which uses DNA-PCR to diagnose HIV infection among children less than 18 months of age. The program targets HIV-exposed infants born to mothers identified during routine visits for antenatal or post-natal care, child immunization, or hospitalization. To date, the EID program is linked to 424 health facilities that range from primary level to hospitals. Dry Blood Spot (DBS) specimens are transported by the Uganda postal system from facilities to reference laboratories for processing. Each district has at least one health facility able to refer or test these specimens. Demand for DNA-PCR has increased significantly: while 281 tests were performed in 2006, over 3,000 are now being conducted every month. MOH and USG partners have continued to increase demand for these services through training of providers and conducting national and regional campaigns incorporating EID with national child immunization days and community outreach.
.
PMTCT services have been scaled up nationally to reach 97% of hospitals, 92% of Health Center IVs, 30% of HC IIIs, and 5% of Health Center IIs. Following this expansion, an estimated 39,694 HIV-positive pregnant women were identified between 2007 and 2008. Of these, 86% received ARVs for PMTCT, of which over 70% received single-dose Nevirapine (SD NVP). Only 16,601 (42%) exposed children, however, received ARVs for PMTCT. In 2008, 17,617 exposed infants accessed the EID program. Of those tested, 18% were HIV-positive (12% among PMTCT recipients and 21 % among infants whose mothers did not receive PMTCT). By April 2009 the overall positivity rate had fallen to 10% and the rate among PMTCT recipients had fallen to 8%. Delays in sample turn-around time, failure to enroll HIV-positive children who do receive their results, and loss to follow-up of children who started treatment remain significant challenges. This demonstrates the need for increased linkages between PMTCT, EID and pediatric care to track mother-infant pairs if pediatric HIV is to be reduced.

The National Pediatric ART Committee, established in 2006, adopted a 10-point Pediatric HIV Management Plan that has guided pediatric care and treatment programs. Core activities include:

1. Early diagnosis of HIV infection
2. Growth and development monitoring
3. Routine childhood immunizations and deworming for helminths
4. Nutrition education and supplementation
5. Aggressive treatment of acute infections
6. Prophylaxis and treatment of opportunistic infections
7. Psychosocial support and palliative care
8. Adolescent care and support
9. Mother and family care
10. Antiretroviral therapy when indicated

The MOH's 2008 guidelines for pediatric care recommend co-trimoxazole prophylaxis for all HIV exposed infants beginning at 4-6 weeks of age until HIV infection is reliably excluded, DNA-PCR testing at 4-6 weeks, initiation of ART for all DNA-PCR positive infants below 1 year irrespective of CD4 count or percentage, and exclusive breast-feeding up to 6 months of age with rapid weaning for all HIV-exposed infants in the absence of affordable and safe infant feeding options. Infants negative by DNA-PCR should have an HIV antibody test 3 months after cessation of breast-feeding and if positive, referred into care. Non breast-feeding infants found negative at 6 weeks by DNA-PCR should have a confirmatory antibody test at 9-12 months.

Accomplishments since the last COP

The USG has supported capacity building for pediatric care and treatment by training health providers and by having partners establish regional mentors for pediatric HIV care and treatment. Through the Clinton Foundation HIV/AIDS Initiative (CHAI), commodities supporting pediatric HIV diagnosis, care and treatment have been available nationally since 2006, greatly improving access to services. These commodities include pediatric first and second line ARVs, laboratory reagents for HIV diagnosis in children, food supplements, and co-trimoxazole. Staffing support and training were also provided to some facilities. When the pediatric component of CHAI support ends in 2010, it is expected that these activities will be rolled into the existing national program supported by PEPFAR, the MOH and the Global Fund. All PEPFAR partners who have been receiving supplies through the CHAI project have been informed about the phase-out of this support and are planning a transition to fill this gap. The annual national pediatric advocacy meeting was held in 2009 with PEPFAR support bringing together all stakeholders.

As a result of these efforts, there has been improvement in identifying HIV-infected children. The number of facilities providing pediatric HIV/AIDS care and treatment increased from 174 in 2007 to 264 by March 2009. PEPFAR supported 95% of all children on treatment through USG inputs in national training, laboratory diagnostics, logistics systems, quality assurance and policy development. During FY09, MOH launched and implemented campaigns through “Child Health Days” to increase access to EID. In FY09 the MOH's AIDS Control Program (ACP), in collaboration with partners, reviewed data collection tools in an effort to harmonize data collection and reporting across partners. The revised ART register and card have been disseminated to some sites. These revised tools will improve reporting and M&E of the national program.

Technical priorities

1. Limited access to pediatric care: Despite the increase in number of children in active HIV care, pediatric clients on treatment comprise only 8% of national figures against the MOH target of 15%. Pediatric care is especially limited in rural areas.

2. Human resource gaps: The shortage of health workers with skills in pediatric treatment remains a major challenge. Children require more physician time and therefore suffer most from understaffing.

Because of these staffing shortages, fewer accredited ART sites provide pediatric HIV/AIDS treatment. The technical expertise and time required for pediatric treatment prevents task shifting from fully addressing the shortage in pediatric treatment staff.

3. Inadequate commodity supplies: Pediatric ARV regimens are more complex than adult regimens. The Clinton Foundation HIV/AIDS Initiative (CHAI) has been supporting the supplies. Although Uganda eventually plans to relieve the ARV drug supply problems by producing its own generic drugs in partnership with Cipla and a Ugandan manufacturer, Quality Chemicals, production of pediatric formulations is yet to be addressed.

4. Limited coverage of EID: Only 424 facilities are linked to the EID service and only about 36% of exposed infants will access DNA-PCR tests in 2009. The system for sample collection, transport to the reference laboratory, sample processing and return of results (turn-around time) needs review for improved efficiency.

5. Data gaps: The burden of pediatric HIV is not really known as there are no definite data on numbers of children infected, in active care, or eligible for ART nationally. The AIDS Indicator Survey, planned for 2010, will fill these data gaps.

6. Continued MTCT: The national PMTCT program is less than optimal. There are weak linkages between the PMTCT program and pediatric and adult care, leading to loss to follow-up of HIV exposed infants and missed opportunities for HIV diagnosis and for timely initiation of treatment. In FY09 more facilities were using combination therapy for PMTCT. There is a need for enhanced assessment in the antenatal clinic for ART eligibility and ART initiation or referral to ART clinics.

7. Adolescent sexuality: Sexuality and reproductive health needs of HIV-infected adolescents remains a challenge. In addition to medical needs, adolescents with HIV are a particularly vulnerable group with a range of psychosocial needs. Lack of child and adolescent-friendly services including reproductive health and family centered care compound the problem. There is a need for tailored prevention with positives interventions among adolescents to overcome these challenges.

8. Adherence to ART: Adherence is a greater challenge in children partly due to the requirement for dose adjustments as weight increases, lack of stable caregivers particularly if orphaned, lack of disclosure of HIV status, and adolescent hormonal changes. This may have implications for earlier drug resistance in children. Generic pediatric fixed-dose combinations (FDCs) enhance adherence by eliminating the difficulties in administering liquid formulations.

9. Linkages with OVC: The linkage between pediatric care and OVC programs is still weak and yet the majority of HIV-infected children are orphaned or vulnerable. Follow-up and community support is either non-existent or inadequate and needs strengthening to reduce attrition.

10. Nutrition: Affordable safe infant feeding options are lacking, increasing the risk of MTCT through breast-feeding. An estimated 30% of HIV infected children are malnourished and require nutritional supplementation. Only a few programs have integrated nutrition into HIV care programs and this linkage needs strengthening. In light of ending CHAI support for ready-to-use therapeutic food (RUTF), a local manufacturer, RECO Industries, has been identified by the MOH's Nutrition Department and the USG's NuLife project to commence production.

Goals and strategies for the coming year

1. Continued capacity building for pediatric health care staff through training, mentorship and supervision. Emphasis will be put on building capacity of community care groups such as PLWA networks, religious

leaders and volunteers to assist with pediatric care. The family-based care model and existing prevention with positives (PwP) interventions will be strengthened to enhance disclosure at the family level and support parents and guardians to test children for HIV. Approaches such as Provider-Initiated HIV Counseling and Testing (PITC) will continue to be encouraged within existing facility, community, and home-based programs. The USG will continue to support the expansion of the pediatric mentoring program using regional pediatricians and experts.

2. Strengthening EID. The USG will work towards reducing the turn-a-round time for EID results through improved coordination of players to allow for better follow-up of exposed children born to HIV-positive mothers. A review of the EID program in 2009 identified the major bottlenecks causing delays. A more efficient system of posting DBS samples to the reference labs will be devised.

3. Referral and linkages: The USG will continue to strengthen linkages among OVC, PMTCT, EID, and pediatric HIV care and treatment services. The program will pilot provision of CD4 testing and ART initiation in the ANC to get all eligible pregnant mothers on ART as soon as possible

4. Address adolescent sexuality issues: USG will support the extension of PwP programs to HIV-infected youth to encourage them to understand the implications of being HIV positive, need for ART adherence, individual responsibility in HIV prevention, use of condoms and family planning services. Focus will be put on integrating confidential care within broad-based youth programs to minimize stigma.

5. Increase nutrition assessment, counseling and supplementation to eligible children and their families. The USG will establish and strengthen linkages with the NuLife project to provide therapeutic and supplemental food to nutritionally compromised children. Routine PITC is required to diagnose infection among malnourished children. HIV diagnosis, care and treatment will be integrated into routine care for children in nutrition units and linkages between the two units strengthened. Micronutrient supplementation with multivitamins will be promoted as part of routine pediatric HIV care and support.

6. Disseminate national policy guidelines: Focus in 2010 will be to disseminate and support implementation of the existing training curricula and guidelines on pediatric care and treatment. The USG will continue to supply the Basic Care Package (BCP) to the mother-child pair and will ensure continued availability of other pediatric care commodities.

7. The USG will work towards achieving increased coordination and leadership from the MOH through the National Pediatric ART Committee to further strengthen pediatric services. Efforts will be made to minimizing the high dependency of the national ART program on PEPFAR through planning for pediatric care in the MOH budget. In addition, the USG will work closely with the MOH, UN and other AIDS development partners to support the GOU in the Global Fund development process to leverage support to plan for the end of Clinton Foundation donations.

Staffing

In FY10 approximately 4 USG FTE will work in this technical area.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	14,910,546	
Total Technical Area Planned Funding:	**14,910,546**	**0**

Summary:
Context and Background

The Uganda HIV Prevention and Modes of Transmission Analysis (2009) estimated that 18% of all new HIV infections are due to transmission from mother to child. The very high fertility rate (6.7%) will result in about 1.5 million pregnancies in 2010. With an antenatal HIV prevalence rate of 6.5% there will be about 97,500 pregnant HIV+ women in 2010. While 94% of pregnant women attend antenatal care (ANC) at least once, only 42% of all deliveries take place in health facilities.

The national PMTCT policy guidelines (2006-2010) emphasize the implementation of WHO's four-element strategy to prevent HIV infection among infants and young chidden (primary HIV prevention, prevention of unintended pregnancies, provision of ARV prophylaxis, and care and support).

The overall goal of the national PMTCT program is to achieve a new generation that is free of HIV and AIDS in Uganda, with the broad objective of reducing MTCT by 50% by 2012. The specific objectives are to: expand PMTCT services to all health facilities up to Health Center (HC) III level; provide counseling and testing services to at least 90% of pregnant women who attend ANC services; reach 100% of HIV infected mothers and their infants with antiretroviral drugs for prophylaxis; start 20% of HIV-infected women on antiretroviral treatment; conduct HIV testing for 25% of male partners; counsel and support 50% of HIV-negative pregnant and lactating women to remain free of HIV; and offer family planning services to 75% of women living with HIV and their partners.

National Scale-up

The USG has supported MOH to scale up PMTCT services since 2003 and is currently the main donor. Other donors include UNICEF, WHO, and the Global Fund. MOH has provided district mapping showing the geographical distribution of PMTCT partners to minimize overlaps and duplication. In FY10, we will continue to scale up PMTCT services to the lower level health facilities and support district-based PMTCT implementation in 70 to 80 districts through local and international Implementing Partners (IPs). In order to improve program ownership and sustainability we will support MOH and local governments to provide program leadership and coordination. IPs will provide conditional financial grants and technical support to districts for program implementation.

Accomplishments since last COP

PEPFAR annual results for the number of pregnant women counseled, tested and received HIV results show a progressive increase over the years, from 95,094 in 2004; 201,782 in 2005; 263,398 in 2006; 410,738 in 2007; and 594,305 in 2008. By March 2009 (SAPR 2009), PEPFAR had supported the provision of PMTCT services in 828 out of 989 targeted health facilities. Out of the 705,027 pregnant women expected to attend ANC in USG supported health units, 403,554 (57%) were counseled, tested and received their results; out of which, 24,812 were found to be HIV+ and 21,725 (45% of the annual target) received ARV prophylaxis. Most districts are taking the lead in PMTCT implementation and the majority of health workers in ANC have been trained and can provide routine opt-out HIV Counseling and Testing (HCT) with same day results. Combination therapy is rapidly replacing single-dose Nevirapine (SD NVP) and is currently available in most PMTCT sites. Despite these achievements, there are a number of challenges facing the program including low population-based coverage, high fertility rates and the fact that the majority of women do not deliver in health facilities.

Goals and strategies for the coming year

The national target for FY10 is to counsel and test 1,269,000 pregnant mothers; provide ARV prophylaxis

to 82,485 HIV+ women and 65,988 infants. PEPFAR will contribute towards the achievement of the above national targets and has set FY10 targets to provide PMTCT services in over 1,000 facilities, train over 2,000 health providers, test 939,443 pregnant women and give them results, provide ARV prophylaxis to 64,589 HIV+ women, and assess at least 70% for ARV eligibility. Of these, 12,940 HIV+ women will be linked to the national ART program for HAART, 32,349 will be put on a combined regimen, and 19,410 on SD NVP. 51,759(80%) of HIV exposed infants will receive PMTCT ARVs and 41,408(80%) of these will undergo early infant HIV diagnosis (EID) from 6 weeks of age. Food supplementation or other nutrition services will be provided to 30% of eligible pregnant or lactating women.

Several strategies will be used to achieve these goals:

1. Providing antenatal ART services
Most HIV+ pregnant women are not linked to chronic care and treatment units during the ANC period due to limited availability of CD4 testing services, thus missing an opportunity of being referred for HAART. ART services are currently offered mainly in the hospitals and in HC IVs while ANC services including PMTCT are available at most HC IIIs and some HC IIs which have active ANC clinics. At every ANC visit a clinical assessment for all HIV+ women and their partners, using WHO clinical staging and CD4 tests, will be done. Sites with both ART and PMTCT clinics will initiate HAART in ANC to the eligible HIV+ pregnant women and later refer them to chronic care clinics. Lower level health units that do not have ART clinics will ensure they are referred to health facilities providing ART. At least 60% of ANC staff will receive training on HIV clinical staging and ART management. IPs will coordinate specimen collection on a weekly basis from HC IIIs, HC IVs and district hospitals that do not have CD4 testing services, transport them to the nearest testing CD4 testing lab, and ensure results are quickly returned. We will collaborate with the ART IPs to ensure that ARV drugs are made available to the midwives at ANC sites.

2. Scaling up combination therapy and improving adherence support
In FY10, we will continue to scale up the use of combined ARV prophylactic regimens for HIV+ women who are not eligible for HAART in order to minimize MTCT risk. In addition, the country is emphasizing the use of more efficacious ARV regimens for PMTCT beginning at 28 weeks or 32 weeks of gestation, depending on the regimen, with a target of scaling up use of effective regimen to 100%, with combination regimens to 80% and HAART to 20%. A preliminary MOH report shows that 33,523 HIV+ pregnant women received ARVs in FY08/09, with uptake by regimen of 53.5% for SD NVP, 30.8% for combination regimen and 15.7% for HAART. We will collaborate with ART partners to ensure adherence to these regimens and to ensure that PMTCT services are part of all ART sites and networks. We will engage community volunteers and support groups to provide adherence support for combined therapy and HAART.

3. Strengthening EID and linkage to pediatric care and treatment
In 2007, the MOH, with support from partners, launched EID services in order to strengthen linkages to pediatric HIV/AIDS care and treatment. The EID program is making steady progress; currently over 400 PMTCT sites (30% of the recommended health facilities) are providing EID services in all districts. In 2008 over 17,000 (19% of exposed infants for that year) were tested for HIV. From 2007 to date over 36,000 exposed babies have been tested, of whom over 5,000 (14%) were HIV infected. However the linkage of these infected infants to care is still weak. The USG will support the scale-up plan for EID services to reach 100% of HC III facilities by 2012 and strengthen linkages to care. We will provide EID services at post-natal, immunization and the sick child clinics and in both inpatient and outpatient services. We will provide co-trimoxazole prophylaxis to all HIV exposed babies at six weeks and take blood samples for EID. The infant EID sample will be coordinated with the mother's CD4 sample and return dates for results to be linked to the immunization schedule. We will refer mothers who receive positive results to the family-based ART clinics to manage both the mother and infant pair and to nutrition and OVC programs to enhance child survival. Community health workers or expert clients will provide follow-up of mothers who do not come back for the results.

4. Integrating family planning into PMTCT services
In Uganda, child bearing is still highly valued and many HIV+ women desire or feel pressured to have children. Collaborative partnerships will be established with UNFPA and USG family planning (FP) programs with the goal of leveraging resources and increasing uptake of FP for HIV+ women who choose it. FP counseling, services and referrals will be provided to women attending the ANC and HIV clinics. HIV+ couples who have decided to have no more children will be counseled and referred for long-term FP methods. Dual protection will be promoted to prevent HIV and STI transmission and unwanted pregnancies. We will train maternal and child health (MCH) and ANC staff in the provision of both short and long-term FP methods and ensure that these FP methods are available in health facilities. We will also continue to work with ART IPs to provide FP services to women in care as part of PMTCT. Community volunteers will provide short-term FP methods.

5. Infant and Young Child Feeding (IYCF)
The USG will continue to strengthen nutrition support for HIV+ pregnant women and exposed children in order to reduce transmission risk through breast milk and ensure child health and survival. We will support the implementation of the revised national IYCF policy guidelines which emphasize interventions that enable HIV+ mothers to exclusively breastfeed for at least 6 months or until AFASS conditions for replacement feeding (acceptable, feasible, affordable, sustainable and safe) are met and to continue with appropriate complementary feeding up to two years. Service providers will assess nutrition status of HIV+ women in MCH and ART sites. The NuLife project will work with IPs to provide ready-to-use therapeutic feeding or other supplementary foods to malnourished HIV+ pregnant or lactating women and their exposed children

6. Supporting maternal nutrition to reduce anemia
All PMTCT IPs will make plans with the districts to provide food supplements to all HIV+ mothers attending MCH clinics. They will provide nutrition assessment and counseling to all mothers who receive food supplements. In addition, IPs will provide feeding supplements to women who need to wean their babies but do not have sufficient capacity to do so. Ferrous salt, folic acid and vitamin supplements are already provided routinely to all pregnant women on each ANC visit to prevent anemia. IPs will also support the facility to ensure no stock out of micronutrients.

7. Integrating TB screening in ANC/MCH
IPs will conduct refresher training for all MCH service providers on TB screening and its relationship with HIV. They will use the national TB screening tool and ask women specific questions focusing on the signs and symptoms of TB. The integrated ANC tools now have TB information and all HIV+ women with a suspicious history of TB will be referred for sputum examination and other investigations.

8. Integrating PMTCT with MCH
The PMTCT program in Uganda is already integrated within MCH although the systems supporting MCH services delivery within the reproductive health (RH) department are currently very weak and affect PMTCT outcomes significantly. Demand for postnatal care (PNC) and RH services are generally low because few sites provide postnatal care services routinely. Hemoglobin testing is not done routinely except in the hospitals. ANC and Young Child Cards (YCC) are often out of stock and MCH clinics are conducted within limited space and are thus congested. In FY10 we will use PMTCT resources to support the essential RH care package that was developed by MOH and extend PMTCT services to primary health centers where mothers take babies for immunization services. Mothers will be encouraged to attend the extended post natal clinic where a range of services are provided including pap smears and infant feeding counseling.

9. Increasing support for primary prevention in ANC
In FY10, we will increase our support for primary HIV prevention. We will promote sexual partner

reduction, couple counseling and testing, discordant couple follow-up services and STI management. HIV-negative pregnant women will be the entry point for primary prevention especially to promote disclosure and partner testing. We will also address cultural factors that make women vulnerable including gender inequalities that limit women's opportunities and making them economically dependent on men, polygamy, multiple sexual partnerships and early marriages.

10. Strengthening M&E with a focus on program outcomes
Current M&E challenges include the frequent stock-outs of data collection tools, (e.g., ANC, PNC, and YCC cards and the integrated RH/PMTCT registers); human resource constraints, barriers in communication, lack of district ownership and utilization of data, as well as incomplete and poor quality data. Most sites have incomplete data and the integrated RH/PMTCT registers are not synchronized with the pre-ART and ART registers and other relevant tools. The supervision of lower health facility workers by the hospital /District Health Office is not done regularly and districts do not submit data to MOH regularly. We will work with the SI team to strengthen monitoring and reporting of PMTCT data at all levels, through appropriate training and regular support supervision. Uganda is also participating in the HOPE (How to Optimize PMTCT Effectiveness) Public Health Evaluation, which is anticipated to begin during 2010.

11. Supply Chain for PMTCT
Uganda still experiences frequent stock outs of PMTCT commodities such as HIV test kits and ARVs. We will continue to support one system for procurement and distribution of PMTCT commodities and related supplies. USG support to strengthen the national supply chain management systems is described in the Health Systems Strengthening technical area narrative.

12. Sustainability
The USG will continue to support district local governments to implement PMTCT through IPs, including the "Strengthening Decentralization for Sustainability" (SDS) project, which will provide conditional grants to districts, technical assistance for financial processes and accountability, and for improved leadership and management. It is expected that a service delivery approach which is maximally integrated with host government health systems, managed by the district health teams, with the combination of targeted technical assistance and performance-based incentives, is the optimal strategy to use PEPFAR funds efficiently, promote host government capacity at all levels, and reduce negative impacts on different components of the health system.

Staffing

In FY10, approximately 5 USG FTE will work in this technical area.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	14,962,743	
HVOP	13,437,942	
Total Technical Area Planned Funding:	**28,400,685**	**0**

Summary:
Context and background

Uganda's response to the HIV/AIDS epidemic is guided by the National HIV & AIDS Strategic Plan 2007/8 - 2011/12 (NSP) with the overall goal of achieving universal access for HIV prevention, care and treatment, and social support. The plan is grounded in epidemiological data from the Uganda HIV/AIDS Sero-behavioral Survey 2004-2005 (UHSBS), cross sectional and longitudinal population based studies and surveillance trends. The steady decline in adult HIV prevalence from a peak of perhaps 14% in 1991 has reached a plateau at about 6.2%. The prevalence peak has shifted from young people to older adults, with the highest prevalence in men 35-44 years and women 30-34 years. The total number of people living with HIV/AIDS (PLWAs) in Uganda was estimated to be 1.1 million in 2009. The majority of these are adults, with children under 15 years contributing about 11%. Females constitute about 58%of all PLWAs. There are also indications that HIV incidence has also increased during the past few years. It is estimated that 135,300 adults and children were newly infected with HIV in 2007.

According to the Modes of Transmission (MoT) study, most HIV transmission occurs through heterosexual contact (81% of new infections) and mother-to-child transmission (18%). The epidemic has geographical and social demographic heterogeneity; women, urban residents and people living in Kampala, the central and mid-northern regions are disproportionately more affected. Some population groups, including fishing communities, security personnel, truckers and cross border communities, commercial sex workers, and the internally displaced people were identified in the NSP to be at a relatively higher HIV prevalence than the general population The changing pattern of people affected by the HIV/AIDS epidemic and the rise in new infections have compelled the country to change its strategy while maintaining approaches that have proved effective in reducing the impact of the epidemic. The NSP recommends implementation of a two-pronged strategy that that maintains the well-established comprehensive ABC+ approach complemented with a refocus on the most cost effective prevention interventions balancing care, treatment and support costs and embracing new prevention technologies.

Accomplishments since the previous COP

In FY09 the USG supported the implementation of a comprehensive ABC + approach through several partners, including NGOs, government institutions, the private sector, the civil society, PLWA networks and faith based organizations. Emphasis was placed on expansion of comprehensive prevention services for adults, youth and high-risk groups through behavior change communication programs.

Youth programming

The USG has continued to support behavior change approaches among in and out of school youth, including promotion of educational counseling and interpersonal efforts. The school based HIV prevention program (Uganda's "Presidential Initiative on AIDS Strategy for Communication to Youth", or PIASCY) was rolled out in all primary schools and Teacher Training Colleges. A similar program is being piloted for post-primary institutions. Behavior change communication initiatives for youth such as "Young Empowered and Healthy (YEAH)", the "Something for Something Love" campaign, the radio series Rock Point 256 and its reinforcing materials, and interpersonal approaches have created a positive "buzz" among the youth. Such initiatives represent intensive programming, combining media and interpersonal approaches, thus working at multiple levels to create conditions required to foster behavior change.

Personalized risk

Sexual prevention programming the youth and adults prioritized support for heighted self-perception of risk and strategies that address social and gender norms that underlie risky sexual behavior. It is of particular concern that risky sexual behaviors were highly prevalent in the UHSBS, and were shown to be on the increase compared to the late 1990s. Yet most people who engaged in risky behaviors, such as having multiple sexual partners, did not perceive themselves to be at high risk of HIV infection. Only 21% of female and 23% of male respondents to the UHSBS believe it very likely that they will contract HIV,

with variations by age, gender, and residence. The USG provided technical and financial support for two national campaigns, "Know Your Status" and "HIV Stigma and Discrimination Reduction". Through this support the MOH has updated the couple HCT training curricula and is currently rolling out service provider training in various parts of the country. Besides increasing HCT coverage in the general population, the campaigns have a deliberate focus on promoting partner and family member testing and disclosure. In addition, the USG provided support for the media campaign and for procuring test kits to meet the increasing demand during the national testing days.

Efforts to reduce stigma and discrimination have been supported through strengthening the network of people living with HIV/AIDS. Support groups of PLWAs have received institutional support for integration of PwP activities in clinical and community-based programs. Positive Prevention training curricula was launched in by the MOH and rollout of service provider training is ongoing.

Gender norms

USG objectives to reduce sexual transmission within prevention programming include a strong focus on the critical role of partner reduction, faithfulness, and increasing gender equalities to sanction this new behavior. Recognizing the importance of the data on male behavior, particularly multiple partners, several USG partners have coordinated their male-oriented campaigns (e.g., Be a Man), sharing similar approaches, materials and messages for training group facilitators, and working with men to challenge accepted gender norms. Several partners are addressing gender-based violence in relation to sexual prevention, counseling testing and disclosure, and alcohol abuse. The centrally coordinated sexual and gender based violence (SGBV) initiative has piloted models for strengthening delivery of comprehensive services to victims of rape including early initiation of ART for post exposure prophylaxis medical and psychosocial care, raising community awareness, and access to legal services.

High-risk sex

USG partners have expanded programs that discourage high-risk sex and harmful gender norms that underlie male behavior. Having multiple concurrent partners, or a discordant partner, and unprotected sex, is the main driver of the generalized Ugandan epidemic. Analysis of sexual behaviors over the last decade shows that among persons having sex since the late 1980s, risky behaviors are on the rise, including an increase in casual sex, sex with multiple partners, and a decrease in condom use. In FY09, partners expanded work place HIV prevention programs in collaboration with the private sector companies and the public sector.

High risk populations

In addition to focusing on decreasing risk behaviors in the general population, USG partners have expanded prevention services that target high risk, vulnerable and mobile populations. These populations include commercial sex workers (CSWs), internally displaced persons (IDPs), truck drivers and fishermen. These groups share risk behaviors. They are more prone to have many sexual partners, to use condoms inconsistently, and consequently increase the risk of acquiring and/or transmitting HIV to several partners, including their cohabiting spouses. Partner activities focusing on truck drivers and CSWs and their clients include providing access to drop-in centers where they can receive peer education targeting HIV/ STI prevention and sexual violence mitigation, counseling and testing services. Recently, the network of organizations working with most-at-risk populations was initiated to coordinate the effort of various providers and provide referrals. Preliminary data from a USG-supported survey for selected most-at-risk groups in Kampala revealed high HIV prevalence among female sex workers (32%), clients of sex workers (17%) and men who have sex with men (14%). These data will be disseminated to key stakeholders and used to develop targeted HIV prevention programs.

Focus on high prevalence areas

Following the mapping of high prevalence areas by UHSBS, resources were provided to increase comprehensive HIV services. The conflict districts in Northern Uganda and districts in the central region including Kampala have benefited from this scaling up of services. The door-to-door counseling and testing programs were launched in the six districts in the central region and in Kalangala and Apac districts. These programs identified over 800 discordant couples who are receiving follow-up intervention services to prevent transmission.

Substance Abuse

Alcohol consumption is associated with an increase in high-risk sexual behavior and with violence, particularly by men against women. Messages discouraging excessive alcohol consumption and its link to HIV included community dialogues, media program and an alliance with beer companies. NGOs working with young people have voiced the concerns to government regarding companies that package small quantities alcohol that are affordable to young people.

Goals and strategies for the coming year

The national HIV prevention policy guidelines and IEC/BCC communication strategy are available but in draft form. In FY10, the USG will continue to devote priority attention to comprehensive HIV prevention programming focusing on addressing key drivers, behaviors/norms, and populations that sustain the HIV epidemic in Uganda. Behavior change communication programs that incorporate a wide range media and interpersonal approach will be intensified among youth, both in and out of school. USG partners will continue to heighten self-perception of risk among youth and within the general population and will support prevention strategies that address social and gender norms that underlie risky sexual behavior. The national program will be supported to procure and distribute condoms. Correct and consistent condom use will be promoted among sexually active populations and social marketing programs will ensure distribution and availability. In FY10, the USG will continue to support behavior change efforts for two national campaigns, reduction of stigma and discrimination, and the ‘Know Your Status’ campaign, aimed at increasing HCT coverage, especially among couples, and the disclosure of results.

Reducing multiple sexual partnerships

Multiple concurrent sexual partnerships are a known predictor of HIV transmission. Expansion of programs that address both serial and multiple partnerships may help to cut down the number of new infections. In FY10, partners will be supported to develop comprehensive programs that support mutual fidelity, reduction of sexual partners and access to reproductive health education including consistent condom use, STI treatment and family planning.

HIV discordance

Sexual intercourse within HIV-discordant couples is associated with an extremely high risk of HIV transmission. In FY10, partners will expand HCT for couples and strengthen prevention interventions for discordant couples. Technical guidelines for running post-test clubs will be reviewed and PLWA networks will be facilitated to scale up the integration of Positive Prevention in community and facility based programs.

Focusing on MARPs

Most-at-risk groups identified in the NSP include CSWs and their partners, fishing communities, IDPs and refugees, security personnel, street children and persons with disability (PWDs). Studies have found that

HIV prevalence in these groups was higher than that of the general population. In FY10, the USG will work with partners to:
1. Sustain social mobilization to address sexual norms, reduction of number of sexual partners, and increase condom use among the MARPs
2. Involve MARPs in delivery of prevention and other HIV and AIDS related services to their peers
3. Scale up prevention interventions for truck drivers, the military, CSWs and their partners and migrant workers
4. Build capacity of actors to reach identified MARPs and other vulnerable populations
5. Improve referral systems and increase access to HIV and AIDS health care for MARPs.

Condom programming

Uganda has a condom policy and guidelines on procurement and distribution to implementing partners developed with support from USG and other partners. While the policy has provided an enabling environment, streamlining procurement and distribution of condoms, service provision is still hampered by shortages and stock outs, limited targeting to MARPS and low levels of condom use in long standing relationships. In FY10, the USG will continue to support procurement of condoms and improved logistics management, free distribution in the public sector, and social marketing. To guard against gender disparity in condom programming, partners may promote both the male and female condoms.

Focus on High Prevalence Areas

In FY10, the USG will continue to target high prevalence regions with comprehensive HIV prevention, care and treatment services. Consensus has been reached within USG, GOU and development partners to support programs that implement activities at a regional level in order to increase coverage and avoid overlaps. New mechanisms for FY10 are therefore designed to offer comprehensive services to a cluster of districts in given geographical location. This approach is expected to strengthen coordination and reporting on HIV/AIDS services through the district systems.

Adolescents and young people

In FY10, the USG partners will implement:
1. Comprehensive life skills program for young people in and out of school, with a focus on delay of sexual debut, secondary abstinence, partner reduction, HIV testing, building values for fidelity in marriage and address negative gender norms and cultural practices that fuel the epidemic.
2. Mass media campaign to raise HIV awareness including vulnerability of young people, especially girls, to the risks cross-generational and transactional sex, and support partners to develop programs for HIV-infected children and adolescents, both in and out of school, to access comprehensive prevention, care and treatment services.

Staffing

In FY10, approximately 6 USG FTE will work in this technical area.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	11,891,032	
Total Technical Area Planned Funding:	**11,891,032**	**0**

Summary:
Context and background

USG Strategic Information activities in Uganda are led by the SI Technical Working Group (TWG). This group includes the SI Liaison and staff from USG agencies with expertise in M&E, epidemiology, surveillance, Health Management Information Systems (HMIS) and Public Health Evaluations (PHEs). This team works with other PEPFAR TWGs to strengthen SI related activities, and to reinforce planning, implementation and coordination of implementing partner (IP) activities.

The SI TWG provides technical oversight and expertise in:
1. Overall PEPFAR country program M&E (including support for PEPFAR program data analysis)
2. Strengthening national surveillance activities
3. Supporting the Government of Uganda (GOU) and USG IPs to develop and maintain HMIS
4. SI capacity building for key GOU sectors (Ministry of Health (MOH), Uganda AIDS Commission (UAC) and Ministry of Gender, Labor, and Social Development (MGLSD))
5. Contribution to the development, implementation and dissemination of findings from PHEs operational research.

USG/Uganda SI activities contribute to the Systems Strengthening technical area of National HIV & AIDS Strategic Plan 2007/8 - 2011/12 (NSP). In order to determine progress of the NSP, the National Performance Measurement and Management Plan (PMMP) and the PMMP Operational Handbook were finalized in 2009. This was a major step towards a single country-level M&E system for HIV/AIDS. The goal of the PMMP is to harmonize existing systems of data collection, reporting and review, facilitate M&E and data use in policy-making, implementation and resource allocation. The Operational Handbook is a supporting document for results-based tracking and management of the national HIV/AIDS response. Current activities are focusing on PMMP roll out.

Although USG and other partners continue to provide support to strengthen the national M&E system, the UAC, which is charged with the coordination of the National AIDS response, has identified the following persistent challenges:
1. Limited coordination and harmonization of HIV/AIDS and health indicators within the various government sectors and among donors
2. Variation and limitations in data quality and use across sectors with Government and donor supported programs
3. Gaps in human and financial resources, and infrastructure to support decentralized M&E systems at site level and local government levels
4. Weak coordination among donors and implementing partners at sites and within geographical regions resulting in inadequate reporting to the national system (HMIS), multiple reporting, delays, inaccuracy and incompleteness of data. Systems and reporting are often based on individual donor needs.

The SI TWG also notes the following challenges:
1. Inadequate M&E capacity among IPs (limited staffing, M&E skills development and inadequate support to M&E functions)
2. M&E and the importance of data are not well appreciated, adversely affecting data quality, staffing, and reporting and reducing the ability to perform meaningful quantitative program evaluations
3. Sub-optimal management of HIV surveillance activities conducted at the MOH level
4. Slow approval processes for Public Health Evaluations.

The UAC developed a 2-year operational plan, the National Priority Action Plan 2008/09-2009/10 (NPAP), to guide all stakeholders. It recommends the following:
1. Equipment, materials and dedicated staff for M&E should be a priority and meet demands at district

levels and facilities
2. Strengthen coordination and reporting across stakeholders and harmonize M&E indicators from UAC, MOH and other stakeholders
3. Institute uniform reporting formats and procedures for IPs at all levels
4. Implement a coherent M&E system at the district level and ensure adequate funding
5. Conduct regular data quality assurance of HMIS and other data sources
6. Build capacity of UAC, government sectors, districts and facilities to collect and use data
7. Expedite database construction at UAC, along with appropriate data collection tools.

Accomplishments since last COP

HMIS
In 2009, Vision 2012 (which represents the vision for the national HMIS) was presented to national HMIS stakeholders. This resulted in greater stakeholder involvement and awareness. The USG team is emphasizing that its implementing partners use nationally developed and approved tools, especially in MOH/GOU settings where services are being provided. Vision 2012 is now being taken forward to the more robust Uganda Health Information System Strategy (UHISS), which has now taken a multi-sectoral approach, under the direction of the Ministry of Health Resource Center (RC).

Specifically, USG is currently supporting the MOH/RC directly to carry out day-to-day activities to improve the overall national HMIS. These activities include revisions and harmonization of tools and forms as MOH implements the new Health Sector Strategic Plan. New tools and forms will include more community-based data, harmonization of various vertical programs and provide indicators that are more relevant. Other activities include supervision to 40 districts to strengthen them in the use of paper and electronic HMIS systems and direct support to districts to allow them to carry out supportive supervision visits to their health facilities. Finally, a database administrator will be recruited to help the RC manage data from a variety of sources.

M&E
During PEPFAR I the Uganda program benefited from the use of a web-based data entry system. The functionalities of the dedicated database to collect and consolidate PEPFAR indicator data from all partners have progressively been enhanced. This system is used to review partners' targets based on performance, data assessments and validations, and to minimize double counting within and across IPs. On-going TA was provided to IPs to ensure uniform understanding of indicator reporting requirements and improve M&E capacity. Site visits to assess data quality and inform programming were conducted. Training in data management occurred within all program areas. USG shared PEPFAR results for the FY09 SAPR with GOU, UNAIDS, UNICEF, WHO and other national stakeholders in a bid for national ownership of the data.

Efforts to improve the ability of partners to collect and analyze their program data continued. IPs were trained on STATA, Epi-Info, and the use of electronic data systems. Evaluation of various Electronic Medical Record (EMR) systems and supporting IPs to develop an EMR or ensuring appropriateness of their current systems were conducted. In addition to EMR, USG supported piloting of new electronic technologies including mobile phones and personal digital assistants (PDA). It is expected that PDAs will be used for improved reporting of facility-based data especially since computer infrastructure and support are lacking. An evaluation of Health Commodities Distribution Systems and MIS of the National Medical Stores was completed. Systems development and installation at selected IP sites was completed for electronic registry, blood transfusion management, HCT and pharmacy.

In strengthening the third "one", USG supported the:
1. National dissemination and roll out to the NSP, PMMP, and the PMMP Operational Handbook
2. Development of the PMMP Standard Forms to collect HIV/AIDS data that are not available in the

existing national line ministries' reporting systems
3. Development and implementation of a national system for M&E of HIV/AIDS social support services at all levels
4. Assessment of the National M&E system and development of appropriate actions to address gaps
5. Inclusion of PEPFAR II indicators in the revised national data tools

The USG conducted a workshop on "Data Use to Impact Program Management" for implementing partners, with keynote speakers from UAC, MOH and USG. The objective was to increase data demand, use and feedback at all levels.

Surveillance and Surveys
A planned joint Malaria and AIDS Indicator Survey was cancelled due to repeatedly missed deadlines. The MIS and AIS components are now planned to be conducted as separate surveys (the MIS without PEPFAR support). The stand-alone AIS protocol was submitted for renewed review at CDC Atlanta and local IRBs. The proposed start date for the AIS is March 2010.

The annual round of ANC sentinel surveillance was started in June 2009 at 30 sites. Central testing of samples will take place at the HIV/AIDS Reference and Quality Assurance Laboratory (HRL) at UVRI. Completion of data analysis and dissemination of results are expected by December 2009. Other HIV surveillance efforts include a sero-behavioral survey among fishing communities as well as selected Most at Risk Populations (MARPs). The latter was conducted in five hard to reach populations, CSWs, their partners, MSM, motorcycle transporters and university students. Using Respondent Driven Sampling and Audio Computer Assisted Self Interview (ACASI) methods led to excellent recruitment.

Secondary analysis of the Uganda Demographic and Health Survey (2006) was performed with funding leveraged by other donors; findings were published in a report and disseminated nationally. Results of the Uganda Service Provision Assessment Survey were disseminated nationally and internationally. The surveillance on anti-TB drug resistance among smear-positive TB patients was initiated. USG actively participated in the HIV Drug Resistance (HIVDR) Working Group (WG) that was established as a subgroup of the National MOH ART TWG. The WG conducted surveys on Early Warning.

To inform GOU and PEPFAR with specific information on key program issues, USG supported the following PHEs and non-PHE surveillance and operational research activities. Details are described in the activity narratives.

1) Evaluating the utility of re-testing HIV-negative VCT clients to identify "window period" infections. Laboratory testing began in FY09 and will continue in FY10.
2) Completion of HBAC I, to evaluate the relative utility of viral load versus CD4 cell monitoring. This study was terminated by the CDC IRB.
3) The Tororo Child Cohort study, to determine interactions between HIV and malaria in African children
4) Comparison of facility and home-based ART delivery systems, implemented by MRC-UK
5) Evaluating home-based confidential counseling and testing in Kumi and Bushenyi Districts. Protocol review and approval by the CDC IRB came too late to implement this activity in Bushenyi District. Field activities in Kumi District are complete. Current efforts focus on data entry and management.
6) PLWHAs as Change Agents. Field activities have yet to start.
7) Strategies to decrease HIV-transmission risk behavior and increase drug adherence among HIV-infected adults initiating antiretroviral therapy in Uganda. Planned completion date: March 2010.
8) Assessing the relationship between intimate partner violence and HIV status disclosure in Rakai District: Collaboration on this PHE was cancelled by the local implementing partner (Makerere University, School of Public Health). OGAC's PHE team was informed accordingly.
9) Evaluating two types of male circumcision procedures: Collaboration on this PHE was cancelled by the

local implementing partner (Makerere University, School of Public Health). OGAC's PHE team was informed accordingly. This PHE has now been re-submitted (COP FY10) in a modified form and is proposed to be conducted under the lead of Walter Reed.
10) "Last 1000 infections" (protocol title: VCT-based surveillance of HIV acquisition): Delays in starting this activity are due to challenges in identifying the right funding mechanism. Preparatory activities are underway to start this activity in the first half of FY10.

Goals and strategies for the coming year

HMIS
USG will support the development of the multi-sectoral Uganda Health Information Systems Strategy and extend the MOH/Resource Center district support on HMIS to an additional 20 districts. MOH will start the development of a data warehouse to serve as a central repository for health data.

M&E
SI will work with PEPFAR TWGs to review partner targets, provide assistance on the next generation indicators (NGI) and improve PEPFAR data quality and alignment with the national reporting system. IP M&E systems will be evaluated to inform IP capacity building. Program evaluations will be conducted for mechanisms that are ending to inform future programming.

In FY10 USG will invest more resources to support the national HIV/AIDS reporting system to support comparability of data reported to OGAC and national data. Expanded support to the PMMP roll out and continued USG support to UAC in its coordination role, and the development and implementation of a national system for M&E of HIV/AIDS social support services at all levels will be provided.

USG will also support the ongoing clinical lab system; an EMR system; the development and implementation of an electronic ART reporting tool at 330 health units; and the continued evaluation of fingerprint technology, smart cards, automated electronic data transfer and use of solar panels

Challenges include comparing trends in PEPFAR I to PEPFAR II indicators, reconciling PEPFAR and national age disaggregation, and avoiding creation of parallel reporting systems while addressing varying data needs.

Surveillance and Surveys
USG will continue to support the implementation of ANC sentinel surveillance, the timely availability of data and reports, as well as MARP surveillance. Uganda's second AIS will be started in FY10. Surveillance-related operational research will include the piloting of a new population based surveillance activity, the Uganda Health Surveillance (UHS), integrating ACASI technology, chronic disease biomarkers, and a sampling design that informs both the district and national level, the latter on a continuous basis. An evaluation and implementation of PMTCT-based HIV surveillance, including both HIV prevalence and incidence surveillance, will take place. USG will work with MOH to develop a national strategic surveillance plan for HIV/AIDS, including the timeline, scope and frequency of key surveillance activities. The SI portfolio will support the HIVDR Working Group in surveillance of early warning indicators and acquired ART drug resistance. Evaluation of anti-TB drug resistance among smear-positive TB patients will also be performed, as well as ART outcome monitoring. FY10 activities will also strengthen surveillance and management of multidrug resistant TB. The five active PHEs that were not completed will be continued. All new (FY08 and FY09 initiated) multi-country PHEs, although approved, have yet to start field activities due to challenges to identify the correct funding mechanism, drop-out of partner countries, or other reasons.

Staffing

In FY10, approximately 61 USG FTE will work in this technical area.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	9,113,758	
Total Technical Area Planned Funding:	**9,113,758**	**0**

Summary:
Context and Background

In Uganda, the estimated incidence of all forms of TB is 330 new cases per 100,000 population/year with an incidence of 128 new cases per 100,000 population/year in HIV-positive people. It is estimated that 39% of all incident TB cases are HIV-positive. Prevalence of all forms of TB is 426 cases per 100,000 population. Mortality is 93 deaths per 100,000 population/year. Estimated multidrug-resistant TB (MDR-TB) among all new TB cases is 0.5%. (Global Tuberculosis Control: WHO Report 2009).

The Uganda TB control indicators remain poor despite the implementation of DOTS throughout the country. The treatment success rate is 74% against the WHO target of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. The TB case detection rate is 57% versus the target of 70%. In 2008, of the 43,493 TB patients notified to the Ministry of Health's National TB and Leprosy Program (NTLP), 22,561(52%) were sputum smear positive. The NTLP is hugely under-funded and relies heavily on donor support. Delayed disbursement of Global Fund grants has contributed to shortage in anti-TB drugs and affected performance of the NTLP in terms of supervision, coordination and management of TB control activities. Program monitoring and evaluation remains weak and there is need to strengthen reporting and recording through standardizing tools as well as strengthening the capacity of the district TB focal persons to supervise and monitor TB control activities. In addition, there is need to conduct a TB prevalence survey so as to obtain more accurate estimates of TB burden in the country. This would provide better estimates of the case detection rate.

In the past year, there has been a rapid expansion of provider-initiated HIV testing and counseling offered to TB patients as well as linkages to care and treatment for TB/HIV co-infected patients. However, there is still a need for intensified efforts in this area. TB screening, diagnosis and treatment of PLWHA is sub-optimal, ranging from 12-90% across USG implementing partners. Although most health providers are aware of the need to screen all HIV/AIDS clients for TB at each visit, screening tools are not standardized. This partly contributes to inaccurate recording and under reporting. The MOH's AIDS Control Program recently modified the recording and reporting tools to capture TB indicators among PLWHA. However, the tools are yet to be widely disseminated. Of the registered TB patients, 58% had the results of an HIV test recorded in the TB register and of these 59% were HIV-positive. Co-trimoxazole was provided to 59% and antiretroviral therapy to 14% of HIV-positive and TB patients (NTLP-2008). The major challenges faced include poor linkage and feedback on referrals between the TB program and HIV clinics at national, district, and facility levels. In addition, frequent stock-outs of HIV test kits in TB treatment sites and follow-up of co-infected clients remain challenges.

National TB infection control guidelines have recently been developed and disseminated to some districts. However, the coverage remains limited resulting in lack of adequate knowledge among health providers and hence minimal implementation of the core TB infection control activities. IEC materials on TB infection control are also lacking. Implementation of isoniazid preventive therapy (IPT) for PLWHA is still minimal and limited to one partner as there has been little headway in developing guidelines and efforts to

promote this at national level. All PEPFAR partners participate in the TB/HIV National Coordination Committee. Anti-TB drugs and TB laboratory reagents are procured through the Global Fund. Other partners supporting TB/HIV integrated activities and community-based (CB) DOTS include the German Leprosy and Tuberculosis Relief Association (GLRA) and WHO. The Foundation for Innovative New Diagnostics (FIND) provides support for new TB diagnostics.

Surveillance and management of multidrug resistant TB remains a great challenge in Uganda. The capacity for diagnosis of MDR-TB using liquid culture methods is only available in 3 laboratories in Kampala. Facilities in rural areas have a challenge to transport of specimens to the reference laboratories. A sputum referral system has been set up to facilitate this transfer and is operational in 2 regions out of 9. Due to delays in conducting the National Drug Resistance Survey, there are no recent country-wide data on prevalence of MDR-TB.

Accomplishments since last COP

In FY09, USG supported the MOH to update National TB Guidelines which incorporate pediatric TB, MDR-TB and TB infection control. Draft guidelines have been developed and expect to be finalized by the end of 2009. With USG support, some headway has been made in implementing TB-HIV/AIDS integrated activities and addressing poor TB infection control. USG implementing partners (IPs) were provided with technical assistance by the Tuberculosis Control Assistance Program (TB CAP) on TB infection control activities and this is now implemented in 12 districts. In addition, TBCAP conducted training-of-trainers with the IPs on TB-HIV/AIDS integration. IPs have in turn begun training service providers with the aim of increasing knowledge and awareness on TB-HIV/AIDS collaborative activities. In PEPFAR-supported sites, more than 80% of the HIV-TB co-infected receive co-trimoxazole prophylaxis. Only 12-43% of co-infected patients, however, are enrolled on ART. Other achievements include revision of the HIV cards and registers to better capture and report on TB-HIV/AIDS variables and to link these to the TB registers. In FY09, USG continued to support TB-HIV/AIDS coordination efforts at national and district level.

USG Child Survival and Health (CSH) TB funds were used to promote TB control activities, as a complement to PEPFAR funding for TB-HIV/AIDS collaborative activities. The overall aim was to increase capacity at national and district levels to manage TB control programs and TB-HIV/AIDS collaborative activities effectively, and contribute to the national goal of increasing case detection and treatment success rates leading to reduced mortality in TB-HIV/AIDS co-infected patients by 50%. As such, among other accomplishments, TB control was integrated within district work plans and budgets. Furthermore, TB and TB-HIV/AIDS activities were expanded into the private sector through support from the Health Initiatives for the Private Sector (HIPS) project.

In March 2009 (SAPR), the USG provided TB treatment to 10, 838 HIV-positive clients and provided counseling and testing of 13,320 TB patients. Among PEPFAR IPs, co-trimoxazole preventive therapy (CPT) coverage was over 80% and ART for TB/HIV co-infected patients ranged from 12 to 43%.

Goals and strategies for the coming year

FY10 activities will build on the achievements in the previous year and focus on improving quality of TB-HIV/AIDS integrated activities. FY10 TB/HIV funds, leveraged and complemented by non-PEPFAR USG CSH/TB funds, will be used to further build capacity at national and district levels to manage TB control programs and TB/HIV collaborative activities effectively. At the national level, PEPFAR funding will complement other sources of TB funding from the WHO, the Global Fund, GLRA and FIND. At the district level, PEPFAR funding will leverage non-PEPFAR USAID funding for expansion of CB-DOTS in PEPFAR-supported districts. These non-PEPFAR funds will provide district level support of CB-DOTS supervisors to oversee linkages between community and facility-based care, and between TB and HIV activities. USG support for integration of TB-HIV/AIDS activities will continue to be in three primary areas:

a) enhancing the working relationships between NTLP and the MOH's AIDS Control Program (ACP); b) assisting the National Coordination Committee to develop National Program Implementation Plans; and c) providing supervisory and technical support at district and facility levels. At the district level, USG will continue to support district level TB/HIV coordination and to ensure that integration activities are incorporated into district health plans. To ensure sustainability, partners will coordinate with and support national, district and facility- level systems and not develop parallel systems. The new national guidelines will be disseminated to all partners and PEPFAR-supported sites.

FY10 objectives and targets include:
1. Improve HIV testing and counseling and linkage to HIV care and treatment in PEPFAR supported sites in order to: provide counseling and testing to at least 80% of registered TB patients; provide co-trimoxazole to more than 80% of TB/HIV co-infected clients; and provide ART to at least 40% of TB/HIV co-infected clients.

2. Strengthen routine TB screening, diagnosis and treatment among PLWHA in PEPFAR supported sites, providing TB screening to at least 80% of patients in HIV care and treatment.

3. Strengthen laboratory services to support TB diagnosis and treatment so that 100% of PEPFAR supported TB/HIV diagnostic units have quarterly external quality assurance for acid-fast bacilli (AFB) microscopy.

4. Strengthen TB infection control (IC) so that all PEPFAR supported facilities will have received training in TB IC and developed a TB IC plan by the end of 2010.

5. Strengthen surveillance and management of multi-drug resistant TB, completing the national TB Drug Resistance Survey and working with the NTLP to provide quality treatment to the MDR-TB cases identified.

6. Strengthening program monitoring and evaluation, ensuring the reporting of TB/HIV data from PEPFAR supported sites to the MOH.

Increased focus will continue to be placed on the following technical priorities:

1. Improvement of Provider-Initiated HIV Counseling and Testing (PICT) as well as linkage and referral of HIV-infected TB patients to HIV prevention, care and treatment services. PICT among TB patients will be improved through training and provision of the national TB guidelines to health workers to provide HIV counseling and rapid HIV testing to all TB patients and TB suspects within the TB clinics and wards. Support will be provided to the NTLP to disseminate the recently approved tools for implementation of Intensified TB Case Finding (ICF). Implementing partners will support logistics management training and procurement or requisition of HIV test kits at sites. TB patients found to be HIV-positive will either be provided with HIV care and treatment at the TB clinic or referred to HIV care and treatment sites. The TB register number will be included in the HIV care and treatment registers to ensure for better linkage and referral tracking between the two clinics. More effort will be put into ensuring more HIV-positive TB patients are enrolled in ART and that this is recorded and reported. Achievement in providing co-trimoxazole to HIV-positive TB patients will be sustained and further improved. Follow-up and adherence support of HIV/TB co-infected patients will be strengthened using a combination of family members and CB-DOTS. Health care providers in TB clinics will be trained to provide a minimum package of prevention with positive services that includes information on PwP, supported disclosure, partner-based counseling and testing, consistent and correct condom use and information on PMTCT, family planning and STI management.

2. Strengthening routine TB screening in PLWHA by disseminating the developed TB screening tool to all

PEPFAR supported sites. The tool will be used in HIV care and treatment settings, PMTCT clinics, congregate settings such as prisons, and in community- based settings.

3. PEPFAR implementing partners will strengthen laboratory services to support TB diagnosis and treatment by ensuring that laboratory infrastructure, human resources, commodities, external quality assurance, supervision, timely diagnosis of sputum smear negative cases and infection control are conducted in the facilities that they support. Activities from the previous year, such as TB sputum microscopy training and support to the National Tuberculosis Reference Laboratory (NTRL) to implement external Quality Assurance, will continue

4. PEPFAR TB/HIV partners will support the implementation of TB-IC control measures at all levels based on the principles of the revised WHO guidelines which includes managerial activities at national, sub-national level, and facility level, administrative controls, environmental controls and personal protective equipment. TB IC guidelines and training materials that were developed will be further disseminated to all PEPFAR implementing partners. Training-of-trainers on TB IC will continue to be conducted, providing a pool of trainers who will in turn train health providers and communities. Health care facilities will have infection control teams, conduct IC needs assessment, and develop infection control plans. Administrative control and low-level technical environmental control measures such as triaging of patients, health education of patients and health providers, and separation of infectious patients from those at risk will be implemented. Infection control measure will also be ensured in congregate settings. REDACTED.

5. FY10 activities will strengthen surveillance and management of multidrug resistant TB. Data collection for the national TB drug resistance surveillance (DRS) will be undertaken. In addition to the Mulago National Referral Hospital, the MOH plans to create 4 additional sites where MDR can be treated. Teams from the regional sites have been identified and initial training has been held. Additional training will be conducted to strengthen the capacity of the regional teams. Support will continue to be given to the NTLP aimed at expediting the process of obtaining the Green Light Committee endorsement of providing MDR drugs to Uganda. Support will include ensuring the availability of standardized guidelines, reporting tools, drugs and supportive supervision teams. PEPFAR will also leverage USG CSH/TB resources to support a full time Medical Officer to support coordination of all MDR activities at the NTLP.

6. Strengthening program monitoring and evaluation is an important FY10 activity. PEPFAR IPs will work in collaboration with NTLP, district, and facility structures in planning and implementing M&E. Partners will support districts and facilities to use the revised TB and HIV registers of the MOH, ensuring that they are available at the sites and that health providers are trained to use them. IPs will report on core indicators for TB/HIV, such as numbers of TB patients receiving HCT, CPT and ART.

Staffing

In FY10, approximately 2 USG FTE will work in this technical area.

Technical Area Summary Indicators and Targets
REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7176	Chemonics International	Private Contractor	U.S. Agency for International Development	GHCS (State)	2,000,000
7181	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
7183	Commodity Security Logistics	NGO	U.S. Agency for International Development	GHCS (State)	2,000,000
7184	Creative Associates International Inc	Private Contractor	U.S. Agency for International Development	GHCS (State)	4,064,357
7185	Deloitte & Touche, Uganda	Implementing Agency	U.S. Agency for International Development	GHCS (State)	7,752,091
7187	Associates in Rural Development	NGO	U.S. Agency for International Development	GHCS (State)	300,000
7188	Emerging Markets	Private Contractor	U.S. Agency for International Development	GHCS (State)	2,857,219
7191	University Research Corporation	Private Contractor	U.S. Agency for International Development	GHCS (State)	2,536,750
7193	Macro International	Private Contractor	U.S. Agency for International	GHCS (State)	750,000

			Development		
7197	The Mitchell Group	NGO	U.S. Agency for International Development	GHCS (State)	1,000,000
7199	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
7308	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHCS (State)	17,112,375
7331	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHCS (State)	1,305,100
7332	Family Health International	NGO	U.S. Agency for International Development		
7432	Inter-Religious Council of Uganda	FBO	U.S. Agency for International Development		
7433	Social and Scientific Systems	Private Contractor	U.S. Agency for International Development		
7973	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development		
9042	African Medical and Research Foundation, South Africa	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9043	Henry Jackson Foundation	Implementing Agency	U.S. Department of Defense	GHCS (State)	3,889,275
9046	Baylor College of	NGO	U.S. Department	GHCS (State)	6,132,397

	Medicine Children's Foundation/Uganda		of Health and Human Services/Centers for Disease Control and Prevention		
9165	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State), Central GHCS (State)	17,500,850
9166	AIDS Information Center	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	593,922
9167	Kalangala District Health Office	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,245,440
9169	Makerere University John Hopkins University Collaboration	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9172	Mildmay International	NGO	U.S. Department of Health and		

			Human Services/Centers for Disease Control and Prevention		
9174	National Medical Stores	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9177	Population Services International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9178	Protecting Families Against AIDS	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9180	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
9181	Research Triangle International	NGO	U.S. Department of Health and Human		

			Services/Centers for Disease Control and Prevention		
9183	The AIDS Support Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	15,257,636
9184	The AIDS Support Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9185	Uganda Blood Transfusion Services	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	218,000
9186	Uganda Virus Research Institute	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,215,000
9236	Integrated Community Based Initiatives	NGO	U.S. Department of Health and Human Services/Centers	GHCS (State)	720,102

			for Disease Control and Prevention		
9238	Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	720,116
9239	The AIDS Support Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	490,000
9240	Uganda Prisons Services	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	320,000
9246	Makerere University School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	4,736,015
9247	Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease	GHCS (State)	5,019,259

			Control and Prevention		
9297	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
9300	Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)	Implementing Agency	U.S. Agency for International Development	GHCS (State)	3,949,263
9301	John Snow Research and Training Institute	NGO	U.S. Agency for International Development	GHCS (State)	6,177,011
9303	DOD-UPDF	Implementing Agency	U.S. Department of Defense	GHCS (State)	1,942,837
9325	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHCS (State)	1,226,477
9326	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	Central GHCS (State)	370,000
9327	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHCS (State)	6,087,561
9334	Family Health International	NGO	U.S. Agency for International Development	GHCS (State)	2,010,000
9335	HOSPICE AFRICA, Uganda	NGO	U.S. Agency for International Development	GHCS (State)	1,386,000
9338	The AIDS Support Organization	NGO	U.S. Agency for International Development	GHCS (State)	3,261,000
9340	The International Union Against	Implementing Agency	U.S. Agency for International		

	Tuberculosis and Lung Disease		Development		
9347	World Vision for Khaulhelo Area Development Program	NGO	U.S. Agency for International Development	GHCS (State)	1,503,302
9483	Infectious Disease Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	2,375,748
9541	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
9542	Johns Hopkins University Center for Communication Programs	University	U.S. Agency for International Development	GHCS (State)	2,738,157
9879	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	5,390,046
10003	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration		
10086	International Medical Corps	NGO	U.S. Department of State/Bureau of Population, Refugees, and Migration	GHCS (State)	283,345

10280	Integrated Community Based Initiatives	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,062,231
10281	University of California, San Francisco School of Nursing	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,401,139
10326	Joint Clinical Research Center, Uganda	NGO	U.S. Agency for International Development		
11429	HHS/Centers for Disease Control & Prevention	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	780,000
11479	U.S. Department of State/Bureau of Population, Refugees, and Migration (State/PRM)	Implementing Agency	U.S. Department of State/Bureau of African Affairs	GHCS (State)	401,000
11480	U.S. Peace Corps	Implementing Agency	U.S. Peace Corps		
12476	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	3,284,696
12477	TBD	TBD	U.S. Department	Redacted	Redacted

			of Health and Human Services/Centers for Disease Control and Prevention		
12478	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12479	Reproductive Health Uganda (RHU)	Implementing Agency	U.S. Agency for International Development	GHCS (State)	1,306,000
12480	Abt Associates	Private Contractor	U.S. Agency for International Development	GHCS (State)	274,000
12481	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12482	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12483	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12484	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12485	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12486	TBD	TBD	U.S. Agency for International	Redacted	Redacted

			Development		
12487	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12488	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12489	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12490	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12491	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12492	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12493	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12494	TBD	TBD	U.S. Department of Health and	Redacted	Redacted

			Human Services/Centers for Disease Control and Prevention		
12495	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12496	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12497	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12498	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12499	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted

12500	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12501	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12502	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12503	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12504	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12505	TBD	TBD	U.S. Agency for	Redacted	Redacted

			International Development		
12506	TBD	TBD	U.S. Department of Health and Human Services/Health Resources and Services Administration	Redacted	Redacted
12507	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7176	**Mechanism Name: Monitoring and Evaluation Agent/Civil Society Fund**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Chemonics International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,000,000	
Funding Source	**Funding Amount**
GHCS (State)	2,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7176**
Mechanism Name:	**Monitoring and Evaluation Agent/Civil Society Fund**

Prime Partner Name:	Chemonics International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	1,400,000	
Narrative:			
continuing activity			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	300,000	
Narrative:			
continuing activity			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	225,000	
Narrative:			
continuing activity			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	75,000	
Narrative:			
continuing activity			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7181	**Mechanism Name: HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

HIV/AIDS remains a daunting challenge to Uganda despite the country's incredible efforts expended in stemming the epidemic. HIV prevalence among the adult population (15-49 years) has declined considerably from an estimated 18% in the early 1990s to the current 6.5%. However, over the past five years, HIV prevalence has stagnated and no longer shows a downward tendency. There have been shifts in epidemiological patterns, with new infections now occurring more in married and co-habiting couples than in youth, as was the case a few years ago. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in the conflict regions are the most severely affected. Approximately 1.1 million Ugandans are HIV positive, of whom approximately 100,000 are children under the age of 18. Of the adults in married and co-habiting relationships, forty percent of those who are HIV positive have an HIV negative spouse.

Uganda has recently concluded a modes of transmission study which indicates, among other things, that there have been shifts in the risk factors and drivers of the epidemic. The key risk factors now include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviours due to antiretroviral treatment (ART). The study also pointed to serious flaws in programming by government and its partners as most data generated over the years have not been utilized in designing new prevention interventions that respond to the changes in the epidemic. As a result, interventions remain in discord with realities. Consequently, populations where available evidence indicates that are at a higher than average risk of HIV infection are not served with the kind of services that they need. Uganda's HIV/AIDS response is still encumbered by serious challenges, notably the low coverage of services, especially in the rural areas.

Currently, about 23% of Ugandan's aged 15-49 years know their HIV status; HIV/AIDS care and support services reach less than 50% of those in need while approximately 40% of individuals eligible for treatment are able to access it. In addition, high mortality of economically active adults witnessed over the last two decades has led to several children being orphaned and families economically devastated. There

are an estimated 7.5 million orphans and other vulnerable children in Uganda. More than half of them are affected by HIV/AIDS and only 20% are receiving care, which often falls short of the total needs. Uganda is reported to have the highest fertility rate in the world, with population projected to hit 36.8 million in 2015 up from 12.6 million in 1980. The age group 10-24 years constitutes 33% of the entire population implying that there are more people who have to be reached with HIV prevention messages and services besides sexual and reproductive health if Uganda is to contain and manage the epidemic

This activity aims to contribute to the national efforts towards increasing access to quality HIV/AIDS prevention, care and treatment services for individuals, families and communities. It will contribute to the national agenda for HIV prevention with particular emphasis on promoting abstinence for youth and mutual faithfulness for couples. The activity will also improve access to and utilization of quality, comprehensive HIV/AIDS care and treatment services by PLHA, orphans and other vulnerable children as well as their immediate families. HIV/AIDS services will have an integral component of family planning information to increase awareness among HIV positive individuals on the importance of making safe and informed reproductive choices that enhance positive living.

The overall goal of this activity is to build a strong, coordinated and sustainable faith-based HIV/AIDS response in Uganda. To realize this goal, the applicant will be expected to focus on the following:

i. Strengthen the overall faith-based HIV/AIDS response in Uganda.
ii. Facilitate access to and utilization of quality, comprehensive HIV/AIDS prevention, care and treatment services for PLHA and their immediate families.
iii. Strengthen the role of religious leaders in advocacy for HIV/AIDS and reproductive health including Family Planning.

Emphasis shall be placed on accessing services to hitherto underserved regions. The recipient will also be expected to work in partnership with other USG and non-USG supported partners to increase access to other essential services such as preventive care commodities, food assistance and support for income generating activities which play a complementary role in the achievement of program objectives.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	REDACTED.
Education	REDACTED.
Food and Nutrition: Commodities	REDACTED.

Food and Nutrition: Policy, Tools, and Service Delivery	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7181**		
Mechanism Name:	**HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

Uganda is still haunted by the growing burden of HIV/AIDS, with approximately more than 1 million individuals currently infected. HIV/AIDS care and support has been a critical piece of the overall HIV/AIDS response in Uganda since the mid 1980s. Over the years, care and support competence has grown in Uganda and a lot of models have evolved, using both facility and community based approaches. Over the past five years, access to ART has increased in Uganda, with resources from global initiatives, notably PEPFAR and the Global Fund. This has resulted into remarkable improvement in the quality of life for those infected and affected. However, like other developing countries, Uganda does not expect any significant increase in resources for ART in the indefinite future. This implies that care and support must be re-emphasized with particular focus on interventions that directly impact the health of PLHA. This will serve to keep the vast majority of PLHA healthy, hence minimizing the need for ART.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), to expand access to HIV and AIDS care and support services through their network of faith-based health units and NGOs. Through this network, IRCU has played an important role in rolling out care and treatment services. By March 2009, IRCU had enrolled over 50,000 individuals into chronic care through its eighteen partner sites. USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a follow on program (TBD) that will build upon and further expand the current achievements of IRCU.

The follow-on program (TBD) will continue to deliver care and support services through the network of

faith-based health facilities and organizations located in various districts of Uganda. A mix of approaches including facility, community and home based care will be applied. Activities will be targeted at men, women and children living with HIV/AIDS and their immediate families with a key focus on sustaining individuals already enrolled in care to mitigate interruption of services. Services will be targeted at both rural and urban areas in response to the burden of the epidemic as reflected in the national prevalence data. Underserved areas (those with little or no coverage of HIV/AIDS services) will continue to be a key consideration of the program.

The new activity will also continue to build care and support competence among providers, with emphasis on updating service providers on emerging challenges and new approaches to AIDS care and support, strengthening linkages with other PEPFAR and non-PEPFAR activities to maximize synergies, continuous improvements in quality of services as well as establishing and institutionalizing user friendly mechanisms for measuring quality and impact of services. IRCU has initiated partnership with the PEPFAR supported Infectious Diseases Institute (IDI) to ensure quality assurance and capacity maintenance. The follow-on program (TBD) will be required to build upon the existing initiatives by working closely with MOH and the USAID supported Health Care Improvement Project and HIVQAL to introduce continuous quality improvement and monitoring approaches in all its supported facilities. The overall aim is to ensure that services delivered conform to the national and international standards and that they are responsive to client needs. The follow-on program (TBD) will also be expected to continue building the capacity for holistic palliative care within faith-based health centers and NGOs. Special focus will be put on integrating pain and symptom management within the exiting AIDS care and treatment services.

The new activity (TBD) will continue to roll out basic preventive care based on its proven efficacy in warding off opportunistic infections. This will entail procurement and distribution of long lasting insecticide treated mosquito nets (ITNs) to PHA and their immediate families, improving access to safe water commodities as well as prescription of prophylactic cotrimoxazole as a standard practice in care and treatment in accordance with the Ministry of Health (MOH) guidelines and policy. The new activity will be expected to build upon the existing partnership with the CDC supported PACE program to ensure sustained delivery of basic care commodities.

Shared care and support will be emphasized to ensure that PLHA access a wide spectrum of services from multiple sources and settings. To the extent possible, care and support services shall be linked with other HIV/AIDS programs, especially counseling and testing, ART, PMTCT and OVC care. To achieve this, the follow-on program (TBD) will be required to build viable inter and intra collaborative networks within facilities and communities to enable PHA access the full continuum of care. In addition, the follow-on program will continue working to further build the skills of religious leaders and harness their

respected positions and connectivity with communities in the delivery of home based care, adherence monitoring and referral. Using the network model approach, religious leaders, PLHA and other volunteers will be supported to consolidate their roles in mobilizing and referring individuals for facility based services while at the same delivering intermediate care and adherence monitoring. Feedback mechanisms, initiated under the ending IRCU program will be strengthened and consolidated to facilitate communication and information on PLHA receiving care from multiple partners. This will improve the success and efficacy of referrals and shared care.

With the support of the Chemonics ACE program, IRCU has established a robust monitoring and evaluation systems that captures data on both qualitative and quantitative progress of activities. The new activity will build upon and further strengthen this system by continuously reviewing its relevance and where necessary updating it to ensure that it is in consonance with the current services being delivered. Short-term operational research studies will be undertaken where necessary to provide new evidence on the efficacy of the existing approaches and services.

By the end of FY 2010, the follow-on program (TBD) is anticipated to have provided care and support to 70,000 people living with HIV/AIDS. 100 health workers will have been trained in HIV and AIDS care and treatment, with the aim of ensuring that their knowledge and skills are in currency with modern approaches and practices. In addition, the follow on program will train 2000 community and religious leaders in basic HIV and AIDS care and treatment to serve as community based HIV and AIDS resource persons and to link facilities with communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

Historically, faith-based organizations were the forerunners in the delivery of health and social services in Uganda. They have since established extensive health and social networks reaching the lowest point in communities. These networks provide an excellent mechanism for rolling out health and social services.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS services through their network of faith-based health units and NGOs. IRCU has been working through its network of community based organizations to deliver a range of services focusing on care and protection of orphans and other vulnerable children (OVC) and their immediate families. Currently IRCU is providing care and support to 11,373 OVC. 4,885 caregivers have been trained in OVC care and micro-enterprise development to reduce economic vulnerability of households and to improve their capacity to offer

sustainable care.

USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU. The primary priority for the follow-on program will be to transition the OVC program from an emergency to a development outlook by crafting interventions that engender community and household capacity to effectively meet OVC needs in a sustainable manner. While doing this, the follow-on program will also strive to ensure that OVC enrolled for basic education continue to receive services since this is the foundation for their future growth and survival. This will entail building the capacity of teachers to create conducive environments within schools that support and encourage OVC to remain in school. Key strategies include training teachers in basic counseling to be able to detect and address emotional needs of OVC, as well as negotiating flexible regimes for payment of school dues, uniforms and other scholastic materials. Vocational training, sourced through community based schools and apprenticeship arrangements will also continue to be prioritized as a way to fast track the OVC capacity to earn a living.

Other key OVC interventions including health care, psychosocial support, as well as HIV prevention education will continue to be prioritized under the new program. Economic strengthening of caretaker families has also been embarked on, with activities focusing on training in micro-enterprise development and linking groups of caregivers, mainly widows to local markets for their produce. This strategy of linking groups of caretakers to markets has yielded promising results, both in terms of stimulating production of indigenous crops and ultimately reducing poverty and household vulnerability. Psychosocial support and legal protection for orphans and caregivers remain strongly felt needs but least addressed. The follow-on program will work to ensure that psychosocial care becomes a key and integral component of OVC care. Children and their caregivers shall be provided opportunities and trusting environments where they engage in frank discussions about HIV and mutually agree upon plans for the future. The program will continue to emphasize legal and child protection by training caregivers and orphans in succession issues, including writing and discussing of wills at family level. This will also entail training the community on the basic child protection laws and rights in order to make child protection a shared responsibility. Also the follow-on program shall identify community based sources of psychosocial care and child protection to which OVC and their caregivers can turn in case of distress. These include among others, community development officers at sub-county levels, religious leaders, Probation and Welfare Officers, as well as local leaders mandated to oversee children affairs.

The program shall educate OVC caregivers on the availability of PEPFAR care and treatment services within their localities so that they can refer or take their OVC for health care when in need. Using simple job cards, program staff and community level volunteers will undertake routine nutritional assessment of OVC and where OVC are found to be malnourished, they will be referred to other PEPFAR support

programs that address nutrition, such as the NuLife program. The program staff will also counsel and educate caregivers will on nutrition, especially on aspects of dietary diversity using locally grown foods.

The follow-on program will adopt a holistic and family based approach to OVC care. This will entail assessing the entire household to determine potential barriers to normal growth and development of children and develop strategies for addressing them. Since most OVC live within households that are vulnerable, picking one OVC for assistance and living others results in stigma, hatred and tension within the family and ultimately compromises program outcomes. Therefore, the family approach will emphasize targeting of care at all eligible OVC in the household. With level funded budgets, it is unrealistic to expect significant expansion of OVC programs under this new activity. Therefore, it is anticipated that the new program will continue to offer care and support to 11, 373 OVC and their households while striving to creatively initiate creative approaches that engender quality and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

In Uganda faith-based organizations (FBOs) have the most extensive health and community infrastructure and networks, and consequently they are the major providers of health care. This makes them a viable mechanism for rapidly expanding quality health services to the lowest point in the community. Using their infrastructure and networks, FBOs have been and still remain a critical part of the Ugandan HIV/AIDS response.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), to expand access to HIV and AIDS treatment services through their network of faith-based health units and NGOs. Through this network, IRCU has played an important role in rolling out care and treatment services. As at March 2009, after two years of initiation of treatment services, IRCU had enrolled 6,167 individuals on treatment through thirteen sites and is poised to reach over 7,200 individuals by December 2009.

USAID/Uganda's partnership with IRCU ends in December 2009. Based on the proven viability of the faith-based networks in quickly expanding access to services, USAID/Uganda plans to initiate a follow on program (TBD) to build upon and further expand the current achievements of IRCU.

Under the follow-on program (TBD) key priority will be to sustain the individuals already enrolled on treatment to ensure that services are not interrupted both in flow and quality. With no guarantee for significant increases in ART resources, the program will be tasked to review the treatment practices

formerly used by IRCU with the aim of coming with creative approaches that enhance cost-efficiency and rational use of resources to sustain services. Recent research findings discount the efficacy of CD4 counts in on-going disease monitoring, signaling the need to adopt new monitoring protocols that enhance treatment success. Although hitherto minimal, resistance to first line treatment is rising, with an average about 2%-5% of all patients failing across all the sites. Despite its shortcomings, CD4 monitoring continues to be the most cost effective and most commonly used approach for monitoring treatment outcomes. Renal and liver function tests are also used prior to initiation of ART and during monitoring of drug toxicity. Viral load, which is currently the most reliable and confirmatory approach to disease monitoring remains largely inaccessible due to its prohibitive cost. These factors pose new challenges to the treatment program for which preparedness has to be built in order to be able to detect early warning indicators for treatment failure. Therefore the new program (TBD) will put emphasis on building and improving health worker skills to monitor and manage ART drug resistance through in-service training and mentorship. Exchange programs will also be facilitated to allow short-term placements and internships for health workers within the larger national PEPFAR supported treatment programs such as JCRC, IDI and TASO. This will provide opportunities for cross-sharing of expertise and ultimately standardization of treatment practices. The new program will also be expected to keep monitoring new developments and to engage actively with MOH and other stakeholders as new disease monitoring options are discussed.

With support from the Clinton Foundation, access to reagents for DNA/PCR tests has improved greatly ultimately improving early infant diagnosis. DNA/PCR is largely used for early infant diagnosis, but use of these tests for on-going disease monitoring is limited due to high costs. Based on CD4 tests, current treatment outcomes look impressive with majority of individuals on treatment scoring above 400 cells/cubic mm on average. Treatment adherence has been the biggest single factor contributing to the treatment success. The adherence approaches currently in use include nomination and training of adherence partners/supporters at the time of treatment initiation, routine pill counts, and home visits by community volunteers. Provider organizations have also established monthly outreach clinics in communities where drug refills, counseling and treatment of opportunistic infections is done. These approaches are paying off and currently adherence is estimated at over 95% across all IRCU sites. For those failing, poor adherence has been attributed largely to lack of food to support therapy, migration which takes individuals away from treatment sites and in few cases failure to disclose HIV status to partners. The new program is expected to build upon and consulate these approaches to further strengthen adherence with particular emphasis on building networks to enable clients access other wrap around services, notably food. The partner will also strengthen referral systems across the various PEPFAR and non-PEPFAR treatment sites to enable individuals to remain on treatment even after change of location.

Treatment services will continue to target both men and women. Currently women constitute about 60% of the total number of individuals receiving treatment. The new activity will continue to build on the existing initiatives to improve treatment seeking behavior for men. IRCU has been providing a broad spectrum of treatment services. Besides ART, other supportive services include relentless diagnosis, treatment and prophylaxis for opportunistic infections. TB screening and diagnosis is steadily gaining ground as a routine care practice within all IRCU sites. All HIV+ individuals attending clinics are screened for TB symptoms using a job card with a set of questions. Those suspected to be exposed are taken through laboratory investigations. All TB-positive individuals are treated. The follow-on program (TBD) will be expected to continue building the capacity for and expanding access to holistic treatment services.

It is anticipated that by the end of FY 2010, the follow-on program (TBD) will have enrolled 7,200 individuals on treatment. With a level funded budget, further recruitment of new individuals will have to be considered carefully and will be done only when there is assurance of resources for continued care. A total of 100 health workers will be trained in HIV and AIDS treatment, especially in the new disease monitoring protocols and management of second line therapy. In addition, the follow on program will train 1000 community and religious leaders in basic HIV and AIDS treatment to serve as HIV and AIDS resource persons and to link facilities with communities.

Ensuring a steady and demand sensitive system for supplying ARVs and other supplies will be essential for the successful implementation of this activity and achievement of targets. IRCU is working in partnership with Supply Chain Management System (SCMS) to procure ARVs as well as other drugs essential in managing critical OIs. The follow-on program (TBD) will be expected to build upon this partnership with SCMS to enhance steady and timely procurement of drugs. The program will also be required to partner with the new USAID funded SURE program to further strengthen the logistics management systems both for itself and its partners.

Quality assurance is key to the success of the treatment services. IRCU has initiated partnership with IDI to ensure quality assurance and capacity maintenance. The follow-on program (TBD) will be required to build upon the existing initiatives by working closely with MOH and the USAID supported Health Care Improvement Project and HIVQAL to introduce continuous quality improvement and monitoring approaches in all its supported facilities. The overall aim is to ensure that services delivered conform to the national and international standards and that they are responsive to client needs. A key focus will be to ensure that criteria for ART eligibility, prescription practices and adherence monitoring protocols are all in line with the national policy.

To the extent possible, treatment services shall be linked with other HIV/AIDS programs, especially counseling and testing, PMTCT and OVC care. To achieve this, the follow-on program (TBD) will be

required to build viable inter and intra collaborative networks within facilities and communities to enable PHA access the full continuum of care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

Over the past three years, USAID/Uganda has been supporting the Inter-Religious Council of Uganda (IRCU), a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS services through their network of faith-based health units and NGOs. This network has been of impeccable utility is rapidly expanding HIV/AIDS services including counseling and testing. In 2008 IRCU counseled and tested 110, 000 individuals.

USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a new program (TBD) to build upon the networks and structures that IRCU has built and further expand access to counseling and testing. Activities will be primarily targeted at youth in and out of school and adult men and women, particularly those living in marriage and cohabiting relationships. In Uganda HIV incidence is reported to occur mostly among married couples, mainly as a result of multiple concurrent partnerships, but also due to sero-discordance and poor partner disclosure. Therefore couple testing and partner disclosure will be a key priority in programming counseling and testing services. The follow-on program is expected to come up with more creative ways, particularly in the area of strengthening couple communication to enhance partner counseling and testing and disclosure. The program will also extend services to reach other high risk and vulnerable groups. IRCU has trained several community level religious leaders in basic HIV/AIDS prevention and care. The leaders have played a major role in mobilizing and referring individuals for counseling and testing. The new program will be expected to build upon and consolidate this imitative to build strong community based resources for provision of HIV/AIDS intermediate care and referral.

IRCU has been delivering counseling and testing using two main approaches namely, voluntary (client-initiated) and routine (provider-initiated) testing and counseling. Voluntary counseling and testing has been undertaken using both facility and community based approaches. Given the high opportunity cost of seeking medical care in Uganda, facility based delivery of counseling and testing services have been found to severely limit access. The follow-on program will emphasize and devote substantial resources in supporting the outreach model of counseling and testing. Priority will be given to areas located further away from health units, targeting populations such as house wives, taxi drivers, fishermen, subsistence farmers, and pastoral communities whose activities entail a high opportunity cost of seeking facility based care services. Routine, opt-out counseling and testing will also continue to be consolidated as an integral

component of health care within all supported health facilities. This will entail further building human resource capacity of health facilities through initiatives like task shifting of basic CT roles such as pretest counseling, phlebotomy, records management and referral to paraprofessionals and volunteers.

IRCU has also initiated counseling and testing within TB care settings. This will require further focus under the new program, particularly training and orientation of health workers in TB facilities to integrate counseling and testing as a routine practice within TB care. The follow on program will also be required to continue consolidating and streamlining the existing referral systems between HCT, care, treatment and PMTCT units to ensure access to comprehensive HIV/AIDS services for its clients.

All the IRCU supported health units that offer counseling and testing also receive support from Ministry of Health with support from the Global Fund. To maximize resources, the follow on program will only provide counseling and testing at these sites during periods when MOH supplies have stocked out. The National Counseling and Testing Policy is based on a three-tier algorithm using Determine® to screen for HIV infection, Statpac® to confirm infection and Unigold® as a tie breaker. Unless modified, the follow-on program will be required to conduct counseling and testing in line with this policy. In case of stock outs of testing kits from MOH, the program will use PEPFAR resources to procure buffer stocks for MOH sites to enable facilities deliver services in a reliable manner. Besides aligning the services to the national policy, the follow-on program will be required to ensure that counseling and testing services offered at its facilities pass for quality on both clinical and behavioral aspects. The new program will be required to institute or further strengthen the existing mechanisms for monitoring of quality across all counseling and testing sites.

The follow on program will be required to ensure that counseling and testing services offered at all supported sites are linked to other HIV and AIDS services, particularly PMTCT, ART and OVC services. Based on the achievements registered by IRCU, it is expected that by the end of FY2010 the new program will have counseled and tested approximately 130,000 by intensifying cost-effective approaches such as outreaches.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

An estimated 200,000 children are living with HIV in Uganda and another 25,000 get infected annually. Although the need for pediatric care is enormous, human resource constraints, poor accessibility to services and limited pediatric care skills have in combination limited wide-scale accessibility to pediatric AIDS care. Expanding access to pediatric and adolescent HIV and AIDS care is outlined as a critical

priority in the National Strategic Plan.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), which is a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS care and treatment services through their network of faith-based health units and NGOs. IRCU has taken a leadership role in expanding access to pediatric care. Through its partnership with the Infectious Disease Institute (IDI) and Mildmay International, both PEPFAR partners, IRCU has trained health workers in its partner sites in comprehensive pediatric HIV care including pediatric counseling skills. USAID/Uganda's partnership with IRCU ends in December 2009. Based on the proven viability of the faith-based networks in quickly expanding access to services, USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU.

One of the critical roles of the follow-on program will be to build upon and consolidate the achievements that IRCU has attained in rolling out pediatric care. Priority activities will, among others, include continuing to build capacity of health workers in pediatric care and update them on emerging challenges and new approaches to management of HIV and AIDS care among children. Many parents and caregivers rarely discuss HIV infection with children under their care. As a result, many HIV infected children live in situations of uncertainty and often exhibit signs of serious depression. To address these challenges, the follow on program will emphasize building skills in pediatric counseling among health workers to be able to engage children and their caregivers in ongoing discussion of HIV and AIDS, and the implications of HIV infection for their future. The program will offer further training to clinical staff to standardize prescription practices and develop job aides for health workers to ensure that services are of uniform quality across all sites and that they conform to national and international standards.

In the context where majority of the children are under the care of poor widows and grandparents, the threat of malnutrition is real. Efforts will be made to routinely assess children for malnutrition and if symptoms occur, therapeutic foods will be provided through linkages with other PEPFAR partners such as the USAID funded NuLife. Caregivers including parents and guardians will also be counseled on infant and child nutrition. Emphasis will be made to ensure that all children born to HIV+ parent(s) access counseling and testing, using both PCR and ELISA technology as determined by the age of the children. A total of 100 health workers will be trained in pediatric HIV and AIDS care, with the aim of ensuring that their knowledge and skills are in currency with modern approaches and practices. Quality assurance is key to the success of the care and treatment programs. IRCU has initiated partnership with IDI to ensure quality assurance and capacity maintenance. The follow-on program (TBD) will be required to build upon the existing initiatives by working closely with MOH and the USAID supported Health Care Improvement Project and HIVQAL to introduce continuous quality improvement and monitoring approaches in all its supported facilities. The overall aim is to ensure that services delivered conform to the national and

international standards and that they are responsive to client needs.

With a total of 58,000 individuals enrolled in chronic care, it is anticipated that the new program will provide care to 11,000 children in FY2010.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

200,000 children are living with HIV in Uganda and another 25,000 get infected annually. However, access to pediatric treatment is still very limited, particularly due to a dearth of diagnostic and case management skills among health workers, stigma among parents, and the high opportunity cost of seeking services, especially in rural areas. Currently 11,000 children are accessing treatment, representing only 22% of all those in need. Expanding access to pediatric and adolescent HIV and AIDS care and treatment is outlined as a critical priority in the National Strategic Plan.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), which is a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS care and treatment services through their network of faith-based health units and NGOs. Through this network, IRCU has played an important role in rolling out care and treatment services. As at March 2008, it had enrolled 23,746 individuals into care and 2,433 on treatment through its eighteen partner sites. Using FY 2007 and FY 2008 resources, IRCU has taken a leadership role in expanding access to pediatric ART beyond the major urban areas. Through its partnership with the Infectious Disease Institute (IDI) and Mildmay International, both PEPFAR partners, IRCU has trained health workers in its partner sites in comprehensive pediatric HIV care including pediatric counseling skills. IRCU is currently setting up systems at its sites to enhance pediatric care, in particular ART, by initiating HIV testing for all exposed infants. USAID/Uganda's partnership with IRCU ends in June 2009. Based on the proven viability of the faith-based networks in quickly expanding access to services, USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU.

One of the critical roles of the follow-on program will be to build upon and consolidate the achievements that IRCU has attained in rolling out pediatric care. Priority activities will, among others, include continuing to build capacity of health workers in pediatric care and update them on emerging challenges and new approaches to management of HIV and AIDS care among children. Many parents and caregivers rarely discuss HIV infection with children under their care. As a result, many HIV infected children live in situations of uncertainty and often exhibit signs of serious depression. To address these challenges, the follow on program will emphasize building skills in pediatric counseling among health

workers to be able to engage children and their caregivers in ongoing discussion of HIV and AIDS, and the implications of HIV infection for their future. The program will offer further training to clinical staff to standardize prescription practices and develop job aides for health workers to ensure that services are of uniform quality across all sites and that they conform to national and international standards. Children will receive quality HIV medical care which includes full access to ARV therapy as well as prophylaxis and treatment of opportunistic infections to reverse disease progression. The program will also put emphasis on follow up of children enrolled in the care and treatment program. This will involve regular periodic CD4 testing to determine ART eligibility in accordance with the national standards. Children will also be monitored and assessed for other health and growth indicators.

In the context where majority of the children are under the care of poor widows and grandparents, the threat of malnutrition is real. Efforts will be made to routinely assess children for malnutrition and if symptoms occur, therapeutic foods will be provided through linkages with other PEPFAR partners such as the USAID funded NuLife. Caregivers including parents and guardians will also be counseled on infant and child nutrition. The program will undertake home visits to be able to assess the living environment of enrolled children initiated on treatment, anticipate potential barriers to treatment adherence and hence develop a supportive foundation and individualized care plan for each child. By the end of FY2009, the follow-on program (TBD) will have provided care to 2,000 children living with HIV and AIDS of whom 200 will be on treatment. In addition, a total of 100 health workers will be trained in pediatric HIV and AIDS care and treatment, with the aim of ensuring that their knowledge and skills are in currency with modern approaches and practices. Quality assurance is key to the success of the care and treatment programs. IRCU has initiated partnership with IDI to ensure quality assurance and capacity maintenance. The follow-on program (TBD) will be required to build upon the existing initiatives by working closely with MOH and the USAID supported Health Care Improvement Project and HIVQAL to introduce continuous quality improvement and monitoring approaches in all its supported facilities. The overall aim is to ensure that services delivered conform to the national and international standards and that they are responsive to client needs. A key focus will be to ensure that criteria for ART eligibility, prescription practices and adherence monitoring protocols are all in line with the national policy.

With a total of 7,200 individuals enrolled on treatment, it is anticipated that the new program will treat 1,200 children in FY2010.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Uganda has recently concluded modes of transmission study which indicates, among other things, that

there have been shifts in the risk factors and drivers of the epidemic. The key risk factors now include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviors due to antiretroviral treatment (ART). The study also pointed to serious flaws in programming by government and its partners as most data generated over the years have not been utilized in designing new prevention interventions that respond to the changes in the epidemic. Over the past three years, IRCU has implemented a variety of HIV prevention interventions focusing on promotion of abstinence and faithfulness through sixteen community based faith-based organizations. In 2008, IRCU reached 529,000 individuals with HIV prevention messages, of whom 343,000 were youth who received abstinence only interventions. A total of 2,070 individuals were trained in activities that promote abstinence and/or being faithful.

USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a new program (TBD) that will build upon the achievements of IRCU to further expand HIV prevention through interventions that promote abstinence and mutual faithfulness. Abstinence programs will be targeted at youth aged 13-24 years, both in and out of school. The implementing partner will use different strategies to reach the youth, depending on their context and perceived vulnerability. Faithfulness interventions will target adult men and women living in both marriage and cohabiting relationships. Activities will aim to promote behaviors that enhance mutual partner communication, disclosure and reduction in concurrent partnerships.

With regard to youth in school, innovative approaches shall be used to create a free and supportive environment in schools to allow children to seek and access age appropriate information on health, HIV/AIDS and sexuality. This will be achieved through training teachers in HIV and AIDS communication to be able to give accurate information as well as realistic options to children. Other creative approaches such as use of anonymous opinion and question boxes will be applied to collect issues and challenges that children face. Such issues shall then be discussed with children in age-segmented sessions. In addition, panel discussions will be held with youth in school in which students will be allowed opportunities for open interaction with experts on issues of HIV/AIDS. In addressing these issues, the moderators will blend scientific facts with religious teachings. The program will continue to strengthen the role of students' bodies such as Anti AIDS Clubs and Straight Talk Clubs to act as channels for HIV/AIDS education. These clubs shall be encouraged to organize and lead discussions on key issues identified by the young people themselves.

Regarding youth out of school, the new program (TBD) will also continue to address HIV prevention among high risk youth groups especially street children as well as youth engaged in informal sector occupations such as taxi drivers and touts, bar maids and housekeepers. The program will build upon and expand initiatives begun by IRCU such as youth fellowships, outreach and revival ministries as well

as targeted workshops to reach the youth. Through the faith-based youth ministries, one on one, and where appropriate, small group sessions will be held with youth to address high risk behaviors such as alcohol and drug abuse that increase vulnerability to HIV infection. Through weekly sermons, religious leaders will continue to implore and encourage youth to access HIV counseling and testing and to internalize and use it as a precondition for entering a marriage relationship.

Mutual faithfulness interventions will be predominantly implemented through the religious structures, including the Mothers/Fathers Union, Women Catholic Guild, the Muslim Women League and weekly cell meetings. These structures provide opportunities for constant and continuous dialogue on HIV/AIDS, relationships, reproductive health and sexuality. Mutual accountability, self efficacy and sound judgment will be emphasized in these meetings. Individuals with problems shall be counseled, either individually or through group therapy. The program will work to integrate HIV/AIDS prevention as a key issue for discussion into these structures. HIV/AIDS information and counseling will also be delivered in a faith-based context, by complementing scientific facts with relevant scriptures from the religious books. Where necessary, the structures will be facilitated to mobilize more members in the community in order to expand attendance and hence coverage. Faithfulness in marriage will also continue to be addressed through other religious gatherings including weekly prayer sermons, weddings and funerals.

The follow on program will continue to build the capacity of religious leaders at community level to enable them to deliver accurate HIV/AIDS information and integrate HIV preventions in their routine clerical duties. By the end of FY 2010, the new program (TBD) is expected to have reached 780,000 individuals with HIV prevention information, 400,000 of whom will be youth.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

Approximately, 200,000 children are living with HIV in Uganda and another 25,000 get infected annually. Peri-natal transmission remains the single most significant cause of HIV infection among children. Uganda is among the countries in Sub-Saharan Africa with the highest fertility rates. With HIV prevalence equally high, HIV transmission among children is bound to continue on the rise unless interventions to prevent mother to child transmission are scaled up. Prevention of mother to child transmission interventions began in Uganda in the year 2000 on a pilot basis. Early success of the pilot initiative resulted into wide scale implementation and development of supportive policy and guidelines. Currently PMTC services are available in over 500 health facilities and over half a million women have benefitted from the services.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), which is a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS care and treatment services through their network of faith-based health units and NGOs. PMTCT was one of the interventions under this program and activities focused on mobilization of rural women to access services as well as creating a supporting environment at household and community level for women seeking these services. USAID/Uganda's partnership with IRCU ends in December 2009. Based on the proven viability of the faith-based networks in quickly expanding access to services, USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU.

The new program anticipated to be awarded by December 2009 will work to roll out comprehensive PMTCT services in faith-based facilities. The new activity will continue intensifying advocacy for PMCTC at community level, particularly strengthening the role of men in the program. This will involve provision of incentives such as free mosquito nets and delivery kits to mothers in order to encourage them to seek antenatal and post-natal services. Routine, opt-out HIV counseling and testing will be accessed to all pregnant women attending antenatal services. Those found HIV+ will be assessed for HAART eligibility using CD4 count or clinical staging in facilities where laboratory services are underdeveloped. In line with the national policy, mothers with CD4 counts above 350 will be given the combined HIV prophylaxis regimen and those with CD4 counts below 350 will be initiated on HAART.

IRCU had initiated partnership with the Joint Clinical Research Center through which it outsourced Early Infant Diagnosis (EID) services. The new program will build upon this partnership to facilitate timely initiation of treatment for children. The linkages between PMTCT and ART will also be further strengthened through provider training, better referral management and minimizing bottlenecks such as stigma and bureaucracies that encumber entry of clients into new service arenas. The new activity will continue to provide PMTCT as a preventive approach to save the unborn child from HIV infection, and not a solution for having an HIV negative baby even when the mother's HIV status is known. Therefore, reproductive health, and in particular, family planning will be a strong component of PMTCT under the new program. The activity will link with the new USAID supported STRIDES program to ensure that family planning services and contraceptives are available and consistent, especially the female controlled devices that may not require engagement of an unwilling partner.

Efforts will be made to routinely assess children for malnutrition and if symptoms occur, therapeutic foods will be provided through linkages with other PEPFAR partners such as the USAID funded NuLife. Caregivers including parents and guardians will also be counseled on infant and young child nutrition.

Quality assurance is key to the success of the care and treatment programs. The new program will build

upon the existing partnerships with programs such as IRCU has initiated partnership with IDI to ensure quality assurance and capacity maintenance. The follow-on program (TBD) will be required to build upon the existing initiatives by working closely with MOH and the USAID supported Health Care Improvement Project and HIVQAL to introduce continuous quality improvement and monitoring approaches in all its supported facilities. The overall aim is to ensure that services delivered conform to the national and international standards and that they are responsive to client needs.

By the end of FY2009, the follow-on program (TBD) will have provided PMTCT services to 1,000 women. In addition, a total of 100 health workers will be trained in PMTCT with the aim of ensuring that their knowledge and skills are in currency with modern approaches and practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

Efficient laboratory services including HIV counseling and testing as well as monitoring of individuals on care and treatment remains at the helm of an effective HIV/AIDS program. However, access to laboratory services still remains a challenge, especially to individuals living in rural areas. In many of the rural areas in Uganda, diagnostic services are deplorable. Health facilities, especially those at level III and below lack laboratories and where they exist, there are acute shortages of staff, equipment and/or reagents. Despite these limitations, these facilities serve the largest number of people, given that they the most easily accessible.

Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), which is a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS care and treatment services through their network of faith-based health units and NGOs. Improvement in laboratory infrastructure has been an integral component of this program. Over the past two years, IRCU has worked with faith based 18 health facilities to strengthen the existing laboratory infrastructure to enable them carry out basic tests that enhance HIV/AIDS care and treatment. This included procuring basic laboratory equipment, limited refurbishment of facilities, training of laboratory staff and reinforcing the human resource needed to carry out the laboratory tests. Of these 18 labs, 12 are hospital labs while the remaining six are lower health center labs

USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a follow on program (TBD) to build upon and further expand the current achievements of IRCU. One of the primary priorities for the follow-on program will be to further strengthen clinical investigative capability among the supported faith-based partners and to further improve quality assurance mechanisms to

enhance state of the art service delivery.

The follow on program will further work with the faith-based facilities to expand the scope of their laboratory services to cover organ function tests as well. IRCU currently has 58,000 clients enrolled in chronic care all of whom will require routine medical tests to better inform care and treatment choices. In addition, they will need routine baseline CD4 tests; lymphocyte and hemoglobin level counts in order to effectively monitor their eligibility for ART. This is essential in order to ensure that individuals initiate ART at the most optimum time. Also over 6,000 patients currently enrolled on ART will continue to have quarterly hemoglobin and lymphocyte estimates, and where possible, viral load tests. The new program (TBD) will be required to ensure that there is adequate preparedness for this growing need by improving the capacity of the existing laboratories and training laboratory staff to ensure that they keep updated on the newly emerging laboratory practices and protocols. Networking with other partners will be prioritized to rationalize access and use of laboratory services across and among the various PEPFAR partners.

Currently all IRCU supported laboratories are accredited by the Ministry of Health and meet the minimum required standards in terms of space and equipment. However, most of them are limited in capacity and can only perform basic microscopy and hematology tests including hemoglobin estimations and total lymphocyte counts, and are unable to carry out more advanced tests like CD4 counts and biochemistry tests although these tests are a key ingredient to an efficient ART service. Therefore, IRCU entered into a Memorandum of Understanding with JCRC to provide laboratory services for advanced disease monitoring from its regional centers of excellence. Under this arrangement, most IRCU supported facilities with proximal JCRC centers of excellence access services, particularly specific tests like full blood counts, organ biochemistry, CD4 cell counts, Polymerase Chain Reaction (PCR) for infant HIV testing and resistance testing. The follow on program will be required to further consolidate this partnership. However, as access and utilization of ART services continues to grow, it is realistic to expect that JCRC regional laboratories will be overwhelmed. Therefore, the follow-on program will explore establishment of auxiliary laboratories building upon the investments already made by IRCU in its faith-based health units, basing on factors like distance between JRC regional labs and the faith-based partners as well as the workload, handling capacity and efficiency of the existing JCRC regional labs.

The follow on program will be expected to work with the Ministry of Health, Program for Supply Chain Management Systems (SCMS) and Joint Clinical Research Centre (JCRC) to train laboratory staff in ordering and forecasting of laboratory reagents and other relevant inputs to ensure a reliable supply; HCT and other HIV/ART monitoring tests and finally good lab practices. The program will undertake routine reliability and quality assurance checks to ensure that lab services conform to nationally acceptable standards. The laboratory activities are coordinated by the Ministry of Health through the Central Public Health Laboratory which will provide quality control, guidelines and where necessary,

technical assistance.

With level funded budgets, the program does not anticipate to expand the current care and treatment program beyond the eighteen sites. Therefore, activities will focus on consolidation of services in these sites, particularly in the ears of quality and building technical capacity for the existing laboratory staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

The estimated TB incidence of all forms of TB is 330 new cases per 100,000 pop/year with an incidence of 128 new cases per 100,000 pop/year in HIV positive people. It is estimated that 39% of all incident TB cases are HIV positive. Prevalence of all forms of TB is 426 cases per 100,000 population. Mortality is 93 deaths per 100,000 pop/year. Estimated Multidrug resistant -TB (MDR-TB) among all new TB cases is 0.5%. (Global Tuberculosis control WHO report 2009).

The Uganda TB control indicators remain below target despite implementation of DOTS throughout the country. Treatment success rate is 74% against target of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. The TB Case detection rate is 57% versus the target of 70%. In 2008, 43,493 TB patients were notified to the Ministry of health National TB/Leprosy Program (NTLP), 22,561 of these were sputum smear positive.
Since 2006, USAID/Uganda has been in partnership with the Inter-Religious Council of Uganda (IRCU), which is a consortium of the five main traditional religions in Uganda to expand access to HIV and AIDS care and treatment services through their network of faith-based health units and NGOs. Over the past three years, IRCU has established HIV/AIDS care and treatment programs in 18 faith-based health units and four non-governmental organizations. Through these facilities, IRCU has embraced the national policy to integrate TB into HIV/AIDS care. Initiatives undertaken in this endeavor include routine screening of all PLHA for any leading TB symptoms, training of health workers in TB management, strengthening of TB laboratories and quality assurance and promoting TB infection control in health care settings. By March 2009, of the 20 palliative care sites supported by IRCU, 13 carried out TB diagnosis and treatment while others were yet to be accredited by MOH with support from IRCU. A total of 1221 (672 males and 549 females) received counseling and testing in TB settings and got their results while 1,297 (675 male and 622 female) individuals were reported on TB treatment.

USAID/Uganda's partnership with IRCU ends in December 2009. USAID/Uganda plans to initiate a follow-on program to build upon and further expand the current achievements of IRCU. The follow-on program will aim to further strengthen the existing TB/HIV integration initiatives with a key focus on

further training of health workers to orient their attitudes and practices towards integrated HIV/TB care and further improvement in infection control procedures.

The follow-on program will continue to work to ensure that routine TB screening of HIV-infected clients and adherence counseling and support for both TB and HIV/AIDS clients are internalized across all health workers. The program will also continue to improve TB diagnostic capacity at its partner health units by further strengthening laboratory infrastructure, provision of key laboratory equipment and reagents as well as training laboratory staff. More importantly the follow-on program will strive to ensure that all TB microscopy equipment and protocols are routinely tested for proficiency in order to sustain the validity of the test results.

Integrating TB care within an immune compromised population requires a high degree of care to minimize cross infection. Therefore, the follow-on program will strive to ensure that adequate infection control procedures are in place within the partner facilities health facilities to prevent TB transmission among PHA and health workers. This will entail expansion of and improvements in ventilation within waiting areas, training health workers in effective waste disposal procedures and counseling PLHA to be part of the infection control agenda.
Albeit a few challenges, IRCU has initiated counseling and testing within TB clinics at all its facilities. Initially, only TB-confirmed individuals were offered counseling and testing, wherefore, the follow-on program will build upon and consolidate this initiative by introducing routine counseling and testing for all individuals attending TB clinics.

In FY 2010, the follow-on program will be expected to provide counseling and testing to at least 80% of registered TB patients, provide co-trimoxazole to > 80% of TB/HIV co-infected clients and provide ARVs to at least 40% of TB/HIV co infected clients. The program will also carry out TB screening to at least 80% of patients in HIV care and treatment IRCU supported sites. Follow up of individuals on treatment is great factor in treatment success. Prior to initiation on treatment, individuals will be required to report with an adherence monitor who will be counseled on the importance of adherence in addition to infection control in the household. The program will also invoke the community based religious leaders trained by IRCU to periodically visit the patients and report progress on adherence. Monthly drug refills will be followed as a mechanism for treatment monitoring.

The follow-on program will continue to coordinate and collaborate with other PEPFAR partners implementing TB and TB/HIV activities. The program will also work with National TB and Leprosy program to provide standardized TB/HIV recording and reporting, streamline TB diagnostic tools and dissemination of TB related IEC materials. The NTLP will also be expected to provide on-going support supervision and maintain oversight on the quality of TB care and efforts towards TB/HIV integration.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7183	**Mechanism Name: Commodity Security Logistics (CSL)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Commodity Security Logistics	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,000,000	
Funding Source	**Funding Amount**
GHCS (State)	2,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

continuing activity

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7183**

Mechanism Name:	Commodity Security Logistics (CSL)		
Prime Partner Name:	Commodity Security Logistics		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	2,000,000	
Narrative:			
continuing activity			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7184	**Mechanism Name: UNITY**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Creative Associates International Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,064,357	
Funding Source	**Funding Amount**
GHCS (State)	4,064,357

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ugandan Initiative for TDMS and PIASCY (UNITY) is a three-year Task Order under the ABE-LINK IQC with the overarching goal of improving education in Uganda and preventing and mitigating the impact of HIV/AIDS amongst children (in primary schools) and youth (in Post Primary Education and Training). The UNITY Project takes into account the prevailing issues in the education system both at the central Ministry level and under the Decentralization system in Uganda and these issues are addressed by the four overarching objectives of the Project.

The project began on November 7, 2006 and has been extended for two years scheduled to end

November 6, 2011. The majority of the project activities are a continuation of interventions initiated under Creative Associates' Basic Education Policy Support (BEPS) project, with the addition of new activities. Similar to the model used under BEPS, the UNITY Project is generally implemented through the decentralized Teacher Development Management System (TDMS) and the existing Ministry of Education and Sports (MoES) structures and its Working Groups Modality. The infusion of the UNITY team's technical expertise with the use of Technical Assistance for specific activities has offered the best support to the various MoES departments and program interventions.

By utilizing the Ministry existing structures, sister institutions and venturing into inter-ministerial collaboration, the project aims to maximize the likelihood that its strategies and benefits will contribute to systems strengthening and ensure ownership and sustainability after USAID assistance terminates.
The USAID strategic objective that guides UNITY Project Implementation is to contribute to improved quality of basic education and expanded implementation of PIASCY program. The project has four broad objectives, which are to:
(i) Improve professional development of teachers and administrators at the primary level, both in pre-service and in-service;
(ii) Expand implementation of the Presidential Initiative on AIDS Strategy for Communication to the Youth (PIASCY);
(iii) Increase parental and community participation in education; and,
(iv) Implement educational policy agenda.

One of the goals of UNITY/USAID Project is the expanded implementation of PIASCY. To be able to realize this goal, the project partners with the Ministry of Education and Sports (MoES) and District Local Governments in implementing a number of HIV/AIDS mitigation interventions. These interventions are generally targeted at accessing strategic information to the learners, especially the Students of Post Primary Education and Training Institutions and Primary School Pupils. The thrust of these interventions is providing education and information which is age appropriate to the target categories of learners. The education and information provision is aimed at increasing the HIV/AIDS literacy levels and awareness. The education and information is also expected to improve the knowledge and understanding of HIV/AIDS and its prevention practices. The information and education will inturn help the learners to continuously practice positive behavior.

For the Financial Year 2010, UNITY Project plans to focus on the following activities:
(i) Reaching a total of 3,500,000 learners both primary and post primary education and training;
(ii) Training a total of 20,000 teachers; and,
(iii) Reaching a total number of 13,000 primary schools and post primary education and training institutions.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7184**		
Mechanism Name:	**UNITY**		
Prime Partner Name:	**Creative Associates International Inc**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	3,614,357	

Narrative:

The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) the main vehicle for reaching out to young people in schools, primary and post primary with age appropriate messages to empower them with knowledge and life skills that influence positive behaviors change and as a result help them stay safe from HIV and AIDS. Preventive education imparts skills and behaviors that protect and nurture children to grow into healthy and productive adults. Education is also critical to providing people infected and affected with HIV/AIDS knowledge, dignity and environment to live positive and fulfilling lives, free of stigma. For children to stay and remain free of HIV and AIDS, their knowledge of correct facts and information about causes and spread of the disease must result in the continuous practice of behaviors that prevent exposure to and the spread of HIV. In this respect, the aim of PIASCY program is to develop lasting behavior change on an ongoing basis. The systems include those places where children are exposed to different influences and actors that protect the child in a typical day in the life of a child. The school environment is a strategic place to reach and assist learners to develop skills, resourcefulness and mindsets that protect

UNITY project in collaboration with the Ministry of Education and Sports reaches learners both at Primary Schools and Post Primary Education and Training institutions (8-21 years) through provision of reading materials, training of teachers to equip them with skills to better handle the challenges faced in dealing

with the effects of HIV and AIDS. Learners will also participate in various school based prevention activities. UNITY will develop national guidelines on school based interventions for teachers and head teachers to conduct school-based prevention activities. The guidelines will include practical recommendations for teachers to integrate HIV/AIDS messages into regular lessons and into other activities such as Music, Dance and Drama.

The program will be national covering all the primary schools and the communities that surround them.

The Primary sub-sector Learner-Led Activities include:

(i) School Level learner led- activities which include:

• Learner-led assemblies with a focus on HIV and AIDS, under the supervision of teachers. A timetable will be drawn for the whole term clearly indicating the topics to be handled and agreed action points for follow up documented at every scheduled assembly.
• Clubs that are led by learners with guidance from their teachers. Issues to be handled during the club activities will be arrived at according to the prevailing needs of each school regarding HIV and AIDS education.
• Role plays and drama carrying messages focusing on Self Awareness, Stigma and Discrimination, disclosure, Basic facts about HIV and AIDS, STI's and TB as well as development of Life Skills.
• Adequate avenues of communication on all issues concerning the children especially as regard to HIV and AIDS.
• Visual AIDS showing of documentaries of proven research.
• Quizzes and debates that are supervised by teachers focusing on Stigma and Discrimination.

(ii) Guidance and Counselling

• Mapping of vulnerable learners in schools, in order to customize the appropriate Guidance and Counselling interventions
• Guidance and Counselling spaces in schools with confidential records/documentation of counselling sessions held, number of pupils reached, home visits and referrals made.
• Have corners where learners can come and see teachers at particular times these corners should have materials and visual aids that will facilitate communication and rapport between learners and teachers.
• Facilitate talks with parent's and this should be done by class to avoid congestion
• Consolidation of school-based good practices and introduction of "school families" to support collective group counselling.

(iii) Community Involvement

• Strengthening of community involvement in HIV education using school activities e.g., sports, Music , Dance and Drama, and Open/Parent Days
• Parent Talk – Community Radio Program in Local Language – STF Grant

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	450,000	

Narrative:

The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) the main vehicle for reaching out to young people in schools, primary and post primary with age appropriate messages to empower them with knowledge and life skills that influence positive behaviors change and as a result help them stay safe from HIV and AIDS. Preventive education imparts skills and behaviors that protect and nurture children to grow into healthy and productive adults. Education is also critical to providing people infected and affected with HIV/AIDS knowledge, dignity and environment to live positive and fulfilling lives, free of stigma. For children to stay and remain free of HIV and AIDS, their knowledge of correct facts and information about causes and spread of the disease must result in the continuous practice of behaviors that prevent exposure to and the spread of HIV. In this respect, the aim of PIASCY program is to develop lasting behavior change on an ongoing basis. The systems include those places where children are exposed to different influences and actors that protect the child in a typical day in the life of a child. The school environment is a strategic place to reach and assist learners to develop skills, resourcefulness and mindsets that protect

UNITY project in collaboration with the Ministry of Education and Sports reaches learners both at Primary Schools and Post Primary Education and Training institutions (8-21 years) through provision of reading materials, training of teachers to equip them with skills to better handle the challenges faced in dealing with the effects of HIV and AIDS. Learners will also participate in various school based prevention activities. UNITY will develop national guidelines on school based interventions for teachers and head teachers to conduct school-based prevention activities. The guidelines will include practical recommendations for teachers to integrate HIV/AIDS messages into regular lessons and into other activities such as Music, Dance and Drama.

Post Primary Education and Training (PPET)

Under UNITY I PIASCY PPET was launched with distribution of manuals for learners and teachers and

training of teachers in 39 out of the 80 districts in the country. UNITY II will focus on;

(i) Training

• Complete and print the revised training sessions for PPET to include HIV counselling, Drug and Substance abuse and how to handle relationships.
• Complete the training and distribution of PPET Manuals for Central, Western and Busoga regions (41 districts)

(ii) Peer education

• Integration of HIV education in all Club activities
• Inter-school competitions based on HIV and AIDS themes
• Buddy system that is learner driven and teacher guided
• Regular and programmed assemblies lead by students

(iii) Community Involvement

• Open days that integrate facts and issues about HIV and AIDS
• PTA Meetings with resources persons to give talks about identified school needs as regard HIV and AIDS Education
• Quarterly Parents House Meetings , ensure that these include something on HIV and AIDS
• Sports Days to include messages on HIV and AIDS.
• Music, Drama, Dance Festivals

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7185	**Mechanism Name: Financial Management Agent/ Civil Society Fund (FMA/CSF)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Deloitte & Touche, Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 7,752,091	
Funding Source	**Funding Amount**
GHCS (State)	7,752,091

Sub Partner Name(s)

STRAIGHT TALK		

Overview Narrative

continuing activity

Cross-Cutting Budget Attribution(s)

Human Resources for Health	700,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7185**		
Mechanism Name:	**Financial Management Agent/ Civil Society Fund (FMA/CSF)**		
Prime Partner Name:	**Deloitte & Touche, Uganda**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	5,675,787	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	485,199	
Narrative:			

None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	822,347	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	768,758	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7187	**Mechanism Name: Food Security and Nutrition Support for OVC Households (APEP follow-on)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Associates in Rural Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHCS (State)	300,000

Sub Partner Name(s)

Comboni Samaritans of Gulu	Facilitation for Peace and Development	Trans cultural Pscychosocial Organisation

Overview Narrative

ARD Inc. was contracted by the Uganda Mission of the U.S. Agency for International Development (USAID) to provide technical assistance and support in helping to raise rural productivity, incomes and competitiveness in Uganda via the program, " Livelihoods and Enterprises for Agricultural Development-LEAD". Program activities commenced in August 2008 and will continue over a five year period.
LEAD's aim is to help integrate farmers and related micro and small and medium enterprises (SMEs) into commodity value chains so that they gain improved access to markets, and more empowered relationships with suppliers, processors and traders. LEAD will improve performance in the rural economies by increasing productivity, improving trade capacity and enhancing competitiveness in targeted value chains, which include staple crops (cereals, roots, pulses and oil seeds), coffee, fish farming together with cotton, fruits, vegetables and livestock. The project is covering 21 districts in northern Uganda and 14 districts currently in Southern Uganda.
The program seeks to help transform Uganda's agricultural sector from subsistence farming to a more commercially oriented perspective with approximately 60% of project resources being directed at Northern Uganda. LEAD seeks to optimize results in this region through a combination of private/public sector partnerships as well as working through partners in the north who have long standing relationships with war-affected populations including IDPs and other vulnerable populations.
ARD uses its successful, innovative Farmer Field School (FFS) methodology in LEAD. The FFS is participatory training approach that can be considered both as an extension tool and a form of adult education, or a school "without walls" for improving decision making capacity of the farming communities. It consists of a group of 20–30 farmers from the same or nearby villages, who meet regularly, guided by a trained facilitator during the course of a cropping cycle. The purpose of FFS is to experiment with new production options. FFS focuses on building farmers' capacities to make well-informed decisions through increased knowledge and understanding of the agro-ecosystem. Farmers are encouraged to experiment on their own farms and make their
own decisions based on observations and knowledge.

LEAD's technical approach to achieve results includes:
• Setting-up FFSs, including identifying candidates for the training of trainers;
• Targeting assistance to prioritized value chains, beginning with robust markets working back through all actors to producers;
• Using Strategic Activities "Grants" Funds to stimulate development of commercial value chains. This is a demand-driven approach where LEAD supports grant applications solicited from the private sector and also in partnership with public sector entities;
• Transferring technology via the FFS to sustainably increase technology adoption rates; and
• Establishing and strengthening commercially-oriented Producer Organizations.
LEAD OVC program is targeting Northern Uganda because the convergence of war and AIDS has increased poverty and food insecurity thereby causing key long-term investments such as proper

nutrition, education, and securing children's property rights to fall by the wayside, as families grapple with ensuring short-term survival.

The OVC not only face the daunting tasks of meeting their basic needs but they are also amongst the poorest and are often the most prone to food insecurity. The OVC households have limited access to land, labour and other inputs which hampers their ability to engage in meaningful agricultural activities.

In order to effectively address the OVC challenge, LEAD secured funding through the PEPFAR program to support OVC and PHA activities in the areas of physical health and nutrition that are targeted at the most vulnerable segments of the rural population in Northern Uganda. LEAD believes that the OVC households have the potential to transform into commercial farmers and be able to improve and sustain their livelihoods through increased agricultural productivity and value addition through the value chains that have been developed.

The LEAD OVC program which started in July 2009 will cover all the 21 districts in Northern Uganda. However implementation has started in 10 districts and will continue in the same districts for the year FY 2009/10 to ensure that some results can be realized before expanding to other districts. The 10 districts including Pader, Gulu, Amuru, Kitgum, Lira, Dokolo, Oyam, Apach, Kaberamaido and Amolatar have been selected on grounds that they have been drastically affected by the war. Subsequently the program will be rolled out to other districts based on availability of funding. The program is delivered through implementing partners; National or local NGOs that have experience in delivering development interventions targeting OVC. In FY 2008/09, three (3) out of the five (5) targeted implementing partners have been identified and contracted. The other two new implementing partners will be identified at the beginning on FY 2009/10. The program will focus on improving food and nutritional security of OVC households through training on improved farm practices, nutrition education, and support to access inputs and improve storage. In addition other services like economic strengthening, vocational training for vulnerable youth, protection and psychosocial services will be provided as they directly contribute to improved food security, nutrition, and livelihoods of OVC and their families. Support will be channeled through the OVC groups and the program will maintain linkages between the commercially oriented producer organizations that LEAD is working with to benefit from knowledge, expertise and joint marketing opportunities. The OVC groups will enventually benefit from the value chains being developed by LEAD.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7187**		
Mechanism Name:	**Food Security and Nutrition Support for OVC Households (APEP follow-on)**		
Prime Partner Name:	**Associates in Rural Development**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	300,000	

Narrative:

The intervention will target children below the age of 18 years living in Northern Uganda who are vulnerable because of the combined after-effects of the 20-year war waged by the Lord's Resistance Army (LRA) and the HIV/AIDS scourge. The overall goal of this intervention is to expand sustainable economic opportunities for improved livelihoods of the OVC and their households. A total of 15,000 OVC will be served in 10 districts including Pader, Gulu, Amuru, Kitgum, Lira, Dokolo, Oyam, Apach, Amolatar and Kaberamaido. The program will provide 5 services including food and nutrition support, economic strengthening, psychosocial support, vocational training and protection services.

LEAD will focus on strengthening 5000 OVC (existing and new) households through increasing their agricultural productivity and off farm income. New households will be identified by the implementing partners working through the LEAD network of Producer organizations. The OVC households will be supported to form 200 groups and their capacity strengthened so that they are able to sustain OVC service delivery. The Farmer field School (FFS) methodology shall be used as an approach to extension. Selected community facilitators will be trained to work alongside farmers as advisors and facilitators, encouraging independence, analysis and organization. The implementing partners will establish a mechanism that will enable agro dealers/stockists within their localities to provide OVC households with free inputs including improved seed, fertilizers, implements and information. This mechanism is intended to build and strengthen linkages between the stockists and the households for continued access of

required inputs beyond the project life. To boost off farm income, OVC household will be supported to set up income generating activities particularly for households that have inadequate agricultural land. It is envisaged that increased productivity and off farm income will improve the economic performance of the households and as such increase their capacity to meet the needs of the OVC including food and nutrition, education, basic care, health among others. Youth from Child headed households will be targeted for apprenticeship skills training based on needs assessment that will be conducted by the implementing partners.

The activity also seeks strengthen the households through enhancing parenting knowledge and practices and providing social support and practical assistance to families for purposes of improving outcomes for children. Through training, home health visiting and group conferencing, capacities of caregivers will be enhanced to support children through critical development stages. The purpose will be to provide OVC households with knowledge on types of nutritious foods rich in vitamins, proteins and other vital nutrients. Discussion sessions will also be conducted with household groups that will enlighten them on how to prepare well-balanced nutritious food for their children and lactating mothers. Households will also be supported to establish kitchen gardens and to consider both commercial value as well as the nutritional content of crops grown. A mentor manual will be developed and used to train facilitators who counsel care givers on improved child care through the home visits. The manual will cover aspects including body hygiene, stigma and discrimination, HIV prevention and care, life skills, counseling, health/nutrition, child needs assessment, emotional symptoms, psychosocial support among others. The purpose is to provide a comprehensive package on OVC care to the care givers. A total of at least 5000 caregivers will be trained. Social workers will also offer psychosocial support and child protection support to households that will require specialized services. Interactive activities that strengthen resilience, coping and build the self esteem of OVC will be delivered. These will include recreational and group counseling activities that target OVC to cope with difficulties. For children under 15 years, the "journey of life tool", an empowerment and communication tool for working with children living in adversity will be utilised. LEAD will ensure that Early childhood development and other health needs like immunization, health screening, HIV testing are addressed through creating linkages and strengthening referrals with health care providers.

The second priority action will be around strengthening community support systems and coordination. Communities have provided the first and often the only line of support for children affected by war and HIV/AIDS and hence the need reinforce effective community action. The OVC groups shall provide the first safety net for the vulnerable children as the members will be trained on OVC care and will be able to refer the children in need of services that cannot be provided by the group.
Community campaigns will be conducted to garner support for OVC and also to build community capacity

to care for children. Campaigns will cover different aspects including HIV, nutrition care, stigma and discrimination, water and sanitation, children's protection and safety in school and home and OVC needs among others. The OVC coordination committees at sub-county level in the targeted districts will be strengthened through assessing capacity needs that impact on their functionality and support will be provided to address those needs. Through community dialogues existing child protection committees, Village Health Committees and opinion leaders will be trained on children's rights and OVC care so that they are able to engage in different child protection activities and act as focal points in the sub county to guarantee sustainability. At the district level, LEAD will participate effectively in the OVC coordination meetings and any district/NGO led OVC activities. Under this priority action, LEAD will also establish linkages with existing OVC service providers such as NUMAT, NuLife, PACE, Path Finder International, Straight Talk, the Aids Information Centre, TASO to enable identified OVC and their households to access wrap around services such as; voluntary counseling and testing, anti-retroviral therapy, HIV prevention messages, TB/HIV information. The OVC groups will be trained on developing their referral systems so that appropriate referrals and follow up can be made for the households.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7188	**Mechanism Name: HIPS (Health Initiatives in the Private Sector)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Emerging Markets	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,857,219	
Funding Source	**Funding Amount**
GHCS (State)	2,857,219

Sub Partner Name(s)

Johns Hopkins University	Mildmay Center, Uganda	O'BRIEN AND ASSOCIATES INTERNATIONAL

Overview Narrative

The HIPS (Health Initiatives for the Private Sector) Project is the culmination of 10 years of USAID/Uganda's work in private sector approaches in health. HIPS works with medium and large Ugandan companies to leverage private sector funding to extend HIV prevention, care and treatment services to employees, their dependants and the surrounding community, including orphan and vulnerable children. HIPS serves as an 'advisor' to the Ugandan Business Community, facilitating partnerships and providing technical assistance to design and implement comprehensive workplace health programs that maximize the accessibility of VCT, HIV/AIDS, TB & Malaria prevention and treatment services and impart Reproductive Health and Family Planning knowledge. The Project collaborates with companies to encourage incorporation of OVC support within their Corporate Social Responsibility (CSR) strategies. To foster sustainability, the project is building the capacity of private sector employer organizations such as the Federation of Uganda Employers (FUE) and the Uganda Manufacturers Association (UMA) to assume the support and partnership role that HIPS is currently serving with Ugandan companies. The project is working in 45 districts in the country with over 50 companies and 90 private clinics.

The overall objectives of the project include:
1. Expand access to and utilization of health services in the private sector;
2. Establish Global Development Alliance (GDA) partnerships to leverage company-sponsored health services;
3. Strenghen private sector employer organizations to support health initiatives; and
4. Implement innovative approaches to support orphans and vulnerable children through the private sector.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	100,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7188**		
Mechanism Name:	**HIPS (Health Initiatives in the Private Sector)**		
Prime Partner Name:	**Emerging Markets**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	650,000	

Narrative:

Under the adult care and support program area, the HIPS Project implements Care and Support services in conjunction with partner companies and clinics. HIPS interventions in the past 2 years have focused on both the clinical and community care perspectives reaching over 8,500 clients with home-based care and clinical services. Services received range from Cotrimoxazole prophylaxis, communication materials, psychosocial support, safe water and ITNs among others. To date, 326 community-based care givers and 127 health workers have received training and kits to provide palliative care to their community members. These trained community members are linked to 66 facilities that provide integrated HIV/AIDS services, and to the existing community resource persons within the catchment area and ensuring continuity of care.

In 2010, HIPS will focus on instituting quality-of-care mechanisms, integrating services and ensuring sustainability within the clinic and at the community level using locally available resources. The project will extend services to the community through training of community-based caregivers and health workers and the provision of logistical support to partner facilities. Selected community-based care-givers will be trained on quality monitoring indicators for palliative care services at the community and clinic level. Using pre-designed data collection tools, the trained CBVs will interact with the Persons Living with AIDS (PHAs) at the community level, gathering information about their views on the services provided, suggested areas for improvement and additional desired services. The trained CBVs will also conduct client exit interviews with clients who have received palliative care services to collect information on the quality and nature of services received from the clinic. These reports will be submitted to the health units. Support to health workers in partner facilities will be given to conduct regular support supervision to the trained community-based caregivers.

Quarterly review meetings will be organized at the health facilities. These quarterly review meetings are intended to appraise the quality of services provided, challenges faced, provide accurate information and share lessons learnt. The project will support selected Post Test clubs to integrate care and support services into their HIV programs. This will be done through training and logistical support.

Key activities for FY 2010 :
1. Train 230 community-based caregivers in selected companies' catchment areas in home-based care and psycho-social support. The trained caregivers will partner with the post test clubs and other trained caregivers in the community to identify and support people in their communities who need clinical care, provide psychosocial support and also facilitate timely referrals
2. Conduct home-based care support supervision visits for the community based care givers who have been trained
3. Train up to 70 private practitioners in care and support with the Mildmay Center.
4. Strengthen referral networks between companies and local CBOs and NGOs providing care and support services to facilitate linkages and referral. Linkage and referral to other CBOs and NGOs is intended to ensure that care and support services are integrated with other services (FP, HIV prevention, PMTCT, IPT2, ART).
5. Organize quarterly review meetings for community caregivers at partner sites
6. Support selected facilities and community caregivers with kits and basic supplies for care and support.
7. Train selected Post Test Club members in Care and support and provide support to their monitoring activities.
8. Develop systems to track progress in health initiatives with the private sector, while building capacity of the private sector to effectively measure progress.

C1.1.D 10,000 eligible adults and children provided with a minimum of one care service
Number of eligible adults and children provided with a minimum of one care service disaggregated by age and sex
<5 years: 2500 (1250 Male, 1250 female)
5-17 years: 2500 (1250 Male, 1250 female)
18+ years: 5000 (2500 Male, 2500 female)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	350,000	

Narrative:

HIPS has established a small matching grants mechanism, intended to leverage companies' CSR investment to OVC care and support programs in their communities. Based on research, HIPS designed four corporate engagement models: 1) The Corporate Sponsorship Model in which private sector partners provide cash and in-kind support to OVC implementing organizations often as part of their CSR program; 2.) The Market Access Model, which helps OVC households develop the capability to produce for markets and are linked to markets; 3) Training / Jobs Creation Model, which provides relevant training

and job placement for OVC who have dropped out of school and their caretakers; and 4) The Supply Chain Model, which leverages company supply chains to identify OVC households and implement OVC care and support programs. The last model places special emphasis on smallholder farmers who sell raw products to the company. These models are used to leverage a company's resources, skills and networks towards best practice OVC programs, using a family-centered approach, focusing on the OVC household with special emphasis on the socio-economic activities. Central to ensuring comprehensive care and support services is the increased involvement of the district-level Community Development Office, with special emphasis on support supervision, ensuring collaboration, partnership building with existing community based organizations, wrapping around of services, and referral to ensure totality of care. OVC monitoring, follow up and referral tools have been developed to ensure follow up at school and at home. Currently, HIPS has 9 OVC grants with companies, with a minimum of a 1:1 match of resources for a total of $300,000 (grants are on average $30,000), providing a minimum of 4 services to 2,540 OVC (1,236 male and 1,304 female).

Key HIPS OVC activities for FY 2010 :
1. Identify 6 new companies and renew 9 current OVC matching grants care using the corporate engagement models.
2. Train over 700 OVC caregivers in the catchment area of selected companies in psychosocial support, economic strengthening, child protection, food and nutrition.
3. 1500 new OVC and 2500 existing OVC will receive, at a minimum, 4 services
4. HIPS will continue to support programs to identify OVC that are HIV-positive and refer them for palliative care and treatment services.
5. Integrate child participation and child protection initiatives in OVC care and support.
6. Scale up teacher involvement in OVC care and support and child protection.
7. Implement cognitive and life planning age specific interventions for OVC.
8. Partnership with the probation office, CDOs, and other NGOs/CBOs, to promote quality service delivery.

TARGETS COVERING THE PERIOD "OCTOBER 1 2009-30 SEPTEMBER 2010"
C5.0.D: 4000 eligible children (OVC) provided services in 3 or more OVC core program areas beyond Psychosocial/spiritual support during the reporting period. Primary Direct: 4000 (1500 new, 2500 existing), Male = 2000, Female = 2000

Supplemental Direct = 0
700 OVC care givers trained in comprehensive HIV management

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HTXS	861,500	

Narrative:

HIPS is currently working with 88 private clinics that have been accredited by the MOH and receive free ARVs. Under this program area, HIPS: provides training in ART management to clinical staff of partner facilities; supports accreditation of workplace and other private clinics to offer free MOH ARVs; provides technical assistance in setting up workplace AIDS treatment programs; and supports the procurement of equipment. Over the last 2 years, the project has developed many partnerships with key stakeholders at the national and district level to enhance technical exchange and harness local resources for private sector partners. HIPS has sponsored 352 staff from partner clinics to participate in AIDS treatment training programs at the Mildmay training center. These staffs are now providing HIV/AIDS Care and Treatment to over 4,000 clients. The HIPS Project provided technical assistance and guidance to companies in setting up AIDS treatment programs, including clinical protocols, MOH clinic accreditation, procurement of basic diagnostic equipment and training of appropriate staff. In partnership with the Ministry of Health, the HIPS Project accredited 88 private facilities for free ARVs from the MOH. The project developed a support supervision tool and conducted comprehensive support supervision visits to all the partner sites in conjunction with district health teams. The emphasis in FY2010 will be to expand to 100 private clinics and to ensure the functionality and delivery of quality programs in all these partner sites.

Key Activities for FY 2010:
1. Regular monitoring and support supervision of accredited sites to ensure the provision of quality services.
2. Supporting the integration of services with HIV, TB, Malaria, FP/RH and promoting sustainability through creating linkages with districts and other key stakeholders to ensure continuity of quality services.
3. Train up to 250 providers in ART including pediatric ART, ART logistics, and management of opportunistic infections. The emphasis will be on onsite practical training and support.
4. Strengthen referral networks between smaller companies with no onsite treatment clinics and clinics that have been accredited to offer these services.
5. Distribute ART registers, treatment cards and monthly report forms to partner clinics.
6. Enhanced support to partner clinics to enable them offer treatment, care and support services. Basic equipment and IEC will be provided to partners.
7. Link HIPS' partner laboratory technicians, dispensers and record-keeping personnel to training in ART logistics and HMIS.
8. Conduct review of ART services at selected partner clinics to assess the extent to which community members access quality affordable services.
9. The Project will continue to guide companies and private clinics through the process for becoming

accredited by the MOH. Emphasis will be placed on indentifying clinics located in the remote, underserved areas in the country.

Key indicators and targets for 2010:
T1.5.D 100 health facilities that offer ART
T1.1.D 1500 adults and children with advanced HIV infection newly enrolled on ART disaggregated by age and sex
<15 year: female 15, male 15
1-4 years: female 45, male 45
5-14 years female 90, male 90
15+ years: female 700, male 500
Number of pregnant women with advanced HIV infection newly enrolled on ART
T1.2.D 4500 of adults and children with advanced HIV infection receiving antiretroviral therapy (ART (CURRENT) disaggregated by age and sex
T1.4.D 6000 of naïve adults and children with advanced HIV infection who ever started on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	100,000	

Narrative:

HIPS will continue providing HIV Voluntary Counseling and Testing (VCT) services to companies by partnering with them to carry out facility-based VCT, conduct regular community outreach and participate in special health fair events that promote VCT. Special attention will be paid to mobilizing couples for counseling and testing. In FY 2008/2009, 3500 peer educators were trained from amongst company staff, out-growers and community members to communicate to their peers the importance of knowing one's HIV/AIDS status. HIPS also works closely with the AIDS Information Center (AIC) and Mulago Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) to provide the counseling and testing services to private facilities and during the health fair/VCT days.
HIPS works with 88 private clinics accredited through the MOH and has trained over 103 counselors in VCT, provided 25,000 people with VCT services through outreach and on-site clinics. Moreover, HIPS has developed a national referral guide for ART services. and has further reproduced and distributed informational material on VCT. Over 200,000 persons have been sensitized through these IEC messages and health fair events on the benefits of knowing their HIV/AIDS status.
Key activities for 2010:
1. The HIPS Project has supported all partner sites with VCT forms and client cards from the MOH and the AIDS Information Centre. The HIPS Project will print additional forms, registers and cards for partner

sites to ensure proper recording, analysis and reporting. VCT is part of HIPS' regular support supervision and during these visits health workers will be supported on how to complete the forms, analyze the data, the various levels of reporting and the integration of services at VCT sites to allow for proper referral for FP or maternal, child health and other services.
2. In conjunction with the MOH and the new SURE Project, HIPS will conduct training for laboratory technicians to equip them with basic skills for HIV testing. Following this training, HIPS will support the accreditation of new partner facilities to access free testing kits from the MOH. Subsequently, HIPS will link partner facilities to the MOH and Joint Medical Stores to access free test kits.
3. HIPS will partner with both AIC and MJAP to support private clinics in HCT. 50 health workers from new partner sites will be trained in HCT. On return to their clinics, these trainees will take on the responsibility of providing HCT services for their clients and conduct HCT outreaches.
4. HIPS will update and distribute the HIPS national referral guide for peer educators which provides relevant information about, when to refer, existing referral centers and ART services provided, to facilitate timely and accurate referral to companies' employees and community members. This guide is particularly useful for casual and migrant workers, in addition to out growers (farming communities).
5. HIPS will pilot home based VCT services for employees and communities with three companies. HIPS will work with AIC and MJAP to train clinical teams at the company clinic in home-based VCT. Companies are willing to share the costs of the program at a minimum of 1:1. This program presents further opportunities for a) increasing the number of people, in particular couples testing for HIV, b) integration of services and c) referral of cases.
6. HIPS Project, in partnership with John Hopkins University (JHU)/Couples Counseling Project, will support the training of 25 trained counselors in couple counseling and testing. These will mainly be selected from partners conducting home based counseling and testing. This will boost partner efforts in mobilizing and recruiting couples for HCT.

P11.O.D: 100 service outlets providing Testing and Counseling (C &T) services
P11.1.D: 35,000 individuals who received Testing and Counseling services for HIV and received their results.
Number of individuals who received Testing and Counseling services for HIV and received their test results disaggregated by age and sex
< 5 years: 2000 (1000 male, 1000 female)
5-17 years: 8000 (4000 male, 4000 female)
18+ years: 25,000 (13000 male, 12000 female)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	191,139	

Narrative:

HIPS support to partner institutions has focused on in-service training for partner staff. The training targets multidisciplinary health care professionals who are active in HIV/AIDS, TB, FP and RH Programs at partner companies and health facilities. In partnership with member companies, the project has conducted peer education training and developed communication materials. The Mildmay Centre has supported the training of health workers in short courses tailored to their workplace programs. The AIC has been instrumental in supporting partner VCT programs through training and support supervision. In addition, the STF, JHCU/CCP and MOH have provide guidance in the design, printing and distribution of IEC materials including job aids, brochures, flow charts, adherence calendars, report forms and registers.

In addition, the project provides on-the-job training and support supervision. The project has developed a comprehensive support supervision tool based on the national supervision guidelines for use while reviewing partner programs. During these visits, the Project in partnership with the local districts, MOH and other partners conducts an in-depth assessment and discussion of partner programs and recommends adjustments. This supervision checks the quality of programs delivered, assesses reporting to the districts and identifies other collaboration opportunities. HIPS also uses our quarterly contacts with these companies to check on progress in implementation and gather service statistics.

In 2010, HIPS will visit all our partners twice a year for comprehensive support supervision. We will form multidisciplinary quality-of-care teams comprising of staff from HIPS, UMA, FUE, the districts and the Health Care Improvement Project. HIPS will collaborate with local government authorities by encouraging sub-district health teams to conduct regular reviews of AIDS programs at HIPS partner sites and recommend needed adjustments. The Project will also work with local AIDS organizations to strengthen the referral systems.
As critical to our sustainability strategy, HIPS has established strong working relationships with the Federation of Ugandan Employers (FUE) and Uganda Manufacturing Association (UMA). The project has made great strides in strengthening the institutional, programmatic and financial capacity of FUE and UMA to increasingly take responsibility for project-initiated activities.
Key activities in FY 2010:
1. Training and refresher training for peer educators-
In Year 1 and 2, a total of 3,500 peer educators have been trained in over 22 companies. In Year 2010, HIPS will train 2,500 peer educators. This will include training of trainers (TOTs) and new training for the companies expected to come on board during the year.

2. Medical male circumcision-

In Year 2, the project supported the training of 13 health care workers from 5 partner facilities at the Rakai Health Services Program. In 2010, the project will support the training of 30 health care workers.

3. Identify and train community caregivers in selected companies' catchment areas in home-based care and psycho-social support-

With support from trained peer educators, HIPS has identified and trained 326 caregivers in basic HIV care and referral in ten companies. These trained home caregivers are linked to 66 facilities that provide integrated HIV/AIDS services, adding to the existing community resource persons within the catchment area and ensuring continuity of care. In 2010, HIPS will continue to use peer educators to identify 230 caregivers to be trained in community based care and psychosocial support.

4. Provide training to private practitioners in Palliative care

HIPS will continue to sponsor partner clinicians' participation in palliative care training at Mildmay. In 2010, 70 doctors, nurses and nurse aids will be trained on basic skills and information to provide palliative care services to their clients. This will increase the pool of trained clinicians in the private sector with the necessary tools to provide palliative care services to clients.

5. Provide training to private practitioners in AIDS treatment
In year 1 and 2, HIPS has sponsored 352 staff from partner clinics to participate in AIDS treatment training programs at the Mildmay training center in the last two years. These staffs are now providing HIV/AIDS care and treatment to over 4,000 clients. In 2010, we will train a total of 250 health workers in AIDS related courses.

6. Provide training to private practitioners in pediatric AIDS treatment and follow up and support of HIV positive children

In 2010, pediatric AIDS training will be provided to 30 health workers from new companies. A new topic 'communicating with children' has been added to this course in response to the demand from health workers. In addition, the project will support partners to conduct home-based visits for these children to ensure that they receive adequate support and are not neglected by their care-takers.

7. Provide training to laboratory technicians in HIV testing

In 2010, with support from the MOH and the new SURE Project, we will conduct training for 30 laboratory technicians to equip them with basic skills for HIV testing. Following this training, we will support the accreditation of new partner facilities to access free testing kits from the MOH.

8. Provide training of private practitioners in HIV testing and counseling-

HIPS, in partnership with AIC, has sponsored the training of 103 counselors from companies in HIV counseling and testing in the past two years. In 2010, HIPS will partner with both AIC and MJAP to support private clinics in HCT. Fifty health workers from new partner sites are expected to be trained in HCT.

9. Train counselors from partner companies in couple counseling and testing-

The Project has received support from JHU to support the training of counselors in couple counseling and testing. In 2010, the Project in partnership with JHU/Couples Counseling Project will support training of 25 trained counselors in couple counseling and testing. These will mainly be selected from partners conducting home based counseling and testing.

2010 Targets
H2.3.D: Number of health care workers who successfully completed in service training during the reporting period
• Pediatric care and treatment; 30
• Adult care and treatment; 550 (care and support 300; adult treatment 250)
• Biomedical Prevention; Male circumcision; 30
• Sexual prevention-AB; 2,500
• Sexual prevention-OP; 2,500
• HIV counseling and Testing; 50

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	354,580	

Narrative:

In 2009, HIPS included Medical Male Circumcision in the HIV prevention communication package implemented by supported companies. This is due to the available evidence that MMC greatly reduces the risk of acquiring HIV among men especially if accessed as part of a bigger prevention package. Given the fact that there is no government policy as yet and public awareness is limited, activities were focused on advocacy to the companies, increasing awareness among employees and neighboring communities and training of health workers regarding the provision of services.
In 2010, HIPS will continue to integrate MMC in the communication interventions that include; workplace

and community videos, community radio discussions and peer educators' trainings among others.

Additionally, HIPS has utilized an innovative approach of interactive mobile SMS messages to increase MMC awareness among employees, their families and neighboring communities. Part of the messaging program will provide baseline data on knowledge, attitudes and practice regarding MMC and provide data which will inform the design for further communication and delivery of services. If the implementation of the program is found to be cost effective and providing increased access, it will be expanded to more companies through a 1:1 cost sharing arrangement. A total of 75,000 people will be reached through the various HIPS communication approaches.
In 2009, HIPS trained five partner clinics in MMC through Rakai Health Services Program. The MMC demand has been high with the majority of those receiving services being adults. In 2010, the Project will support an additional 5 clinics for training in MMC, for a total of 10 partner clinics providing MCC, with an estimated 1000 men receiving services (circumcised). HIPS will work closely with these 10 clinics, providing support supervision and regular updates to ensure quality services.
Key Activities to promote and support MMC in 2010:

1. Peer educator training; in FY 2009/2010. A component on Medical Male Circumcision is being added to the peer educators training manual. The 2,000 peer educators who will be given refresher trainings will also be trained in mobilization and promotion of the practice. The 500 peer educators from new partners will also receive training on the same.
2. Continue to support companies to utilize the interactive SMS health messaging program to increase awareness and motivation for MMC
3. Adapt and disseminate MMC communication materials to companies
4. Continue to utilize community videos and radio discussions to promote MMC
5. Support the training of health workers in MMC at 5 company clinics
6. Conduct regular support supervision visits to clinics with district health teams to ensure quality services

P5.3.D 10 locations providing MC surgery as part of the minimum package of MC for HIV prevention services within the reporting period

P5.1.D 1000 males circumcised as part of the minimum package of MC for HIV prevention services disaggregated by age
<5 years: 200

5-17 years: 300
18+ years: 500

WHO/UNAIDS recommended MC as part of a comprehensive HIV prevention package in 2007.Uganda endorsed this recommendation and started MMC policy development in 2009. the policy has recently been approved and USG through the Health Communication Partnership, will work with MOH to have a national and dissemination workshops. MMC is however being done in some Public and private health facilities and the demand is increasing. PEPFAR supported pilot MMC projects namely: SPH-Rakai, Walter Reed Kayunga, UPDF and HIPs.

With additional resources, PEPFAR is going to scale up provision of Safe Male Circumcision (SMC). This will be contributing to the NSP goal of reducing HIV incidence rate by 40% by 2012.

The key target groups for Safe Male Circumcision are: HIV negative males including older adolescents and sexually active men; older men at particularly high risk (truck drivers, uniformed services, STI patients, and uninfected men in HIV discordant couples and in the long term, Neonatal male circumcision.

With the additional funding, both HIPS will undertake HU assessments to determine the human resource and infrastructure needs. The needed personnel will be trained by either Rakai or Walter reed training centers. Both projects will, working hand in hand with HCP, will undertake IEC and BCC activities with the aim of creating demand but also increasing correct and appropriate knowledge about SMC in particular and HIV prevention in general. HIPS will extend to 10 new health units while at both level IV and III .

The Key activities will include :

• Developing a plan to provide Voluntary Safe Male Circumcision services as a minimum package alongside other known HIV prevention interventions

• Supporting the rapid scale up of facility based VMMC services in Government, Private, FBO and community based health facilities

• Supporting the provision of outreach (temporary or mobile) Voluntary Safe Male Circumcision services to increase access, particularly in remote areas.

• Undertaking advocacy, community sensitization/mobilization, and education to create informed demand for VMMC services,

• Undertaking in-service training of service providers in public, Private, Faith based and community health facilities. At least 3 training centers will be supported

• Long-term sustainable and integrated VMMC capacity in health facilities including capacity for provision of neo-natal and pediatric MC services

• Facilitate referrals and linkages of VMMC services to other HIV/AIDS prevention, care and treatment services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	200,000	

Narrative:

HIPS has a mandate to help Ugandan companies find cost-effective ways to extend health services to employees, dependants and communities. HIPS will support communication interventions to reach young people attending schools of partner companies and OVC within companies and communities with HIV risk-prevention messages. Activities to be supported will include the dissemination of abstinence print materials and supporting school-based HIV/AIDS or related clubs and programs with communication materials, video and drams shows among others. Club leaders will be oriented to impart life planning and other communication skills. The life skills communication materials developed by the Ministry of Education with USAID will be reproduced and distributed to the clubs to enhance HIV prevention skills among school-going young people. The 2004/2005 Behavioral Survey of the Ministry of Health indicated multiple concurrent sexual partnerships as a key driver of the HIV epidemic. In FY2010, HIPS will support companies to integrate messages promoting mutual sexual faithfulness in peer education activities that include inter-personal discussions, community video and radio discussions, among others. Faithfulness will also be promoted among special groups that include teachers and staff of the schools supported by the partner companies. Behaviors and practices that influence being faithful to one sexual partner like alcohol abuse and gender based violence will also be addressed during the discussions.

Key Activities for FY2010:
1. Training of peer educators: 2000 peer educators will attend refresher trainings to include orientation on abstinence and faithfulness promotion. The 500 new peer educators will also go through the orientation.
2. Adapt, reproduce and disseminate communication materials on abstinence and being faithful.
3. Support the integration of abstinence content in drama scripts of supported schools.
4. Conduct school-based and community/work place video shows that promote abstinence and faithfulness.
5. Continue to use interactive SMS/text messaging to relay interactive health messaging to promote being faithful.
6. Support companies to conduct community radio discussions that promote faithfulness and address issues that limit capacity to practice mutual sexual faithfulness.
7. Facilitate company and community videos on abstinence and being faithful
P8.2.D: 75,000 reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required [675,000]
15-24 years- 37,500
25+ years - 37,50

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	150,000	

Narrative:

In partnership with the private sector, HIPS implements activities to improve accessibility to information and messages on abstinence, being faithful and correct and consistent condom use among other prevention practices. HIPS adopted the Uganda Health Marketing Group 'Good Life' communication platform and adjusted it to the 'Good Life at Work'. Under this communication strategy HIPS, has conducted health fairs, training of peer educators to ensure dissemination of accurate information, procurement and distribution of condoms and other health products. Health fairs are an initiative designed to communicate health messages to workplace and community members in an entertaining manner. These activities are aimed at preventing HIV transmission through the promotion of correct and consistent condom use, reduction of concurrent multiple sexual partners and early treatment of sexually transmitted infections at work place settings and in surrounding communities. These messages are also targeted at other company workers such as migrant workers and company out-growers (part of a company's supply chain). To date, HIPS has reached company employees, employee dependants, out-growers, migrant workers and the surrounding communities with messages on sexual prevention. This communication drive has laid a special emphasis on bringing men on board in community sexual and reproductive health programs where over half of those reached are men. At least 3,500 male and female peer educators have so far been trained; over 20 health fairs have been held. Through these and other mechanisms, over 170,000 persons have been reached with sexual prevention messages. Condoms have also been sold to partner companies who distribute these to the company workers, out-growers and surrounding communities.

During FY2009, HIPS integrated communication on multiple sexual partners in existing activities that include community health fairs, community radio discussions and video shows. In addition to these, relevant communication materials will be adapted, produced and disseminated to employees, their families and communities through the supported companies. HIPS support to companies in FY2010 will pay special attention to quality improvement, integration and sustainability.

Key activities in FY2010:

1. Peer educator training; HIPS will conduct refresher trainings of 2,000 peer educators, trainings of 500 peer educators from new partners and Training of Trainers workshops for 60 peer educators. Emphasis will be put on strengthening partner capacity to implement and sustain quality peer education activities including data collection and reporting mechanisms. The trained peer educators will continue to disseminate health messages and information aimed at reducing risk behavior and preventing HIV transmission among company workers, out growers, migrant workers and surrounding communities. In addition to condom distribution, the peer educators will be supported to conduct low cost health fairs and workplace and community video among others.

2. Promote correct and consistent condom use and reduction of multiple concurrent sexual partners through community and work place communication approaches that include; low cost health fairs, drama shows, radio discussions, men only seminars among others.

3. Support companies to distribute communication materials through the peer educators at work place and neighboring communities. 4. Develop and disseminate quality assurance guidelines to peer educators. 5. Scale up the use of interactive SMS messaging to promote correct and consistent condom use and reduction of multiple concurrent sexual partnerships. Sexual prevention Targets for 2010: •P8.1.DNumber of targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required [120,000]. 15-24 years- 60,000 25+ years - 60,000

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7191	**Mechanism Name: Health Care Improvement Project - HCI/NuLife**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,536,750	
Funding Source	**Funding Amount**
GHCS (State)	2,536,750

Sub Partner Name(s)

Agricultural Cooperative Development International Volunteers in Overseas Cooperative Assistance	RECO Industries	Save the Children/US

Overview Narrative

NuLife – Food and Nutrition Interventions for Uganda is three-year project implemented by University Research Co., LLC (URC), in partnership with Save the Children and ACDI/VOCA. It is funded through a USAID Cooperative Agreement under PEPFAR. The program goal is to improve the quality of life of PLHIV and to increase use of and adherence to antiretrovirals (ARVs), as well as to improve the effectiveness of treatment through food and nutrition interventions that complements antiretroviral therapy. The program builds on URC's work in Uganda under the Health Care Improvement Project (HCI), to support 54 health facilities scattered across 51 districts through the Ministry of Health and USG partners. The primary beneficiaries for the program are: PLHIV including adults and children (aged below 18 years) in ART and care programs; HIV-positive pregnant & lactating women/mothers with children less than six months; and Orphans and Vulnerable Children (OVC) irrespective of the Sero status.

The program's three primary objectives include: 1) provision of technical support to the MOH, USG partners to integrate food and nutrition interventions in HIV care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable Ready to Use Therapeutic Food (RUTF) made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities.

To meet these objectives, NuLife uses the following interventions: 1) At the national level, provide technical support to the MOH in the development nutrition related policies, guidelines, training manuals and the establishment of competent team of national trainers; 2) Strengthening human capacity by training and coaching health workers at community, facility, and district levels in nutrition care and support for PLHIV; 3) Strengthen capacity of health facilities to sustain the management of acute malnutrition for people living with and affected by HIV using ready to use RUTF, Fortified Blended Foods (FBF) and counseling, as part of Outpatient Therapeutic Care (OTC); 4) Improving the health facility-community linkages for active case finding, referral and follow-up care to improve treatment adherence, loss to follow up and recovery for HIV individuals receiving treatment for acute malnutrition; 5) Building local capacity for the development and manufacture of RUTF that meets national and international standards.

NuLife made substantial progress in FY 2009 in integrating food and nutrition interventions for PLHIV at all levels. At the national level, NuLife supported the development of the infant and young child feeding (IYCF) guidelines and its accompanying job aids, finalized the National Nutrition and HIV and TB Strategy (2009-2014), supported activities for the Sub-Committee on Nutrition (SCN) within the MOH and trained a team of 204 national and regional trainers in nutrition care and support for PLHIV. At the facility level, the program trained over 625 facility-based health workers to provide nutritional care for PLHIV. Over 14000 PLHIV were vassessed for nutritional status and 3000 treated for malnutriton through the OTC

program; developed data collection tools; supplied sets of anthropometric equipment and related job aides and using the quality improvement approach successfully integrated nutrition in HIV care at 34 health facilities across 29 districts. Through the supply chain system, a total of 57.4 Metric Tons (MT) of RUTF were positioned to 34 facilities and 32 MT distributed to program beneficiaries. At the community level, the program strengthened the community–facility links through the mobilization of partners and district officials and training of 1039 community volunteers to identify refer, and follow up nutritionally compromised HIV-positive individuals.

Monitoring, evaluation and reporting will be the basis for documenting needs, activities, results and decision-making for the program and will be integral to realizing integration of food and nutrition into the national HIV care and treatment programs. In FY 2010, NuLife will focus on strengthening reporting systems at the 54 health facilities, district USG partners and national level for improved data collection of nutrition care and support for PLHIV. Specifically, the program will continue to work with the MOH-ACP program to pretest and review the HIV care monitoring tools especially the HIV care card to ensure that all nutrition related indicators are captured. At the facility and district level, the program will train 180 health facility staff responsible for data collection at the HIV clinics. The new HIV care monitoring tools and the new MOH Integrated Management of Acute Malnutrition (IMAM) tools for will be utilized for data collection and reporting. At the community level, the program will pilot use of the community nutrition data collections tools and encourage partners to integrate nutrition indicators into their data collection tools, as initaited in FY2009. Health worker and partner community volunteer coordinators will have the sole responsibility for data collection at the facility and community level respectively. Following on with the process of integrating nutrition indicators into partner reporting tools, the program will proactively work with each USG partner to support facility level staff to collect all nutrition related data for PLHIV.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	185,000
Food and Nutrition: Policy, Tools, and Service Delivery	490,000
Human Resources for Health	469,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7191**		
Mechanism Name:	**Health Care Improvement Project - HCI/NuLife**		
Prime Partner Name:	**University Research Corporation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	600,000	

Narrative:

Strategies implemented in Phase I facilities have yielded positive and rapid results, which need to be sustained. NuLife will continue to use the quality improvement (QI) approach to expand the provision of comprehensive nutrition care for PLHIV to 20 additional health facilities and their catchment areas across the country, bringing the total number of directly supported facilities to 54. In FY2010, the program will support 26,360 HIV-positive adults (including pregnant women and mothers with children less than 6 months) with nutritional assessment for admission into Outpatient Therapeutic Care (OTC). Treatment for acute malnutrition through OTC will be provided to 3500 HIV positive individuals primarily using RUTF. Coupled with treatment for acute malnutrition, the adults will be counseled to prevent development of new episodes of malnutrition. Major topics/issues for which they will be counseled include eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, dealing with loss of appetite, preventing infections, maintaining physical fitness, encouraging positive living and seeking early treatment. To support nutrition service delivery to the PLHIVs, the program will conduct a total of 20 training workshops through which 470 health workers will be retrained and 200 health workers newly trained in comprehensive nutrition care and support for adult PLHIV.

In order to facilitate nutrition assessment and counseling, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 2,500 MUAC tapes, 10 adult weighing scales, and pallets for selected health facilities. With the finalization of the national guidelines for Integrated Management of Acute Malnutrition (IMAM), Uganda now has a blue print to guide all organizations supporting nutrition. The IMAM guidelines focus on the treatment of acute malnutrition in all groups including PLHIV. NuLife contributed four of the seven chapters in the guidelines focusing on Nutrition and HIV and Community Mobilization. Similar to the IYCF component, NuLife will support the MOH to print and disseminate the guidelines, the training curriculum and accompanying job-aids to the focus facilities.

Technical support to USG Partners: As the major mandate, the program will focus collaborative efforts and provide technical support to USG partners implementing Adult Care and Treatment programs to integrate nutrition into HIV care and support for the adults. Technical support will range from training health workers in partner facilities, provision of a minimum technical package required to integrate nutrition, through meeting and special training workshops. The major Adult Care and Treatment partners include JCRC, TASO, World Vision/SPEAR, NUMAT, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites. Technical assistance will be through regular meetings, training of partner staff, support to integrate nutrition indicators into data collection tools and reporting system, provision of all training manuals and job aides developed.

Support to Ministry of Health: NuLife has provided technical support to the Uganda MoH through development and updating of guidelines, development of training manuals, training a team of national trainers and job aides. This support will be mainly through the established HIV taskforce under the MOH Sub-Committee on Nutrition in the MCH cluster whose role is to provide overall guidance and coordination for development of policies, strategies, materials and curriculum related to nutrition. This taskforce which meets quarterly is responsible for the selection of national trainers, approval and revision of materials and provision of overall policy and technical guidance for implementation of nutrition and HIV activities in the NuLife supported facilities and those of collaborating organizations. In addition, the program will advocate for inclusion of nutrition and HIV/AIDS in pre- and in-service training for Village Health Teams (VHT), nurses and midwives, clinical officers and doctors.
Support to districts: Districts have responsibilities for support to and supervision of health facilities. The district health teams access budgets to implement health activities. During FY 10, NuLife will build the capacity of districts to understand and support nutrition interventions. This will be accomplished in collaboration with the Health Care Improvement project, which is setting up Quality Improvement teams at district level. NuLife already has contributed a chapter on nutrition in the curriculum being used to train districts. The NuLife team will orient trainers of district QI teams and as much as possible participate in the training sessions. Progress and outcomes of data generated monthly from health facility sites will be shared with district leaders, the District Health Officer and the District Health Team to generate discussion and influence programming and budgeting.

Support to the health facility: Building on the quality improvement process established last FY, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions to support the facilities in integrating nutrition into HIV care and treatment clinics at the 54 sites. The teams will make bi-monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into HIV care and treatment using the developed seven steps developed from the training manual to simplify activity implementation at the facility. The visits will jointly be supported by HCI. The seven steps include: nutrition assessment for all HIV positive individuals; the second is categorization into normal, moderate

and severe acute malnutrition based on the colour of the MUAC tape; the third is nutrition counseling of malnourished HIV positive individuals; the fourth is RUTF prescription using the recommended dosing charts; the fifth is client follow-up for those receiving RUTF; the sixth is general nutrition education for all PLHIV at the HIV clinics; and the seventh being community mobilization at the community level for identification and follow-up. To augment the coaching team, the NuLife technical team will provide quarterly technical support visits to support and follow-up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of integrating nutrition into HIV routine care using data from the process indicators, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 Phase I sites, while the second phase will be for the 54 Phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

Support at community level: Establishing a functional link between the community and the health facility in support of client treatment is a key aspect of any outpatient therapeutic care intervention. It is this link that increases adherence, minimizes default rates and results in good treatment outcomes. With health facilities now equipped and organized to treat malnutrition and volunteers trained in assessment, referral and follow-up, NuLife seeks to ensure sustained implementation. Early results and anecdotal from facilities show a positive trend towards increased community and health facility capacity to collectively identify clients in need of nutrition services and link with each other to provide quality nutritional support and care for PLHIV and those affected. NuLife will thus train and equip an additional 500 community volunteers in 20 facility catchment areas using the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for PLHIV, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, and management of malnutrition at community level. The community volunteers are drawn from USG partner organizations and their primary role will be to identify, refer and follow up malnourished HIV positive individuals within the 54 facility catchment areas to health facilities for nutrition care and support. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes and 1400 national counseling cards to the community volunteers. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team. The role of the community coordinator will be share with the facility QI teams successes and challenges and the operationalization of the bi-directional referral

mechanism established by the program.

Support to the community volunteers for quality activity implementation, capacity building meetings at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow-up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers for the partner organizations and selected community volunteer coordinators will be responsible for provision on site support for the community to monitor and mentor community volunteers on how they are integrating nutrition into care and treatment services. The frequency and fora of support will be dependent on the partners' plans for supporting community volunteers. NuLife will also support and advocate for inclusion of nutrition into the village health team training manual currently being revised.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when the patients graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organizations that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation and Africare among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	150,000	

Narrative:

In FY2010, the program will support targeted food and nutritional support services to 2500 HIV negative clinically malnourished OVC aged 0-17 years identified at both the facility and community level. In most cases, these OVCs will be identified at other clinics other than the HIV clinic which the outpatient department, Young Child Clinic, the MCH clinics and acute care clinics. The nutrition related services to be provided to the OVCs will include nutritional assessment, counseling, Infant and Young Child Feeding, and treatment for acute malnutrition. The malnourished children and their care takers will be counseled on eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, infant and young child feeding practices, dealing with loss of appetite, preventing infections, encouraging positive leaving and

seeking early treatment. In addition to counseling, the malnourished will be treated using RUTF so as to improve on their nutritional status.

To facilitate nutrition assessment and counseling for OVC at the facility level, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 7500 MUAC tapes, 80 pediatric weighing scales, and pallets for selected health facilities. The program will also support printing IMAM guidelines when they are finalized. To accompany the IYCF and IMAM guidelines, the following job aides will be printed and distributed to the new sites national counseling cards for comprehensive nutrition care and support, facility level job aids, accurately measuring MUAC wall chart, RUTF dosing chart, target weight wall chart, and eligible client wall chart.

Technical support to USG OVC Partners: As the major mandate, the program will focus collaborative efforts and provide technical support to USG partners implementing OVC programs to integrate nutrition into their OVC programs. Technical support will range from training health workers in partner facilities, training of partner staff as trainers, provision of a minimum technical package required to integrate nutrition, regular one on one meetings, and organized workshops to update partners on the minimum package and new developments in the area of nutrition, support to integrate nutrition indicators into data collection tools and reporting system, provision of training manuals and job aides developed. The major OVC partners include Baylor College of Medicine, TASO, ICOBI, NUMAT, the STAR program in central and Eastern Uganda, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites.

Building on the quality improvement process established last FY, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions. The coaching team will support facility level QI teams in integrating nutrition care and support into service delivery for OVC at the facilities. Working with the facility nutrition focal person, the Q.I teams will support the identification of clinically malnourished children in the HIV clinic, PMTCT clinic, the young child clinics, the nutrition unit and the outpatient department. The coaching teams will make monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into OVC services at the facility level using the seven steps developed from the training manual to simplify activity implementation at the facility. The first step is nutrition assessment for all OVCs; the second is categorization into normal moderate and severe acute malnutrition based on the colours of the MUAC tape; the third is nutrition counseling of malnourished OVC; the fourth is RUTF prescription using the recommended dosing charts; client follow up for those receiving RUTF; the sixth is general nutrition education for all OVC and their caretakers at the clinics; and the seventh being community mobilization at the community level for identification and follow up of malnourished OVC. To augment the coaching team, the NuLife technical team will provide quarterly

technical support visits to support and follow up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of providing nutrition care to OVC at HIV clinics and the nutrition units, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 phase I sites, while the second phase will be for the 54 phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

As a strategy for strengthening the facility-community linkages for increased accessibility for nutrition care and support services for OVC, the program will train and equip 500 new community volunteers using the community training cascade model and the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for OVCs, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, and management of malnutrition at community level. The community volunteers are drawn from USG partner organizations and their primary role will be to identify, refer and follow up malnourished OVC to health facilities providing nutrition care and support. The community volunteers will be drawn from the 54 health facility catchment areas. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes and 1400 national counseling cards to the community volunteers. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team, whose role will be to be to share successes and challenges, the operationalization of the bi-directional referral mechanism established by the program with the facility QI teams.

Support to the community volunteers for quality activity implementation, capacity building meetings will be conduct at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers of partner organizations and selected community volunteer coordinators will be responsible for provision on site support for the community to monitor and mentor community volunteers on how they are integrating nutrition into care and treatment services. The frequency and fora of support will be

dependent on the partners plans for supporting community volunteers.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood and food security programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when OVCs graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organization that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation, Africare among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	733,400	

Narrative:

Strategies implemented in Phase I facilities have yielded positive and rapid results, which need to be sustained. NuLife will continue to use the quality improvement (QI) approach to expand the provision of comprehensive nutrition care for PLHIV to 20 additional health facilities and their catchment areas across the country, bringing the total number of directly supported facilities to 54. In FY2010, the program will support 11,600 HIV positive adults (aged 15 years and above) receiving ART with nutritional assessment for admission into Outpatient Therapeutic Care (OTC). Treatment for acute malnutrition through OTC will be provided to 2700 HIV positive individuals receiving ART primarily using RUTF. Coupled with treatment for acute malnutrition, the adults will be counseled to prevent development of new episodes of malnutrition. Major topics/issues for which they will be counseled include eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, dealing with loss of appetite, preventing infections, maintaining physical fitness, encouraging positive leaving and seeking early treatment. To support nutrition service delivery to the PLHIVs, the program will conduct a total of 20 training workshops through which will be 470 health workers will be retrained and 200 health workers newly trained in comprehensive nutrition care and support for adult PLHIV.

In order to facilitate nutrition assessment and counseling, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 2,500 MUAC tapes, 10 adult weighing scales, and pallets for selected health facilities. With the finalization of the national guidelines for Integrated Management of Acute Malnutrition (IMAM), Uganda now has a blue print to guide all

organizations supporting nutrition. The IMAM guidelines focus on the treatment of acute malnutrition in all groups including PLHIV. NuLife contributed four of the seven chapters in the guidelines focusing on Nutrition and HIV and Community Mobilization. Similar to the IYCF component, NuLife will support the MOH to print and disseminate the guidelines, the training curriculum and accompanying job-aids to the focus facilities.

Technical support to USG Partners: As the major mandate, the program will focus collaborative efforts and provide technical support to USG partners implementing Adult Care and Treatment programs to integrate nutrition into HIV care and support for the adults. Technical support will range from training health workers in partner facilities, provision of a minimum technical package required to integrate nutrition, through meeting and special training workshops. The major Adult Care and Treatment partners include JCRC, TASO, World Vision/SPEAR, NUMAT, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites. Technical assistance will be through regular meetings, training of partner staff, support to integrate nutrition indicators into data collection tools and reporting system, provision of all training manuals and job aides developed.

Support to Ministry of Health: NuLife has provided technical support to the Uganda MoH through development and updating of guidelines, development of training manuals, training a team of national trainers and job aides. This support will be mainly through the established HIV taskforce under the MOH Sub-Committee on Nutrition in the MCH cluster whose role is to provide overall guidance and coordination for development of policies, strategies, materials and curriculum related to nutrition. This taskforce which meets quarterly is responsible for the selection of national trainers, approval and revision of materials and provision of overall policy and technical guidance for implementation of nutrition and HIV activities in the NuLife supported facilities and those of collaborating organizations. In addition, the program will advocate for inclusion of nutrition and HIV/AIDS in pre- and in-service training for Village Health Teams (VHT), nurses and midwives, clinical officers and doctors.

Support to districts: Districts have responsibilities for support to and supervision of health facilities. The district health teams access budgets to implement health activities. During FY 10, NuLife will build the capacity of districts to understand and support nutrition interventions. This will be accomplished in collaboration with the Health Care Improvement project, which is setting up Quality Improvement teams at district level. NuLife already has contributed a chapter on nutrition in the curriculum being used to train districts. The NuLife team will orient trainers of district QI teams and as much as possible participate in the training sessions. Progress and outcomes of data generated monthly from health facility sites will be shared with district leaders, the District Health Officer and the District Health Team to generate discussion and influence programming and budgeting.

Support to the health facility: Building on the quality improvement process established last FY, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions to support the facilities in integrating nutrition into HIV care and treatment clinics at the 54 sites. The teams will make bi-monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into HIV care and treatment using the developed seven steps developed from the training manual to simplify activity implementation at the facility. The visits will jointly be supported by HCI. The seven steps include: nutrition assessment for all HIV positive individuals; the second is categorization into normal, moderate and severe acute malnutrition based on the colour of the MUAC tape; the third is nutrition counseling of malnourished HIV positive individuals; the fourth is RUTF prescription using the recommended dosing charts; client follow up for those receiving RUTF; the sixth is general nutrition education for all PLHIV at the HIV clinics; and the seventh being community mobilization at the community level for identification and follow up. To augment the coaching team, the NuLife technical team will provide quarterly technical support visits to support and follow up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of integrating nutrition into HIV routine care using data from the process indicators, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 Phase I sites, while the second phase will be for the 54 Phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

Support at community level: Establishing a functional link between the community and the health facility in support of client treatment is a key aspect of any outpatient therapeutic care intervention. It is this link that increases adherence, minimizes default rates and results in good treatment outcomes. With health facilities now equipped and organized to treat malnutrition and volunteers trained in assessment, referral and follow-up, NuLife seeks to ensure sustained implementation. Early results and anecdotal from facilities show a positive trend towards increased community and health facility capacity to collectively identify clients in need of nutrition services and link with each other to provide quality nutritional support and care for PLHIV and those affected. NuLife will thus train and equip an additional 500 community volunteers in 20 facility catchment areas using the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for PLHIV, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, and management of malnutrition at community level. The community volunteers are drawn from USG partner organizations

and their primary role will be to identify, refer and follow up malnourished HIV positive individuals within the 54 facility catchment areas to health facilities for nutrition care and support. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes and 1400 national counseling cards to the community volunteers. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team. The role of the community coordinator will be share with the facility QI teams successes and challenges and the operationalization of the bi-directional referral mechanism established by the program.

Support to the community volunteers for quality activity implementation, capacity building meetings will be conduct at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers for the partner organizations and selected community volunteer coordinators will be responsible for provision on site support for the community to monitor and mentor community volunteers on how they are integrating nutrition into care and treatment services. The frequency and fora of support will be dependent on the partners' plans for supporting community volunteers. NuLife will also support and advocate for inclusion of nutrition into the village health team training manual currently being revised.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when the patients graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organization that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation, Africare among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	150,000	

Narrative:

NuLife will use the quality improvement (QI) approach to expand the provision of comprehensive nutrition care for HIV Positive and exposed children to 20 additional health facilities and their catchment areas

across the country, bringing the total number of directly supported facilities to 54. Specific to pediatric care and support, the program will support nutritional assessment of 3600 HIV positive children for admission into outpatient therapeutic care. Those found to be malnourished will be provided with treatment for acute malnutrition using Ready to Use Therapeutic Foods (RUTF) and approximately 2400 HIV positive and exposed children will receive treatment for acute malnutrition. Coupled with treatment for acute malnutrition, the children and care takers will be counseled to prevent development of new episodes of malnutrition. Major topics/issues for which they will be counseled are eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, infant feeding, dealing with loss of appetite, preventing infections, encouraging positive leaving and seeking early treatment.

Skilled health workers are critical to the provision of quality nutritional care for HIV positive children. As such, the program will conduct training workshops in which 470 health workers will be trained through refresher training, and 200 health workers will be newly trained to provide nutrition care and support.

In order to facilitate nutrition assessment and counseling, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 7500 MUAC tapes, 80 pediatric weighing scales, and pallets for selected health facilities. With the finalization of the national guidelines for Integrated Management of Acute Malnutrition (IMAM), Uganda now has a blue print to guide all organizations supporting nutrition. The IMAM guidelines focus on the treatment of acute malnutrition in all groups including PLHIV. NuLife contributed four of the seven chapters in the guidelines focusing on Nutrition and HIV and Community Mobilization. Similar to the IYCF component, NuLife will support the MOH to print and disseminate the guidelines, the training curriculum and accompanying job-aids to the focus facilities.

Technical support to USG Partners: During FY2009, interested USG implementing partners were identified, their activities mapped in relation to the NuLife facility catchment areas and mutually acceptable formal arrangements were made between the two parties to clarify roles and responsibilities, including cost share. During FY2010, the program will focus on building on the established collaborative efforts and provide technical support to partners integrate nutrition care into their pediatric Care and Treatment programs. Technical support will range from training health workers in partner facilities, provision of a minimum technical package required to integrate nutrition, through meeting and special training workshops. The major pediatric Care and Treatment partners include Baylor College of Medicine, JCRC, TASO, EGPAF, PREFA, NUMAT, the STAR program in central and Eastern Uganda, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites. Technical assistance will be through regular meetings, training of partner staff, support to integrate nutrition

indicators into data collection tools and reporting system, provision of all training manuals and job aides developed.

Support to Ministry of Health: NuLife has provided technical and financial support to the Uganda MoH through development and updating of guidelines, development of training manuals, training a team of national trainers and job aides. This support will be mainly through the established HIV taskforce under the MOH Sub-Committee on Nutrition (SCN) in the MCH cluster. The role of the SCN is to provide overall guidance and coordination for development of nutrition related policies, strategies, materials and curriculum for the health sector. This taskforce which meets quarterly is responsible for the selection of national trainers, approval and revision of materials and provision of overall policy and technical guidance for implementation of nutrition and HIV activities in the NuLife supported facilities and those of collaborating organizations. As a request from MOH, NuLife to support the dissemination and distribution of the national IYCF guidelines launched last year especially to districts and facilities supported by the ;program.

Support to health facilities: Building on the quality improvement process established in FY 2009, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions to support the facilities in integrating nutrition into HIV clinics at the 54 sites. The teams will make bi-monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into HIV care and treatment using the developed seven steps developed from the training manual to simplify activity implementation at the facility. The first step is nutrition assessment for all HIV positive individuals; the second is categorization into normal moderate and severe acute malnutrition based on the colours of the MUAC tape; the third is nutrition counseling of malnourished HIV positive individuals; the fourth is RUTF prescription using the recommended dosing charts; client follow up for those receiving RUTF; the sixth is general nutrition education for all PLHIV at the HIV clinics; and the seventh being community mobilization at the community level for identification and follow up. To augment the coaching team, the NuLife technical team will provide quarterly technical support visits to support and follow up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of integrating nutrition into HIV routine care using data from the process indicators, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 phase I sites, while the second phase will be for the 54 phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

Support at community level: Early results and anecdotal from facilities show a positive trend towards increased community and health facility capacity to collectively identify clients in need of nutrition services and link with each other to provide quality nutritional support and care for PLHIV and those affected. As a strategy for strengthening these established facility-community linkages for increased accessibility for nutrition care and support services, the program will train and equip 500 new community volunteers using the community training cascade model and the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for PLHIV, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, and management of malnutrition at community level. The community volunteers are drawn from USG partner organizations and their primary role will be to identify, refer and follow up malnourished HIV positive children areas to health facilities for nutrition care and support. The community volunteers will be drawn from the 54 health facility catchment areas. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes and 1400 national counseling cards to the community volunteers. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team. The role of the community coordinator will be to share with the facility QI teams successes and challenges and the operationalization of the community-facility referral mechanism established.

To support to the community volunteers for quality activity implementation, capacity building meetings will be conduct at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers for the partner organizations and selected community volunteer coordinators will be responsible conduct follow-up and mentoring visits to the trained volunteers, organize progress review meetings to share experiences, discuss challenges and find solutions, supporting community volunteers to ensure data on referral process is collected, among others.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when the children graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that

involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organization that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation, Africare among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	183,350	

Narrative:

NuLife will use the quality improvement (QI) approach to expand the provision of comprehensive nutrition care for HIV Positive and exposed children to 20 additional health facilities and their catchment areas across the country, bringing the total number of directly supported facilities to 54. Specific to pediatric care and support, the program will support nutritional assessment of 1600 HIV positive children receiving ART for admission into outpatient therapeutic care. Those found to be malnourished will be provided with treatment for acute malnutrition using Ready to Use Therapeutic Foods (RUTF) and approximately 1050 HIV positive children receiving ART will be treated for acute malnutrition. Coupled with treatment for acute malnutrition, the children and care takers will be counseled to prevent development of new episodes of malnutrition. Major topics/issues for which they will be counseled are eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, infant feeding, dealing with loss of appetite, preventing infections, encouraging positive leaving and seeking early treatment.

Skilled health workers are critical to the provision of quality nutritional care for HIV positive children. As such, the program will conduct training workshops in which 470 health workers will be trained through refresher training, and 200 health workers will be newly trained to provide nutrition care and support.

In order to facilitate nutrition assessment and counseling, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 7500 MUAC tapes, 80 pediatric weighing scales, and pallets for selected health facilities. With the finalization of the national guidelines for Integrated Management of Acute Malnutrition (IMAM), Uganda now has a blue print to guide all organizations supporting nutrition. The IMAM guidelines focus on the treatment of acute malnutrition in all groups including PLHIV. NuLife contributed four of the seven chapters in the guidelines focusing on Nutrition and HIV and Community Mobilization. Similar to the IYCF component, NuLife will support the MOH to print and disseminate the guidelines, the training curriculum and accompanying job-aids to the focus facilities.

Technical support to USG Partners: During FY2009, interested USG implementing partners were identified, their activities mapped in relation to the NuLife facility catchment areas and mutually acceptable formal arrangements were made between the two parties to clarify roles and responsibilities, including cost sharing. During FY2010, the program will focus on building on the established collaborative efforts and provide technical support to partners integrating nutrition care into their pediatric Care and Treatment programs. Technical support will range from training health workers in partner facilities, provision of a minimum technical package required to integrate nutrition, through meeting and special training workshops. The major pediatric Care and Treatment partners include Baylor College of Medicine, JCRC, TASO, EGPAF, PREFA, NUMAT, the STAR program in central and Eastern Uganda, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites. Technical assistance will be through regular meetings, training of partner staff, support to integrate nutrition indicators into data collection tools and reporting systems, provision of all training manuals and job aides developed.

Support to Ministry of Health: NuLife has provided technical and financial support to the Uganda MoH through development and updating of guidelines, development of training manuals, training a team of national trainers and job aides. This support will be mainly through the established HIV taskforce under the MOH Sub-Committee on Nutrition (SCN) in the MCH cluster. The role of the SCN is to provide overall guidance and coordination for development of nutrition related policies, strategies, materials and curriculum for the health sector. This taskforce which meets quarterly is responsible for the selection of national trainers, approval and revision of materials and provision of overall policy and technical guidance for implementation of nutrition and HIV activities in the NuLife supported facilities and those of collaborating organizations. As a request from MOH, NuLife to support the dissemination and distribution of the national IYCF guidelines launched last year especially to districts and facilities supported by the ;program.

Support to health facilities: Building on the quality improvement process established in FY 2009, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions to support the facilities in integrating nutrition into HIV clinics at the 54 sites. The teams will make bi-monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into HIV care and treatment using the developed seven steps developed from the training manual to simplify activity implementation at the facility. The first step is nutrition assessment for all HIV positive individuals; the second is categorization into normal moderate and severe acute malnutrition based on the colours of the MUAC tape; the third is nutrition counseling of malnourished HIV positive individuals; the fourth is RUTF prescription using the recommended dosing charts; client follow up for those receiving RUTF; the sixth is general nutrition education for all PLHIV at the HIV clinics; and the seventh being community mobilization at the community level for identification and follow up. To augment the coaching team, the NuLife

technical team will provide quarterly technical support visits to support and follow up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of integrating nutrition into HIV routine care using data from the process indicators, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 Phase I sites, while the second phase will be for the 54 Phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

Support at community level: Early results and anecdotal from facilities show a positive trend towards increased community and health facility capacity to collectively identify clients in need of nutrition services and link with each other to provide quality nutritional support and care for PLHIV and those affected. As a strategy for strengthening these established facility-community linkages for increased accessibility for nutrition care and support services, the program will train and equip 500 new community volunteers using the community training cascade model and the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for PLHIV, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, and management of malnutrition at community level. The community volunteers are drawn from USG partner organizations and their primary role will be to identify, refer and follow up malnourished HIV positive children areas to health facilities for nutrition care and support. The community volunteers will be drawn from the 54 health facility catchment areas. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes and 1400 national counseling cards to the community volunteers. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team. The role of the community coordinator will be to share with the facility QI teams successes and challenges and the operationalization of the community-facility referral mechanism established.

To support to the community volunteers for quality activity implementation, capacity building meetings will be conduct at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing

challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers for the partner organizations and selected community volunteer coordinators will be responsible conduct follow-up and mentoring visits to the trained volunteers, organize progress review meetings to share experiences, discuss challenges and find solutions, supporting community volunteers to ensure data on referral process is collected, among others.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when the children graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organization that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation, Africare among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	720,000	

Narrative:

Strategies implemented in Phase I facilities have yielded positive and rapid results, which need to be sustained. NuLife will continue to use the quality improvement (QI) approach to expand the provision of comprehensive nutrition care for HIV positive pregnant women and lactating mothers with children up to six months to 20 additional health facilities and their catchment areas across the country, bringing the total number of directly supported facilities to 54. In FY2010, the program will support 3000 HIV positive pregnant and lactating women in a PMTCT setting with nutritional assessment for admission into Outpatient Therapeutic Care (OTC). Treatment for acute malnutrition through OTC will be provided to 200 HIV positive pregnant and lactating women primarily using RUTF. Coupled with treatment for acute malnutrition, these women will be counseled to prevent development of new episodes of malnutrition. Major topics/issues for which they will be counseled include eating well, relationship between HIV and nutrition, increasing their energy and nutrient intake, dealing with symptoms and signs of opportunistic infections, food and drug interactions, dealing with loss of appetite, preventing infections, maintaining physical fitness, encouraging positive leaving, good infant and young child feeding practices and seeking early treatment. To support nutrition service delivery to the HIV positive pregnant and lactating women, the program will train 50 peer counselors using the existing training module (Theme 3 of the Community Volunteers Training Module and the section on flash heating of breast milk).

In order to facilitate nutrition assessment and counseling, the program will develop, purchase and distribute a set of anthropometric equipment and accompanying materials to the 20 additional sites. For anthropometric equipment, the program will purchase and supply 2,500 MUAC tapes, 10 adult weighing scales, and pallets for selected health facilities. With the finalization and launch of the national guidelines for Infant and Young Child Feeding (IYCF), Uganda now has a blue print to guide all organizations supporting maternal and young child nutrition. NuLife will support the MOH to disseminate these guidelines, the training curriculum and accompanying job-aids to the focus facilities and districts where NuLife is present at the request of MOH.

Support to Ministry of Health: NuLife has provided technical support to the Uganda MoH through development and updating of guidelines, development of training manuals, training a team of national trainers and job aides. In coordination with EGPAF, support to MOH will be mainly through the established Sub-Committee on Nutrition in the MCH cluster whose role is to provide overall guidance and coordination for development of policies, strategies, materials and curriculum related to nutrition. This subcommittee which meets quarterly is responsible for the selection of national trainers, approval and revision of materials and provision of overall policy and technical guidance for implementation of nutrition and HIV activities in the NuLife supported facilities and those of collaborating organizations.

Coordination with other USG Partners: During FY2009, USG partners implementing PMTCT programs at community and facility level were identified, their activities mapped in relation to the NuLife facility catchment areas and mutually acceptable formal arrangements were initiated between the two parties to clarify roles and responsibilities, including cost share. During FY2010, the program will focus on building on the established collaborative efforts and provide technical support wherever necessary to partners integrate nutrition care into their PMCT programs. Coordination efforts will range from training health workers in partner facilities, provision of a minimum technical package required to integrate nutrition, and printing of developed IYCF guidelines, training materials and accompanying job aids. The major PMTCT partners include Baylor College of Medicine, ICOBI, THETA, EGPAF, PREFA, NUMAT, the STAR program in central and Eastern Uganda, CRS/AIDSRelief, where programming overlaps with the NuLife Phase I and II Sites. Technical assistance will be through regular meetings, training of partner staff, support to integrate nutrition indicators into data collection tools and reporting system, provision of all training manuals and job aides developed.

Support to districts: Districts have responsibilities for support to and supervision of health facilities. The district health teams access budgets to implement health activities. During FY 10, NuLife will build the capacity of districts to understand and support nutrition interventions. This will be accomplished in collaboration with the Health Care Improvement project, which is setting up Quality Improvement teams at district level. NuLife already has contributed a chapter on nutrition in the curriculum being used to train

districts. The program will support Village Health Team (VHT) Coordinators in the District Health Offices to provide intensive coaching and mentoring to trained peer counselors and community volunteers. Progress and outcomes of data generated monthly from health facility sites will be shared with district leaders, the District Health Officer and the District Health Team to generate discussion and influence programming and budgeting.

Support to the health facility: Building on the quality improvement process established last FY, NuLife will form additional nutrition and HIV coaching teams for Mbale, Mbarara, and West Nile regions to support the facilities in integrating nutrition into HIV care and treatment clinics at selected regional referral and general hospitals. The teams will make bi-monthly visits to the facilities to mentor facility QI teams to systematically integrate nutrition into the PMCTC package using the developed seven steps developed from the training manual to simplify activity implementation at the facility. The visits will jointly be supported by HCI. The seven steps include: nutrition assessment for all HIV positive pregnant and lactating women; the second is categorization into normal, moderate and severe acute malnutrition based on the colour of the MUAC tape; the third is nutrition counseling (including IYCF) of malnourished HIV positive pregnant and lactating women; the fourth is RUTF prescription using the recommended dosing charts; client follow up for those receiving RUTF; the sixth is general maternal nutrition education for all pregnant and lactating at the PMTCT clinics; and the seventh being community mobilization at the community level for identification and follow up. To augment the coaching team, the NuLife technical team will provide quarterly technical support visits to support and follow up on technical issues raised through the coaching and mentoring visits.

To facilitate sharing of experiences and challenges of integrating nutrition into HIV routine care using data from the process indicators, the program will hold up to six learning sessions for the facilities. These learning sessions are aimed at improving service delivery at facilities when facilities share challenges and successes. The first phase learning sessions will be for the 34 Phase I sites, while the second phase will be for the 54 Phase II and I sites and the target people will be the nutritional focal person and the head of the facility QI team. In addition NuLife will mentor and support those health workers who are interested in preparing abstracts and papers around emerging good experiences at facility and community levels to write and where possible, submit/present these to national and international workshops and conferences.

Support at community level: Establishing a functional link between the community and the health facility in support of client treatment is a key aspect of any outpatient therapeutic care intervention. It is this link that increases adherence, minimizes default rates and results in good treatment outcomes. With health facilities now equipped and organized to treat malnutrition and volunteers trained in assessment, referral and follow-up, NuLife seeks to ensure sustained implementation. Early results and anecdotal from facilities show a positive trend towards increased community and health facility capacity to collectively

identify clients in need of nutrition services and link with each other to provide quality nutritional support and care for PLHIV and those affected. NuLife will thus train and equip an additional 500 community volunteers in 20 facility catchment areas using the revised set of training manuals. Training topics include adult learning and effective facilitation skills, effective communication skills, basic nutrition care and support for PLHIV, the role of the community in integrated management of acute malnutrition, counseling materials for nutrition care and support, management of HIV related symptoms, IYCF and management of malnutrition at community level. Specific to IYCF, NuLife will train additional 50 peer counselors using the existing training module on IYCF (Theme 3 of the Community Volunteers Training Module and the section on flash heating of breast milk) to equip them with IYCF counseling skills. The community volunteers and peer counselors are drawn from USG partner organizations and health facility catchment areas with their primary role being to identify, refer and follow up malnourished HIV positive pregnant and lactating women within the 54 facility catchment areas to health facilities for nutrition care and support as well as counseling on IYCF practices. To facilitate active case finding through nutrition assessment and counseling at the community level, the program will develop, purchase and distribute 11000 MUAC tapes, growth promoters' kits and 1400 national counseling cards to the community volunteers and peer counselors. Furthermore, the program will proactively support the inclusion of the community volunteer coordinator as part of the facility QI team. The role of the community coordinator will be share with the facility QI teams successes and challenges and the operationalization of the bi-directional referral mechanism established by the program.

Support to the community volunteers for quality activity implementation, capacity building meetings will be conduct at each of the 54 facilities and the composition of the participants will be QI team leader, the nutrition focal person, member of the district health team, and a USG filed officer responsible for that facility catchment area. Topics for these meetings will range from discussion of the developed follow up strategy, technical support issues for the volunteers, reporting and documentation as well as addressing challenges for integrating nutrition into HIV care and support activities for the community volunteers. Field Officers for the partner organizations and selected community volunteer coordinators will be responsible for provision on site support for the community to monitor and mentor community volunteers on how they are integrating nutrition into care and treatment services. The frequency and fora of support will be dependent on the partners' plans for supporting community volunteers. NuLife will also support and advocate for inclusion of nutrition into the village health team training manual currently being revised.

Based on lessons from FY2010, it will be critical that the program strengthens and develops new linkages with partners implementing livelihood programs in the 54 facility catchment areas to take on graduates from the outpatient therapeutic care. We envisage that this will lead to a reduction in the number of relapses and allow for continuity of nutrition care and support when the patients graduate from the OTC program. The program will develop a comprehensive "graduation and continuum of care strategy" that

involves the provision of (or graduation to) supplemental foods for PLHIV suffering from moderate acute malnutrition and livelihood support for PLHIV and their families. Examples of organization that the program will work with are ACDI-VOCA who implement Title II MYAP program, World Vision, World Food Program, Lutheran World Federation, Africare among others.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7193	**Mechanism Name: AIDS Indicator Survey Final Activities- MACRO**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Macro International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 750,000	
Funding Source	**Funding Amount**
GHCS (State)	750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

One of the key data sources for indicators used for measuring the impact of USG/Uganda HIV/AIDS program is the AIDS Indicator Survey (AIS). Initially, this survey was to be jointly designed and implemented with the Malaria Indicator Survey (MIS). The two surveys have since separated. Since the AIS implementation has been funded in FY 2009 COP, the FY 2010 funds will go towards supporting the shortfalls resulting from splitting of the two surveys. Further, these resources will be used to support follow-on activities such as secondary data analysis, focused dissemination, and training course on "communicating data to policy makers". In 2004 AIS, the MOH professionals teamed up with USG experts to write and publish papers. In 2010 AIS, the USG will explore the possibility of expanding the involvement to include members of the local universities. The FY 2010 funding is also expected to cover new target groups for specific information dissemination based on the results of the survey. MACRO will

also be expected to develop a short training program that is build upon the standard AIS research assistant's training to put together a training package that covers these themes which go beyond field data collection. In total, 100 (including AIS reasearch assistants) will be trained in strategic information.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7193**		
Mechanism Name:	**AIS Indicator Survey Final Activities- MACRO**		
Prime Partner Name:	**Macro International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	750,000	

Narrative:

One of the key data sources for indicators used for measuring the impact of USG/Uganda HIV/AIDS program is the AIDS Indicator Survey (AIS). Initially, this survey was to be jointly designed and implemented with the Malaria Indicator Survey (MIS). The two surveys have since separated. Since the AIS implementation has been funded in FY 2009 COP, the FY 2010 funds will go towards supporting the shortfalls resulting from splitting of the two surveys. Further, these resources will be used to support follow-on activities such as secondary data analysis, focused dissemination, and training course on "communicating data to policy makers". In 2004 AIS, the MOH professionals teamed up with USG experts to write and publish papers. In 2010 AIS, the USG will explore the possibility of expanding the involvement to include members of the local universities. The FY 2010 funding is also expected to cover new target groups for specific information dissemination based on the results of the survey. MACRO will also be expected to develop a short training program that is build upon the standard AIS research assistant's training to put together a training package that covers these themes which go beyond field data collection. In total, 100 (including AIS reasearch assistants) will be trained in strategic information.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7197	**Mechanism Name: Mid-term and End of Program Evaluations/UMEMS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: The Mitchell Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHCS (State)	1,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Automated Directive System (ADS) 203.3.6.1 requires that end of project evaluations should be conducted when there is a distinct and clear management need to address an issue. This activity will undertake 6-8 mid-term and/or end of project evaluations for USAID PEFPAR projects. End of project evaluations will focus on those that are scheduled to end in FY2010. The purpose of the evaluations is to extract lessons that would benefit the USG/Uganda Team and GOU partner institutions with future programming either through extending or modifying current agreements, or ensuring that key lessons learned are built into existing or newly designed activities. Secondly, these evaluations will provide critical information to USAID and the USG in improving program design, management and implementation. The evaluation will also distill lessons learned about program implementation that will have a bearing on scaling up HIV/AIDS intervention and replication of similar intervention nationwide. Resources are requested to conduct program evaluations for key USAID supported projects including: End of project evaluation for "Food and Nutrition Interventions for People Living with HIV/AIDS – NuLife Project", End of project evaluation of the "Capacity Project",
JCRC organizational effectiveness assessment, indigenous partner capacity assessments for JCRC, TASO, IRCU, Hospice, and ICOBI. The remaining are TBD pending PEPFAR priorities for ongoing programming.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7197**		
Mechanism Name:	**Mid-term and End of Program Evaluations/UMEMS**		
Prime Partner Name:	**The Mitchell Group**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	1,000,000	

Narrative:

Automated Directive System (ADS) 203.3.6.1 requires that end of project evaluations should be conducted when there is a distinct and clear management need to address an issue. This activity will undertake 6-8 mid-term and/or end of project evaluations for USAID PEFPAR projects. End of project evaluations will focus on those that are scheduled to end in FY2010. The purpose of the evaluations is to extract lessons that would benefit the USG/Uganda Team and GOU partner institutions with future programming either through extending or modifying current agreements, or ensuring that key lessons learned are built into existing or newly designed activities. Secondly, these evaluations will provide critical information to USAID and the USG in improving program design, management and implementation. The evaluation will also distill lessons learned about program implementation that will have a bearing on scaling up HIV/AIDS intervention and replication of similar intervention nationwide. Resources are requested to conduct program evaluations for key USAID supported projects including: End of project evaluation for "Food and Nutrition Interventions for People Living with HIV/AIDS – NuLife Project", End of project evaluation of the "Capacity Project", JCRC organizational effectiveness assessment, indigenous partner capacity assessments for JCRC, TASO, IRCU, Hospice, and ICOBI. The remaining are TBD pending PEPFAR priorities for ongoing programming.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7199	**Mechanism Name: Technical Management Agent / Civil Society Fund**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Human Resources for Health	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7199**
Mechanism Name:	**Technical Management Agent / Civil Society Fund**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	Redacted	Redacted
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	Redacted	Redacted
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7308	**Mechanism Name: Partnership for Supply Chain Management Systems (SCMS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 17,112,375	
Funding Source	**Funding Amount**
GHCS (State)	17,112,375

Sub Partner Name(s)

Euro Health Group	Fuel PHD	Makerere University/IDI

Overview Narrative

The Partnership for Supply Chain Management Systems (SCMS) was established to strengthen or establish secure, reliable, cost-effective and sustainable supply chains to meet the care and treatment needs of people living with or affected by HIV and AIDS. In collaboration with in-country and international partners, SCMS works to employ innovative solutions to assist programs to enhance their supply chain capacity; ensuring that accurate supply chain information is collected, shared and used; and providing quality, best-value, health care products to those who need them.

In Uganda, SCMS will no longer provide technical support to the MOH and other government agencies for supply chain management system. This support will now be provided by the new SURE (Securing Ugandans' Right to Essential Medicines) project, the activities of which are described in the OHSS section. SCMS will, however, continue to provide ARV procurement services to PEPFAR implementing partners. The number of partners procuring ARVs through SCMS will increase from two to the following seven partners: Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), Strengthening TB and AIDS Response East (STAR-E) and STAR East Central, and STAR-South West. SCMS will also provide procurement services to the TREAT (JCRC) program during the period Oct 2009 to Sept 2010 to ensure uninterrupted supplies while the program is in a transition period.

The procurement support will be provided by a fulltime national trained by SCMS HQ on procurement policies, procedures and software tools, who will assist programs to forecast and quantify their ARV requirements, updated quarterly, throughout the year. and update their . ceas: The procurement services include

To ensure uninterrupted supply of ARVs to seven partners in the coming year, two fulltime in-country SCMS staff will be managing the procurement process (quantification preparation, submission of orders, shipment tracking, communication with HQ, USAID, partners) and oversee the customs clearance, NDA verfication, and storage and distribution services provided by Joint Medical Stores. Assistance in quantification will also be provided to partners as needed. The SCMS staff will be housed with the new SURE project to reduce administrative costs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7308**		
Mechanism Name:	**Partnership for Supply Chain Management Systems (SCMS)**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXD	17,112,375	

Narrative:

HTXD budget $17,112,375 (unable to paste into planned amount)

SCMS will procure the following list of ARVs for seven USG partners. The JCRC/TREAT program has always procured its own products but in FY 2010, SCMS will do their procurement to ensure no supply disruptions as this program undergoes a transitioning period. JCRC uses the widest range of products of any partner because they have the most mature program and have conducted a number of ART research studies which may have included drugs not in the clinical treatment guidelines.

Abacavir(ABC)(300mg), Atazanavir (as sulfate) 300mg , Darunavir [Prezista] 300MG/tab, Didanosine (DDI) (200mg), Didanosine EC (DDI) (250mg), Didanosine EC (DDI) (400mg), Efavirenz (EFV) (600mg), Indinavir (IDV) (400mg) (Crixivan), Lamivudine (3TC) (150mg), Lopinavir / Ritonavir (LPV/r) (200/50mg), Nevirapine (NVP) (200mg), Stavudine 30 (d4T30) (30mg), Stavudine 30 / Lamivudine (d4T30/3TC) (30/150mg),
Stavudine 30 / Lamivudine / Nevirapine (d4T30/3TC/NVP) (30/150/200mg), Saquinavir (SQV) (500MG), Ritonavir (RTV) (100MG), Tenofovir (TDF) (300mg), Tenofovir / Emtricitabine (TDF/FTC) (300/200mg), Tenofovir disoproxil fumarate-Lamivudine (300+150mg), Zidovudine (AZT) (300mg), Zidovudine / Lamivudine (AZT/3TC) (300/150mg

Products procured by Clinton Foundation that SCMS will procure when CF ceases their pediatric drug procurement: Abacavir (ABC) (20mg/ml), Abacavir (ABC) (20mg/ml), Didanosine (DDI) (50mg), Didanosine (DDI) (100mg), Efavirenz (EFV)(50mg), Efavirenz (EFV) (200mg), Lamivudine (3TC) Syrup (10mg/ml), Lopinavir / Ritonavir (LPV/r) Oral Solution (80/20 mg/ml), Lopinavir-Ritonavir [Pediatric Aluvia]

(100+25MG), Nevirapine (NVP) Syrup (10mg/ml), Stavudine 15 (d4T15) (15mg), Stavudine 20 (d4T20) (20mg), Stavudine (d4T) Syrup (1mg/ml), Stavudine / Lamivudine / Nevirapine (d4T/3TC/NVP) (6/30/50mg)-Triomune Baby, Stavudine / Lamivudine / Nevirapine (d4T/3TC/NVP) (12/60/100mg)-Triomune Junior, Zidovudine (AZT) (100mg), Zidovudine (AZT) Syrup (10mg/ml). The two partners receiving SCMS procurement services this past year did not experience any stock outs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7331	**Mechanism Name: Health Care Improvement Project (HCI)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,305,100	
Funding Source	**Funding Amount**
GHCS (State)	1,305,100

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Uganda through field-support is funding The Healthcare Improvement Project (HCI) implemented by University Research Co. (URC) to support the Ministry of Health's (MoH) Quality of Care Initiative (QoC) to improve the quality of comprehensive HIV care for adults and children, building upon work initiated by HCI's predecessor the Quality Assurance Project (QAP). In FY2009, HCI supported 136 facilities in 71 health districts in all regions and 39 District Health Teams (DHT) to coach sites in QI. The overall objective of the program is to improve the quality of HIV services available in Uganda and to build a quality improvement structure that is integrated into all levels of the health system.
Some of the major accomplishments of HCI include supporting sites to make their care delivery system

more efficient and effective so as to improve patient outcomes. In HCI supported sites over 95% of patients in our sites are assessed for TB at their last visit; over 95% of HIV infected patients were prescribed cotrimoxazole at their last visit; the % of exposed children who are tested for HIV has increased from 60% to over 80%.

HCI supports health facilities through training staff to form a QI team and guide them through the improvement process: identifying problems and setting improvement goals, forming the correct team, analyzing their system, designing changes to improve the system and collecting and analyzing data to measure the effects of these changes. HCI uses a two-pronged approach to supporting health facilities: a two day classroom training on the basics of QI to new teams and bimonthly on-site visits. The on-site approach not only reduces absenteeism but also adapts support to the context of each facility. On-site coaching visits are conducted by HCI staff, central, regional and district MoH staff. In addition to building QI capacity, these visits strengthen communication within the health system and add accountability. Examples of the benefits of communication are that HCI keeps a registry of untrained staff in facilities and works with the MoH to link these people with relevant trainings. This builds upon other partner's training activities and helps ensure that training is targeted to the right people according to need.

In addition to supporting sites, HCI works extensively to support the National Quality of Care Initiative of the MoH. This government initiative is designed to ensure a consistent approach to improving quality of care in Uganda. HCI has trained coaches at the national, regional and district level. This improves government ownership of the program, increases the chances of sustainability and dramatically decreases the costs associated with HCI operations (it is substantially cheaper for a District Health Team member to coach a site than for a HCI staff to travel for a coaching visit). HCI will continue with this approach and also focus on supporting the Quality Assurance Department in the Ministry. With the current restructuring, this department is taking an increasingly important role in support supervision and quality improvement. It is severely under-resourced and thus would warrant continued support.

Health Systems Strengthening: HCI interventions are expected to improve the functioning of the health system at all levels including: health facility management; MoH central support supervision, improving referral mechanisms for patients and laboratory tests and improving communication between various facilities and between different levels of the system. HCI's current focus is on improving HIV care but the systems put in place also benefit other areas in health service delivery.

In FY2010, increased focus will be placed on key areas of paediatric care, reproductive health and TB. HCI will continue to emphasize improving programme cost-efficiency through a number of strategies such as increasing the proportion of coaching visits being carried out by regional and district level staff rather than HCI or Central MoH staff. For sustainability and possibly increasing coverage in a low-cost manner, HCI will develop a QI toolkit that sites can use to orient new staff so as to ameliorate the effect of high staff turnover. QI team members who move to a new site without a QI team can also use the toolkit to set up a new team and start improvements in their new facility.

In regard to monitoring and evaluation of the program, HCI will report to PEPFAR on number of health

workers trained in strategic information, adult ART and paediatric ART. HCI will also continue to monitor data that supported health facilities individually collect to measure their own performance and, where appropriate, HCI will aggregate this and report in quarterly reports.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	30,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7331**		
Mechanism Name:	**Health Care Improvement Project (HCI)**		
Prime Partner Name:	**University Research Corporation, LLC**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	784,000	

Narrative:

HCI supports teams in 136 facilities providing ART to over 70,000 people to improve the quality of the care they provide. Provision or ART, cotrimoxazole and TB screening are key elements of good quality care and are emphasized in the HCI approach. Over 95% of patients are assessed for eligbility for ART (between 9-25 sites), provided with cotrimoxazole (between 5-37 sites) and screened for TB (between 21 - 84 sites) at sites working on improving these aspects of care. HCI support also emphasizes the importance of adherence support. HCI supports facilities to explore innovative adherence mechanisms that are best suited and appropriate to context. This includes adherence counselling, involving caregivers and family members, community outreach programs, adherence groups for patients to learn from each other.

In addition to measuring these process or proxy indicators, HCI will encourage sites to measure patient outcomes. Some sites use MoH cohort forms and some use the MoH outcome indicator which is defined as the % of patients with no opportunistic infection, no weight loss and a functional status that enables them to be ambulatory or working. HCI plans to train 1120 individuals in adult ART and 630 individuals in

paediatric care and treatment as the budget targets for FY2010. Paediatric HIV will increasingly become a priority area of focus. The targets are calculated based on support to 7 people in each site: 160 sites in 2010, 90 sites in 2011 and 80 using COP 2010 funds. The decrease in targets reflects HCI handing over activities to the STAR district-based projects.

1. Activities related to objective 1: to improve the quality of HIV services available in Uganda

In COP 10, HCI plans to address five key quality gaps in HIV care in Uganda. Each site will work in collaboration with other facilities on one of these areas and HCI will synthesize the lessons learned by the sites to develop a series of best practices in each area which will then spread to other sites and partners.

The Coverage Collaborative: The aim of sites working in the coverage collaborative will be to increase the number of people who start antiretroviral therapy. Because it is unlikely additional health staff will become available in the near future, it is imperative that HCI uses existing human resources as efficiently as possible. Sites will develop efficient triage systems and innovative approaches to using expert clients and to applying patient self management approaches to increase clinic efficiency. Sites will also build stronger links between different parts of the health facility and the HIV care clinic. In particular, weak links to PMTCT, HCT and TB programs lead to attrition of patients in need of care and ultimately lead to an inefficient system. Strengthening these links is expected to bring people in to care earlier which is associated with improved patient outcomes and is less resource intense than focusing on the sickest patients. Sites that make rapid progress in this collaborative will then focus on improving links between community-based testing programs and the HIV care clinic.

The Retention Collaborative: Another problem that leads to poor patient outcomes and wasted resources is attrition of patients or loss to follow-up. Sites in the retention collaborative will work with the patients to identify reasons for patients not remaining in care and to develop strategies that patients think will help improve retention and that sites have control over. Examples of these types of problems may include poor privacy in the clinic, long waiting times, rude staff or inconvenient visit schedules. They may also identify issues such as long distance from clinics and community stigma which may require support from other levels of the health system and from partners.

The Tuberculosis Collaborative: Tuberculosis (TB) remains the leading killer of people with HIV. HCI will, therefore, plan a new collaborative focused on improving TB services. This will apply to both HIV infected and uninfected persons. The goals will be for sites and districts to improve case detection and treatment completion rates. Special emphasis will be placed on the integration of HIV and TB diagnosis and treatment. QI teams from the District and the Facilities will work together to ensure all components of the TB system (and its links with the HIV system) are coordinated. This will include improving active case finding in high risk groups, improving specimen referral to laboratories and improving laboratory diagnosis, improving treatment adherence support and provider adherence with standards for follow up of patients with TB. Sites will also improve infection control procedures in their clinics. HCI will work closely with TB CAP and the Regional Centre for Quality of Health Care to ensure that sites and districts in this

collaborative receive training in TB.
The Data Management Collaborative: The provision of HIV care is very data intense. This is a major shift for health facilities that are used to dealing with acute diseases with no need for longitudinal patient information. Consequently, many sites are struggling with data management. Sites in this collaborative will work to improve data collection and storage (retrieval of patient records is a major component of long patient waiting time in some sites), the use of data for making good decisions about clinic management, and data reporting. This will include forecasting for ART's and other supplies.
The Nutrition Collaborative: The NuLife project has built on HCI's structure and used a QI approach to integrate nutrition into HIV care. HCI will continue to support them in COP2010 or to continue to emphasize the importance or nutrition. Most of this work is being carried out by NuLife but it is more cost-effective for the QI activities related to nutrition integration to be carried out by HCI.
2. Activities related to objective 2: to build a quality improvement structure that is integrated into all levels of the health system
HCI works with all levels of the health system to ensure that there is the appropriate support mechanism for health facility level QI teams.
District level: HCI will continue to support 39 Districts. HCI will provide mentoring to DHT staff to improve their ability to provide QI coaching to the sites in their Districts. DHT are currently supporting an average of 3 in their Districts through HCI - one old site so that they can see a well functioning QI program and two new sites so that can practice their coaching skills. Transferring the coaching responsibilities to the DHT will dramatically increase the cost-effectiveness of HCI program and lead to a more sustainable national QI program.
Sites currently supported through the District approach are currently working on improving specific processes related to quality of care: assessing all patients for TB at each visit, assessing patients for eligibility for ART at each visit, improving patient adherence and improving clinic flow. Once sites are comfortable in applying their new QI skills to these areas they (and their District coaches) will join one of the new collaboratives.
HCI provides various forms of training to District Health Team (DHT) staff. In the classroom HCI provides training on quality improvement methods as well as technical updates related to HIV care. DHT staff have generally been overlooked in HIV training programs and therefore, HCI will work with the MoH to develop a one week training course for DHTs focusing on clinical HIV care. This is essential for DHT to be able to appropriately supervise facility level staff. HCI will undertake regular joint coaching visits with District staff to continue to strengthen their QI and coaching skills. DHT staff from different districts will be brought together to learn from each other.
Regional level: HCI supports multidisciplinary QI teams in all 12 regions. The teams include an adult clinician, a paediatrician, a data person, laboratory person and pharmacist. Regional QI teams provide some coaching visits for sites in their regions as well as updates on their technical area to sites supported by HCI. In addition, the teams play an important role in improving communication between the

sites and higher levels to address problems such as stock outs and training gaps. The regional coordinators also support the DHT QI teams to strengthen their coaching skills. HCI will continue to support the regional teams to coach sites and will hold two learning sessions to bring all the teams together in 2010 to learn from each other about how to best support sites.

National level: HCI supports the National Quality of Care Coordinator in the Department of Clinical Services who coordinates quality issues in HIV for the Ministry of Health. With the restructuring of the Ministry, the Quality Assurance Department is taking on additional responsibilities of support supervision and quality issues. The department is currently dramatically understaffed and HCI plans to second a staff member to the Quality Assurance Department who will assist them in revitalizing their activities. This person will be responsible for increasing the focus on quality of care and improvement within the MoH in all areas of care. Their specific roles will depend on MoH priorities but it is likely that they will continue to revise the supervision guidelines to integrate QI into routine support supervision visits and to manage a mentorship program to improve new QI coaches in addition to new activities.

Working with partners:

STAR District-based Projects: HCI initiated meetings with JSI and MSH to ensure collaboration. From the meetings it was clear that the new projects did not have a clear strategy for quality improvement. It was agreed that all USG partners work within the framework of government's Quality of Care Initiative as the failure to harmonize could lead to multiple QI approaches that may negatively impact investments/gains achieved so far in QI. HCI has attempted to address this through organizing a coordination meeting with the Quality of Care Initiative steering committee unfortunately nothing concrete materialised. HCI will continue to liaise with USG district-based programs to ensure coordination and collaboration. Once the programs have sufficiently developed their QI strategy and began implementation, HCI will hand over sites and districts to the district-based programs to continue providing QI support. HCI will continue to ensure that communication between the ministry and these districts remains intact.

HIVQUAL: HCI continue to work closely with HIVQUAL to ensure no duplication. One important new initiative is that HIVQUAL will be starting to work with the regional coordinators and district staff that HCI has trained and supported. HIVQUAL will provide funding to these staff to visit HIVQUAL facilities while HCI will provide overall support for regional and district staff to build their QI skills.

Other partners: HCI will continue to work closely with the NuLife project to integrate nutrition into HIV care HCI supported sites. HCI will also work closely with training partners such as Mildmay, IDI, EGPAF, Baylor College and others to link untrained staff in supported facilities with the appropriate training. After classroom trainings by these partners, HCI will continue to help sites apply their new knowledge to their own clinics to improve care for their patients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	521,100	

Narrative:

HCI supports teams in 136 facilities providing ART to over 70,000 people to improve the quality of the care they provide. One of our areas of focus is to increase the availability and quality of care for children. To accomplish this HCI will form the supported sites into five groups who will work in a collaborative fashion to improve care in these key areas: coverage of ART, retention in care, paediatric care and treatment, nutrition integration, data management.
HCI plans to train 380 people in paediatric ART in FY2010, 280 in FY 2011 and 210 during the period we will spend FY 2010 money. These targets are calculated from supporting 7 people in each site ans supporting 40 sites in 2010 plus also training 100 District health staff, supporting 40 sites in 2011 and 30 sites using COP 2010 funds (the decrease is due to handing sites over to the STAR projects).
Improving paediatric HIV requires a strong link with general paediatric care to not only identify HIV infected children but to ensure that these children get the correct non-HIV care. HCI will therefore be working with QI teams to involve paediatric clinic staff in their improvement activities. Possible shared goals may include improved detection of HIV infected children, stronger referral mechanisms between the different units, increased access to cotrimoxazole for exposed infants and improved nutrition support for new mothers.

Activities related to objective 1: to improve the quality of HIV services available in Uganda
The coverage collaborative: The aim of sites working in the coverage collaborative will be to increase the number of children who start antiretroviral therapy. Because it is unlikely additional health staff will become available in the near future, it is imperative that existing human resources are used as efficiently as possible. Sites will develop efficient triage systems and innovative approaches to using expert clients and to applying patient self management approaches to increase clinic efficiency. Sites will also build stronger links between different parts of the health facility and the HIV care clinic. In particular, weak links to PMTCT and child health clinics lead to attrition of children in need of care and ultimately lead to an inefficient system. Strengthening these links is expected to bring children in to care earlier which is associated with improved patient outcomes and is less resource intense than focusing on the sickest patients. Sites will also work on improving early infant diagnosis (EID). HCI recently completed an assessment of 10 laboratories in facilities ranging from a regional referral hospital to Health Centre IV. EID was identified as a major area in need of improvement. Only 37% of infants born to women who delivered in the facilities were tested in the first 6 months of life and fewer than 50% of those tested received their results. Median turn-around time for sites to get the results was as long as 60 days in some sites. Addressing these issues will require teamwork between clinic and laboratory staff and on improving specimen referrals within the facility and between facilities.
The retention collaborative: Another problem that leads to poor patient outcomes and wasted resources is attrition of patients after they are in the HIV care clinic. Sites in the retention collaborative will work with the patients they care for and their families to identify reasons for children not remaining in care and

to develop strategies that will help improve retention and that sites have control over. Examples of these types of problems may include poor privacy in the clinic, long waiting times, rude staff or inconvenient visit schedules. Health workers may also identify issues such as long distance from clinics and community stigma which may require support from other levels of the health system and from partners to address.

The Paediatric HIV and TB Collaborative: Paediatric care for HIV and TB still lags behind adult care. HCI plans to bring 15-20 sites and their DHT's together to improve paediatric care. They will focus on ensuring that standards for paediatric HIV and TB are met in facilities and that systems to link children to the services they need are strengthened. Sites will develop systems to diagnose HIV and or TB in children wherever they are receiving care and then link these children with the appropriate treatment services. HCI plans to work with the African Network for Care of Children Affected by HIV/AIDS (ANNECA) to ensure that the correct standards of care are applied.

The Nutrition collaborative: The NuLife project has build on HCI's structure and used a QI approach to integrate nutrition into HIV care. Most of this work is being carried out by NuLife but it is more cost-effective for the QI activities related to nutrition integration to be carried out by HCI. HCI will not provide any commodoties (these are provided by NuLife) but will work to improve the system of care.

The Data management collaborative: The provision of HIV care is very data intense. This is a major shift for health facilities that are used to dealing with acute diseases with no need for longitudinal patient information. Consequently many sites are struggling with data management. Sites in this collaborative will work to improve data collection and storage (retrieval of patient records is a major component of long patient waiting time in some sites), the use of data for making good decisions about clinic management, and data reporting. This will include forecasting for ART's and other supplies.

Activities related to objective 2: to build a quality improvement structure that is integrated into all levels of the health system

District level: HCI will continue to support the 39 Districts we are currently working with. HCI will provide mentoring to DHT staff to improve their ability to provide quality improvement coaching to the sites in their Districts. DHT are currently supporting an average of 3 in their Districts through HCI - one old site so that they can see a well functioning QI program and two new sites so that can practice their coaching skills. Transferring the coaching responsibilities to the DHT will dramatically increase the cost-effectiveness of our program and lead to a more sustainable national QI program.

Sites currently supported through the District approach are currently working on improving specific processes related to quality of care: assessing all patients for TB at each visit, assessing patients for eligibility for ART at each visit, improving patient adherence and improving clinic flow. Once sites are comfortable in applying their new QI skills to these areas they (and their District coaches) will join one of the six new collaboratives.

Regional level: HCI supports multidisciplinary QI teams in all 12 regions. The teams include an adult clinician, a paediatrician, a data person, laboratory person and pharmacist. They provide some coaching

visits for sites in their regions as well as updates on their technical area to sites supported by HCI. In addition they play an important role in improving communication between the sites and higher levels to address problem such as stock outs and training gaps. The regional coordinators also support the DHT QI teams to strengthen their coaching skills. HCI will continue to support the regional teams to coach sites and will hold two learning sessions to bring all the teams together in 2010 to learn from each other about how to best support sites. National level: HCI supports the National Quality of Care Coordinator in the Department of Clinical Services. He coordinates quality issues in HIV for the Ministry of Health. HCI will continue to fund this position to strengthen QI activities in HIV. With the restructuring of the Ministry, the Quality Assurance Department is taking on additional responsibilities of support supervision and quality issues. They are currently dramatically understaffed and HCI will second a staff member to the Quality Assurance Department who will assist them in revitalizing QI activities. This person will be responsible for increasing the focus on quality of care and improvement within the MoH in all areas of care. Their specific roles in FY 2011 will depend on MoH priorities but it is likely that they will continue to revise the supervision guidelines to integrate QI into routine support supervision visits and to operate the mentorship program to improve new QI coaches in addition to new activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7332	**Mechanism Name: Contraceptive and Reproductive Health Technologies and Utilization (CRTU)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is an ongoing activity using COP09 funds. There is no change to the scope of work outlined in COP09.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7432	**Mechanism Name: The INTER-RELIGIOUS COUNCIL OF UGANDA, PREVENTION, CARE & TREATMENT PROGRAM**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Inter-Religious Council of Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Church of Uganda	Seventh-Day Adventist Church, Uganda Union (SDA,UU)	The Born Again Faith Federation of Uganda (BAFFU)
Uganda Catholic Church (UCC)	Uganda Muslim Supreme Council	Uganda Orthodox Church

Overview Narrative

The Inter-Religious Council of Uganda (IRCU) is an initiative established as a national faith-based Non-governmental Organization and constituted by five religious organizations in Uganda. They are the Catholic Church in Uganda, the Uganda Muslim Supreme Council, the Church of Uganda, the Uganda Orthodox Church and the Seventh Day Adventist church. However, other religious organizations notably the independent Pentecostal and evangelical churches under the Born Again faith Federation of Uganda work with IRCU to deliver HIV/AIDS programs. Since 2004 IRCU has been receiving funding from the United States Agency for International development (USAID) under the President's Emergency Fund for AIDs Relief (PEPFAR). The IRCU program supports religious communities and institutions to play a greater role in expanding access to and utilization of quality HIV/AIDS, prevention, palliative care and treatment for people affected and infected by HIV/AIDS and their families. The program has enhanced attainment of PEPFAR and IRCU goals for HIV prevention, care and treatment.IRCU delivers its programs by providing grants to credible FBOs to deliver services at the community level. Under the program IRCU has built capacity, provided, logistics and has given resources to FBOs in order to enable them deliver quality HIV/AIDS services. The program further strengthens linkages within and between the existing religious, community and service provision networks to enhance easy access to comprehensive HIV/AIDS services within the context of public-private partnership. In FY 2010, the overall approach of IRCU will be to strengthen the capacity of FBOs to plan, implement and deliver faculty and community based HIV and AIDS services while building on their existing structures, unique experiences and assets. This approach will be anchored on the following strategies. Service Integration, partnerships and linkages, training in service delivery, system strengthening and working with and strengthening the capacity of communities and families as first line structures for prevention and care. IRCU will use the faith based approach Model (FBM), a five pillar approach that emphasizes belief in God's power and guidance, acquiring and utilizing HIV/AIDS scientific knowledge, using relevant faith teachings and best practices based on the holy scriptures to complement prevention, care and treatment service delivery, use of religious structures and religious leaders and promotion of application of self control skills.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7433	**Mechanism Name: MEEPP (Monitoring and Evaluation of the Emergency Plan Program)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Social and Scientific Systems	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is an existing activity aimed at supporting the monitoring and evaluation of the Presidential Emergency Plan for AIDS Relief (PEPFAR). The activity will support, and work with, the Uganda's PEPFAR Inter-Agency Team which includes the Centers for Disease Control (CDC), the US Department of Defense (DOD), the US National Institute of Health (NIH), Peace Corps, United States Agency for International Development (USAID), and Walter Reed under the leadership of the Department of State (US Embassy) to accomplish the primary objective of improving PEPFAR's program performance management including results reporting to the Office of the Global AIDS Coordinator (OGAC).

Since 2005, PEPFAR has been utilizing the services of the current monitoring and evaluation project (MEEPP) which is coming to an end in December 2009. MEEPP used proven portfolio management

approaches to coordinate with, and complement, the monitoring activities of PEPFAR-funded Implementing Partners (IPs), facilitated harmonization and aggregation of data, and in collaboration with the PEPFAR Strategic Information Technical Workgroup and AIDS Development Partners, shares results with the Government of Uganda, PEPFAR Advisory Committee and Uganda AIDS Development Partners. By providing PEPFAR Country Team and PEPFAR-funded IPs with a unified picture of USG-funded HIV/AIDS activities, the MEEPP project has helped to maximize the extent of the USG resources in achieving PEPFAR targets and goals. Although the primary purpose of the MEEPP project is for PEPFAR reporting there has been a component of capacity building for Implementing Partners (IPs) which contributed to strengthening knowledge and systems for a sound, sustainable HIV/AIDS monitoring system among the PEPFAR-funded IPs.

The activity has no targets in this COP since it is closing in December 2009 and most of its final results will be reported in FY 2009 Annual Report.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7973	**Mechanism Name: EGPAF**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

MUJHU Care Limited		

Overview Narrative

Introduction: EGPAF Uganda supports the Uganda National PMTCT program to prevent HIV infection among infants and utilizes the PMTCT program as a point of identification of HIV-infected and affected individuals to provide care and support and access to HIV treatment services for families. EGPAF has provided PMTCT services in Uganda since 2000 with the initiation of a PMTCT program at Mulago Hospital with some of the Foundation's private funds. Over the past eight years, the Foundation's strategy in Uganda has been to support the PMTCT program of the Uganda MOH through design, development, management, monitoring, and technical support activities. In 2003, USAID funding allowed for substantial expansion of PMTCT services in the public sector which enabled EGPAF to scale up the PMTCT and HIV care and treatment programs to over 300 sites in 27 districts of Uganda. The Foundation works closely with the Uganda MOH and other PMTCT and treatment partners in Uganda to coordinate support and maximize coverage of PMTCT and HIV treatment services. These include: the Supply Chain Management System (SCMS) that we work with to coordinate training of district health workers, forecasting, reporting and requisitions for HIV test kits, ARVs and drugs for opportunistic infections; JCRC which provides laboratory services for CD4 cell counts to HIV positive pregnant women as well as providing ARVS for PMTCT and ART; ICOBI offers community HIV counseling and testing in Bushenyi district and refers patients into care at various health facilities within the district. Uganda Cares provides CD4 cell testing in the districts of Masaka, Sembabule and Rakai; WHO and UNICEF are collaborating partners in the development and distribution of job aides, advocacy and participate in the various technical working groups at ACP/MOH; other USG PMTCT implementing partners including PREFA, Mild May, TASO, AIC, Baylor Children's Foundation Uganda, CRS/AIDS Relief collaborate in the sharing of best practices and the coordination of district activities. EGPAF also supports treatment services at 5 sites using private funds donated through the Abbott Fund.

Progress and Achievements: The EGPAF Uganda program has continued to make achievements against its broad objective to prevent HIV infection among infants and link identified HIV-positive mothers and their families to comprehensive care and support. The number of service outlets has increased from 37 to 363 in 27 districts. The use of more complex regimens for PMTCT has been scaled up within the EGPAF

supported districts as part of a strategy to integrate affordable, family-based quality HIV/AIDS care and ART services into maternal and child health services. Building on the successful establishment of Family Support Groups a peer educator program has been initiated to integrate People Living with HIV/AIDS into routine HIV services.

FY 2010 activities: Activities to support service delivery will be focused on consolidating the achievements and successes of the past eight years of EGPAF programs in Uganda with an aim of final close out in March of 2010. The Foundation will continue to provide technical assistance to the national PMTCT and care and treatment programs by participating in MOH pediatric ART and PMTCT technical committees to ensure the full integration and transition of services to the ministry of health and to other partner organizations like JSI, Infectious Disease Institute (IDI), UNICEF and other new programs as will be determined by USAID. Technical assistance activities will mainly provide support for: 1) Transition of PMTCT and HIV Care and Treatment programs 8 districts (i.e. Iganga, Mayuge and Namutumba to the JSI Star East Central program; Kasese, Kabarole, Bundibugyo and Kamwenge to UNICEF; and Kibaale to the IDI; 2) To integrate IYCF services into MCH, Reproductive health, Pediatric, PMTCT, HIV/AIDS care and treatment services at 300 USG supported PMTCT facilities; 3) Increased knowledge of good nutrition among health workers and caretakers of HIV exposed children; and 4) Improved dietary practices among HIV+ pregnant and lactating women and their infants.

As part of the transition processes during FY 10 the Foundation will not provide budget support to the 27 district-based local government health service networks. During this transitional period the Foundation will however continue to provide limited funding to a local NGO, MUJHU Care Ltd, which provides support for the programs in Mulago, Rubaga and Mengo hospitals. Technical support will however continue to be provided to 19 districts as assigned by the MOH with concurrence from USAID/Kampala.

The EGPAF M&E officers will continue to work with the district officers to improve data collection, analysis and utilization by the districts. Specific capacity building at the site level and district level will include improving coordination of data collection from clinic service registers and client logs and reporting to the Ministry of Health Resource Center and AIDS Control Program database.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9042	**Mechanism Name: Laboratory Services Strengthening at Health Center IV and Above**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation, South Africa	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The African Medical and Research Foundation (AMREF) is an independent international non-profit organization whose mission is to improve the health of disadvantaged in Africa as a means for them to escape poverty and improve the quality of their lives. The overall goal is to identify gaps in health needs and develop, test, evaluate and implement innovative projects to meet those needs through service provision, capacity building, operations research and advocacy. AMREF defines the disadvantaged as people who suffer high prevalence and impact of major health problems and challenges like HIV/AIDS, Malaria, Tuberculosis, sexual and reproductive health problems, inadequate water and sanitation facilities and have poor access to health care because of distance, poverty and poor health seeking behaviour. AMREF is headquarters in Nairobi and was founded in 1957. The foundation has country offices in Kenya, Uganda, Tanzania, and South Africa. In Uganda, AMREF started its operations in Uganda in the

1970's. Currently, AMREF Uganda offices are located at Plot 29, Nakasero Road, Kampala. In 2004, AMREF received an award of PEPFAR funds, under grant number U62/CCU224317 from the Government of the United States of America through the Centres for Disease Control and Prevention (CDC) to implement the Laboratory Services Strengthening Project at Health Centre IV (HC IV) and above in the Republic of Uganda in collaboration with Ministry of Health (MoH). The goal of the project is to reduce HIV transmission and improve care of persons living with HIV/AIDS with a purpose of improving the quality of health laboratory services at health units in Uganda from the health sub-district to regional hospitals. The objectives of the project are: (i) Improve the physical laboratory structures and equipment for effective support of VCT services (ii) Strengthen the skills, knowledge and attitudes of laboratory staff, clinicians and other staff for effective VCT services (iii) Strengthen the National Laboratory Quality Control System in support of effective HIV counselling and testing (iv) Enhance stakeholder support for laboratory services (v) Build capacity of unqualified microscopists working at at HC III laboratories. AMREF implements the project by working closely with various departments of MoH, Ministry of Education and Sports (MoE & S) and other partners using the existing systems. Through this approach, the procurement of goods and services is based on the MoH and MoE & S guidelines and specifications to ensure value for money. The contributions of the project to the health systems strengthening since 2004 are: (i) standardized basic laboratory design for health units which has been adopted by the Health Infrastructure Division of MoH (ii) developed in-service training approaches for health workers by conducting joint training sessions of laboratory staff, clinicians and counsellor (iii) Developed laboratory Standard Operating Procedures and training curricullum for in-service course for health laboratory service providers, these have been adopted by Central Public Health Laboratories (CPHL) (iv) strengthened the capacity of CPHL and districts to carry out monitoring of health laboratory services in the country (v) fostered human resource for health development through supporting Medical Laboratory Training Schools (vi) initiated sponsoring of untrained laboratory staff serving in health laboratories, for professional medical laboratory courses. To carry out monitoring and evaluation of the project, monitoring tools are used to assess performance of health workers (Laboratory staff, Clinicians and Counselors), status health facilities, laboratory equipment, communication and information flow. Also work with district health authorities to conduct support supervision to monitor quality health services delivery. Regular management meetings are held to review implementation. AMREF prepares narrative and financial progress reports that are submitted to the donor and partners.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9043	**Mechanism Name: Makerere University Walter Reed Project (MUWRP)**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Henry Jackson Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,889,275	
Funding Source	**Funding Amount**
GHCS (State)	3,889,275

Sub Partner Name(s)

Makerere University Walter Reed Project		

Overview Narrative

The Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc. (HJF) is a transfer mechanism to local organizations. HJF officially receives funds and transfers them to The Makerere University Walter Reed Project (MUWRP) in Uganda to implement HIV program activities. MUWRP thus falls under the auspices of the US Military HIV Research Program and has a Memorandum of Understanding with Makerere University of Uganda. MUWRP has been working in Uganda since 1998 in the area of HIV research and more recently in the provision of HIV care, treatment, and prevention services. Among the goals of MUWRP is to build the infrastructure, capacity, and systems of local public and private partners in central Uganda to ensure sustainable, quality, comprehensive HIV services for

communities that have participated or could participate in research studies. Since 2005, MUWRP has increased its PEPFAR support to the Kayunga and Mukono Districts by supporting cross-cutting HIV programs including: expanding the number of HIV clinical sites, provision of efficient laboratory capacity, infrastructure remodeling, District-level data system strengthening, supply-chain management strengthening, human capacity development, innovative task shifting, youth-focused programs, short-term technical staffing, comprehensive home-based OVC services, and a variety of counseling and testing and prevention programs including medical male circumcision and house-to-house testing. MUWRP manages only data-driven programs from on-going program monitoring and evaluation. Finally, MUWRPs strong emphasis on efficiency have achieved improved economies in procurement, highly coordinated service delivery, and expanded coverage of programs with low marginal costs.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Economic Strengthening	70,500
Education	40,000
Food and Nutrition: Commodities	23,000
Food and Nutrition: Policy, Tools, and Service Delivery	64,000
Gender: Reducing Violence and Coercion	23,000
Water	5,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9043**		
Mechanism Name:	**Makerere University Walter Reed Project (MUWRP)**		
Prime Partner Name:	**Henry Jackson Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	500,000	

Narrative:

The Adult Care and support program described below continues to be part of a comprehensive HIV program and activities do link to other program areas. Specific program activities that are linked to adult care and support include: OP, SI, CT, laboratory, ARV drugs, Adult treatment, male circumcision, and OVC services. During FY2008 and FY2009, MUWRP greatly expanded facility-based adult care and support services to cover all of Kayunga District (older than 18 years (now including the north of Kayunga District –specifically the rural, underserved, fishing communities of Galilyra via the facility; Galilyra Health Center III). The rate at which adults sought HIV care and treatment rose during FY 2009, largely as a result of: (1) provider initiated HIV testing and (2) HIV+ referrals from a house-to-house CT program which started in July 2008. To address this, MUWRP partnered with the remote Busana Health Center III in FY 2009 in eastern Kayunga and this clinic began providing the MUWRP model of comprehensive HIV services, including adult care and support. Finally during FY2009 MUWRP also expanded adult care and support services to support one additional clinic in the neighboring District of Mukono, specifically to the Kojja Health Center IV in Mukono South sub-district. Expansions to these facilities were carefully targeted by MUWRP and fit nicely into the overall Uganda PEPFAR specific country strategy of regionalization. Each year, MUWRP sends all of the clinicians at each of its supported HIV facilities and NGO's (nurses, medical officers, clinical officers, record keepers, etc) to attend a two-week course on the delivery of comprehensive HIV services. The course is delivered by a team of trainers from the Uganda MOH and strictly follows MOH HIV guidelines and policy. Also pertaining to QAQC, MUWRP continues to provide supportive supervision (expanded now to all seven HIV MUWRP supported facilities). More specifically, this includes HIV clinic day supervision from MUWRP's mobile clinical team comprising of two nurses, two clinical officers, one pharmacist, and one medical officer. A primary strength of MUWRPs model of providing adult care and support includes the routine training of district lay workers, treatment club members, and members of PLWHA groups to deliver the most basic of ARV services. As a result of this capacity building, volunteers have now developed 5 rural treatment club nutrition farms (23 acres total) to supplement the diet of adult care and support patients – each of the farms has had several successful harvests and all patients have benefited regardless of the percent time they have spent working on the farms. Most recently, MUWRP supported the distribution of cows, chickens and pigs to these farms who collectively use the Send a Cow model as a successful IGA. Through a MUWRP partnership with PACE, treatment club volunteers also distributed over 2300 basic care packages to HIV+ persons on care and probably most notably, the treatment club members themselves spearhead a follow-up program that traces patients deemed lost-to-follow-up to their homes. Data from this lost-to-follow-up program was presented at the International AIDS Conference in Mexico City. As a result, lost-to-follow-up issues in Kayunga are (relatively) very low. Also recently, MUWRP supported the implementation of Post Exposure Prophylaxis Programs at each of the 7 HIV clinics in Kayunga and Mukono for victims of rape, defilement, or any other person who has had immediate exposure to HIV and also supported 30 District clinicians to attend a two-week training on reproductive health. Finally, and possibly most

importantly under this program area, because OI supplies are not stable in Uganda; MUWRP has always served as a back-up source to ensure that neither PEPFAR nor GOU MOH patients in Kayunga experience OI drug stock outs.

.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	200,000	

Narrative:

During FY2009, and in collaboration with Child Advocacy International (CAI), MUWRP supported CAI activities which center around a home-based counseling/ follow-up program that provides community based outreach, support, counseling, and education for Kayunga District OVC's, their families, and the community. CAI priorities lay in improving families and households, improving quality service delivery and improving community support and coordination. Last year, CAI expanded their coverage of Kayunga District and consequently expanded the number of OVC's they provide primary direct support through scheduled monthly home visits. CAI will continue to offer OVC families a comprehensive list of home-based services which include HIV education, counseling, psycho-social activities, emotional backing, scholastic materials, clothes, nutritional evaluation and counseling, supplemental food based on need, and school fees for 100 OVC's in FY2010. CAI will also continue their on-going home-based education through monthly home visits to include technical assistance to caregivers and families on how to care for pediatric ART/HIV+ patients as well as the direct provision of some basic palliative needs such as symptom control for the patients themselves. Support for the caregivers includes linking families of pediatric ART patients together for group/peer counseling and psychosocial support. Most recently, and as a result of routine monitoring and evaluation, home-based services were expanded to the fishing villages and the remote northern and southern most regions of Kayunga District. CAI continued to refine their quality of services at each of the existing OVC points of service during FY09. This was accomplished by provision of quality trainings, technical advisors, focus groups, institution of best practices, and standard operating procedures. A recent success was the result of a consultation with 120 caregivers of OVC, in which nearly 500 mattresses, blankets and mackintoshes were supplied to the caretakers during FY09. One notable challenge during FY2009 is that CAI has acted as a referral mechanism for MUWRP's house-to-house CT program. Consequently, CAI has increased the number of OVC families it must support and its staff and budget have been stretched. MUWRP funding levels to CAI currently support the cost of staffing, training of volunteers in HIV service provision (home-based care), and community-based activities including monthly home visits/follow-up visits/fuel to OVC, care-

giver counseling, tools for home monitoring of OVC and household evaluation, psycho-social activities, and bi-monthly community sensitizations. During FY2010, CAI will continue to provide high quality OVC services that link with other District services such as PMTCT, care and support, ART, HCT as well as other NGO services in Kayunga (listed below) to strengthen the capacity of the family unit (caregiver) to care for OVC.

Also during FY2009, MUWRP continued its support of the highly successful Kayunga District Youth Recreational Center. This center was founded in 2006 as a joint effort between the Kayunga District Hospital, the Kayunga District Government and MUWRP as an organization/facility to build district capacity in identifying and providing HIV prevention services to Kayunga Districts' youth population, and especially their orphans and vulnerable children. The Center priorities lay in improving families and households, improving quality service delivery and improving community support and coordination. The Center currently provides youth with counseling and care in a manner which is specifically geared toward persons between the ages of 12-18 who are HIV positive or defined as OVC's. Any youth found to be HIV+ are successfully referred for evaluation for ART by clinical staff of the District Hospital. The Center continues to provide community based counseling to youth, emotional support, and meets psycho-social needs through recreational games, sports, music, big competitions, and drama. Community focused activities include district-wide youth outreach, education and psycho-social activities at schools and in communities with emphasis on identifying orphaned children or vulnerable adolescents. Special emphasis is put on vulnerable children, especially those made vulnerable due to: unemployment, disability, early child labor, gender or those living outside of family care. This Center also works closely with community structures which protect and promote healthy child development, such as schools, churches, clinics, and the Kayunga District police force. During FY09 three of the volunteer youth staff at the Center, all of whom were out-of-school and living outside of family care, were supported with school fees with the goal of accessing higher paying careers. Two other volunteer staff were awarded competitive Youth Center scholarships, one for university and one for starting a business. Finally five of the volunteer staff have been given advanced contracts with MUWRP to work in other MUWRP program areas such as male circumcision, SI, and as program coordinators.

CAI and the Kayunga Youth Recreational Center and MUWRP have collaborated and/or partnered with the following civil society groups in Kayunga in order to build local capacity: (1) Boy brigades, (2) Kayunga town youth council, (3) Kayunga District youth council, (4) Community and Response to AIDS, (5) Busaana Women Community HIV/AIDS Positive Living and Orphanage Care, (6) Girl guides, (7) Uganda scouts association of Kayunga, (8) Nazigo youth health and development association, (9) Disabled school of Bukoloto and (10) Fare Ministries, (11) Human Rights and Civic Education Forum, (12) the Rubaga Youth Development Association, and (13) Youth in Action of Kayunga.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	473,820	

Narrative:

Specific program activities that are linked to Adult Treatment include: OP, SI, CT, laboratory, ARV drugs, Adult care and support, male circumcision, and OVC services. The MUWRP model of comprehensive care and treatment is delivered at each of its seven supported facilities, including ART, cotrimoxazole prophylaxis and routine TB screening at each patient visit. Each year, MUWRP sends all of the clinicians at each of its supported HIV facilities and NGO's (nurses, medical officers, and clinical officers) to attend a two-week course on the delivery of comprehensive HIV services including adult treatment. The course is delivered by a team of trainers from the Uganda MOH and strictly follows MOH HIV guidelines and policy. Also pertaining to QAQC, MUWRP continues to provide supportive supervision (expanded now to all seven HIV MUWRP supported facilities). More specifically, this includes HIV clinic day supervision from MUWRP's mobile clinical team comprising of two nurses, two clinical officers, one pharmacist, and one medical officer. A primary strength of MUWRPs model of providing adult treatment includes the routine training of district lay workers, treatment club members, and members of PLWHA groups to deliver the most basic of ARV services. Very large treatment club meetings are supported each month by MUWRP at each of the 7 supported HIV clinics. MUWRP and clinic facilitators ensure that at each meeting, adherence and nutrition issues are fully addressed as are: treatment club IGA issues and particular clinician concerns from each facility. Linking this program area to MUWRPs laboratory program area, routine viral load tests are performed on every patient on ART as per WHO guidelines. Clinical patients outcomes are tracked by (1) CD4's, (2) viral loads, (3) routine patient screening for OI's, especially TB, (3) patient presentation, (4) other diagnostic tests. Data from viral load testing and individual patient counseling indicate that although adherence is routinely addressed at each clinic visit and each treatment club meeting, IGA meeting, home visit, etc,. adherence is still an issue for between 8-13% of ART patients. As a result of the capacity building at the patient level, volunteers have now developed 5 rural treatment club nutrition farms (23 acres total) to supplement the diet of adult care and support patients – each of the farms has had several successful harvests and all patients have benefited regardless of the percent time they have spent working on the farms. Most recently, MUWRP supported the distribution of cows, chickens and pigs to these farms who collectively use the -Send a Cow- model successfully. Through a MUWRP partnership with PACE, treatment club volunteers also distributed over 2300 basic care packages to HIV+ persons on care and probably most notably, the treatment club members themselves spearhead a follow-up/adherence program that traces patients deemed lost-to-follow-up to their homes. Data from this lost-to-follow-up program was presented at the most recent International AIDS Conference in Mexico City. MUWRP has greatly expanded facility-based adult treatment services to cover all of Kayunga District, persons older than 18 years (now including the north of Kayunga District –specifically the rural, underserved, fishing communities of Galilyra via Galilyra Health Center III facility). The rate at which adults sought HIV treatment rose during FY 2009, largely as a result of: (1) provider initiated HIV testing and (2) HIV+ referrals from a house-to-house CT program which started in July 2008. To address this, MUWRP partnered with the remote Busana Health Center III

in FY 2009 in eastern Kayunga and this clinic began providing the MUWRP model of comprehensive HIV services. Finally during FY2009 MUWRP also expanded adult treatment services to support one additional clinic in the neighboring District of Mukono, specifically to the Kojja Health Center IV in Mukono South sub-district. Expansions to these facilities were carefully targeted by MUWRP and fit nicely into the overall Uganda PEPFAR specific country strategy of regionalization.

.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	297,000	

Narrative:

MUWRP's HIV counseling and testing (CT) program occurs throughout Kayunga District and in FY09 was expanded to the Kojja Health Center IV in Mukono District. The program provides provider-initiated (routine at all MUWRP supported clinics), client initiated, couples testing, medical male circumcision, and special events/CT campaigns through 9 health units in Kayunga including the Kayunga District Youth Recreation Center Clinic and the Kojja Health Center IV. Note that CT testing at PMTCT sites is done through another implementer. Further, the program initiated a house-to-house (H2H) CT program in August 2008 (only in Kayunga District). The H2H program is on-going and as a result, more than 35000 Kayunga residents have been tested, counseled, received their results in their homes and strongly referred (with persistent follow-up) for PMTCT, TB, OVC, ART or care services if appropriate. The Uganda MOH HIV testing algorithm (Determine, Stat Pak, and Uni Gold-as a tie-breaker) is employed for all HIV tests. For those few individuals whose results are still inconclusive after undergoing the MOH algorithm, a red top tube of blood is drawn and sent to the MUWRP research laboratory in Kampala for an both an Eliza and a Western blot test.

MUWRP has provided strong follow-up to those who test HIV positive, especially those who tested through the H2H program. H2H program staff routinely return to the homes of individuals who tested HIV+ to gage and ensure that no harm was introduced by informing persons of their HIV+ status in their homes. As of this writing, no harms have been reported. Further, MUWRP has formed and supported an active discordant couples group with an emphasis on prevention with positives. Promotional activities to reach the target populations (couples counseling and the H2H program) have included billboard advertising, market place announcements, posters, drama presentations and sporting events. All CT services, despite the program, are provided by either highly trained/tested/monitored para-professionals or clinical staff. Ongoing support supervision at all of the health centers, the sporting events, the youth center clinic, the H2H program, post-test clubs, or the drop-in centers is provided by a full time MUWRP

CT technical specialist operating in strict accordance with Uganda MOH CT guidelines. For the purposes of quality control, two process take place monthly within the program; (1) dried blood spots (DBS) from all clients who test HIV+ (following the MOH algorithm) as well as DBS from 2% of the HIV- clients are collected and sent to a reference lab for retesting, using the DNA PCR technique - the results from the retesting are compared with the field results to determine the proportion of true positives and false positives; and (2) quarterly testing of quality control samples prepared in the lab are randomly distributed to the HCT staff and their results are compared with the known results - thus staff competency is routinely ascertained and remedial action taken whenever necessary.

Routine monitoring and evaluation of all data from the HCT program have informed program policy at the District level and driven MUWRP program policy to expand program services to clearly identified MARPS, including fishing villages and youth.

Due to the fact that availability of commodities remains sporadic, MUWRP has always provided technical support in supply chain management as well as back-up commodity supplies to all of the CT sites/programs to ensure that there will be no stock outs. Funds are also used for training, staffing, transportation, supportive supervision, sub-contracts, and on-going technical assistance in the areas of service delivery. The increase in demand for CT has been met through training of additional counselors and medical staff to provide this service not only at the HIV clinic and VCT centers, but as part of inpatient and out patient services, including the TB clinic, where a majority of treatment eligible patients are found. MUWRP also works alongside other health agencies in Kayunga and Mukono, such as Doctors with Africa (CUAMM) and the National TB and Leprosy Programme (NTLP), so that capacity was developed to ensure that individuals being screened for TB at NTLP sites were concurrently tested for HIV and referred to HIV services if HIV-positive.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	107,000	

Narrative:

The Pediatric care and support program described below continues to be part of a comprehensive program with activities linked to other program areas. Specific program activities in this comprehensive program include pediatric treatment, prevention, SI, CT, laboratory, ARV drugs, and OVC services. In partnership with Child Health Advocacy International - Uganda (CHAI), MUWRP has expanded activities of its mobile clinical/counseling follow-up program which provides home-based care and support to HIV+ pediatrics. CHAI's coverage now includes all of Kayunga District (all HIV+ persons between 0-18 years old) and consequently expanded the number of HIV+ pediatrics they provide direct support through scheduled monthly home visits. This included expansion to the fishing villages and the remote northern and southern most regions of Kayunga District. Most recently, MUWRP expanded their pediatric care and support program to the neighboring District of Mukono to provide care and support services through

the Kojja Health Center IV in Mukono South Sub-district (again, all HIV+ persons between 1-18 years old). CHAI offers HIV+ pediatrics a comprehensive list of home-based services which include care, treatment, HIV education, counseling, psycho-social activities, emotional backing and (when appropriate) school fees, scholastic materials, clothes, mattresses, blankets, mackintoshes, and supplemental food. MUWRPs laboratory support ensures that all pediatrics on care routinely get chemistry, hematology, and CD4's. During FY2008, CHAI continued their on-going home-based care and treatment through these visits to include technical assistance to caregivers and families on how to care for pediatric ART/HIV+ patients as well as the direct provision of some basic palliative needs such as symptom control for the patients themselves. Support for the caregivers also includes linking families of pediatric ART patients together for group/peer counseling and psychosocial support. CHAI also has refined their quality of services at each of the existing points of service. This was accomplished by provision of quality trainings, technical advisors, focus groups, institution of best practices, and standard operating procedures. The Kayunga District Youth Recreational Center was founded in 2005 as a joint effort between the Kayunga District Hospital, the Kayunga District Government and MUWRP as an organization/facility to build district capacity in identifying and providing HIV services to Kayunga Districts' youth population, and especially HIV+ pediatrics. The Center currently provides youth with care and clinical services in a manner which is specifically geared toward persons between the ages of 12-18 who are HIV positive. The Youth Clinic at the Center counsels and tests youth and successfully retains 100%of those testing positive for care and treatment. Finally, because an array of OI supplies is not stable in Uganda, MUWRP has always served as a back-up source to ensure that Kayunga District HIV+ pediatrics never experience OI drug/commodity stock outs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	118,455	

Narrative:

The Pediatric Treatment program described below continues to be part of a comprehensive program with activities linked to other program areas. Specific program activities in this comprehensive program include pediatric care and services, prevention, SI, CT, laboratory, ARV drugs, and OVC services. MUWRP, in partnership with Child Health Advocacy International - Uganda (CHAI), MUWRP has expanded activities of its mobile clinical/counseling follow-up program which provides home-based care and treatment to HIV+ pediatrics. CHAI's coverage now includes all of Kayunga District (all HIV+ persons between 0-18 years old) and consequently expanded the number of HIV+ pediatrics they provide direct support through scheduled monthly home visits. This included expansion to the fishing villages and the remote northern and southern most regions of Kayunga District. Most recently, MUWRP expanded their pediatric treatment program to the neighboring District of Mukono to provide treatment services through the Kojja Health Center IV in Mukono South Sub-district (again, all HIV+ persons between 1-18 years

old). CHAI offers HIV+ pediatrics a comprehensive list of home-based services which include treatment, HIV education, and counseling, and when appropriate supplemental food. MUWRPs laboratory support ensures that all pediatrics on treatment routinely get chemistry, hematology, and CD4's. Beginning in FY 2009, all patients on ART, including pediatrics, were routinely given viral load tests. CHAI has continued their on-going home-based care and treatment through these visits to include technical assistance to caregivers and families on how to care for pediatric ART/HIV+ patients as well as the direct provision of some basic palliative needs such as symptom control for the patients themselves. Support for the caregivers also includes linking families of pediatric ART patients together for group/peer counseling and psychosocial support. CHAI also has refined their quality of services at each of the existing points of service. This was accomplished by provision of quality trainings, technical advisors, focus groups, institution of best practices, and standard operating procedures. The Kayunga District Youth Recreational Center was founded in 2005 as a joint effort between the Kayunga District Hospital, the Kayunga District Government and MUWRP as an organization/facility to build district capacity in identifying and providing HIV services to Kayunga Districts' youth population, and especially HIV+ pediatrics. The Center currently provides youth with clinical services in a manner which is specifically geared toward persons between the ages of 12-18 who are HIV positive. The Youth Clinic at the Center counsels and tests youth and successfully retains 100%of those testing positive for treatment. Finally, because ART supplies are not stable in Uganda, MUWRP has always served as a back-up source to ensure that Kayunga District HIV+ pediatrics never experience ART or OI drug/commodity stock outs. MUWRP funding to CHAI currently supports the cost of ART/OI drugs and commodities, some staffing, training, mobile activity overhead, monthly home visits/follow-up visits to HIV+ pediatrics, care-giver counseling, tools for home monitoring of HIV+ pediatrics, household evaluation, evaluation of nutritional status, nutritional counseling and provision of supplemental food based on needs. Currently, pediatric care and treatment patient enrollment rates are rising in Kayunga due to HIV+ referrals from a house-to-house counseling and testing program which started in July 2008. This trend is expected to continue.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	173,000	

Narrative:

Program activities that are included in MUWRP's comprehensive approaches, such as care, treatment, laboratory, and CT services, are budgeted under their respective program areas. However, in order for these programs to operate successfully, MUWRP leverages SI funding to cover required expansion of staffing, increased materials and data management and training of local implementing partners. The focus of MUWRP's SI program during FY2009 was to strengthen the HMIS capacity of Kayunga District Hospital and six health centers for accurate and timely reporting on required indicators to GOU MOH. Technical assistance was provided to continue collection, management and analysis of data not only

across PEPFAR Program areas but for all District health data collection and analysis. MUWRP provided technical and infrastructural support to the District, including computer and email access to seven key District HIV staff personnel operating in remote areas. A MUWRP data officer has partnered with District HMIS staff (both at the District level and at 6 health facilities) to ensure they receive adequate training in data collection, management and analysis. Monthly supportive supervision by District level HMIS staff to the lower level facilities was also supported by MUWRP. SI funding supported salary of 4 SI staff, training, maintenance, six computers, supplies, technical expertise and internet service provision. Finally during 2009, MUWRP staff continued to conduct analysis of data that are collected as a part of routine patient/client visits. Some of the analysis includes exploring and describing change among treatment cohorts, factors associated with lost-to-follow-up, youth, CT trends etc., in order to inform program implementers and policy makers. Because of these analyses, MUWRP and Kayunga District officials have presented abstracts and posters at local and international AIDS conferences. Also during FY2009, MUWRP began partnering with the CDC to pilot test an electronic tracking system for HIV/AIDS patients at the Kayunga District Hospital. This system is not yet complete, but in FY2010 the goal will be to expand the pilot to include electronic laboratory data. The current system being used is paper-based and with the staff and facility now operating at a higher level of capacity with increased patient loads, the time is right for an automated system. This system will provide more efficient means of managing files and tracking patients. This will involve providing material and technical support to the District Hospital clinic and laboratory which has the largest patient load of all the HIV clinics in Kayunga District. During the past year, other program areas within the MUWRP comprehensive model experienced great success in task-shifting to treatment club members. During FY2010, MUWRP intends to task shift to the patient level and build capacity among treatment club members for services such as data entry and data verification. Also during FY2010 MUWRP intends to build on past success by continuing to support an SI innovative. The goal is to develop capacity, infrastructure, and provide technical training to enable the Kayunga District Health authorities to export all health indicator data from their locally maintained database directly to the Uganda Ministry of Health databases. Support includes material support as well as technical assistance. Efforts so far have been successful in completely customizing a specialized soft wear (the DHIS) for the Uganda HMIS system, with over 2000 indicators added to the software and all of the Uganda HMIS forms entered into the database back to the year 1995. Further, MUWRP has supported a two-week training by DHIS engineers which was offered to technicians from Uganda MOH, USG agencies, as well as technicians from MUWRP and Kayunga District. After months of trial and error, Kayunga health data was successfully exported for the first time into the Uganda MOH HMIS system in June 2009.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	1,382,000	

Narrative:

During FY09 MUWRP implemented Uganda's first non-research medical male circumcision (MMC) program at the Kayunga District Hospital. The program was officially launched in July 2009 when a renovated surgical theatre was handed-over to the District. Implementation of this service included: (1) training support for 15 doctors, clinical officers, nurses and counselors through the Rakai Health Services Program; (2) generation of MUWRP MMC program policy, procedures (in accordance with international guidance), quality assurance guidelines (including safety/support supervision) and clinical tools; (3) provision of equipment and commodities; (4) establishment of a target population-specific messaging program that included billboards, radio talk-shows, posters, market-place announcements, drama groups (specifically trained in MMC messaging for both males and females), and weekly community outreach and sensitization; (5) the implementation of an MMC basic program evaluation of the first 300 service participants and a community survey to gage pre-post MMC sensitization knowledge attitudes and behaviors; and finally (6) the complete remodeling of a minor surgical theatre for performing MMC surgeries. HIV testing and counseling was provided for every service recipient as well as; pre and post-operative sexual risk reduction counseling, assessment and/or treatment of STIs, strong promotion of consistent use of condoms, counseling on the need for abstinence from sexual activity during wound healing, wound care instructions, and post-operative clinical assessments and care. Of paramount importance to MUWRP was to roll out a safe program that was efficient with low marginal costs. This was made possible by securing strong buy in from District and National health officials, community/religious/opinion/political leaders, and by primarily utilizing District hospital clinicians in the provision of service. During FY10, in an attempt to reach more service recipients, plans are already underway to expand the exact MMC program described above to neonates and through two additional sites; the Kojja Health Center IV in Mukono District and the Kangulumira Health Center IV in Kayunga District. Training for neonatal circumcision will be done by pediatric surgeons based at Mulago Hospital. Also, using data from the basic program evaluation that was conducted and, with continued strong emphasis on cost savings and safety (out of 330 males circumcised during FY09 - only 3 experienced very small adverse events such as bleeding) MUWRP intends to pilot a clinical ledger tool. The aim of this tool is to greatly reduce paperwork for clinicians by allowing them to record all (WHO recommended) surgical, pre and post clinical information in one book. With this expansion plan, it is expected the Program can perform 3000 circumcisions during FY10.

The Henry Jackson Foundation seeks to establish a Medical Male Circumcision (MMC) training center in Kayunga that will facilitate expansion of MMC services and best practices for Uganda. The medical cadres that will be trained through this center are comprised of: surgeons, doctors, clinical officers, theater assistants, and councilors. Training will focus on service provision to sexually active men and adolescents as well as neonate surgery. This application requests funding for infrastructure remodeling, supplies, equipment, staff, trainee facilitation, mobilization; an M&E component; and other direct costs.

In 2009, MUWRP launched the first non-research MMC site in Uganda at the Kayunga District Hospital. The Kayunga event was endorsed by the MOH and was attended by representatives from the Uganda ACP, AIDS Commission, and the US Embassy. Most recently, MUWRP expanded MMC service delivery to another fixed site in Mukono District, and has served as a pilot site to implement Uganda's recently developed MMC counseling curriculum.

Of strategic importance in the implementation of MMC services is the availability of MMC training for health workers. While MMC training is available in Uganda through Rakai Health Sciences Program (RHSP), due to RHSP's funding and large number of international applicants, the wait to receive MMC training at Rakai is nearly 6 months. In October 2009, recognizing that the wait for training was causing a bottleneck to a more rapid MMC scale up, RHSP representatives requested that MUWRP establish a satellite MMC training center in Kayunga.

On March 5, 2010, 15 Mukono and Kayunga health workers completed the first 2-week MMC training in Kayunga. This was done using MUWRP and District staff whom RSHP had already trained-as-trainers, and with technical oversight from RHSP. The course was funded with non-obligated limited MUWRP funds. During exit evaluations the 15 trained health workers were asked if the Kayunga training course had provided them with sufficient technical skills/knowledge to implement MMC; 53% strongly agreed, 40% agreed, and 6% had no opinion.

MUWRP has already hired an architect and a quantity surveyor management consultant to assist in the remodeling of 4 areas at the Kayunga District Hospital that have been allocated to MUWRP. These include a large MMC training classroom, 3 breakout session rooms, a MMC resource center with internet capacity, a lunch area, a laundry room, and most critically; the expansion of the present surgical center into a 6-surgical table training facility.

Based on the MUWRP experience, there is a need to avoid provision of MMC training to inappropriate medical staff or to medical staff who will not be appropriately supported. For that reason, before any training is offered to an individual or to a team of individuals, as part of MUWRPs training curriculum, a MUWRP team will first need to conduct a pre-training site assessment visit. The conditions and issues to be assessed at every site include: (1) MMC infrastructure, (2) MMC supplies/equipment/materials, (3) willingness and availability of medical staff to implement MMC, and (4) MMC program commitment from the District Health Officer. Furthermore, the MUWRP team will need to meet with the Director and managers of the MMC program of the implementing partner. The purpose of this meeting is to assess the supply chain management plan for all MMC sites.

Post training supportive supervision will be carried out by the MUWRP supportive supervision team as per the following schedule:

*Month 1 post MMC training - 1 supportive supervision visit every two weeks

*Months 2, 3, 4, and 5 post MMC training – 1 supportive supervision visit per month

MUWRP supervisors may determine that some subsequent visits should be canceled. Reasons for canceling a supportive supervision visit could include perfect performance at a MMC site as deemed by the supervisors, or that the site has never operationalized MMC provision. Finally, the supportive supervision team will always be available by telephone.

Supportive supervision for the MUWRP MMC training center will continue to be supplied by RHSP in a collaborative and on a contractual basis. More specifically supervision will be supported from RHSP surgeon Daniel Namuguz and RHSP gynecologist Steven Watya. MUWRP will now endeavor to have the training center accredited by the Ugandan Ministry of Health, again collaborating with colleagues from RHSP who have already provided MUWRP with templates for most of their training materials and training curriculum.

In addition, the Henry Jackson Foundation will establish two pilot sites providing a comprehensive Medical Male Circumcision (MMC) package in Mukono and Kayunga utilizing the "Broken Chair Room" (BCR) Model recently accepted by the Uganda USG HIV Transmission Prevention Task Force. This application requests funding to establish two much reduced cost sites, including; 5 staff per site, supplies, equipment, mobilization, BCC counseling, site identification, cleaning and other direct costs. Staff training will be provided by the Kayunga District – MUWRP MMC Training Center.

According to all mathematical models on the number of infections averted due to MMC, if Uganda is to attempt to prevent a sizeable number of HIV transmissions using MMC, a much larger number of circumcision surgeries must be performed. The BCR model of rolling out MMC in Uganda was carefully developed by the MUWRP and DOD USG agencies in an effort to provide a realistic solution to this problem with the main goals of providing a large number of MMC surgeries at a reduced cost without sacrificing safety. The costing data for this model was based on successful MMC program data and budget set for just one BCR site is meant to include everything except training.
If administered carefully and medically, the goal for each of these BCR MMC sites is to perform 2250 circumcisions per year, with less than five adverse events reported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	138,000	

Narrative:

Last year, MUWRP's Abstinence and Be Faithful program trained and supported volunteers and District lay workers, including 46 dedicated youth volunteers, to carry out AB prevention activities. During FY 2010, AB activities are aimed at all of Kayunga District, rural and semi-rural areas, males and females. However, MUWRP's HCT data reveal that the vast preponderance of HIV infections in Kayunga occur

from age 21 through age 32. Thus; MUWRP has thus tailored its AB program so that persons falling within this age group are pinpointed for the highest number of interventions. This is made possible due to the strong mobile prevention presence, which includes CT and OP activities, that MUWRP has supported since its inception in 2005, However, abstinence activities are primarily aimed at those under the age of 18 who are both in-school and out-of-school and include counseling on the delay of sexual activity. Supportive supervision for counselors is given by MUWRP's full-time prevention coordinator, who monitors program counselors and provides regular feedback. Last year as a further measure of quality, MUWRP coordinated and supported the standardization and all AB IEC materials and training curricula in Kayunga District. Faithfulness messages and trainings have also been standardized and focus on those older than 15 years of age (District-wide) and include messaging campaigns, prevention with positive activities, male norms and behaviors, increasing gender equity, cross generational sex, increasing women's legal rights and access to income and productive resources including life skills as they are related to HIV prevention. Although other target populations get faithfulness messages, MUWRP's faithfulness programs target men and women age 21-32 in concurrent partnerships. MUWRP's program will continue to support the infrastructure and activities of a vibrant and well-attended youth center, the Kayunga District Youth Recreation Center. In partnership with the US Peace Corps and the Kayunga Town Council, MUWRP supports this center to be a place of recreation and education for young people, especially at-risk out-of-school youth, ensuring that they are active, engaged, and provided with an array of health related services, including HIV education, testing and counseling. Specific community activities include bi-weekly mobile HIV education outreaches, youth outreaches to schools and communities, AB messages delivered during a District house-to-house HIV testing program, outreach to boda boda (motorcycle taxi) drivers, and at least 4 District-wide sports competitions with strong HIV education, messaging, counseling and testing components. During FY 2009, these programs reached more than 10,000 individuals who were provided with abstinence and be faithful services and 10 new individuals were trained. During FY 2010, these programs will continue and, if appropriate, client services will be strongly linked/integrated to MUWRP's OP activities, which include: prevention with condoms, male circumcision, prevention with positives, and domestic violence community sensitizations and messaging campaigns. AB data is monitored routinely and reported to the Kayunga District health authority so as to assist them (and MUWRP) in prevention programming and plans, especially pertaining to identifying geographical gaps.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	

Narrative:

During FY 2010, OP activities will continue to be aimed at all of Kayunga District, rural and semi-rural areas, males and females. However, MUWRP's HCT data reveal that the vast preponderance of HIV

infections in Kayunga occur from age 21 through age 32. Thus; MUWRP has thus tailored its OP program so that persons falling within this age group are pinpointed for the highest number of interventions, especially condom distribution. This is made possible due to the strong mobile prevention presence, which includes CT and AB activities that MUWRP has supported since its inception in 2005. Another big MUWRP focus during FY2010 will be to continue to push for reducing violence and coercion throughout Kayunga District, in all 9 sub-counties. Several reinforcing approaches will be used in this respect, including re-training the entire Kayunga District police force, District clinicians, and lay workers - as well as a billboard campaign utilizing the local police force in the photos. MUWRP will partner with technical experts from the SHARE project and Raising Voices, both local NGOs with expertise in gender based violence to ensure quality trainings, billboard messages, and consistent (WHO standards), effective IEC messages are disseminated to the District communities through a variety fixed and mobile venues. Moreover, MUWRP will support a District-wide HIV drama competition that focuses on domestic violence and the winning group will tour all 9 sub-counties performing their play deep in the communities. As a result of MUWRP's house-to-house testing program that began in 2008, a large number of discordant couples throughout the District have been identified. Under this program area, MUWRP supports these couples (District-wide) with follow-up visits to the home and with quarterly meetings which include re-testing. Also under this program area, MUWRP will continue to train and support expert clients at each of the 8 MUWRP supported HIV clinics to conduct education sessions while patients wait to see a clinician. The topics covered by these lay workers include: prevention with positive, condom use, reproductive health measures, and pre-exposure prophylaxis. Supportive supervision for counselors is given by MUWRP's full-time prevention coordinator, who monitors all program counselors and provides regular feedback. Last year as a further measure of quality, MUWRP coordinated and supported the standardization of all OP IEC materials and training curricula in Kayunga District. Further, messages and trainings pertaining to condom use, cross-generational sex, male norms, reproductive health, and prevention with positives were standardized. All of these programs focus on those older than 15 years of age. Dissemination of messages under this program area will be District wide, utilizing: face-to-face counseling, group counseling, radio, marketplace loud speakers, roadside billboards and (coordination of District) state-of-the-art IEC materials. Also during FY2010, MUWRP will retrain District clinicians on the standard operating procedures of a post-exposure prophylaxis program that was implemented at each HIV clinic site in Kayunga for victims of rape, defilement, or any other person who has had immediate exposure to HIV. MUWRP will also continue its revolving billboard messages in FY2010, these messages currently focus on testing for HIV, medical male circumcision, couples counseling, the benefits of disclosing ones' HIV status, condom use, and as mentioned above, an entire billboard series on preventing domestic violence. Finally, MUWRP will support age-appropriate reproductive health training to 30 youth counselors from the Kayunga District Youth Recreation Center as well as in-depth training (including surgical techniques) to an additional 30 District clinicians.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	HLAB	400,000	

Narrative:

The MUWRP supported laboratory program for Kayunga and Mukono Districts described below continues to be part of a comprehensive HIV program and activities do link to Counseling and Testing, Strategic Information, Adult and Pediatric Care and Treatment, ARV drugs, and OVC services. During FY2009, MUWRP supported the Kayunga District Hospital laboratory which operates at full capacity. This capacity has been built over-time and this laboratory is now processing and reporting CD4 enumeration, chemistry, and hematology for all HIV samples originating in Kayunga District and from the Kojja Health Center IV in Mukono District. Further, MUWRP supports routine viral load testing for those patients on ART at each of the 8 MUWRP supported HIV clinics. The addition of this test during FY 2009 has led to significant policy changes and patients being switched to second line drugs. Presently, testing of viral loads (and routine early infant PCR testing) is done through MUWRP's research laboratory in Kampala. The lessons learned by MUWRP in the achievement of their laboratory goals were presented at the 2009 International AIDS Conference in Mexico City. During FY 2010, MUWRP will continue to support laboratory services in Kayunga and Mukono Districts with; supply chain management supervision, strong daily supportive supervision, staffing support, task shifting programs to lab assistants, power solutions, perishables, trainings, and maintenance contracts for all equipment. The laboratory follows SOPs for all the testing they perform and strictly run controls on machines before testing any patient samples. Furthermore monthly comparability runs are done monthly between the hospital laboratory and MUWRP's research laboratory. Moreover on issues pertaining to Quality Control the laboratory is enrolled with the United Kingdom External Quality Assessment Service (UK NEQAS), which sends US samples bimonthly for EQA. Most recently the laboratory started receiving External QC flow cytometry samples from Synex life sciences, South Africa called Lymphosure. MUWRP intends to continue provision of these services, especially on their successful model of task shifting and building local capacity in FY2010. MUWRP intends to convert an underused research field laboratory in to a regional QA laboratory with the capacity to test viral loads and perform Elisa confirmatory tests. Access to this second laboratory operating at capacity will improve planning, forecasting and budgeting for laboratory support activities. Finally, plans are underway for MUWRP to partner with CDC in launching an electronic data system at the Kayunga District Hospital which will link patient clinical data to their laboratory data.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9046	**Mechanism Name: Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Baylor College of Medicine Children's Foundation/Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 6,132,397	
Funding Source	**Funding Amount**
GHCS (State)	6,132,397

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Introduction and overview

Baylor College of Medicine Children's Foundation-Uganda (Baylor – Uganda) is a child health, not-for-profit NGO committed to delivering high quality, high impact and highly ethical paediatrics & family HIV/AIDS prevention, care and treatment services, health professional training and clinical research in Uganda. It is affiliated to Baylor College of Medicine International Pediatric AIDS Initiative (BIPAI) based in Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Makerere University Department of Pediatrics and Child Health at Mulago Hospital. Baylor –Uganda signed a memorandum of understanding with Ministry of Health in 2005 to support the expansion of paediatric and adolescent HIV services in Uganda.
It also works collaboratively with the Makerere University Department of Pediatrics and Child Health in training of health workers. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda, a new Children's Centre of Excellence has been constructed at Mulago Hospital. This Centre provides additional space for provision of HIV/AIDS services to children and their families, training and research.

Since 2007, Baylor-Uganda is implementing a 5-year project to expand paediatric and adolescent

HIV/AIDS services in the country. The project is funded by PEPFAR through CDC grant contract number 1U2GPS000942. The goal of the project is to reduce new HIV infections and HIV/AIDS associated morbidity and mortality amongst children & adolescents in Uganda.
The project objectives are to increase by 40%, the proportion of HIV infected children and adolescents utilizing HIV prevention, care & treatment services in Uganda; expand access to paediatric and adolescent HIV/AIDS care and treatment to 133 Ministry of Health accredited ART sites and strengthen capacity of Baylor-Uganda ART supported sites to generate, manage, utilize & disseminate information on paediatric & adolescent HIV/AIDS.

The organization also receives support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs. Other collaborating partners include Canadian Feed the Children which supports the nutrition program, Pediatric AIDS Canada that support 250 children and 50 adults on ART; and Save the Children in Uganda, Children's Fund International (CFI) for community programs support.

Baylor -Uganda is operating a family-centred model for care and treatment, and support of Children Living with HIV and AIDS (CLHA). In this model, CLHA are an entry point into the family where they live; to care and treat adult caretakers alongside their children.

Two service delivery modes are used:
(a) Direct provision of comprehensive HIV/AIDS services through 12 health facilities: Mulago Hospital Pediatric Infectious Diseases Clinic (PIDC), six urban satellite clinics [Kiswa, Kiruddu, Kawempe and Kitebi under Kampala City Council, Kanyanya TASO Centre and Upper Mulago Post Natal Clinic] and 5 UNICEF supported health facilities: Northern Uganda (Kitgum Hospital), North Eastern region (Kaberamaido HCIV and Lwala Hospital) and Western region (Kilembe Mines & Bwera Hospitals). Five of the urban satellites are run as family clinics with KCC and other partners which include Infectious Diseases Institute (IDI), Mulago-Mbarara Joint AIDS Program (MJAP) and The AIDS Support Organization (TASO). The service package includes HIV counseling and testing for children (6 weeks – 14 years) and their adult family members, growth and development monitoring, immunization, nutrition supplementation, OI prophylaxis and treatment, TB screening and treatment, psychosocial support groups, home-based HIV counseling, testing and follow-up, and ARVs when indicated.
(b) Indirect provision through integration of pediatric and family-centered HIV/AIDS/TB services into existing MoH ART accredited health facilities in Uganda. The support includes capacity building; training, mentorship and support supervision, infrastructure improvement, systems strengthening, commodities for HIV testing, care and treatment, Paediatric ARV formulations and buffer stocks of adult ARV formulations and opportunistic infection drugs.

Progress to-date and achievements

In FY2009, Baylor – Uganda conducted additional site assessments (for ART preparedness) in 46 health facilities in 34 districts in Uganda. Memoranda of Understanding were signed with all districts to financially support integration of pediatric HIV care in MOH ART accredited health facilities. To date 78 health facilities are being supported to provide pediatric HIV/AIDS services in their adult clinics. The program has achieved remarkable results; 241,749 people received HCT services in 74 service outlets. Know Your Child's HIV Status' (KYCS) campaign a new strategy implemented by Baylor-Uganda among children of clients in care yielded 260 HIV positive children, an HIV prevalence of 3.4%. A total 8,889 children (0-14 years) and 29,681 adults (15+ years) were receiving HIV/AIDS related care & support from Baylor-Uganda sites; of these 4,664 children and 11,201 adults were receiving ART.
Pediatric HIV services at the COE, six Kampala satellites and the five UNICEF supported health facilities have continued to receive direct support to manage the clinics. The patients at the COE continue to be closely monitored so as to inform practice in the other facilities. The treatment efficacy at COE -measured as the number of children initiating HAART who attain 10+% increases in CD4 after 6 months on therapy has remained high at 76.3% well above the world average of 70%; mortality over the last years has reduced from 4% in FY06/07 to 3.2% in FY07/08 to the current 2.8%.
To achieve this close to 2000 health care providers have been trained in pediatric HIV management and community follow up. Through support of regional coordinators who are district based pediatricians or senior medical officers, Baylor – Uganda has continued to conduct monthly on-site mentorship to staff graduating from didactic trainings.
Health Information systems have also been strengthened by training of 265 records assistants and data management personnel and provision of Ministry of Health data collection tools and equipment to respective districts. Baylor-Uganda regional assistant data managers and district Health Management Information officers (HMIS) mentor the health facility data clerks/records assistants to enhance data management and utilization.
In terms of leadership, HIV focal teams at health facilities have been rejuvenated to start monthly meetings. Currently each facility is at a different stage on the continuum of capacity to lead and manage its programs and hence, out of the 66 rural health facilities supported only 22 have so far graduated from mentorship to support supervision. Through such assistance, over time, the district is expected to expand its capacity to plan, oversee and manage programs, to deliver quality services sustainably once Baylor-Uganda exits.

Infrastructure improvement and remodeling of health facilities to enhance privacy, confidentiality and provision of adolescent friendly services was carried out in Kitgum Hospital, Kiswa, Kiruddu and Kitebi Health Centers.
Five laboratories were strengthened to perform CD4 laboratory tests with provision of CD4 machines at the following facilities; COE at Mulago Hospital, Kaberamaido HCIV, Pallisa, Kitgum and Kilembe Hospitals while 52 laboratories received haemacue machines for Hemoglobin monitoring. An assortment

of pediatric clinical equipment was provided to 63 health facilities e.g. weighing scales, height scales, thermometers and suction machines.

A system for measuring performance, tracking progress and informing programmatic fine-tuning and further planning has been instituted by directly engaging the district Health management and Health Management Information officers.
Monitoring and evaluation
Baylor – Uganda has a robust M&E system that will take charge of this process. Quarterly support supervision visits will be conducted to monitor progress and ensure continuous implementation to achieve project milestones. Standardized Ministry of Health (MOH) tools will be used in all Baylor – Uganda supported health facilities including registers, ART cards, logistics management and support supervision tools. All partnership reporting agreements will be respected to avoid data duplication. Memoranda of understanding will be drawn with implementation partners to complement each other's activities and avoid duplication. Routine program reporting will be done to inform program implementation and to update partners of program progress. By 2011, Baylor – Uganda targets to have computerized data in all the supported health facilities and districts to simplify data collection, analysis, reporting and enhance utilization. This will contribute towards efforts of creating a national database of paediatric HIV care.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Food and Nutrition: Commodities	3,000
Food and Nutrition: Policy, Tools, and Service Delivery	60,000
Water	60,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9046**
Mechanism Name:	**Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers**
Prime Partner Name:	

	Baylor College of Medicine Children's Foundation/Uganda		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	120,000	

Narrative:

In FY 2010, Baylor-Uganda will continue to support adult care in the context of family clinic or family centered HIV/AIDS services in 84 NEP sites in 36 districts. Our target population will be adult women and men who are caretakers or family members of HIV infected children and adolescents, and adolescents who have matured into adulthood with HIV. This model of care fits into the Ministry of Health strategy of caring for families together as this improves efficiency and quality of care given to clients. The types of HIV care and support services will include: prevention and management of opportunistic infections eg malaria, diarrhea, pain, and symptom relief, nutrition support, procurement and distribution of pharmaceuticals (non ARVs), basic care package (ITN's, safe water vessel, etc) to all supported sites. Technical support to upcountry health facilities through on site mentorship and support supervision will be provided to develop systems, and competencies of staff in both adult and adolescent HIV/AIDS management.

Community volunteers who are part of the village team will be identified and trained to support both pediatric and adult care to ensure client retention and adherence to treatment. Through the use of Ministry of Health registers client attendance will be tracked daily and details of those who will not have turned up will be given to the community health worker to track. In return the community volunteer will give a report to a designated heath worker for follow up. In addition, community volunteers will follow up clients with poor adherence, critical laboratory results and those with nutrition deficiencies.

It is estimated that up-to 30,047 adults will be reached in 2009/2010 and by 2010/2011 these numbers are estimated to reach 32,150. As not all health facilities have the capacity to provide laboratory services efforts will be made to link with facilities that can offer more laboratory support. Linkages will be made with lower health facilities that may not be able to offer ART to so that they can refer clients for further care. Effort will be made to link HIV adult clients to support groups and PHA networks to help them access income generating activities. Quarterly meetings for clients to deliberate on issues pertaining to their care will be supported through this initiative. There will be focus on fostering partnerships to link clients for complementary services including food support and security. Reproductive health services including family planning and cancer cervix screening will be provided to all sexually active females.

Systems for measuring performance, tracking progress and informing programmatic fine-tuning and further planning will continue to be instituted by directly engaging the district health management teams

and Health Management Information officers. The existing Assistant Data Managers who are Baylor-Uganda employees will continue to mentor and support the health workers in data collection, storage, simple analysis, utilization and dissemination. In collaboration with School of Public Health a fellow has been identified to support Baylor-Uganda to develop a community monitoring and evaluation framework.

In order to ensure sustainability, Baylor-Uganda will continue to work though the health systems to strengthen the HIV/AIDS prevention care and treatment services in the various rural health facilities.

Below are activities for adult care and support services:

• Continuous clinical and laboratory monitoring of the clients
• Procurement and distribution of basic supplies for management of adult HIV/AIDS where needed
• Prevention and management of opportunistic infections as above
• Provision of reproductive health services including cancer cervix screening
• Procure and distribute pharmaceuticals, basic care package to all supported sites
• Provide technical support to upcountry health facilities through on site mentorship and support supervision in provision of family centered HIV/AIDS treatment and care
• Support care taker support groups and community groups that aid in the client retention and adherence
• Mobilize communities on family centered HIV/AIDS treatment and care
• Support for data management and utilization
• Undertake quality improvement projects for adult HIV care

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	344,000	

Narrative:

Baylor-Uganda is a child health organization serving majorly orphaned and vulnerable children. Up to 56% of the children under Baylor care have lost at least one parent while 35% have lost both parents. These children are often marginalized and require support to live with dignity. The priority OVC areas Baylor-Uganda addresses include:

Increase data development and use for strategic planning: Baylor -Uganda will provide computers to all

health facilities with reliable power sources. Records assistants/personnel responsible for data management will be trained to ensure proper data capture and storage to enhance accurate and timely reporting. Baylor-Uganda regional Assistant Data managers will mentor these personnel to acquire basic analysis skills and results interpretation to inform decision making and practices for improved livelihood of the children. Community volunteers will also be equipped with basic skills in records management and reporting to improve OVC follow up. This action addresses the care and support service area.

Strengthening systems/Government/policy: Baylor-Uganda will continue to advocate for orphans and vulnerable children due to HIV that they too can live a healthy and productive life if they receive appropriate and timely care and support. Through strategic partnership with other organization, resource mobilization for OVC services shall be continued. Canadian feed the children will continue providing Food and nutrition commodities to the COE and the six satellites in Kampala. A to Z another child health organization dealing in psychosocial assistance also provides transport to children living in, Kawempe, one of administrative divisions of Kampala. This action cuts across several service areas including care and support, child protection and psychosocial assistance.

Community support and coordination: Baylor-Uganda will train community volunteers in home based care and support of clients. In partnership with Food and Nutrition for Uganda (NuLife), these volunteers will also be empowered to integrate nutrition support interventions (education, assessment and referral) in home based HIV care programs. Support to hold community peer support groups' meetings which strengthen follow up (for adherence to treatment and clinic appointments) and referral of clients. This addresses the care and support service area.

Family/household strengthening: in partnership with Canadian Feed the Children, clients attending the COE and the six satellites in Kampala are provided with snacks as they wait to receive treatment and individual food rations. In addition they provide 50 family food rations to the most food insecure households. Emergency feeds will continue to be provided to food insecure families especially those failing in replacement feeding. This is in response to the food security and nutrition service area. Primarily, the target population will be children below 18 years that are attending HIV/AIDS clinics at COE and Satellites in Kampala and their care takers.

Activities to include:
• Provide life planning skills training (including making of hand crafts).
• Provide clinic based feeding for children attending clinics and supplemental take home food rations for OVC families.
• Provide play therapy to children attending supported clinics
• Provide transport reimbursement to (960/year) OVC identified with the greatest need to ensure their

regular clinic attendance and treatment adherence.
• Support child participation activities such as monthly, quarterly and annual meetings and camps for OVC who are HIV infected.
• Procure and supply toys and other play materials for children to play with while waiting for treatment and care at the COE, satellites and national expansion facilities
• Conduct nutrition education to OVC families.
• Provide basic treatment and care services for OVC at Baylor-Uganda supported facilities
• Organize and Facilitate participation of children in observation of nationally and internationally important advocacy days (like World AIDS Day, Day of the African Child, candle light Memorial Day etc)
• Establish networks and build alliances with other stakeholders and social groups with an aim to provide holistic comprehensive services and mobilize resources to support OVC's

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	420,000	

Narrative:

In FY 2010, Baylor-Uganda will continue to support adult treatment in the context of family clinic or family centered HIV/AIDS services in 84 health facilities in 36 districts. 35 will be rural districts covering 77 health facilities that include district hospitals, health centre IV's and some health centre III's. The comprehensive package will include ART provision, cotrimoxazole prophylaxis and tuberculosis to adult patients on ART. Our target population will be adult women and men who are caretakers or family members of HIV infected children and adolescents; and adolescents 15 years and above who have matured into adulthood with HIV. 12,096 clients on ART in FY2009/2010 will be reached.

In order to provide quality treatment to the clients, Baylor-Uganda will continue to offer support to the districts to conduct various trainings. Districts will take lead in selection of participants to attend the different didactic trainings and in organizing the trainings. As most of the districts already have resident trainers, these will be used to facilitate the trainings while Baylor-Uganda staff will ensure quality of the trainings. The following in service trainings will be conducted:
• Training on Logistic management for HIV/AIDS commodities to ensure that there are no stock outs of HIV commodities including Non ARVs and ARV's
• Training on records and data management and use
• Pediatric HIV management that includes PMTCT management to impart knowledge to health care providers
• Community volunteer's trainings that impart knowledge and skills in HIV care, tracking loss to follow up and adherence monitoring
• Counselor training to impart knowledge and skills to health workers to be able to provide quality

counseling to clients
• Positive prevention to HIV positive clients and health care providers
Following the above didactic trainings, on site mentorship will be conducted to various cadres of health providers to ensure that knowledge is translated into practice. Baylor-Uganda overtime has developed regional and district mentors and these will be facilitated to support the mentorship activities. In addition, district health teams will be supported to conduct support supervision to ensure sustainability of standards of care. Baylor- Uganda will conduct technical supervision quarterly or as needed.
Tracking of clinical outcomes will be monitored through clinical evaluation through the use of data capture using MOH tools. Baylor- Uganda will continue to mentor MOH facility staff in the use of these tools and where the tools are not available they will be procured with the support of MOH. The clinical outcomes to be tracked will include: WHO stage, weight, Karnofsky performance score to assess quality of life, opportunistic infections especially tuberculosis, drug toxicities and correction of malnutrition.
In order to ensure good clinical outcomes, adherence activities that will be supported include: adherence assessment in the clinic and at home by community volunteers , supporting drama groups and client support groups, and conducting adolescent camp activities geared to improving adherence and positive prevention. The outcome of these adherence activities will be improved health status and quality of life of the clients that Baylor-Uganda will support.
Baylor-Uganda will support the districts plans geared towards the activities mentioned below. Funds will be transferred to a designated district account where they will be requisitioned from by the health facilities. In order to ensure that funds are utilized for the intended purpose, internal audit will be regularly conducted.

Activities:

• Conduct training as mentioned above
• Organize and conduct on site mentorship to different cadres of staff
• Organize clinical placement in high volume HIV adult clinics for those health care providers that have potential to supervise
• Collection and transfer of data from the health facilities to the districts
• Orient district health teams in support supervision tools
• Conduct support supervision
• Conduct camps for adolescents
• Conduct client meetings
• Identify and support the volunteers to work in the clinic to support adherence activities
• Monitor the training activities and budget implementation

Funding for these activities is provided for under budget code12 (ARVs)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	250,000	

Narrative:

In FY 2010 Baylor-Uganda plans to reach 180,069 clients with HIV counseling and testing services for each of the years 2009/2010 and 2010/2011: 13,865 aged < 5 years; 28,811 between 5-17 years; and 13,7393 =18 years. The geographical coverage will be across the country in 84 Baylor-Uganda supported sites (COE inclusive) in the 36 districts. For quality assurance, the counseling and testing process will be based on the approved Ministry of Health testing algorithm. Internal and external quality control measures will be instituted. For the COE and Kampala satellites 5% samples will be sent to the Makerere University Johns Hopkins University collaboration (MUJHU) Core laboratory for quality assurance while the NEP point laboratories send samples to the district Joint clinical research centres laboratories.

HIV Counseling and Testing (HCT) is the entry point to HIV prevention, care and treatment. Baylor-Uganda will offer HCT services according to the National HCT guidelines that recommend various approaches including Voluntary counseling and testing (VCT), Home based HCT (HBHCT) and provider-initiated routine HCT in clinical settings. For the diagnosis of HIV among infants, DNA-PCR is essential, Baylor-Uganda will continue to support transportation of DBS samples to JCRC laboratories to facilitate early infant diagnosis (EID).

The main client mobilization strategies will include 'Know Your Child HIV Status' (KYCS) campaigns, RCT, couple testing and VCT. Baylor –Uganda will continue with the KYCS strategy which targets children of HIV positive adults attending the ART clinics who may have asymptomatic or ill children that are not yet identified as infected. RCT will continue to be done in all paediatric wards and mother and child clinics to increase child identification. Outreach counseling and testing services will be conducted for high risk communities aiming to identify both infected children and adults. Baylor-Uganda in partnership with MoH will continue to build capacity for EID and disseminate the guidelines and necessary monitoring tools.
Counseling and testing services will be provided by facilities accredited for provision of prevention, care and treatment services, so that clients testing HIV positive will be actively linked to care and treatment services. HIV negative clients will also be linked to preventive services.

Activities:
• Train health care providers in HIV counseling and testing
• Train health care providers in Dry Blood Spot (DBS) sample collection
• Procure and supply buffer stocks of HIV test kits to all Baylor-Uganda supported sites

• Provide HIV counseling & testing services: EID using DNA-PCR, RCT to children and adults in supported sites
• Support the roll out of Paediatric HIV Routine Counseling & Testing (RCT) in all facilities through provision RCT registers
• Support counseling and adolescent peer support groups to provide psychosocial counseling & support, including stigma reduction
• Conduct monthly meetings with community volunteers to empower them with mobilization skills and aid linkage of clients into care
• Revise and translate the community reporting tool used in monitoring support services to clients
• Support health facilities to conduct "Know Your Child's HIV Status" campaigns
• Conduct HIV Counseling and Testing outreach services to most at risk populations and underserved areas such as orphanages, detention centers
• Develop and distribute customized calendars and T-shirts with prevention messages for patient mobilization and advocacy purposes
• Support and hold radio talk shows and public service announcements to increase public awareness and mobilize communities to seek pediatric HIV/AIDS services
• Sensitize persons in testing points to link identified HIV positive children and adults to ART clinics for care

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	630,000	

Narrative:

In FY 09/10, Baylor-Uganda will continue to provide pediatric HIV/AIDS care and support at the Baylor – Uganda Centre of Excellence (PIDC), 6 Kampala city council satellite clinics and 77 rural health facilities in 35 districts. Our target population will be children and adolescents up to 18 years of age. This is intended to scale up pediatric service coverage to nearly 80% of the 364 health facilities currently providing adult HIV/AIDS care and support in the country.

Mechanism: In partnership with MOH, Baylor-Uganda will continue to work with district health offices and management of the 64 health facilities to strengthen pediatric HIV care and support services that were initiated in the previous fiscal year. The strategies will include capacity building through training of health providers, infrastructure improvement, procurement of equipment and commodities and sustenance of human resources for health; community mobilization for pediatric HIV testing, care and support through "Know your child's HIV status" campaigns and local radio programs; service delivery through provision of integrated comprehensive HIV/AIDS care and functional referral between HIV testing and care; establishing and strengthening existing MOH mechanisms for supervision, monitoring and evaluation.

The strategies will be coordinated through district structures to ensure continuous quality services provision and sustainability of operations.

Activities that provide drugs, food and other commodities:
• Procure and distribute basic care package (ITNs, safe water vessels, etc) to all supported sites
• Procure and distribute pediatric supplies including weighing scales, stadiometers and pediatric stethoscopes
• Procure and distribute office supplies and medical supplies to the COE, urban facilities and buffer stocks to the district health facilities
• Provide drugs for prevention & treatment of opportunistic infections (excluding TB) to HIV +ve and HIV exposed infants
• Train health workers in pediatric HIV/AIDS management and pediatric HIV/AIDS counseling
• Train community volunteers in home based care
• Conduct team building exercise to support sustenance of human resources for health
• Conduct radio talk shows addressing pediatric HIV/AIDS issues
• Write news paper articles to create awareness on pediatric HIV/AIDS
• Procure and distribute Information, Education and Communication materials
• Support community outreach & individual child/family psychosocial needs counseling, including coordination of OVC & community program
• Conduct camps for children and adolescents to enhance adherence to drugs, promote positive prevention and build life support skills
• Provide therapeutic food interventions for malnourished children
• Provide food rations for all clients attending the COE and urban satellite clinics and provide snacks to all children and adolescents as they wait for services.
• Provide family food rations to the food insecure while working with the families on improving food security
Activities for supervision, improved quality of care and strengthening of health services
• Conduct quarterly technical support supervision with district health teams
• Support MOH and district staff to conduct mentorship
• Support the district health teams to conduct monthly support supervision
• Conduct quality improvement projects in collaboration with HIVQUAL program under the Ministry of Health
• Carry out minor infrastructure improvement to make the health facilities child friendly
• Participate in International Pediatric HIV/AIDS Conferences/Meetings
Integration with routine pediatric care, nutrition services and maternal health
• Support in-patient care costs for HIV infected children admitted at Acute Care Unit, Mulago Hospital
• Conduct and or support routine HIV testing in all pediatric outpatients and wards in particular nutrition

and TB wards

Laboratory support and diagnostics for pediatric patients
• Train in logistics for commodities to ensure no stock outs of laboratory supplies
• Procure and distribute HIV testing commodities
• Train health workers in Early Infant Diagnosis to ensure integration of the services in Maternal and Child Health activities
• Train in Dry Blood spot collection, packaging and transportation
• Procure and distribute MOH HIV testing registers
• Provide technical support supervision by Baylor-Uganda laboratory staff
• Support district Health teams to conduct support supervision
• Support districts to transport DBS samples
Monitoring and Evaluation of the program
• Support the routine collection, compilation, analysis and reporting of program data
• Print and distribute MOH ART cards for capturing data
• Train records staff in records, data management and reporting
• Conduct bi annual review meetings with the districts and key health facility staff

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	1,530,000	

Narrative:

In FY 2010, Baylor-Uganda will continue to provide pediatric HIV/AIDS treatment at the Baylor –Uganda Centre of Excellence (PIDC), 6 Kampala city council satellite clinics and 77 rural health facilities in 35 districts. Our target population will be children and adolescents up to 14 years of age. This is intended to scale up pediatric treatment coverage to nearly 80% of the 364 health facilities currently providing adult HIV/AIDS care and support in the country. 5838 children and adolescents will benefit from this life saving treatment contributing 30% of the country pediatric target of 20,000.

Mechanism: In partnership with MOH, Baylor-Uganda will continue to work with district health offices and management of the 64 health facilities to strengthen pediatric HIV treatment services that were initiated in the previous fiscal year. The strategies will include capacity building through training of health providers, infrastructure improvement, procurement of equipment and commodities and sustenance of human resources for health; community mobilization for pediatric HIV testing, care and support through "know your child HIV status" campaigns and local radio programs; service delivery through provision of integrated comprehensive HIV/AIDS care and functional referral between HIV testing and care; establishing and strengthening existing MOH mechanisms for supervision, monitoring and evaluation.

The strategies will be coordinated through district structures to ensure continuous quality services provision and sustainability of operations.

Activities that provide drugs, food and other commodities:

• Train health workers in pediatric HIV/AIDS management and pediatric HIV/AIDS counseling
• Train community volunteers in home based care to ensure adherence to ART
• Conduct team building exercise to support sustenance of human resources for health
Procure and distribute office supplies and medical supplies to the COE, urban facilities and buffer stocks to the district health facilities
• Conduct radio talk shows addressing pediatric HIV/AIDS issues
• Write news paper articles to create awareness on pediatric HIV/AIDS treatment
• Procure and distribute Information, Education and Communication materials
• Support community outreach & individual child/family psychosocial needs counseling, including coordination of OVC & community program
• Conduct camps for children and adolescents to enhance adherence to ARV drugs, promote positive prevention and build life support skills

Activities for supervision, improved quality of care and strengthening of health services

• Conduct quarterly technical support supervision with district health teams
• Support MOH and district staff to conduct mentorship
• Support the district health teams to conduct monthly support supervision
• Conduct quality improvement projects in collaboration with HIVQUAL program under the Ministry of Health
• Carry out minor infrastructure improvement to secure drug stores for ARV's
• Conduct quarterly drug audit in health facilities and monthly spot audits at the COE
• Conduct value for money audit to ensure proper utilization of drugs
• Participate in International Pediatric HIV/AIDS Conferences/Meetings

Integration with routine pediatric care, nutrition services and maternal health

• Support in-patient care costs for HIV infected children admitted at Acute Care Unit, Mulago Hospital
• Conduct and or support routine HIV testing in all pediatric outpatients and wards in particular nutrition and TB wards

Laboratory support and diagnostics for pediatric patients

• Train in logistics for commodities to ensure no stock outs of laboratory supplies
• Procure and distribute HIV patient monitoring commodities
• Train health workers in Early Infant treatment
• Procure and distribute MOH HIV ART registers
• Provide technical support supervision by Baylor-Uganda laboratory staff

• Support district Health teams to conduct support supervision
• Support districts to transport samples for monitoring labs
Monitoring and Evaluation of the program
• Support the routine collection, compilation, analysis and reporting of program data
• Print and distribute MOH HIV logistics tools for capturing data
• Train records staff in records, data management and reporting
• Conduct bi annual review meetings with the districts and key health facility staff

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	200,000	

Narrative:

The target by age goup in 2009/2010 for AB activities are: 10-14 years, 1,305; 15-24 years, 1,740; = 25 years, 1,305. Overall the sex ratio of persons reached will be, 50% females in age group 10-14, 60% females in 15-24 and 25+ in the implementation periods. Interventions will cover Mulago COE and 84 NEP sites in 2009/2010.

In reaching out to the targeted population, the following activities will be implemented:
• Conduct health education and counseling sessions at COE, Kampala Satellites and national expansion health facilities on clinic days on AB prevention interventions.
• Hold monthly adolescent & youth peer support group meetings that include counseling, health education, condom distribution, etc, targeting 120 individuals per month
• Organize annual adolescent (9 - 11 years) meeting at Sanyuka Camp & children (12 - 18 years) Hope camp; with 80 children participating in both camps.
• Conduct quarterly care givers meetings to discuss AB prevention messages with about 150 participants/meeting
• Train youth and community volunteers in positive prevention.
• Support radio programs that disseminate messages on AB and other prevention.
• Conduct ABC meetings with adolescent and adults
• Produce IEC materials to support health education and community sensitization
• Coordinate advocacy activities for upcountry sites
• Document best practices, print quarterly reports

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	172,686	

Narrative:

Majority of Baylor – Uganda clientele in Kampala are children with an average age of 6 years. This is a

population that needs sexual prevention services of abstinence. In up country sites Baylor – Uganda takes care of both adults and children therefore; requiring the ABC strategy.

In total, 9,650 clients in 2009/2010 and 10,150 clients in 2010/2011 COP periods are targeted. The target for PwP is 5,300 for each budget period, but 4,350 and 4,850 other clients are targeted for 2009/2010 and 2010/2011 respectively. The target by age group in 2009/2010 is: 10-14 years, 600; 15-24 years, 1,740; = 25 years, 1,305. In 2010/2011, the target by age group is: 10-14 years, 1,455 ; 15-24 years, 1,940 ; and = 25 years, 1,455. Overall, 50% of females in age group 10-14, 60% of females in 15-24 and 25+ years will be reached in the implementation periods. Interventions will cover Mulago COE and 76 NEP sites in 2009/2010 and 92 sites in 20/2011.

Health education sessions on AB held bi-annually in NEP sites and quarterly in Kampala clinics and upcountry sites employing the direct mode of service delivery will be conducted for children aged 10-14. As part of the strategy we intend to take HIV prevention messages of Abstinence, AB and ABC (as appropriate) to schools around Kampala. Teachers in selected schools from the different divisions in Kampala will be trained in delivering abstinence, AB and ABC messages to children. In the upcountry schools in the North Eastern and Western regions of the country where Baylor – Uganda operates will be supported to incorporate Abstinence and AB messages in their schools programs.

Family planning and sexually transmitted Infections/Cervical cancer screening services as part of prevention services will continue to be provided at the COE in Kampala. Untreated STIs increase the risk of HIV acquisition and transmission.Therefore, treating them and addressing their sexual and reproductive health needs in a manner that reduces the risk of HIV (re)infection with their partners is vital in sexual prevention program. Identified cases will continue to be managed and referred appropriately. Family Planning and condoms will continue to be provided to clients (who need them) at all supported facilities.
Implementation of sexual prevention interventions is aimed at increasing the proportion of the target audience adopting safer sex practices (abstinence, being faithful and condom use) to reduce the risk of new HIV (re)infection.

In reaching out to the targeted population, the following activities will be implemented:
• Conduct health education and counseling sessions at COE, Kampala Satellites and national expansion health facilities on clinic days on AB and other prevention options.
• Hold monthly adolescent & youth peer support group meetings that include counseling, health education, condom distribution, etc, targeting 120 individuals per month
• Organize annual adolescent (9 - 11 years) meeting at Sanyuka Camp & children (12 - 18 years) Hope camp; with 80 children participating in both camps.

• Conduct quarterly care givers meetings to discuss prevention messages with about 150 participants/meeting
• Purchase Home Based Care kits for home health workers and community volunteers, and supplies for health education
• Procure and distribute condoms, and demonstrate their effective use during counseling, health education talks and service delivery
• Provide sexual and reproductive health services: STI management, family planning and screening of cancer of the cervix
• Train youth and community volunteers in positive prevention.
• Support radio programs that disseminate messages on sexual prevention (AB and others).
• Conduct ABC meetings with adolescent and adults
• Produce IEC materials to support health education and community sensitization
• Coordinate advocacy activities for upcountry sites
• Document best practices, print quarterly reports

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	450,000	

Narrative:

In order to expand and fully integrate paediatric HIV/AIDs care and treatment services in MoH ART accredited health Facilities, Baylor - Uganda will continue to provide basic laboratory equipment, reagents and consumables to all its 84 supported health facilities country wide. In partnership with MoH, training of health facility personnel in Good clinical Laboratory Practice (GCLP), laboratory logistics management and quality improvement/Assurance will be continued with aim of strengthening diagnosis and monitoring of clinical outcomes. Four PointCare equipment have been procured and installed in four regions across the country. Baylor Uganda will continue to procure reagents for running the equipment. In addition, a referral system will be developed for samples tested with PointCare equipment to other selected laboratories with a similar equipment to ensure external quality for the CD4 results generated at supported health facilities. To strengthen internal quality assurance, quarterly monitoring of batch samples collected from the four sites shall be tested at the COE.

Activities supported will be integrated into the overall district health plans to ensure sustainability of programs. These invlude:

• Train Health facility personnel in GCLP and laboratory logistics and supply chain management
• On-site training in dry blood spot collection
• Conduct mentorship and Support supervision visits to sites provided with Point Care Equipment for

CD4 testing in the four sites
• Bi-annually service and maintain Point Care Equipment
• Hold bi-annual meetings with the District laboratory focal persons (DFLP) and facility laboratory in-charges to review the logistics management of laboratory supplies in the district
• Provide support for transportation of laboratory tests that are not performed on-site, including DNA-PCR and CD4 samples.
• To procure and supply all NEP sites with buffer stock for HIV test kits for routine and voluntary counseling and testing
• Procure and supply laboratory equipment (including Hamocue 201/ StatSite Hb machines), supplies & reagents for supported health facilities.
• Facilitate accreditation process of health facility laboratories
• Link all NEP sites to regional reference laboratories (for example JCRC, National TB lab)for proficiency testing for complete blood counts, CD4 and sputum smears
• Lobby district health management team integration of laboratory activities into district health work-plans
• Conduct internal and external quality assurance and quality control programmes for COE and all NEP sites
• Provide Standard Operating Procedures and Bio-safety manuals for reference when performing routine sample testing
• Regularly review Standard Operating Procedures for laboratory practices

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	1,718,750	

Narrative:

Baylor-Uganda currently supports integration of paediatric services in 78 health facilities majority of which are public. Drug supplies are often erratic and not sustained in these facilities. With on-going mobilization we anticipate increase in the number of children to be enrolled and retained in ART program. Many factors including lack of ARVs may affect enrolment, adherence and retention of children into ART, with negative impact on resistance development, treatment failure and subsequent increased childhood morbidity and mortality. To ensure continued enrollment of children into care, Baylor-Uganda will continue to procure and provide ARVs to the more than 4,600 children and a buffer stock for the 11,201 adults currently on ARV's in the supported sites to avoid stock outs. Recommended 1st line & 2nd line regimens for children and 1st line regimens for adults will be procured in line with MOH guidelines.

We plan to procure adult ARVs in order to provide family-centred HIV/AIDS care for infected children and their care givers at the same time and in the same place. Baylor – Uganda will continue to secure ARV drugs from Clinton foundation till October 2010. Paediatric AIDS Canada will provide additional ARVs to

250 children and 50 care givers who are on treatment from Baylor-Uganda supported sites.
Most of ARVs drugs procured by Baylor-Uganda will be accessed through Medical Access.

The family-centred HIV/AIDS care strategy builds on experience at COE, 6 Kampala satellite sites and 5 up-country UNICEF facilities where there was no reported ARV stock outs in the previous year. In the NEP sites, there were no stock outs reported in 60% of the sites. The target is to have 80% of all the supported facilities without ARV stock outs in 2010 and 100% in 2011. Strategies will focus on improving health workers skills in logistics chain management systems and close stock monitoring and drug audits. Up 30% of buffer stocks for paediatric ARVs will be procured in 2009/2010 and 15% of adult ARVs.

Activities:
• Train health care providers in logistics and supplies management
• Fore cast, procure and distribute of both first and second line ARVs for children in the 84 supported sites
• Fore cast, procure and distribute first line ARVs for adult care givers in context of family-centered approach in all supported sites
• Train health providers to compile and submit end of cycle ARV reports
• Install drug storage cabinets for proper storage of ARV stock
• Provide on-going technical support (mentorship, support supervision, tools and systems development) to all Baylor-Uganda supported sites for better ARV management and accountability.
• Procure ARVs for management of Post exposure prophylaxis
• Conduct weekly, monthly and quarterly drug audits in all supported sites
• Provide logistical and operational policies and procedures to accurately forecast, procure and store are availed to Baylor-Uganda health facilities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	296,961	

Narrative:

Baylor – Uganda will collaborate with the National TB/Leprosy Programme and National TB/HIV coordination committee to implement TB activities in all the 84 sites to be supported. Implementation will be based on the National TB/HIV policy guidelines including strengthening coordination mechanisms at District and Health facility levels, contributing to reduction in TB among HIV positive individuals and advocacy, communication and social mobilization for paediatric TB/HIV. Emphasis of Baylor – Uganda's TB/HIV activities will be geared to reducing the inequalities between access to TB care between adults and children.

In order to maintain the district TB/HIV services delivery mechanisms in place, the programme will utilize the available health facility staff and will work in regular consultation with the District TB/Leprosy Supervisor. Support to health facilities and districts will be based on quantified unmet needs identified by the health facility and/or district. Baylor – Uganda's approach will be to strengthen the capacity of the health workers at the facilities to diagnose and manage TB/HIV patients; provide buffer stocks of anti TB drugs, diagnostic supplies and patient management tools for children and adults; and health management Information systems support.

Monitoring and Support Supervision teams will be formed mainly using local capacity, with Baylor-Uganda staff offering support only in areas not covered by district capacity. Health facilities will be supported to collect, analyze and utilize data for TB/HIV services using existing MOH data collection tools.

Activities:
• Perform PPD testing in all children, adolescents and adults attending in high volume clinic attendance health facilities. This will target at least 2600 children
• Support x-ray services for children suspected of TB.
• Procure and distribute buffer stocks of TB diagnostic supplies
• Support TB diagnostic microscopy on sputum, biopsies and nasogastric aspirates.
• Provide buffer stocks of drugs for TB treatment and prophylaxis in all Baylor-Uganda supported health facilities.
• Train health workers through didactic, on site mentorship and support supervision in prevention, diagnosis and management of tuberculosis among HIV infected individuals.
• Initiate TB infection control measures at HIV care clinics by providing face masks to TB cases and health workers
• Perform HIV counseling and Testing for TB patients
• Reproduce and distribute MOH TB/HIV job aides, patient management tools and registers
• Produce and distribute TB/HIV IEC materials in local languages and with particular emphasis on paediatric tuberculosis
• Support the health facilities and districts to record, compile and report TB/HIV data to the MOH TB control program
Accomplishments, lessons learnt and proposed activities to address challenges

During the last year, 945 patients had been targeted to be provided with TB treatment but up to 920 were treated from 44 sites. The inability to reach the target was a result of the lack of appropriate diagnostic skills, materials and equipment in most sites. PPD was only availed at the Mulago centre due to logistical and technical constraints. The PPD vial contains 20 doses which must be used in 24 hours of

opening. This is not feasible for sites that have few patients as it would create wastage. Chest X-ray machines are also available only in limited high level health units. We however piloted supporting patients to travel to where these facilities are available and it worked for one of the centres in Eastern Uganda. This is going to be replicated during this year's COP. In order to improve case finding, Baylor Uganda has recruited a TB/HIV focal person who will work closely with MOH/TB control program team to train health workers in the 84 supported sites in TB/HIV diagnosis and management. Also PPD will be provided to high patient volume facilities while chest x-ray availability mapping will be done and a referral system will be drawn to link patients from facilities that do not have access.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9165	**Mechanism Name: AIDSRelief**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 17,500,850	
Funding Source	**Funding Amount**
Central GHCS (State)	6,264,675
GHCS (State)	11,236,175

Sub Partner Name(s)

TBD		

Overview Narrative

AIDSRelief Uganda is comprised of three of the five AIDSRelief global consortium members, Catholic Relief Services (CRS), Futures Group International, and the Institute of Human Virology of the University of Maryland School of Medicine (IHV). In Uganda, the program also partners with Children's AIDS Fund (CAF). AIDSRelief is funded by PEPFAR through HRSA and CDC and is currently in its sixth year of

program implementation.

As the lead agency in the consortium, CRS provides overall program coordination and oversight for grant administration and compliance, in addition to coordinating overall representation of the grant to USG, local government and other stakeholders. CRS oversees the implementation of all project activities within an effective planning framework and manages the necessary USG financial resources for each consortium member, enabling them to carry out their work based on clear program deliverables within donor-approved funding limits.

The Institute of Human Virology of the University of Maryland School of Medicine (IHV) serves as the clinical lead for AIDSRelief in developing and implementing activities that build our local partners' capacity to provide comprehensive high-quality HIV care and treatment within the framework of National policies and guidelines. IHV oversees services that include testing and counseling; medical, pediatrics, prevention of mother to child transmission, nursing and psycho-social care; adherence training and monitoring; health system strengthening; laboratory services; technology selection; support of palliative care staff; and continuing medical education. The medical strategy is aimed at implementing high quality and sustainable care at each of the sites.

Futures Group manages strategic information through data collection, analysis, monitoring, and generation of reports for donors, government and other key stakeholders. Futures Group is involved in building LPTF capacity in collecting, managing, and analyzing clinical and programmatic information, and is building an accessible patient database. Future sustainability plans include a focus on building partner capacity to use this data not only to practice adaptive patient management but also to ensure improved LPTF planning and management of treatment and care. Finally, Futures Group facilitates sharing and transmission of internal reporting data among consortium members for use in various activities.

Overall site management responsibilities are shared between CRS and CAF. Both organizations ensure that LPTFs receive the strengthening and support they need to provide care and treatment services within the protocols developed by the country's Ministry of Health guidelines and AIDSRelief Uganda.

Currently, AIDSRelief Uganda supports 18 LPTFs providing comprehensive HIV care and treatment services in Northern, Western and Central Uganda. Through these LPTFs and their satellites, the program has provided care to 66,000 patients, of whom 22,000 are on treatment as of April 2009. The program plans to enroll 25,908 patients on treatment by the end of Year 6.

AIDSRelief Uganda is divided into structured program areas including the following: Adult care and treatment, pediatric care and treatment, counseling and testing, supply chain management for ARV and

OI, prevention including AB, laboratory infrastructure, prevention of mother to child transmission, orphans and vulnerable children, finance and compliance, strategic information, community based treatment support, health care management and quality improvement program. The program has also established linkages with the Uganda Ministry of Health (MOH) and other organizations such as the Clinton Foundation and Population Services International in order to increase the services available to HIV patients and their families (e.g. ARV provision, PMTCT, nutrition, and basic care package provision).

Cross-Cutting Budget Attribution(s)

Education	20,000
Food and Nutrition: Commodities	72,388
Food and Nutrition: Policy, Tools, and Service Delivery	24,872

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9165**		
Mechanism Name:	**AIDSRelief**		
Prime Partner Name:	**Catholic Relief Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	296,000	

Narrative:

AIDSRelief supports a comprehensive continuum of care for adults and adolescents (male and female) living with HIV with the goal of prolonging their lives while enhancing its quality. These services are provided at 18 hospitals and clinics and at associated satellites across Northern, Western and Central Uganda with a total of more than 70,000 patients ever being enrolled into care. The adult care and support component builds on existing clinical and social services in all Local Partner Treatment Facilities (LPTFs), extending the scope and reach of these services by integrating facility based care delivery systems with community and home-based mechanisms. This is accomplished by employing networks of community-based organizations, community health workers and volunteers, treatment supporters and

patient support groups.

The program provides access to a comprehensive care package that includes routine scheduled clinical follow-up, access to unscheduled clinical visits for the management of acute illness and routine CD4 testing for all patients enrolled in care. In addition it provides for comprehensive diagnosis and treatment of opportunistic infections and HIV associated conditions including but not limited to TB, cryptococcal meningitis, pneumocistis jeroverci, Kaposi's sarcoma; diagnosis and treatment for other acute illnesses including but not limited to malaria, community acquired pneumonia; facilitation with hospitalization for enrolled patients; and with the management of co-morbid chronic conditions such as cardiovascular disease, diabetes and hypertension; routine health screening including TB, STI and pregnancy screening. In Y2010 AIDSRelief will explore the possibility of piloting routine cervical cancer screening for women. The AIDSRelief OI Drug Policy and treatment manual, including a list of essential OI drugs and reporting template, provides a guide the sites in the procurement, utilization and reporting on consumption of OI and other non-ARV drugs used in the program.

A guiding principle of the AIDSRelief program is to provide services as close to the end user as possible and to link those services to facilities through an integrated system of referrals. In order to ensure that this happens efficiently while preserving the quality of patient care AIDSRelief encourages and supports LPTFs to open satellite clinics and community based outreach centers. The decentralization of HIV services through satellite sites and outreaches increases accessibility of these services for those who live in remote areas. As such, this is an important component of the AIDSRelief strategy to reduce loses to follow-up and promote patient retention. All LPTFs have outreach teams led by a community nurse or a clinical officer. These teams are linked with community based volunteers, many of whom are PLWHAs, emphasize adherence to clinical appointments and assist the facilities in tracking patients who have missed appointments. As a result there has been very good retention rate for patients in care. The teams also provided community based and household preventative services which included education on the importance of disclosure, prevention among positives, using Insecticide Treated Mosquito Nets (ITNs), basic hygiene, use of safe water and good nutrition. The teams have also been trained to provide basic health and symptom assessments and to refer ill patients to the parent facility for timely medical management. These strategies are intended to limit mortality and morbidity among patients in care who have not yet qualified for ARVs.

The AIDSRelief program emphasizes the strengthening linkages among the different services provided at the LPTFs and among the LPTFs and other service providers. This increases overall service delivery, and ensures greater coordination and integration of services provided within the community. In particular, the referral linkages between ANC, PMTCT and ART services enable HIV positive mothers who don't yet require ARVs, their partners and their exposed babies to access ART services including

community follow-up. This promotes partner testing and loses to follow-up of women and their infants after delivery. The program has recognized the strong link between access to nutritional support and the successful provision of care to HIV infected individuals. However, providing this access remains a significant challenge. LPTFs have been encouraged to link with other organization able to provide food, especially for severely malnourished PHAs. Training and guidance (national guidelines in nutrition and HIV/AIDS) is provided to staff at LPTFs so that they can conduct nutritional assessment, education and counseling at facility and community and clinical levels.

AIDSRelief also employs a training model that includes didactic trainings, on site supportive supervision and clinical preceptorship for service providers, with a special emphasis on maximizing the role of nurses, adherence counselors and community workers. Activities included training of health workers in improved pain and symptom evaluation and control; recognition of signs and symptoms opportunistic infections and other common illnesses and appropriate referral for management. Activities include comprehensive training for 720 non-medical community workers as well as 290 medical staff to support and maintain care and treatment for all PLWHAs and their home caregivers. Extensive technical support is also provided to all LPTFs through quarterly week-long site visits made by the technical team and regular comprehensive CMEs.

FY 2010 activities

In FY2010 AIDSRelief AIDSRelief will continue to support a comprehensive and integrated continuum of care for HIV infected patients building on existing services at the LPTFs. Services provided will comprise psychosocial support, prevention for positives, clinical follow-up and assessment for ART eligibility, laboratory testing (including CD4), treatment of opportunistic infections, HIV associated conditions and other illnesses, and nutrition counseling and education for the 43,146 adult HIV + patients enrolled in care in 18 LPTFs and their satellites. AIDSRelief will also be strengthened linkages with other health facility services, especially for PMTCT and TB. Technical support activities will be concentrated in these areas of focus: On consolidating the quality of services provided at existing LPTFs and satellite sites in order to support the 43,146 adult and adolescent patients in care; on building capacity at LPTFs for greater technical independence in view of transitioning; on the devolution of services to alternate cadres of service providers through 'task shifting,' networking with other service providers, and on greater integration into the overall Ministry of Health response in view of sustainability.
At the LPTFs, the strategy for task-shifting will focus on protocols enabling nurses and other cadres be more involved in the routine follow-up of stable patients, in the management of non-critical acute symptoms, in routine medication dispensing to stable patients; in routine TB screening of patients and in the recognition of patients requiring transition from care onto treatment.

The AIDSRelief technical team will continue to provide comprehensive training and technical assistance to 200 medical and 30-40 non-medical staff aimed at increasing the capacity of LPTFs to appropriately manage patients with HIV infection. This technical assistance will target the recognition and management of opportunistic infections (particularly TB), treatment failure, adult counseling, and psycho-social assessments.

AIDSRelief will follow-up didactic training with on- site clinical mentorship for clinicians and site level support for other cadres of workers. AIDSRelief will continue the development a network of model centers from exemplary LPTFs, where practitioners can gain practical clinical experience in a controlled setting. Regional Continuous Medical Education Sessions and Partner Forums will complement LPTF's staff training, allowing experience sharing, and reinforcing knowledge and skill transfer from AIDSRelief technical staff. The AIDSRelief team will develop a training and mentorship program that prepares senior medical officers, clinical officers, nurses and counselors at the LPTFs to provide supportive supervision and mentorship to dependent satellites and to newly hired staff. A structured program of nurse refill services will also be implemented at selected LPTF

At the community level, AIDSRelief will encourage further development of community based satellite clinics and outreach staffed by clinical officers and nurses for the routine care of stable patients and a community health team for the delivery of home based care and medications; this will include the development of linkages to MoH supported village health teams. The decentralization of HIV services through the use of satellites and outreach will aim at increasing access to those who live in remote areas. This approach reinforces AIDSRelief's model of providing integrated services to families at the community level by inter-linking facility-based health providers and community health workers and volunteers in order to meet the needs of HIV/AIDS patients. AIDSRelief will continue providing education on the importance of using ITNs, basic hygiene and good nutrition at household and community levels. It will further enhance its community health programs by promoting family-based care through home-based symptom monitoring, disclosure counseling, comprehensive secondary prevention (prevention among positives), and family-based testing and education.

In FY 2010, LPTF community volunteers will continue to support patients in care through the dissemination of HIV care and prevention literacy. AIDSRelief will identify gaps in the media and adapt or develop locally appropriate Information Education and Communication (IEC) and Behavior Change Communication (BCC) materials on prevention, care, and treatment of HIV. AIDSRelief will also assist LPTF develop networks with PLHA groups serving as volunteers in the community to strengthen adherence programs. Emphasizing the importance of adherence and community linkages at all AIDSRelief supported sites has enabled the program to achieve high rates of retention.

The program will also strengthen linkages with other service providers operating within the communities served by AIDSRelief supported facilities. Current relationships with organizations such as PACE and UHMG (Uganda Health Marketing Group) will be strengthened in order to increase access to ITNs (to prevent spread of malaria) and clean water at all LPTFs. In addition, the program will link LPTFs to the Ministry of Health to access cotrimoxazole and malaria treatment. Reinforcing the integration of services that can be accessed through LPTFs will enhance the overall package of care available to adults.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	300,000	

Narrative:

AIDSRelief implements the OVC program along side its care and treatment programs targeting children ages 0-17 years, which are infected with and/or affected by HIV. The goal of the OVC program is to increase access to services for children infected with and/or affected by HIV. The program directly provides psychosocial support to OVC as one of the OVC core program areas and ensures that linkages for other OVC core services are created to reduce the OVC service gap.

During FY010, the OVC program will focus on strengthening families, community support and coordination as well as increasing data development for use in strategic planning. All 18 AIDSRelief LPTFs will work with community leadership to mobilize the caregivers and children to respond to the identified needs of the vulnerable children aged 0-17years (male and female). The identified needs will include food security, with special focus on training and supporting households with food production (e.g. Kitchen Gardens, support with farms inputs and seeds). In addition to provision of inputs, the program will also train caregivers and OVC peer leaders in nutritious feeding, safe food storage and appropriate use. This intervention will target the entire household while directly working with the caregivers who will, in turn, work with their children to improve food security within their respective households. A total of approximately 2000 care givers/households will be trained and receive seeds to do kitchen gardens which will in turn benefit a total of 8000 children .

Education support will be extended to children in primary and secondary schools. The program will support the government initiative to promote universal primary and secondary education in government funded schools. Children will be provided with scholastic materials such as exercise books, pens/ pencils, school uniforms. Those already out of school OVC will be encouraged to return to school to complete at least senior four while others will be linked to other organizations supporting vocational skills training. A total of 6400 children are expected to be supported with education. Indirectly, the program will reach out to the 0-5 year olds through their caregivers by providing training programs in early childhood development, with specific emphasis on communication skills with children, socialization, self confidence,

and motor skills.

Psychosocial support will be a cross cutting activity during FY010. The program will continue to ensure that it provides a comprehensive OVC psychosocial package that caters for the provision of age appropriate life skills to meet their social, physical, emotional and spiritual needs. A total of 8000 OVC both infected with and affected by HIV will be targeted.
This program will mainly be implemented through the OVC peer support groups already formed at each AIDSRelief implementing site (at the community level). These groups will be encouraged to come up with innovative ways to engage and sensitize members about various issues of concern to the OVC. Each group will be attached to one or two community volunteers who will act as the patron of the group. Such innovative ideas might include activities like music, dance and drama, weekly sensitization meetings and methods for economic empowerment.
Retreats will also be major activity to be implemented under psychosocial support and these will be organized twice a year. The purpose of the retreats is to promote peer to peer learning. HIV awareness talks will also be conducted during the retreats by the counselors and community health workers.
Community mobilizations for voluntary counseling and testing will be done to ensure that caregivers are aware of their HIV status as well as their children's status and thus be able to obtain HIV support services early enough. Children found to be HIV positive and their caregivers will be referred to AIDSRelief sites for enrollment into care. A total of about 10,133 children are expected to be reached with VCT community services to be provided either through AIDSRelief or through leveraged support from organizations such as GOAL, TASO etc.

Child protection services will be another core program area to be implemented under the AIDSRelief OVC program. This program will ensure that children are protected from harm and abuse and can exercise their rights as elaborated in the UN convention on the rights of a child. The program recognizes that all children are vulnerable but orphans and children living with HIV or whose parents or guardians are living with HIV are more at risk of facing various forms of emotional, physical and psychological abuse, including neglect and exploitation. Children's rights need to be protected in full. During FY2010, the program will develop active collaboration and referral mechanisms with local authorities responsible for child protection and labor such as the probation officers under the police department and the women and child welfare officers within the local council administrative units. It will also support training of caregivers and older children and communities in child rights and conduct sensitization on rights to property inheritance. Trainings will also cover the recognition of signs of abuse and how to obtain appropriate support services from within their localities. This program will also work hand in hand with teachers and school authorities to create protective learning environments in school to encourage retention. A total of about 2000 care givers/ 8000 children will benefit from this program.
The program will also sensitize local authorities such as the local council representatives (women

leaders, child welfare officers, youth leaders) as well as the community volunteers on the right of children to protection. One training per implementing site will be organized during the year targeting a total of ten leaders in each site.

Lastly, the program will continue to build capacities of health workers, social workers and community volunteers at LPTFs , enabling them to identify OVC both at the health facilities and in the community, enroll them into the program, and link them for comprehensive OVC packages. Specific regional trainings in OVC management will be provided for LPTF health workers and volunteers with facilitators from the consortium member staff and Ministry of Health, Ministry of Gender, Labor and Social development. The trainings for health workers will enhance skills for providing OVC friendly services such as empathy skills, counseling and listening skills as well supervision and monitoring of OVC activities. Training for community health workers will include identification and referral of sick OVC to health facilities for necessary health services. A total of 600 health workers and community volunteers / OVC peer educators will be trained.

With respect to strategic information activities, Futures Group International will continue to utilize paper-based and computerized patient monitoring and management systems. All the 18 LPTFs will continue to receive site visits and technical assistance, in order to ensure continued quality data collection, data entry, date validation, analysis and dissemination of findings across a range of stakeholders. In FY 2010, further efforts will be made to track OVC at community level using existing infrastructure and resource persons like community volunteers. LPTF staff will be trained to acquire additional skills in tracking, monitoring and reporting on OVC activities using the update OVC tracking tools. The training will also focus on understanding the various definitions of OVC activities, core program areas and as well as means of avoiding double counting.

Sustainability lies at the heart of the AIDS Relief program, and is based on durable therapeutic programs and health systems strengthening. AIDSRelief will focus on the transition of management or care and treatment activities to indigenous organizations by actively using its extensive linkages with faith based groups and other key stakeholders to develop a transition plan that is appropriate to the Ugandan context. The plan will be designed to ensure the continuous delivery of quality OVC ctivities to be implemented in close collaboration with the Government of Uganda to ensure coordination, information sharing and long term sustainability. For the transition to be successful, sustainable institutional capacity must be present within the indigenous organization and the LPTFs they support, therefore, the AIDSRelief will strengthen the selected indigenous organizations according to their assessed needs, while also continuing to strengthen the health systems of the LPTFs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HTXS	5,895,941	

Narrative:

AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLWHAs, their family, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have access to Antiretroviral Therapy (ART) and quality medical care in order to prolong their lives and to enhance its quality. As of the end of February 2009, AIDSRelief in Uganda will be supporting 18 LPTFs and 33 satellite sites to provide antiretroviral treatment to 22,908 adult patients.

The adult care and treatment component has built on existing clinical and social services in all LPTFs extending the scope and reach of these services by integrating facility based care delivery systems with community and home-based mechanisms for delivering care and treatment support. This is accomplished by employing networks of community-based organizations, community health workers and volunteers, treatment supporters and patient support groups. The program provides adult and adolescent men and women with 1st line, alternative 1st line, and 2nd line therapies. To date the program has provided ARV treatment to more than 22,000 adult patients. The choice of first line regimens supported by the program are consistent with national guidelines while using best evidence for optimizing tolerability, limiting toxicity, reducing pill burden and preserving the activity of second line options. In addition, the comprehensive care package that the program supports includes access to routine scheduled clinical follow-up, access to unscheduled clinical visits for the management of acute illness and routine CD4 testing for monitoring patient response to therapy. It provides access to targeted clinically driven viral load testing to assist in the management of patients whose response to treatment is not readily ascertained by clinical and immunologic means alone. In addition to assuring access, through MOH, donor and private means, to cotrimoxazole prophylaxis and alternatives for sulfa-allergic for all patients, the program provides for comprehensive diagnosis and treatment of opportunistic infections and HIV associated conditions including but not limited to TB, cryptococcal meningitis, pneumocistis jeroverci, Kaposi's sarcoma; diagnosis and treatment for other acute illnesses including but not limited to malaria, community acquired pneumonia; hospitalization linkages for enrolled patients; and with the management of co-morbid chronic conditions such as cardiovascular disease, diabetes and hypertension; routine health screening including TB, STI and pregnancy screening.

In Y2010 AIDSRelief will explore the possibility of piloting routine cervical cancer screening for women as well as the introduction of INH prophylaxis for patients with preserved immune systems, evidence of TB exposure and no evidence of active TB disease. The AIDSRelief OI Drug Policy and treatment manual, including a list of essential OI drugs and reporting template, provides a guide to the sites in the procurement, utilization and reporting on consumption of OI and other non-ARV drugs used in the program.

AIDSRelief encourages and supports LPTFs to open satellite clinics and outreach centers. The decentralization of HIV services through satellites and outreaches increases accessibility of these services for those who live in remote areas, facilitates clinical follow-up, monitoring of adherence and tracking of patients who may be lost to follow-up. All LPTFs have outreach teams led by a community nurse or a clinical officer. These teams were linked with community based volunteers, many of who are PLWHAs themselves on treatment. These volunteers are trained to assess for side effects and to monitor adherence at the community and in patient's homes. These teams are an integral component of the structured treatment preparation and treatment support program that is emphasized by AIDSRelief. This program includes an emphasis on disclosure to a partner, family member or close friend, on treatment buddies, home visitation, membership in a support group, individual and group treatment preparation sessions, on going facility and community based adherence assessment and counseling. As a result there has been very good retention rate for patients on ART and an average adherence rate of over 95%. The teams also provided community based and household preventative services which included education on the importance of using ITNs, basic hygiene and good nutrition.

The AIDSRelief program emphasizes maintaining and strengthening linkages and networks among the different services provided at the LPTFs and among the LPTFs and other service providers. These linkages promote a more efficient provision of health care delivery by promoting overall health systems strengthening. In particular, the referral linkages between ANC, PMTCT and ART services enable HIV positive mothers, their partners and their babies to access ART services at the facilities. This promotes greater male involvement, facility based delivery; and reduces losses to follow-up of positive mothers and their exposed infant.

AIDSRelief employs a training model that includes didactic sessions, on site supportive supervision and clinical mentorship, and periodic CMEs for service providers. The program emphasizes maximizing the role of nurses, adherence counselors, dispensers and community workers. Activities include training of health workers in improved pain and symptom evaluation and control, recognition of and appropriate referral for management of signs and symptoms of ARV toxicity, treatment failure and opportunistic infections (OIs).

In addition to the use for routine CD4 testing for monitoring response to treatment, AIDSRelief evaluates the clinical outcomes of the program by systematically relating patient outcome measures such as viral suppression rates, adherence, and treatment support models to program level characteristics at each LPTF. This assessment is done on a random selection of 15% of the patients on treatment. This assessment has demonstrated viral suppression rates over 15 months of greater than 85%.

FY 2010 activities

In FY2010 AIDSRelief support will comprise provision of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. Technical support activities will be concentrated in the following areas of focus: On consolidating the quality of services provided at existing LPTFs and satellite sites; on building capacity at LPTFs for greater technical independence in view of transitioning; and on the devolution of services to alternate cadres of service providers through 'task shifting', on networking with other service providers, and on greater integration into the overall Ministry of Health response in view of sustainability. At the LPTFs, the strategy for task-shifting will focus on protocols enabling nurses and other cadres to be more involved in the routine follow-up of stable patients, in the management of non-critical acute symptoms, and routine medication dispensing to stable patients. This will increase service delivery, and ensure greater coordination and integration of services provided within the community.

The AIDSRelief technical team will continue to provide comprehensive training and technical assistance to medical and non-medical staff aimed at increasing the capacity of LPTFs to appropriately manage patients with HIV infection. This technical assistance will target the recognition and management of opportunistic infections (particularly TB), treatment failure, adult counseling, and psycho-social assessments. AIDSRelief will follow-up didactic training with on- site clinical mentorship for clinicians and site level support for other cadres of workers. Regional Continuous Medical Education Sessions and Partner Forums will complement LPTF's staff training, allowing experience sharing, and reinforcing knowledge and skill transfer from AIDSRelief technical staff. The AIDSRelief team will develop a training and mentorship program that prepares senior medical officers, clinical officers, nurses and counselors at the LPTFs to provide supportive supervision and mentorship to dependent satellites and to newly hired staff. A structured program of nurse refill services will also be implemented at selected LPTFs.

At the community level, AIDSRelief will encourage further development of community based satellite clinics and outreaches staffed by clinical officers and nurses for the routine care of stable patients and a community health team for the delivery of home based care and medications; this will include the development of linkages to MoH supported village health teams. The decentralization of HIV services through the use of satellites and outreach will aim at increasing access to those who live in remote areas. This approach reinforces AIDSRelief's model of providing integrated services to families at the community, satellite sites and LPTFs level by inter-linking facility-based health providers and community health workers and volunteers in order to meet the need of HIV/AIDS patients. AIDSRelief will further enhance its community health programs by promoting family-based care through symptom monitoring, disclosure counseling, secondary prevention, and family-based testing and education.

In FY 2010, LPTF community volunteers will continue to support patients on therapy, but will additionally disseminate HIV care and prevention literacy. AIDSRelief will identify gaps in the media and adapt or

develop locally appropriate Information Education and Communication (IEC) and Behavior Change Communication (BCC) materials on prevention, care, and treatment of HIV. AIDSRelief will also assist LPTF to strengthen networks with PLHA groups serving as volunteers in the community to strengthen adherence programs. Emphasizing the importance of adherence and community linkages at all AIDSRelief supported sites has enabled the program to achieve high and durable viral suppression.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	150,000	

Narrative:

In FY2009 AIDSRelief procured test kits to carry out tests through community outreaches and at the health facilities. The program, in addition, integrated counseling and testing services into AB and OVC activities. This encouraged couples who participated in the Faithful House trainings and the youth who participated in the Value of Life trainings to undergo HIV testing. The program encouraged LPTFs to strengthen their linkages with the Ministry of Health for additional support in provision of HIV Test kits to supplement on those procured by AIDSRelief.

AIDSRelief has built strong community networks and has also provided mentoring at all LPTFs on counseling and testing. In Northern Uganda Community based organization Comboni Samaritans of Gulu, Meeting Point and Christian HIV/AIDS Prevention and Support (CHAPS) have been following up patients on ART treatment as well as carrying out community mobilization and sensitization. In other LPTFs AIDSRelief has encouraged the enrollment of community volunteers who have played a key role in mobilizing the community, linking them to counseling and testing facilities. The clients that test positive are further linked to AIDSRelief care and treatment facilities. Those that test negative are encouraged to join existing community groups that assist in the retention of the negative HIV status.

In FY2010, through greater coordination and integration of services provided within the community by networking with other service providers including the Ministry of Health, AIDSRelief will endeavor to strengthen counseling and testing services. In the area of testing and counseling the program will focus on three essential aspects: strengthening the capacity of LPTFs to perform CT at satellites, at community outreaches; integrating RTC in all clinical areas of the facilities it supports; enhancing referral networks between the LPTFs and other service providers in their areas to ensure that all patients identified as positive are referred to HIV care and services. Due to limited funding AIDSRelief will support LPTFs to build strong referral networks to access C&T and those people who test positive are referred for care and treatment to other service providers.

Decentralizing counseling and testing services to satellite sites, community outreaches and integrating

RCT will enable community members to have easier access to testing and counseling services and will increase HIV status awareness particularly among under-represented populations such as men and children in line with Ministry of Health Guidelines. Community volunteers, especially people living with HIV/AIDS (PLHA) who have been trained on how to engage communities, will mobilize communities to come for these services and will continue to be supported in this role by AIDSRelief. These will serve as key agents in linking household members, communities and CT services. The existing system of networks from the service provision all the way to the household level will ensure that couples, children and adolescents receive CT services in line with the Ministry of Health Guidelines.

In FY2010, AIDSRelief will continue to emphasize the importance of providing pediatric CT services in line with the Ministry of Health Guidelines. This emphasis will be supported by ongoing pediatric counseling training aimed at enhancing the capacity of LPTFs to increase the number of children being tested for HIV.)

In FY2010, AIDSRelief will support LPTFs to provide CT services through which the program expects to have 40,000 people tested, counseled and receiving their results. In order to address LPTFs challenges of test kits shortages, AIDSRelief will strengthen the linkages of the sites with MOH supply chain system and will purchase kits for 8,000 tests to temporarily fill the gap created. Linkages will be created between the MCH, out- and in-patient departments promoting routine counseling and testing and targeting families of infected patients. A concerted effort will be made to reach adolescents through collaborations with organizations that target adolescent services.

AIDSRelief will further strengthen the existing PLHA networks and will utilize them to sustain the active referral systems between communities and care and treatment services. Community volunteers will be trained to increase knowledge on HIV care and treatment and to reinforce their role in conducting community sensitization on CT services. A total of 200 health workers and 30-40 community volunteers will be trained.

AIDSRelief will support the LPTFs to integrate Counseling and testing services within the AB trainings and community activities that focus on OVCs. This will encourage couple testing as well as the OVCs will know their HIV status and those that are positive will be linked into care and treatment facilities.

Coordinated by Futures Group International, strategic information (SI) activities incorporate program level reporting, enhancing the effectiveness and efficiency of both paper-based and computerized patient monitoring and management (PMM) systems, assuring data quality and continuous quality improvement, and using SI for program decision making across all LPTFs. AIDSRelief has built a strong PMM system using in-country networks and available technology at 18 LPTFs in FY 2009. In FY 2010, it will ensure

compilation of complete and valid HIV patient treatment/ARV data; enhance analysis of required indicators for quality HIV patient treatment and ARV program monitoring and reporting; and provide relevant, LPTF-specific technical assistance to develop specific data quality improvement plans. The program will promote M&E systems through a Training of Trainers (TOT) and peer to peer training model in SI, where "expert" LPTF staff will train others in various skills. AIDSRelief will promote the data use culture, to enable LPTFs use data for informed clinical decisions and adaptive management. The program will work with LPTFs to document and report individuals counseled, tested, and received results, including family members. This information will show those eligible to enroll into care, discordant couples, and those who should be targeted with prevention messages. Technical assistance will be provided to LPTFs on how to eliminate double counting of repeat testers, identifying clients testing under other program areas such as PMTCT and TB, and putting in place data collection tools to track CT information

In FY 2010, the program will work with LPTFs to implement and strengthen integration of the HIV clinics into mainstream hospital/facility M&E systems. This will involve: cross program training on different data needs and indicators; linking both paper and electronic data collection and storage systems for the facilities; working with LPTF management and boards to understand and respond to their data demand and information use needs; use the data to inform and support decisions for the HIV clinics and entire facility. It will also involve organizing joint meetings to share information. To enhance data access and utilization across a wide spectrum of the facility, various sections within the facility will be linked to the patient management system, and staff trained in the use of the system.

Sustainability lies at the heart of the AIDSRelief program, and is based on durable therapeutic programs and health systems strengthening. AIDSRelief will focus on the transition of the management of care and treatment activities to indigenous organizations by actively using its extensive linkages with faith based groups and other key stakeholders to develop a transition plan that is appropriate to the Ugandan context. The plan will be designed to ensure the continuous delivery of quality HIV care and treatment, and all activities will continue to be implemented in close collaboration with the Government of Uganda to ensure coordination, information sharing and long term sustainability. For the transition to be successful, sustainable institutional capacity must be present within the indigenous organizations and LPTFs they support; therefore, AIDSRelief will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2010, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	74,000	

Narrative:

AIDSRelief supports a comprehensive continuum of care for children and adolescents (male and female) below the age of 18 living with HIV with the goal of prolonging their lives while enhancing its quality. These services are provided at 18 hospitals and clinics and at associated satellites across Northern, Western and Central Uganda. The pediatric care and support component builds on existing clinical and social services in all LPTFs, extending the scope and reach of these services by integrating facility based care delivery systems with community and home-based mechanisms. This is accomplished by employing networks of community-based organizations, community health workers and volunteers, treatment supporters and patient support groups.

The program provides access to a comprehensive care package focused on a holistic family-centered approach. This package includes routine scheduled clinical follow-up, access to unscheduled clinical visits for the management of acute illness and routine CD4 testing for all patients enrolled in care. In addition it provides for comprehensive diagnosis and treatment of opportunistic infections and HIV associated conditions including but not limited to TB, cryptococcal meningitis, pneumocistis jeroverci, Kaposi's sarcoma; diagnosis and treatment for other acute illnesses including but not limited to malaria, community acquired pneumonia; hospitalization linkages for enrolled patients; routine health screening including TB and, where appropriate, STI and pregnancy screening. The AIDSRelief OI Drug Policy and treatment manual, including a list of essential OI drugs and reporting template, provides a guide the sites in the procurement, utilization and reporting on consumption of OI and other non-ARV drugs used in the program.

The AIDSRelief family centered approach acknowledges the central role of the family as the unit of health care provision for children and adolescents. It also acknowledges the importance of delivering health care service to children in a manner that is 'child-friendly and that engages the child whenever possible as an active, essential and valued participant in their health care. This includes the provision of a program of pediatric psycho-social support that encourages disclosure of their status to children when it is possible and appropriate.

The program has recognized the strong link between nutritional inputs and the provision of comprehensive HIV care for children. However this remains a significant challenge. While AIDSRelief supports limited access to therapeutic nutrition these resources are hardly sufficient to meet the need. To bridge the gap, LPTFs have been encouraged to link with other organizations to able to provide food, especially for severely malnourished patients. Training and guidance according to national guidelines in nutrition and HIV/AIDS is provided to staff at LPTFs so that they can conduct nutritional assessment, education and counseling at community and clinical levels.

In FY2010 AIDSRelief will concentrate on consolidating the quality of services provided at existing LPTFs

and satellite sites. In many of the regions supported by AIDSRelief access to pediatric care and treatment services is limited. AIDSRelief has identified bringing more infants and children into care and treatment as an area of targeted expansion and urges increased funding for this. AIDSRelief will assure integration and linkages between ANC, Labor and Delivery Services, Maternal and Child Health and Immunization services to identify and enhance the follow-up of HIV infected mothers and their exposed children. AIDSRelief will maintain linkages with JCRC and other groups, which provide access to early infant diagnosis so that all HIV exposed infants delivered can be diagnosed in a timely manner, receive their results and be referred for comprehensive HIV care. To assure continuity of care and to minimize losses to follow-up all exposed children will be followed up in the ART program until they are at least 2 years old and are documented negative. After this they will continue to access services through the OVC program. Strengthening provider-initiated testing in out and inpatient pediatric services has also been recognized as an important strategy for identifying HIV infected children. Consequently, AIDSRelief will strengthen referral linkages among pediatric OPDs, pediatric inpatient services and the ART clinic in order to assure increased testing and that those children found positive are referred for comprehensive HIV care.

In FY2010, AIDSRelief will, in accordance with national guidelines promote prophylaxis with cotrimoxazole from 6 weeks of age with a goal of assuring that all exposed infants and positive children receive this service. In an effort to ensure that all children and their families have access to the basic care package, linkages with organizations such as PACE and UHMG will be strengthened in order to increase access to a basic health care package comprising ITNs and water guard. In addition, the program will continue to ensure that nutritional assessment, education and counseling are provided to caretakers and their children at LPTFs. The program will strengthen integration of the nutrition component into the LPTFs adherence and community outreach activities. In order to assure that all children receiving services at AIDSRelief supported facilities receive comprehensive age appropriate psycho-social counseling and treatment and adherence support, the AIDSRelief program will provide training and technical assistance to all service providers in the area of pediatric psycho-social counseling. This training and TA will utilize both the existing technical expertise within AIDSRelief as well as collaboration with regional networks such as ANNECA.

Task shifting to maximize human resources will be emphasized at facility and community levels. At LPTFs, the strategy will focus on using nurses and clinical officers for the routine follow-up of stable patients, using protocol driven nurse and clinical officer management of non-critical acute symptoms; nurses and pharmacy staff will also be trained in routine medication dispensing to stable patients. In line with a family centered approach to care, at the community level, AIDSRelief will encourage the development of community based satellite clinics and outreaches staffed by clinical officers/nurses/community health workers for the routine care of stable patients and the use of

community health teams for the delivery of home based care and for medication delivery.

The decentralization of HIV services satellites and outreaches will increase access to those who live in remote areas. This approach reinforces AIDSRelief's model of providing integrated services to families at the community by inter-linking facility based health providers and community health workers and volunteers. AIDSRelief supported facilities are currently providing varying levels of home based care, ARV treatment support and community preventative services using outreach teams led by a community nurse or a clinical officer. The outreach teams coordinate with CHWs and community based volunteers, many of whom are motivated PLHAs themselves on treatment to support patients in their communities. Further development of these community health programs to provide integrated HIV care, support adherence and promote preventative services is critical to ensuring sustainable treatment programs and maximizing funding investments. Community health programs will be structured to promote family based care through symptom monitoring, disclosure counseling, secondary prevention, and family based testing and education. In addition, the LPTFs' community volunteers will be used as resources to support patients on therapy, disseminate HIV care and prevention literacy. AIDSRelief will adapt existing, locally appropriate Information Education and Communication (IEC) and Behavior Change Communication (BCC) materials. AIDSRelief will provide education on the importance of using ITNs, basic hygiene and good nutrition at household level and to communities. AIDSRelief will assist LPTF to strengthen their networks with PLHA groups who serve as volunteers in the community in support of adherence programs. AIDSRelief supports several LPTFs in Northern Uganda and will continue to assist them in developing outreach programs that provide support to those affected by internal displacement. The program will also strengthen linkages within the LPTFs, particularly those between PMTCT, TB and CT services with ART services. LPTFs will also be linked to organizations that provide community based therapeutic feeding programs to support the malnourished. In addition, the program will link LPTFs to the Ministry of Health to access cotrimoxazole and malaria treatment. Reinforcing LPTFs external and internal integration will ensure that core AIDSRelief care and treatment activities will be integrated with ancillary services and program activities of other providers in the same region.

Pediatric technical capacity is an area of emphasis for AIDSRelief. The program will continue to assure that all involved cadres of service providers have the capacity to provide age appropriate services to children. To accomplish this, the technical team, using a model of clinical training and on-site mentoring, will provide comprehensive pediatric training and technical assistance to medical and non-medical staff to increase the capacity of LPTFs to appropriately manage and monitor pediatric patients with HIV infection. AIDSRelief will provide training in pediatric counseling and will strengthen LPTF staff capacity to develop community based psycho-social assessments. AIDSRelief is developing a network of model centers where practitioners can gain practical clinical experience in a controlled setting. 12 Regional CME (including 3 focusing on pediatrics and 3 on PMTCT) and one partners' forum will complement LPTF's

staff training, allow experience sharing and reinforce knowledge and skill transfer from AIDSRelief technical staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	1,473,985	

Narrative:

AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLWHAs, their family, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have access to Antiretroviral Therapy (ART) and quality medical care in order to prolong their lives and to enhance its quality. As of the end of February 2009, AIDSRelief in Uganda will be supporting 18 LPTFs and 33 satellite sites to provide antiretroviral treatment to 3,000 children.
The pediatric care and treatment component has built on existing clinical and social services in all LPTFs extending the scope and reach of these services by integrating facility based care delivery systems with community and home-based mechanisms for delivering care and treatment support. This is accomplished by employing networks of community-based organizations, community health workers and volunteers, treatment supporters and patient support groups. The program provides children and adolescents with 1st line, alternative 1st line, and 2nd line therapies. The choice of first line regimens supported by the program are consistent with national guidelines while using best evidence for optimizing tolerability, limiting toxicity, reducing pill burden and the preserving the activity of second line options.

The comprehensive care package that the program supports includes access to routine scheduled clinical follow-up, access to unscheduled clinical visits for the management of acute illness and routine CD4 testing for monitoring patient response to therapy. It provides access to targeted clinically driven viral load testing to assist in the management of patients whose response to treatment is not readily ascertained by clinical and immunologic means alone. In addition to assuring access to cotrimoxazole prophylaxis and alternatives for sulfa-allergic for all patients, the program provides for comprehensive diagnosis and treatment of opportunistic infections and HIV associated conditions including but not limited to TB, cryptococcal meningitis, pneumocistis jeroverci, Kaposi's sarcoma; diagnosis and treatment for other acute illnesses including but not limited to malaria, community acquired pneumonia; hospitalization linkages for enrolled patients; routine health screening including TB screening. In FY2010 AIDSRelief will initiate the introduction of INH prophylaxis for children with evidence of TB exposure and no evidence of active TB disease.

AIDSRelief in Uganda will provide antiretroviral treatment for 3,000 HIV-infected children below 15 years of age. In FY2010 AIDSRelief will concentrate on consolidating the quality of services provided at the existing LPTFs and satellite sites with the goal of maintaining these 3,000 pediatric patients on

AIDSRelief provided ART (13%)

The program has recognized the strong link between nutritional inputs and the provision of successful HIV treatment for children. However this remains a significant challenge. While AIDSRelief supports access to therapeutic nutrition these resources are hardly sufficient to meet the need. To bridge the gap, LPTFs have been encouraged to link with other organizations to able to provide food, especially for severely malnourished patients. Training and guidance according to national guidelines in nutrition and HIV/AIDS is provided to staff at LPTFs so that they can conduct nutritional assessment, education and counseling at community and clinical levels.

In many of the regions supported by AIDSRelief access to pediatric care and treatment services is limited. AIDSRelief has identified bringing more infants and children into HIV care and treatment as an area of targeted expansion and urges increased funding for this. AIDSRelief will assure integration and linkages between ANC, Labor and Delivery Services, Maternal and Child Health and Immunization services to identify and enhance the follow-up of HIV infected mothers and their exposed children. AIDSRelief will maintain linkages with JCRC and other groups which provide early infant diagnosis so that all HIV exposed infants delivered can be diagnosed in a timely manner receive their results and be referred for comprehensive HIV care. To assure continuity of care and to minimize losses to follow-up all exposed children will be followed up in the ART program until they are at least 2 years old and are documented negative. After this they will continue to access services through the OVC program at least until the age of 5 years. Strengthening provider-initiated testing in outpatient and inpatient pediatric services has also been recognized as an important strategy for identifying HIV infected children. Consequently, AIDSRelief will strengthen referral linkages among pediatric OPDs, pediatric inpatient services and the ART clinic in order to assure increased testing and that those children found positive are referred for comprehensive HIV care.

In FY2010, AIDSRelief will promote prophylaxis with cotrimoxazole from 6 weeks of age. In an effort to ensure that all children and their families have access to the basic care package, linkages with organizations such as PACE and UHMG will be strengthened in order to increase access to a basic health care package comprising ITNs and water guard. In addition, the program will continue to ensure that nutritional assessment, education and counseling are provided to mothers/caretakers and their children at LPTFs. The programs will strengthen integration of the nutrition component into the LPTFs adherence and community outreach activities in order to assure that all children receiving services at AIDSRelief supported facilities receive comprehensive age appropriate psycho-social counseling and treatment and adherence support, the AIDSRelief program will provide training and technical assistance to all service providers in the area of pediatric psycho-social counseling. This training and TA will utilize both the existing technical expertise within AIDSRelief as well as collaboration with regional networks

such as ANNECA.

Task shifting to maximize human resources will be emphasized at facility and community levels. At LPTFs, the strategy will focus on using nurses and clinical officers for the routine follow-up of stable patients, using protocol driven nurse and clinical officer management of non-critical acute symptoms; nurses and pharmacy staff will also be trained in routine medication dispensing to stable patients. In line with a family centered approach to care, at the community level, AIDSRelief will encourage the development of community based satellite clinics and outreaches staffed by clinical officers/nurses/community health workers for the routine care of stable patients and the use of community health teams for the delivery of home based care and for medication delivery.

The decentralization of HIV services satellites and outreaches will increase access to those who live in remote areas. This approach reinforces AIDSRelief's model of providing integrated services to families at the community by inter-linking facility based health providers and community health workers and volunteers. AIDSRelief supported facilities are currently providing varying levels of home based care, ARV treatment support and community preventative services using outreach teams led by a community nurse or a clinical officer. The outreach teams coordinate with CHWs and community based volunteers, many of whom are motivated PLHAs themselves on treatment to support patients in their communities. Further development of these community health programs to provide integrated HIV care, support adherence and promote preventative services is critical to ensuring sustainable treatment programs and maximizing funding investments. Community health programs will be structured to promote family based care through symptom monitoring, disclosure counseling, secondary prevention, and family based testing and education. In addition, the LPTFs' community volunteers will be used as resources to support patients on therapy, disseminate HIV care and prevention literacy. AIDSRelief will adapt existing, locally appropriate Information Education and Communication (IEC) and Behavior Change Communication (BCC) materials. AIDSRelief will provide education on the importance of using ITNs, basic hygiene and good nutrition at household level and to communities. AIDSRelief will assist LPTF to strengthen their networks with PLHA groups who serve as volunteers in the community in support of adherence programs. AIDSRelief supports several LPTFs in Northern Uganda and will continue to assist them in developing outreach programs that provide support to those affected by internal displacement. The program will also strengthen linkages within the LPTFs, particularly those between PMTCT, TB and CT services with ART services. LPTFs will also be linked to organizations that provide community based therapeutic feeding programs to support the malnourished. In addition, the program will link LPTFs to the Ministry of Health to access cotrimoxazole and malaria treatment. Reinforcing LPTFs external and internal integration will ensure that core AIDSRelief care and treatment activities will be integrated with ancillary services and program activities of other providers in the same region.

Pediatric technical capacity is an area of emphasis for AIDSRelief. The program will continue to assure that all involved cadres of service providers have the capacity to provide age appropriate services to children. To accomplish this, the technical team, using a model of clinical training and on-site mentoring, will provide comprehensive pediatric training and technical assistance to medical and non-medical staff to increase the capacity of LPTFs to appropriately manage and monitor pediatric patients with HIV infection. AIDSRelief will target the recognition and management of medication side effects, treatment failure and opportunistic infections (particularly TB), and will provide training in pediatric counseling and will strengthen LPTF staff capacity to develop community based psycho-social assessments. AIDSRelief will follow-up didactic training with on- site clinical mentorship for clinicians and site level support for other cadres of workers. Regional CME s and partners' forums will complement LPTF staff training, allow experience sharing and reinforce knowledge and skill transfer from AIDSRelief technical staff. The AIDSRelief team will develop a training and mentorship program that prepares senior medical officers, clinical officers, nurses and counselors at the LPTFs to provide supportive supervision and mentorship to dependent satellites and to newly hired staff. A structured program of nurse refill services will also be implemented at selected LPTF

The AIDSRelief program emphasizes maintaining and strengthening linkages and networks among the different services provided at the LPTFs and among the LPTFs and other service providers. These linkages promote a more efficient provision of health care delivery by promoting overall health systems strengthening. In particular, the referral linkages among ANC, PMTCT, MCH, pediatric inpatient and ART services enable HIV affected families and their children and infants to access ART services at the facilities.

In addition to the use for routine CD4 testing for monitoring response to treatment, AIDSRelief evaluates the clinical outcomes of the program by systematically relating patient outcome measures such as viral suppression rates, adherence, and treatment support models to program level characteristics at each LPTF. This assessment is done on a random selection of 15% of the patients on treatment. This assessment has demonstrated viral suppression rates over 15 months of greater than 85%.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	500,000	

Narrative:

AIDSRelief supports partners to strengthen behavior change activities aimed at reducing the risk of HIV transmission due to multiple and concurrent sexual partners. With the main focus continuing to be on the promotion of abstinence and being faithful, some additional prevention activities will also be included in COP 2010.

Abstinence will be encouraged through building the confidence of the youth to delay sexual debut until marriage and through empowering the already sexually active youths and adolescents with life skills to practice secondary abstinence. This will be accomplished through the using the "Value of Life" curriculum to train the youth and adolescents. The intervention will reach 6,762 males and 7038 females, ages 10-14 and 16170 males and 16,830 females ages 15-24.Faithfulness is encouraged through community sensitization and training using the "Faithful House" curriculum for the married couples through small focused trainings. A total of 13,200 married persons will be reached through trainings conducted by 18 LPTFs and three community based organizations.

A total of 541 people already trained as facilitators for both curricula will carry out the trainings. Facilitators will train couples, youth and adolescents at community level. Prevention priorities will include: behavior change, risk reduction, risk avoidance, counseling and testing, education to patients, community health and secondary prevention. AB activities will be integrated with the PMTCT, OVC, care and treatment activities through linkages. Pregnant women testing negative in ANC will be encouraged to attend the trainings with their spouses. To promote male involvement, spouses of PMTCT mothers will be invited to attend the Faithful House curriculum trainings where they will be able to access VCT services so that those testing HIV positive can be linked to the ART clinic. LPTFs will receive technical assistance in the area of prevention with mentoring and coaching.

HIV positive persons shall further be linked to facilities that provide care and support, while negative couples and youths will form support groups that help them to maintain their status through behavior change enhancement and mutual support. Secondary prevention messages will also be further integrated into the care and treatment activities at the LPTFs through providing training to counselors, social workers and nurses in positive prevention. In addition an emphasis will be put on discordant couples to adopt risk reduction strategies.

Coordinated by Futures Group International, strategic information (SI) activities incorporate program level reporting, enhancing the effectiveness and efficiency of both paper-based and prevention activities monitoring and management (PMM) systems, assuring data quality and continuous quality improvement, and using SI for program decision making across all LPTFs. AIDSRelief has built a strong PMM system using in-country networks and available technology at 18 LPTFs. Futures Group International carries out site visits to all LPTFs to provide technical assistance to ensure continued quality data collection, data entry, data validation and analysis, and dissemination of findings across a range of stakeholders. Using standard data collection tools, the program tracks and reports on Sexual Prevention activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	450,000	

Narrative:

AIDSRelief will continue to encourage increased uptake of comprehensive PMTCT services at 18 LPTFs. The program will directly support a comprehensive package of PMTCT and HIV care services at 10 LPTFs. The key strategies the program will include: primary prevention of HIV infection among women of child bearing age through AIDS education, behavior change programs at the LPTFs and communities; clinical and immunological staging of HIV positive women; prevention of mother to child transmission of HIV through the provision of ARV prophylaxis and HAART where appropriate, promotion of exclusive breast feeding or replacement feeding where AFFAS through infant and young child feeding counseling and support and support for maternal nutrition; promotion of male partner involvement and testing; increased access to care and treatment for HIV infected women, their infected children and their families through the promotion of linkages between ANC, MCH and ART services; community follow-up of pregnant and breast-feeding mothers and exposed infants to promote the timely delivery of ARV prophylaxis to infants not delivered in health care facilities, early infant diagnosis and to minimize loses to follow-up.

The primary focus of the program will be on the following groups: HIV + pregnant who have been identified from ANC, Delivery Suite or MCH clinic; HIV+ women on ART who become pregnant; HIV + women in non-ART care who become pregnant, and HIV exposed and HIV positive children.

In FY2010, AIDSRelief proposes to reach 40,000 pregnant women with HIV counseling and testing for PMTCT and 2,800 HIV + pregnant women and their exposed infants (2800) with antiretroviral prophylaxis, in accordance with Uganda National Guidelines and supported by treatment preparation and adherence support. The program will strengthen the linkages between the ANC and ART clinics, and ensure that the community component of the PMTCT program is also strengthened. This will be promoted through LPTF/field exchange visits and technical support visits. Through the ART clinic, the program will provide ARVs for treatment, and will supplement ARVs for provided by the Ministry of Health. Existing PMTCT focal persons will be supported to ensure that the referral linkage between the ART clinic, ANC, Labour and Delivery and MCH clinic are in place and fully operational. AIDSRelief will provide CD4 testing for all HIV positive women pregnant women and those eligible will be initiated onto HAART.

HIV positive infants will be enrolled into care. AIDSRelief laboratory staff will facilitate the collection of DBS for early infant diagnosis and these will be sent to JCRC centers for laboratory investigations per the collaboration between AIDSRelief and JCRC. The HIV infected infants/children will be linked to the AIDSRelief treatment clinics for pediatric care and treatment.

For FY 2010, community activities will include the following: Increased male partner involvement, strengthening existing mother-to-mother support groups and initiating additional groups, supporting already existing psychosocial support groups, community outreaches for ANC, strengthening TBA and LPTF collaborations as a strategy to increase delivery at health facility, community sensitization in regard to PMTCT', strengthening community follow up of the pregnant/lactating mother and her infant.

AIDSRelief has strong community programs and strategies already in place to promote primary prevention through various community mobilization and sensitization programs targeting the women of child bearing age. Through its AB prevention strategy, AIDSRelief will focus on training couples to promote faithfulness in their marriages in order to maintain their HIV negative status or to encourage open communication and disclosure among HIV positive or discordant couples. All women who attend the antenatal clinic and live in an area where a Faithful House training will take place, will be linked and encouraged to attend the training together with their spouses. The spouses will be tested and if positive will be referred to care facilities at the AIDSRelief LPTFs for counseling in prevention of infection to their partners. The PMTCT program will continue to be emphasize strong community outreach and follow-up of all HIV positive women during pregnancy and after delivery. HIV positive pregnant women will be linked with a community volunteer, who will follow up with her through home visits to promote adherence to treatment, provide information about PMTCT, and to encourage her and her family members to deliver her baby from a health facility.

Maternal nutrition and infant and young child feeding nutrition counseling and education will be provided by health workers at the facilities. This component will be further enhanced by additional information provided at community level by community volunteers during home-based follow up visits. Provision of maternal nutritional information and counseling on infant and young child feeding will continue through ANC and ART clinics. Malnourished HIV + pregnant and lactating mothers (216) will also be linked to therapeutic nutritional support programs as part of a commitment to promoting better maternal and infant health.

Training, including updates on the new MOH adopted PMTCT guidelines, blood collection for CD4 screening and dry blood spots, and HIV rapid tests will be provided to 200 health workers, including midwives, at ANC clinics providing PMTCT services. Activities targeting TBAs will also be strengthened at LPTF level in order to better engage the widely utilized informal health sector. TBA engagement will be evidenced-based, in line with the Ministry of Health National Policies and Guidelines, and will focus on initiating and improving TBA and LPTF relationships, and incorporating TBAs into the already existing community structures such as VHTs and community volunteers. Specific issues addressed with TBAs will include: HIV/AIDS and PMTCT basic knowledge; issues of confidentiality; encouraging HIV positive women to deliver at a health facility and referring them to facilities for delivery;

supporting women who deliver at home to receive the prophylaxis for their infants with prompt referral of those mother infant pairs to health facilities; encouraging women with unknown HIV status to test and referring them to testing centers.

Support to HIV positive mothers at the AIDSRelief supported clinics will include clinical and immunological assessment of eligibility for HAART for all HIV + women and provision of HAART to the eligible women identified through the PMTCT clinics. To encourage male involvement, LPTFs will adopt strategies such as writing love letters, and inviting partners of HIV positive pregnant women to the Faithful House trainings as a precursor to VCT. Long lasting insecticide treated nets will continue to be provided to the mothers and their families through linkages with PACE/CDC. 30-40 additional community volunteers will be trained as trainers of reinforcing malaria prevention
messages during their outreach activities and given skills to identify patients with the symptoms of malaria and to refer them to a health institution. There will be increased sensitization of care providers to provide intermittent Sulphadoxine-Pyrimethamine (SP) or Cotrimoxazole to pregnant women in care.

Coordinated by Futures Group International, strategic information (SI) activities incorporate program level reporting, enhancing the effectiveness and efficiency of both paper-based and computerized patient monitoring and management (PMM) systems, assuring data quality and continuous quality improvement, and using SI for program decision making across all LPTFs. Using the MOH standard guidelines and data collection tools, Futures Group International will ensure compilation of complete and valid PMTCT data that relate to adult and infant patient information at the sites.
On-site technical assistance and training will be provided to LPTF staff, focusing on identifying barriers to data collection, avoiding double counting and reporting, and timeliness of reports. In addition to capturing data in IQCare, a new electronic
data base will be rolled out to all LPTFs implementing PMTCT that will capture relevant PMTCT data, from ANC to L&D. The same will be used to efficiently and effectively report on PMTCT indicators to all stakeholders, including USG, MOH,
and the donor. Staff will be trained in using the data base for sustainability purposes. On a monthly basis, LPTFs will compile and disseminate a PMTCT report based on already agreed upon indicators, but also compile similar reports on a quarterly, semi-annual, and annual basis. Feedback from these reports will be used by AIDSRelief and LPTFs to improve service delivery, provide forecasting for drugs and testing kits, and gauge the need for human resource planning. Using available data, AIDSRelief will strengthen the linkages between ANCs and HIV/AIDS clinics, and provide information
for accurate tracking of pregnant mothers in the community and at health facilities during the duration of a pregnancy.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic regimen choices

and health systems strengthening. AR will focus on the transition of the management of care and treatment activities to indigenous organizations by actively using its extensive linkages with faith based groups and other key stakeholders to develop a transition plan that is appropriate to the Ugandan context. The plan will be designed to ensure the continued delivery of quality HIV care and treatment, and all activities will continue to be implemented in close collaboration with the Government of Uganda to ensure coordination, information sharing and long term sustainability. For the transition to be successful, sustainable institutional capacity must be present within the indigenous organizations and the LPTFs they support; therefore, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2010, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions and enhance LPTF/MoH systems and collaborations relevant for sustainability. LPTFs will be encouraged to explore approaches in the health systems that are efficient and effective for sustainability purposes. This will include better allocation of resources that will increase cost effectiveness.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	600,000	

Narrative:

The program provided a total of 18 LPTFs with laboratory equipment and supplies. Equipment procurement was done in accordance with CDC and MOH guidelines through local vendors; AIDSRelief identified local service providers for the procurement and distribution of lab reagents needed for the tests to support treatment of HIV infected patients (CD4 tests, LFT, RFT, cryptoccocal antigen, malaria, syphilis, HIV& TB, HB, TOXO, CBC, WBC count). AIDSRelief also provided support for viral load testing at selected LPTFs and linked others to nearby facilities that provide such services. The program continued its collaboration with Center for Disease control (CDC) Uganda to get support for viral load testing for CQI, and referral CD4 testing, and 9/18 AIDSRelief LPTF laboratories participated in UKNEQAS external assessment scheme for CD4 proficiency testing with support from CDC. AIDSRelief also provided support to LPTFs to enhance continuous power supply so that reagents and other lab materials are properly stored at all times. These included solar powered backup systems and inverters. Accessories such as surge protectors, stabilizers and UPS were also supplied in order to protect delicate equipment from frequent power surges.

The program additionally conducted on-site, regional continuing medical education trainings, and at AIDSRelief laboratory centers of excellence for laboratory staff to strengthen their capacity to initiate and monitor patients on ARVs, and to conduct diagnostic tests for opportunistic infections. A total of 96 laboratory personnel received refresher courses in standard operating procedures, good laboratory

practices, reagents forecasting and procurement , quality assurance and quality control, infection control, DBS collection techniques, Direct & Flourescent TB smear Microscopy, HIV rapid testing, basic flow cytometry, equipment maintenance techniques and viral load techniques. These trainings were conducted in accordance with the national guidelines. As AIDSRelief focused on decentralization of services, it further increased the laboratory capacity of 33 LPTF satellite sites, enabling them to perform rapid HIV tests, malaria smears, TB smears and other diagnostic tests and to collect and process specimens for other tests that are performed at referral laboratories. Pediatric diagnostic capacity was accessed by all LPTFs and their satellite sites and early infant diagnosis enabled the earlier initiation of therapy as required. AIDSRelief provided support for viral load testing at Some LPTFs. AIDSRelief provided clinical management and reagents inventory management tools to ensure collection and compilation of laboratory data for all HIV patients and reagents consumed

FY 2010 Activities

In FY 2010, Laboratory technical assistance visits will be expanded to be performed monthly, for which purpose number of laboratory technical teams will be increased from 3 to 4. The FY 2010 request will include provision for lab supplies and technical assistance to the LPTF. AIDSRelief laboratory support will continue to include the procurement and distribution of necessary reagents from local distributors (HIV test kits, CD4 reagents and reagents for the diagnosis of opportunistic infections including CrAG and PCP testing, and viral load testing reagents). Laboratory equipment will also be upgraded and renewed to meet the increased testing needs, including innovative equipment for point-of-care testing of CD4 and HIV viral load. AIDSRelief will establish regional excellence labs to serve as referral, training, and external quality assurance centers. AIDSRelief in collaboration with WHO, Find diagnostics and NTLP will roll out modern TB diagnostic procedures such as Flourescent microscopy to all LPTFs, as well as testing for MDR-TB.

AIDSRelief anticipates increased demand for viral loads measurements due to increased number of patients accessing ART. Regional excellence labs will be equipped to conduct viral load measurements, while others will access it through referral of samples. Tools and reference materials to monitor OIs and ARV drug toxicities will also be revised. The program will continue the provision of clinical management tools to ensure collection and compilation of laboratory data for all HIV patients. Through strengthening internal controls, and with support from CDC, AIDSRelief will ensure that all laboratories build on the current quality assurance program through participation in external quality assurance schemes such as UKNEQAS. External Quality Assurance schemes will be expanded to involve all LPTF labs into EQA for HIV rapid testing, all CD4 testing, clinical chemistry, hematology, and OI diagnosis. Excellence labs will be involved in EQA programs for HIV viral load testing. AIDSRelief will expand service contracts with local and regional providers to cover all laboratory equipment currently serving AIDSRelief purposes to ensure that routine preventative service visits and prompt maintenance and repair occur. The program

will also maintain support for the maintenance of solar back up power systems and surge protectors, and all major equipment will be put on power management systems. To enforce sustainability the program will strengthen local capacity in country to perform equipment maintenance/ service.

AIDSRelief will develop unified and comprehensive training curriculum for lab personnel to cover the full continuum of HIV- and OI-related laboratory services, including latest HIV testing and monitoring technologies and testing strategies and algorithms; CD4-testing technologies; microbiology and molecular biology techniques used for OI diagnosis; laboratory biosafety, quality assurance and quality control; principles of laboratory management, to include personnel management, financial management, planning and budgeting; laboratory logistics management and control; laboratory equipment maintenance; laboratory information and data management; and professional ethics of HIV laboratory work. The revised curricula will include new, innovative topics to address latest developments in the field of HIV/AIDS/OI laboratory science and service provision. To maximize teaching effectiveness, the curricula will be designed in modular format, each module covering key conceptual areas mentioned above. The curriculum development will be closely coordinated with the Ministry of Health, with subsequent endorsement by MOH. AIDSRelief will again provide refresher trainings for 96 laboratory personnel to emphasize standard operating procedures, good laboratory practices, laboratory commodities management and quality control to ensure a safe working environment, personal safety and reliable laboratory test results. AIDSRelief will expand laboratory training to involve all laboratory staff at LPTFs. Additionally, in order to address the shortage of laboratory personnel, the program will shift HIV rapid testing to non-laboratory cadres such as Counselors, nurses and midwifes to conduct HIV rapid tests and link them to MOH and CDC for quality assurance. LPTFs will also be encouraged to send less qualified staff for further trainings in order to improve their skills. Additional efforts will be made to create linkages between LPTFs and training institutions in order to facilitate the recruitment of qualified staff. As AIDSRelief continues its focus on decentralization of services, it will continue support for the 33 satellites laboratories. This includes continued training for these sites in rapid HIV testing, malaria smears, TB smears and other diagnostic tests and in the collection processing and transportation of specimens for other tests that are performed at referral laboratories.
Support to home based and community HIV testing will also be expanded. Selected satellite labs will be strengthened to initiate and monitor patients on ART if sufficient funding is made available for this.

In FY 2010, AIDSRelief will continue engagement with the Ministry of Health to ensure that AIDSRelief is represented in the Laboratory Technical Working Group, and diffuse relevant information from this group to LPTFs. The program will continue its collaboration with Center for Disease control (CDC) Uganda to get support for viral load testing for QA/QI program, and referral CD4 testing. AIDSRelief LPTF laboratories will continue to participate in UKNEQAS external assessment scheme for CD4 testing with support from CDC and TB slide rechecking supported by NTLP. Through Futures Group International,

AIDSRelief will continue to support all sites to accurately document and track laboratory tests. All data will be captured in the current electronic data base for easy retrieval. On a monthly basis, reports will be made indicating number of tests performed and staff trained. The PMM system will help to identify those clients that need monitoring tests like CD4s, and link up with relevant personnel to have the tests performed. The close monitoring and reporting will eventually feed into forecasting and procurement of laboratory reagents and supplies.

In FY 2010, the program will work with LPTFs to implement and strengthen integration of the HIV clinics into mainstream hospital/facility M&E systems. This will involve: cross program training on different data needs and indicators; linking both paper and electronic data collection and storage systems for the facilities; working with LPTF management and boards to understand and respond to their data demand and information use needs; use the data to inform and support decisions for the HIV clinics and entire facility. It will also involve organizing joint meetings to share information. To enhance data access and utilization across a wide spectrum of the facility, various sections within the facility will be linked to the patient management system, and staff will be trained in the use of the system.

Sustainability lies at the heart of the AIDSRelief program, and is based on durable therapeutic programs and health systems strengthening. AIDSRelief will focus on the transition of the management of care and treatment activities to indigenous organizations by actively using its extensive linkages with faith based groups and other key stakeholders to develop a transition plan that is appropriate to the Ugandan context. The plan will be designed to ensure the continuous delivery of quality HIV care and treatment, and all activities will continue to be implemented in close collaboration with the Government of Uganda to ensure coordination, information sharing and long term sustainability. For the transition to be successful, sustainable institutional capacity must be present within the indigenous organizations and LPTFs they support; therefore, AIDSRelief will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2010, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions. AIDSRelief will particularly focus on its relationship with indigenous organizations such as the Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, and Joint Medical Stores to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	7,661,937	

Narrative:

AIDSRelief will procure adult and pediatric preferred and alternative 1st and 2nd line ARVs for 22,908

adults and 3,000 children. These are generics which are relatively cheaper but are of good quality, safe and efficacious. The bulk of the drugs will be FDCs for both adults and children to ensure adherence and minimize occurrence of resistance. AIDSRelief has not experienced any stock outs in the last year due to its efficient and effective supply chain management systems and has mechanisms in place to ensure no stock outs in the FY 2010. These include: policy of 2 months buffer stock at LPTFs and 3 months buffer stock at JMS; timely placement of orders; ensuring that deliveries are made within the lead time; efficient LMIS; use of ART Dispensing Tool at LPTFs for accurate and timely reporting.

AIDSRelief will continue to procure 1st and 2nd line ARVs for adults and children through a global procurement mechanism that provides very competitive pricing. Joint Medical Stores (JMS), an FBO will continue to warehouse and distribute ARVs on behalf of the Program with continued support from the AIDSRelief supply chain team.
The Program will continue to leverage ARVs for pediatric patients from Clinton Foundation, and also cover other ART related support including purchase of OI drugs, laboratory supplies and Technical Assistance to LPTFs.

AIDSRelief Supply Chain Management Team will continue with capacity building/systems strengthening through technical backstopping and on-going training and mentoring in supply chain management. In-depth training and mentoring of the LPTFs pharmacy staff in use of SOPs and Dispensing Tool, forecasting and quantification, ordering and quality reporting for ARVs and OI drugs, will continue to be conducted.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	98,987	

Narrative:

As of the end of February 2009, AIDSRelief in Uganda will be supporting 18 LPTFs and 33 satellite sites to provide care and support to 36,746 patients, including 25,908 on antiretroviral treatment of whom 3,000 will be children.
In FY 2009 AIDSRelief supported 18 LPTFs and 33 satellite sites to provide a family-centered approach to diagnosis and treatment of 1,770 TB, co-infected HIV positive patients. This incorporated routine opt out counseling and testing for HIV within TB treatment facilities, systematic referral for TB screening within HIV testing facilities, and systematic TB screening within HIV care and treatment facilities. Family members of TB patients were also encouraged to be screened for TB. HIV prevention messages, such as avoidance of high risk behaviors and secondary prevention, were integrated into counseling and testing sessions for TB patients. AIDSRelief followed the Government of Uganda policy guidelines and AIDS Control Program guidance on TB/HIV integration and TB/HIV communication strategy.

LPTFs' laboratory infrastructure was strengthened to assure safe and quality processing of TB samples. AIDSRelief continued linking LPTFs to the Ministry of Health's National TB and Leprosy Program for TB drugs and supplies for basic laboratory investigations. Referral linkages within the LPTFs and between LPTF and satellite sites for TB patients were improved, and HIV + patients who required care were referred to HIV/AIDS clinics. These patients were also treated for other opportunistic infections and received the basic care package through the CDC/PSI program.

Training of health workers and community volunteers were key activities in FY 2009. AIDSRelief trained 290 community health nurses and 720 volunteers as trainers of trainers on how to recognize TB signs and symptoms. On-going training of medical and clinical officers in TB X-ray interpretation and clinical mentorship on TB diagnosis and care was also provided. Additionally, three regional continuous medical education (CME) sessions, focused on TB and the integration of TB and HIV care and treatment services, were held in FY 2009. The AIDSRelief technical team made an average of one week-long visit each quarter to all LPTFs to provide technical assistance related to TB/HIV. The program also encouraged LPTFs to coordinate with the MOH's District Health Department to train health workers in TB/HIV.

Coordinated by Futures Group International, strategic information (SI) activities incorporated program level reporting, enhancing the effectiveness and efficiency of both paper-based and computerized patient monitoring and management (PMM) systems, assuring data quality and continuous quality improvement, and using SI for program decision making across all LPTFs. AIDSRelief has built and maintained a strong PMM system using in-country networks and available technology at 18 LPTFs in FY 2009. Futures Group carried out site visits to all LPTFs to provide technical assistance to ensure continued quality data collection, data entry, data validation and analysis, and dissemination of findings across a range of stakeholders.

By the end of FY 2009, AIDSRelief will have evaluated the program by relating patient outcome measures such as viral suppression rates, adherence, and treatment support models to program level characteristics at each LPTF. Over 1500 patients receiving care and treatment from 14 LPTFs will be included in this analysis, grouped into three cohorts (36, 24 and 12 months) representing the length of time they had received therapy.

FY 2010 activities

In FY2010, AIDSRelief program will intensify the diagnosis and treatment of TB/HIV co-infected patients by ensuring that all HIV+ patients presenting with symptoms suggestive of or previous history of TB infection are appropriately evaluated and properly managed if found to be positive. AIDSRelief will

provide TB treatment to 2,500 HIV + patients, and all family members of TB patients will be screened for TB. A total of 2,000 registered TB patients will receive HIV counseling and testing results at AIDSRelief supported LPTFs and all patients testing positive will be referred to HIV care and treatment. Routine, opt-out counseling and testing for HIV within TB treatment sites will continue, as will systematic referral for TB screening at HIV testing sites.

The program will continue implementing a family-centered approach to both HIV testing and TB screening. Under this approach AIDSRelief will assist the LPTFs to implement a contact tracing strategy that ensures that family members of all HIV+ patients diagnosed with TB be screened for TB. This will be accomplished using the community based treatment support mechanisms that are implemented at all AIDSRelief supported centers. AIDSRelief will strengthen the TB-DOTS system through integration with the existing HIV community follow-up programs. A total of 200 LPTF staff will be trained in the provision of clinical treatment for TB to HIV + patients, and 30-40 community volunteers will be trained as trainers of trainers to provide community-based treatment support for TB patients. On-going training clinical mentorship of medical and clinical staff (including laboratory personnel) will also be provided by the AIDSRelief technical team. This will include TB diagnosis and management (including TB X-ray interpretation), preparation and handling of specimens, proper infection control procedures. In addition, AIDSRelief will continue to encourage LPTFs to coordinate with the MOH's District Health Department to train health workers in TB/HIV.

AIDSRelief will ensure that all Uganda National TB reporting requirements are followed and collaborate with the Uganda National regional and District TB programs to assist all LPTFs to become MOH-registered TB/HIV treatment centers. The ability to treat co-infected patients at one site will increase adherence to treatment and simplify monitoring, lessen the health-care burden on co-infected patients, and enhance sustainability. The program will continue strengthening LPTF laboratory and clinical infrastructure to assure safe and quality processing of TB samples and effective infection control. AIDSRelief will also ensure participation of all supported labs in an external and internal quality control program for TB specimens. In addition, through linkages with the NTLP labs will increase surveillance for MDR- and XDR-TB.

To enhance TB tracking and reporting, Futures Group, the monitoring arm of AIDSRelief, will ensure compilation of complete and valid HIV patient treatment/TB data; enhance analysis of required indicators for quality HIV patient treatment and ARV program monitoring and reporting; and provide relevant, LPTF-specific technical assistance to develop specific data quality improvement plans for tracking TB cases. The program will use IQCare, the current PMM system, to track TB patients who are counseled, tested, and receive their HIV results and HIV + patients screened for TB. In addition, all patients accessing care and treatment, and being treated for TB, will be captured using the existing clinical management tools,

and their data captured in the data base for further analysis and reporting.

To enhance tracking and reporting of comprehensive TB data, LPTF staff will receive training in the following areas: TB indicator definitions; analysis of TB data captured on the different tracking tools-both manual registers and electronic; and tracking and reporting on patients completing treatment, and capturing defaulters. In FY 2010, TB indicators (from screening, diagnosis, treatment, and outcome monitoring) will be fully incorporated in IQCare for all LPTFs to enhance tracking and reporting to various stakeholders.

AIDSRelief will promote the data use culture, to enable LPTFs use data for informed clinical decisions and adaptive management. It will ensure that different data systems at health facilities are harmonized for effective and efficient reporting.

In FY 2010, the program will work with LPTFs to implement and strengthen integration of the HIV clinics into mainstream hospital/facility M&E systems. This will involve: cross program training on different data needs and indicators; linking both paper and electronic data collection and storage systems for the facilities; working with LPTF management and boards to understand and respond to their data demand and information use needs; use the data to inform and support decisions for the HIV clinics and entire facility. It will also involve organizing joint meetings to share information. To enhance data access and utilization across a wide spectrum of the facility, various sections within the facility will be linked to the patient management system, and staff trained in the use of the system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9166	**Mechanism Name: Tuberculosis/HIV Intergration Activities**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: AIDS Information Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 593,922

Funding Source	Funding Amount
GHCS (State)	593,922

Sub Partner Name(s)

(No data provided.)

Overview Narrative

AIDS Information centre-Uganda (AIC) is a Non-Governmental Organization established in 1990 to provide HIV information to the general public including letting people know their status through Voluntary Counseling and Testing (VCT) for Human Immune Deficiency Virus (HIV). The Organization was founded by individuals in Kampala with support from United States of Agency for International Development (USAID) and Centre for Disease Control (CDC) as a response to growing demand from people who wanted to know their HIV status. It has since grown into a national organization with its offices in all regions of Uganda and nearly 170 staff. The objectives of AIC include to: Scale up initiatives for counseling and testing for 3.5 million people in 5 years; Scale up approaches for care and support to 3.5 million people in 5 years; Promote disclosure, anti stigma and non discrimination through post test clubs, couple clubs, and ongoing counseling to cover 250,000 people in the next 5 years; and Refer 25 percent of all HIV positive clients who are eligible for chronic care and other services in 5 years.

AIC is providing a number of HIV prevention, care and support services. The main focus is on HIV counseling and testing, Palliative Care and treatment of opportunistic infections. Services are offered through its 8 stand-alone branches that cover all regions of Uganda. These include Arua Lira ; Soroti ; Mbale ; Jinja; Kampala ; Mbarara and Kabale . AIC through the 8 branches, works closely with all hospitals, Health Center IVs and Health Center IIIs (also referred to as indirect sites or supported sites) to provide quality routine counseling and testing services. Coordination of these activities is done through the office of District health services in line with the national Health Sector Strategic Plan. The specific services targeted include: Clinical services like, diagnosis and Management of sexually transmitted diseases (STDs), Tuberculosis, family planning, prevention of mother to child transmission of HIV (PMTCT) and management of opportunistic infections (including contrimoxazole and Isoniazid prophylaxis). To date, AIC has reached more than 120,000 people with medical care and support.

HIV prevention is promoted through Post Test Club (PTC)/Philly Lutaaya Initiative services, which provide a range of services including: psychosocial support for people living with HIV/AIDS and conduct drama performances through which people are mobilized and sensitized on the different aspects of HIV. Post test clubs in AIC consist of more than 10,000 members. Monitoring the progress of the HIV/AIDS disease is done through CD4/8 tests that are readily available at all the branches. Furthermore, AIC conducts

outreaches to reach the Most at Risk Persons (MARPS), with HIV counseling and testing (HCT). These HCT services are provided as an integrated package of comprehensive management of HIV/AIDS. These services are often preceded by drama sessions from Post test clubs (PTC) on a variety of topics including: Abstinence, Be-faithful and Condom use, discordance, other prevention services, public speaking and disclosure.

Since 1990 AIC has offered HCT services reaching a cumulative total of over 2,200,000 clients who had received HCT as of December 31st 2008. In 2008 alone more than 300,000 clients were counseled, tested and received their results. In-spite of its achievements, AIC noted that it has not been able to reach all its potential clientele through traditional approaches (facility based and outreaches). Secondly, the number of clients seeking VCT services has increased over the years; hence AIC realized the need to scale up services both geographically and in scope so as to ensure a wider coverage of services at community level.

AIC has received funding from a number of donors since its inception in 1990 to date. The Civil Society Fund (July 2007-June 2009) has supported AIC to scale up HCT services, in the three branches of Arua, Kabale and Mbale. USAID first funded AIC in 1990 this funding has continued to increase over time through PEPFAR. USAID through John Snow Inc (JSI) to scale up HCT services in Northern Uganda under the Northern Uganda Malaria, HIV/AIDS and TB Program (NUMAT). From CDC, AIC received a 5 year cooperative agreement to implement TB/HIV integration activities. Department for International Development (DFID), United Kingdom was instrumental in provision of bridge funding and budget support to AIC.

Implementing Partners: The Ministry of Health has a well established and decentralized health delivery system in the country through national and regional hospitals, and health centers at different levels. At District level, the Local governments through their structures have also been part of the support to implementation. To ensure ownership and sustainability, AIC works closely with the District Health Officer's (DHO) office and heads of Health sub-districts (HSDs). At sub-county level, AIC provides HCT services on an outreach basis. The communities are mobilized on pre-set dates and HCT is provided by trained service providers. Furthermore, AIC builds capacity of service providers through regular trainings at AIC facilities. In FY 2009/10 AIC will support 45 government health units, through the 8 AIC branches. AIC will also scale up collaboration with the private sector to support HCT in privately owned health units including work place settings. AIC has been implementing programs together with other partners like the Alliance of Mayors and Municipal Leaders Initiative in HIV/AIDS in Lower Local government (AMICALL), Health Communication Partnership (HCP) and Program for Accessible Health, Communication and Education (PACE). The partner organizations facilitate mobilization of clients while AIC provides the actual service of HCT. The private sector like the stanbic bank have supported AIC to carry out some activities. These include health education of the population they serve and HCT services including other services like provision of condoms. Other government sectors like the UAC, the police force, the Army, the Uganda prison services have all approached AIC to provide health education on prevention and care

and HCT services.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9166		
Mechanism Name:	Tuberculosis/HIV Intergration Activities		
Prime Partner Name:	AIDS Information Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	593,922	

Narrative:

Activities under this program will contribute to the implementation of the Uganda National policy on Tuberculosis (TB)/HIV integration, and will help to reduce morbidity and mortality related to TB among people with HIV.

The project will seek to achieve the following objectives:
i. To promote HIV diagnostic counseling and testing among persons with TB disease;
ii. Strengthen and expand screening, diagnosis and treatment for Active and Latent TB among HIV infected persons for one year;
iii. Strengthen prevention, care and support to active and latent TB clients for one year;
iv. To ensure effective TB infection Control among service providers and clients at AIC facilities.

TB-HIV Care Statistics
According to the WHO (2009), it is estimated that 9.27 million new cases of TB occurred in 2007 (139 per 100,000 population). Of the 9.27 million new cases, an estimated 4.1 million (44%) were new smear positive cases. Furthermore, among the 9.27 million incident cases in 2007, an estimated 1.37 million (14.8%) were HIV positive. A total of 456,000 deaths occurred from TB among HIV positive people

(equivalent to 26% of deaths from TB in HIV positive and HIV negative people, and 23% of an estimated 2 million HIV-related deaths). Uganda is one of the world's 22 TB high-burden countries, with an incidence of 136 smear positive TB cases per 100,000 people per year [WHO, 2009]. TB is one of the most common causes of morbidity and the leading cause of mortality in people living with HIV/AIDS. HIV is the biggest risk factor for the development of active TB and at present an estimated 39% of TB patients are also co-infected with HIV [WHO, 2009]. The treatment success rate remains low because of the high proportion of patients who die, default from treatment or the treatment outcome is not evaluated (WHO, 2009).

TB/HIV Collaborative activities in AIDS Information Center

The AIDS Information Center started TB/HIV collaborative activities in 2001, with support from the CDC and the National TB and Leprosy Control Program (NTLP). Over 44,861 HIV positive clients have been screened for TB under this collaboration. Of those screened, 1,072 (2.4%) clients were found with active TB and were started on treatment. Furthermore, AIC has provided HCT services to over 2,500,000 clients since its inception. Approximately, 150,000 clients are counseled tested and provided with results in the AIC system every quarter. This has strategically positioned AIC, with an opportunity to screen all HIV positive clients under the TB/HIV collaboration.

During the third year of the cooperative agreement with CDC, AIC continued to counsel and test for HIV among TB patients. Over 3,221 TB clients were tested for HIV; because of AIC's major objective is to provide HCT to the general population, with support from CDC over 3,457 HIV positive clients were screened for TB during the 3rd year of funding; and a total of 955 clients were started on anti TB drugs. Other services provided during the year included: Isoniazid preventive therapy (IPT) for people living with HIV and a total of 82 clients accessed this service; Septrin prophylaxis was provided to over 2,035 HIV positive clients; and a total of 1,562 HIV positive clients accessed the CD4 count tests during the year. Of those with a CD4 less than 250 were referred for treatment in centers like MOH hospitals, TASO and JCRC. Well as those with CD4 above 250 were enrolled into chronic care at AIC and received septrin, management of OIs and psychosocial care through our post test clubs.

Capacity building in TB/HIV collaborative activities for the supported sites has greatly improved outputs in terms of quality TB/HIV activities under this collaborative agreement. To-date, AIC has built capacity of over 58 facilities to counsel and test all TB patients. Further more capacity has also been built in these facilities to screen all HIV positive clients for TB. Hence AIC is strategically positioned to expand coverage of TB/HIV collaborative activities in Uganda.

Human resource capacity and sustainability: The program has continued to recruit medical doctors, clinical officers and laboratory technicians. These have undergone training in the provision of HIV/TB integrated Services.

A number of training activities took place during the 3rd Year of the project. These include:

• Trainer of Trainers (TOT) in TB infection control and TB-HIV co-infection conducted by TB-CAP. It

involved 5 health workers from AIC.
• Eight laboratory supervisors were trained by Becton Dickson in use of CD4% soft ware to be able to carry out and report on pediatric immunological profiles.
• 75 health workers from Wakiso, Mbarara, Kabale, Arua, Moyo and Koboko underwent a training TB-HIV co-infection. These health workers are now able to understand TB-HIV co infection and are carrying out TB-HIV co infection activities in their respective facilities.

Challenges for the TB/HIV Collaborative activities in AIDS Information Center
AIC experienced a number of challenges during implementation of the TB/HIV collaborative activities. These were both system and programmatic challenges and they included:

1. The low levels of knowledge on TB/HIV collaborative activities among staff at the supported sites. This has greatly affected outputs from this collaboration.
2. Stock out of anti-TB drugs from the District TB and Leprosy Office, especially streptomycin. This was a country wide problem, which affected most of the AIC branches. This compromised treatment of clients.
3. Lack of skilled health workers in most of the supported sites. The most affected cadre was that of laboratory technicians.
4. Transport for clients on anti-TB drugs especially those on facility DOTs. The difficulties in transport have greatly contributed to the loss to follow-up of clients.
5. Lack of basic equipment including: electric beam balance and measuring cylinders for measure minute amount of raw materials used to prepare and X-Ray services, especially in the rural facilities.
6. Follow-up of clients on active and latent TB treatment is increasingly becoming difficult. Volunteerism is no more and most TB patients have depended on volunteers to bring them drugs. AIC has also supported these volunteers with a lunch and small transport refund. However because of the ever escalating costs of food and transport it's becoming expensive to maintain these volunteers hence affecting the program. The program has noted losses to follow-up.

Targets for year 4 (FY 2009-2010): During FY 2009-2010, AIC will continue to address the challenges identified on top of continuing to implement. AIC provide IPT to 150 clients; active TB treatment to 350 individuals; HCT for 3,000 TB clients; TB screening for 24,000 HIV positive clients; CD4 testing for 2,000 TB/HIV co-infected clients; cotrimoxazole prophylaxis for 24,000 HIV positive clients; referral of 400 clients for ART. To improve drug adherence, AIC will continue to implement the DOTS program in all its branches covering 400 clients including follow-up in the community. These clients will also receive treatment for OIs and will be referred for ART where applicable.
AIC will continue to build capacity of 50 health workers in public and private facilities in TB-HIV Co infection and TB infection control.

In collaboration with selected Health centers IIIs, AIC will provide diagnostic HCT for the TB clients through provider initiated testing and counseling (PITC). Those found to be infected with HIV will be provided with CD4 cell counts and referral for ART if eligible. All planned activities will be closely monitored through a comprehensive monitoring and evaluation plan in collaboration with the respective District Health Management Teams. Monitoring and Evaluation AIC branch teams consisting of the manager, Medical, Laboratory and data supervisors have held 34 meetings with the District Health officer (DHO), and the District TB and Leprosy supervisor (DTLS)/focal person. The joint teams conducted 10 support supervision visits to the supported health facilities and submitted 30 monthly and 14 quarterly reports in year 3. At least two support supervision visit by headquarter staff were carried out in all the 7 branches. AIC data collection tools were harmonized with those of MOH with assistance from CDC. The national TB register is in use and the program is in close collaboration with the National TB and Leprosy program and Uganda AIDS Commission. This has made it simple for AIC to report on the national indicators according to the national M&E framework.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9167	**Mechanism Name: Provision of Full Access Home-Based Confidential HIV Counseling andTesting and Basic Care Services in Kalangala District and the surrounding fishing communities**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Kalangala District Health Office	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,245,440	
Funding Source	**Funding Amount**
GHCS (State)	1,245,440

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing (HCT) and basic care (BC) in Kalangala district and the surrounding fishing communities. The objectives of the five year program were to 1) achieve 100% awareness on HIV counseling and testing among fishing communities Kalangala district; 2) Provide confidential HIV counseling and testing to 22,000 adults (including 5,000 couples) and their eligible children; 3) to identify 6,000 new HIV-positive people ad offer them basic care and referral to care and treatment; 4) To reduce the risk of HIV infection in the population through appropriately targeted prevention interventions.

Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited. The district was specifically targeted with this program to respond to the unique geographical location where the population of 100,000 is served by only 11 health facilities (two Health Centre (HC) IVs, six HC IIIs and three HC IIs).In addition, fishing communities are among the highest risk groups with susceptibility to HIV in Uganda, stemming from the complex interactions of occupational mobility, large amounts of time spent away from home, easy access to cash income, and the easy availability of commercial sex in fish landing sites.

In the first year of program implementation (FY 08) the program operated in the confines of Kalangala district to implement both HCT and BC services. During FY 09, started the expansion process to cover HCT and BC needs of the surrounding fishing communities of Rakai and Masaka districts. In these two districts, service provision was limited to communities in sub counties neighboring Lake Victoria. In addition to the expansion process, the project received additional funding to implement two program areas: TB/HIV and Prevention (Abstinence/Be faithful, AB and Other Prevention, OP) that were started within Kalangala district.

Key constraints to service delivery included the high cost of water transport and the limited number of identified HIV-positive individuals that accessed chronic care at Kalangala Health Centre IV.

In FY 10, the project will provide HCT and BC services in additional neighboring districts, depending on assessed needs and services provided by other players. The project will collaborate with other stakeholders and districts to ensure provision of quality HIV/AIDS services to the target communities. The camping strategy will be utilized where appropriate to minimize on transport costs, the project will

continue to support the referral process for CD 4 monitoring and strengthen access to chronic care clinics for HIV-positive individuals.

Cross-Cutting Budget Attribution(s)

Water	20,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9167**
Mechanism Name:	**Provision of Full Access Home-Based Confidential HIV Counseling andTesting and Basic Care Services in Kalangala District and the surrounding fishing communities**
Prime Partner Name:	**Kalangala District Health Office**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	200,000	

Narrative:

The basic care component of the program was initiated in the first year of the project. Project staff received orientation on planning, implementation and monitoring of the adult care and treatment component. The project Basic Care Officer working with the Community Educators, counselor and laboratory supervisor lead this component

In FY 2009, by 31st August the program provided HIV counseling and testing services to 13,035 of whom 2621 were HIV positive, 123 couples inclusive and eligible for Basic care services.
Major challenges for this component included low turn up of the referred cases to the referral sites possibly due to difficulties encountered with water transport as a result of water barriers between the islands and the referral sites. On and off stock outs of these Basic Care kits from PACE given the high demand in this high HIV Prevalence project area.
In FY 2010, the program will target 25,000 individuals with HIV counseling and testing services of whom 5,000 are expected to be HIV-positive and 98 discordant couples. Through this program people infected

with HIV (PHAs), discordant couples, and family members will be provided with basic HIV/AIDS care services by the HIV Counseling and Testing (HCT) field teams and selected Health Units. Additional collaborative linkages have been made with health units in the mainland, including Kalisiizo hospital, Kakuuto health centre IV, Masaka and Kitovu Hospitals, for more specialized care. The program developed and is implementing a referral system for HIV+ individuals for care and support with a view to reduce stigma towards HIV, reduce chances of transmission, and improve the quality of life of PHAs. Cotrimoxazole prophylaxis is provided along with care for opportunistic infections (OI). Over 1558 people were started on Septrine prophylaxis including index HIV/AIDS clients at Kalangala HCIV which is our main referral site. Safe water vessels and supplies, insecticide treated bed nets, and condoms, as appropriate, are provided through leveraging with other the PEPFAR partner PACE to provide adequate Basic Care Packages for HIV+ individuals and their families.

In FY 2010 the program will continue to expand access to referral services for HIV+ individuals for care and support with a view to reduce stigma towards HIV, reduce chances of transmission, and improve the quality of life of PHAs. Cotrimoxazole prophylaxis will be provided to all individuals who test HIV-positive along with care for opportunistic infections (OI), as well as malaria diagnosis and treatment. Safe water vessels and supplies, insecticide treated bed nets, and condoms, as appropriate, are provided through leveraging with other the PACE program to provide adequate Basic Care Packages for HIV+ individuals and their families.

This basic care initiative will be further strengthened through enhanced referrals to Kalangala Health Centre IV, Entebbe, Kalisizo, Masaka and Kitovu Hospitals to ensure that all patients have access to chronic care services and ART eligibility screening. Chronic care clinics at these referral sites will be supported to provide basic care kits to all registered clients. This program also will promote participation of and enhanced partnerships with community based organizations (CBOs), and non-governmental organizations (NGOs) operating HIV/AIDS service delivery in the district, thereby building capacity and infrastructure for sustainable services. In addition emphasis on staff training will be placed on prevention with positives (PWP) counseling support. PWP interventions include counseling of patients on disclosure of sero-status to partners, partner testing, and promotion of behavior change that emphasize correct and consistent condom use among sero-discordant couples and populations that engage in high-risk behaviors.

The program will continue to work to provide access to basic and palliative HIV/AIDS care services and support to PHAs in Kalangala District and the surrounding fishing communities. Cotrimoxazole, treatment of OI, and diagnosis and treatment of malaria will continue to be provided to PHAs in collaboration with the available health facilities. For more specialized care, individuals will continue to be

linked to Masaka, Entebbe and Kitovu Hospitals on the mainland. Support will be provided to individuals to access mainland health units when referrals are made. The program will continue to work with PACE to obtain safe water vessels, bednets and condoms as needed for patients. The program will also continue to build partnerships with organizations in the district providing health services so that PHAs and other family members can be referred to these agencies for services such as family planning and PMTCT as needed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	100,000	

Narrative:

The basic care component of the program was initiated in the first year of the project. Project staff received orientation on planning, implementation and monitoring of the adult care and treatment component. The project Basic Care Officer working with the Community Educators, counselor and laboratory supervisor lead this component

In FY 2009, by 31st August the program provided HIV counseling and testing services to 13,035 of whom 2621 were HIV positive, 123 couples inclusive and eligible for Basic care services.

In FY 2010, the program will target 25,000 individuals with HIV counseling and testing services of whom 5,000 are expected to be HIV-positive and 98 discordant couples. Through this program people infected with HIV (PHAs), discordant couples, and family members will be provided with basic HIV/AIDS care services by the HIV Counseling and Testing (HCT) field teams and selected Health Units. Additional collaborative linkages have been made with health units in the mainland, including Kalisiizo hospital, Kakuuto health centre IV, Masaka and Kitovu Hospitals, for more specialized care. The program developed and is implementing a referral system for HIV+ individuals for care and support with a view to reduce stigma towards HIV, reduce chances of transmission, and improve the quality of life of PHAs. Cotrimoxazole prophylaxis is provided along with care for opportunistic infections (OI). Over 1558 people were started on Septrine prophylaxis including index HIV/AIDS clients at Kalangala HCIV which is our main referral site. Safe water vessels and supplies, insecticide treated bed nets, and condoms, as appropriate, are provided through leveraging with other the PEPFAR partner PACE to provide adequate Basic Care Packages for HIV+ individuals and their families.

Major challenges for this component included low turn up of the referred cases to the referral sites possibly due to difficulties encountered with water transport as a result of water barriers between the islands and the referral sites. On and off stock outs of these Basic Care kits from PACE given the high demand in this high HIV Prevalence project area

In FY 2010 the program will continue to expand access to referral services for HIV+ individuals for care and support with a view to reduce stigma towards HIV, reduce chances of transmission, and improve the quality of life of PHAs. Cotrimoxazole prophylaxis will be provided to all individuals who test HIV-positive along with care for opportunistic infections (OI), as well as malaria diagnosis and treatment. Safe water vessels and supplies, insecticide treated bed nets, and condoms, as appropriate, are provided through leveraging with other the PACE program to provide adequate Basic Care Packages for HIV+ individuals and their families.

This basic care initiative will be further strengthened through enhanced referrals to Kalangala Health Centre IV, Entebbe, Kalisizo, Masaka and Kitovu Hospitals to ensure that all patients have access to chronic care services and ART eligibility screening. Chronic care clinics at these referral sites will be supported to provide basic care kits to all registered clients. This program also will promote participation of and enhanced partnerships with community based organizations (CBOs), and non-governmental organizations (NGOs) operating HIV/AIDS service delivery in the district, thereby building capacity and infrastructure for sustainable services. In addition emphasis on staff training will be placed on prevention with positives (PWP) counseling support. PWP interventions include counseling of patients on disclosure of sero-status to partners, partner testing, and promotion of behavior change that emphasize correct and consistent condom use among sero-discordant couples and populations that engage in high-risk behaviors.

The program will continue to work to provide access to basic and palliative HIV/AIDS care services and support to PHAs in Kalangala District and the surrounding fishing communities. Cotrimoxazole, treatment of OI, and diagnosis and treatment of malaria will continue to be provided to PHAs in collaboration with the available health facilities. For more specialized care, individuals will continue to be linked to Masaka, Entebbe and Kitovu Hospitals on the mainland. Support will be provided to individuals to access mainland health units when referrals are made. The program will continue to work with PACE to obtain safe water vessels, bednets and condoms as needed for patients. The program will also continue to build partnerships with organizations in the district providing health services so that PHAs and other family members can be referred to these agencies for services such as family planning and PMTCT as needed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	400,000	

Narrative:

The HIV counseling and testing (HCT) component of the program was initiated in the first year of the

project. Project staff received training on the basic HIV counseling and testing skills as well as the home-based HCT approach. In addition, staff received orientation on planning, implementation and monitoring of the adult care and treatment component. The program Counselor and Lab supervisors and Basic care officer working with 13 Counselor/Laboratory assistant pairs lead this component.

In FY 2009, by 31st August the program provided HIV counseling and testing services to 13,035 clients of whom 2621 were HIV positive hence, eligible for Basic care services including 123 discordant couples. In FY 2010, the program will target 25,000 individuals with HIV counseling and testing services. Major challenges for this component included high cost of water transport, poor road networks, poor sanitary facilities and the limited number of identified HIV-positive individuals that accessed chronic care services at Kalangala Health Centre IV, Masaka, Kitovu & Kalisizo hospitals. The major reason for low enrollment in the chronic care clinics include large water barriers between the health facilities and the islands from where clients are identified which has a lot of financial implications for vulnerable fishing communities. Other challenges included; un-anticipated expenditures during scaling up of HCT activities in Kalangala (Call back Strategy) at the same time expansion to neighboring Districts (Rakai and Masaka), Lack of CD4 count machine in Kalangala district which affected enrollment of positive clients referred by the programme for Anti Retroviral Therapy/Treatment , rough waters and heavy rainfall
In FY 2010, the program will continue with the door-to-door HCT initiative in the surrounding fishing communities of Masaka and Mpigi Districts in order to increase the number of individuals who receive HCT in the region as part of scale -up. Kalangala District will also continue to be covered as part of a call back mechanism due to the migratory patterns of the fishing communities. This activity proposes to reach 25,000 individuals with HBCT services with FY 2010 funding. The programme will continue to use the available HCT teams trained to provide HBHCT and will continue community mobilization through the CORPS to provide support and reduce discrimination, stigma and negative attitudes about HIV and HCT.

The program will also work to strengthen partnerships with other CBOs and NGOs providing health services in the district and in the surrounding districts to increase the capacity to provide comprehensive HIV/AIDS services as needed to individuals in the area. The testing teams will be routinely supervised by our experienced Laboratory and Counsellor supervisors. For Quality assurance, all positive samples will be taken to the CDC reference Laboratory as well as 2% of all the negative samples. All the identified positive clients will continue to be refered for comprehensive care to Kalangala H/C IV, and the nearby facilities that provide comprehensive HIV/AIDS care. All the HIV negatives will be encouraged to remain negative by giving them the appropriate preventive messages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,000	

Narrative:

In FY 2010, working with Baylor College, the project will support the provision pediatric HIV care and treatment services at Kalangala Health Centre IV and lower level health facilities.

Child clients will be facilitated to access a comprehensive package of high quality pediatric care and treatment services as advocated by the African Network for the Care of Children affected by AIDS (ANNECA). Pediatric care and treatment services to be offered include; early confirmation of HIV infection status; growth and development monitoring; immunizations according to the recommended national schedule; prophylaxis against opportunistic infections especially Pneumocystis Pneumonia; treatment of acute infections and other HIV-related conditions; counseling caretakers on optimal infant feeding, personal and food hygiene, disease staging; ART where indicated, psychosocial support for the infected child, caregiver & family; and referral of the infected child for specialized care if necessary; and community-based support programs. This activity proposes to reach 1,250 children with HIV care and treatment services

Pediatric care and treatment program area is related to the program areas of PMTCT, adult care and treatment, TB/HIV, psychosocial support, Counseling & Testing, ARV Drugs and laboratory infrastructure and will be delivered as part of an integrated service.

The partners will use a continuous quality improvement approach to enhance data management, as well as conduct quality assurance support visits and clinical mentoring. Staff from the district health teams, Kalangala HBHCT Project and Baylor will conduct regular quarterly mentoring, support and supervisory visits to health facilities, outreaches and community drug distribution points to support basic primary care services for HIV exposed and infected children, OI management, TB/HIV integration and PMTCT. Support supervision will entail assessment of clinic infrastructure, training needs, staffing and other HR issues, logistics, transportation, children/client satisfaction, liaison with families and communities. Continuing Medical Education will be ensured through clinical case reviews, assessment of guideline use and ART regimen decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	80,000	

Narrative:

In FY 2010, working with Baylor College, tje project will support the provision pediatric HIV care and treatment services at Kalangala Health Centre IV and lower level health facilities.

Child clients will be facilitated to access a comprehensive package of high quality pediatric care and treatment services as advocated by the African Network for the Care of Children affected by AIDS

(ANNECA). Pediatric care and treatment services to be offered include; early confirmation of HIV infection status; growth and development monitoring; immunizations according to the recommended national schedule; prophylaxis against opportunistic infections especially Pneumocystis Pneumonia; treatment of acute infections and other HIV-related conditions; counseling caretakers on optimal infant feeding, personal and food hygiene, disease staging; ART where indicated, psychosocial support for the infected child, caregiver & family; and referral of the infected child for specialized care if necessary; and community-based support programs. This activity proposes to reach 1,250 children with HIV care and treatment services

Pediatric care and treatment program area is related to the program areas of PMTCT, adult care and treatment, TB/HIV, psychosocial support, Counseling & Testing, ARV Drugs and laboratory infrastructure and will be delivered as part of an integrated service.

The partners will use a continuous quality improvement approach to enhance data management, as well as conduct quality assurance support visits and clinical mentoring. Staff from the district health teams, Kalangala HBHCT Project and Baylor will conduct regular quarterly mentoring, support and supervisory visits to health facilities, outreaches and community drug distribution points to support basic primary care services for HIV exposed and infected children, OI management, TB/HIV integration and PMTCT. Support supervision will entail assessment of clinic infrastructure, training needs, staffing and other HR issues, logistics, transportation, children/client satisfaction, liaison with families and communities. Continuing Medical Education will be ensured through clinical case reviews, assessment of guideline use and ART regimen decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	80,000	

Narrative:

The prevention component of the program was initiated in the second year of the project. Project staff received orientation on planning, implementation and monitoring of the AB component. The two Community Educators and 89 trained Peer Educators/Community mobilisers lead the prevention component that was implemented in school and community based approaches.

In FY 2009, the program reached 1,048 individuals by community outreach that promoted HIV/AIDS prevention through abstinence against a target of 30,000 and 209 individuals through community outreaches that promoted HIV/AIDS prevention through abstinence and/or being faithful and with AB messages against an FY 2009 target of 50,000. The wide variance between target and actual achievements was mainly because; a number of prevention related activities took place such as

information on prevention for positives, condom education & distribution within the HCT operational sites which data could not reliably count for the indicator as by preliminary reporting period, this indicator needed further clarifications. Following technical support from CDC- Entebbe, it was streamlined that for reporting purposes, AB indicators are reported against community outreach activities and NOT mass media campaigns or prevention counseling for people receiving HCT services as previously had anticipated, and that groups should be manageable, lead to discussion/interaction between the service provider and recipients/community members, and that rallies at market places did not qualify as community outreaches, whereas mass media campaigns & talk shows were important for community sensitization and had been part of KDLG activities these did not count towards reporting for AB.

Major challenges for this component included indicator misinterpretation, age of children in primary schools that was not uniform as most of them were between 10-14, and some 17, 18 and 19 years who qualified to receive messages of AB and OP which needed much caution at this school level. People especially at the landing sites always wanted to be facilitated for the time spent with them yet it was not budgeted for. Others included illiterate population that could not write their names on the attendance lists.

In FY 2010, the project will continue implementation of AB activities in Kalangala district. The objectives of this component will be to provide targeted community behaviour change communication interventions aimed at stemming HIV infections among individuals, couples, and families. This activity proposes to reach approximately 10,000 individuals with AB interventions in FY 2010. The expected population of people we shall be serving is 53,900 out of which the % of Abstinence and/ or Being Faithful which is all people 10 years and above is 60.5% equivalent to 32,609 individuals. Mobilization of communities for prevention programs will be done through radio programs, community meetings, and education sessions at fish landing sites. Once mobilized, small group interactive sessions will be organized and conducted for age disaggregated audiences. Abstinence messages will be disseminated to age groups 10 to 15 years through school based programs. The project will work closely with the district education department and other stakeholders to disseminate messages that encourage staying in school, delaying sex and promote life skills.

Be-faithful messages will be disseminated to age groups 15 years and above and also to the married/cohabiting people. Messages will center on mutual fidelity, reduction in sexual partners and addressing gender norms.

In collaboration with the District Directorate of Health Services, other district departments (education, fisheries and community development) and local fishing groups this program will use a variety of communication channels to reach communities, including music, dance and drama; and community meetings. Working with local community groups, the program will support the set-up and/or strengthening

of community-based support groups and post-test clubs to assist in providing psychosocial support to persons who have accessed HIV testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	70,000	

Narrative:

The prevention component of the program was initiated in the second year of the program. Project staff received orientation on planning, implementation and monitoring of the OP component. The two Community Educators and 89 trained Peer Educators/ Community mobilizers lead the prevention component that was implemented in school and community based approaches.

In FY 2009 as of 31st August, the program reached 3963 individuals with OP messages against an FY 2009 target of 10,000. The variance between target and actual achievements was mainly because a number of prevention related activities took place such as information on prevention for positives, condom education & distribution within the HCT operational sites which data could not reliably count for the indicator as by preliminary reporting period, this indicator needed further clarifications. Following technical support from CDC, we realized that for reporting purposes, OP indicators are reported against community outreach activities and NOT mass media campaigns or prevention counseling for people receiving HCT services as previously had anticipated, and that groups should be manageable, lead to discussion/interaction between the service provider and recipients/community members, and that rallies at market places do not qualify as community outreaches and that whereas, mass media campaigns & talk shows were important for community sensitization and had been part of KDLG activities these did not count towards reporting for OP.

Major challenges for this component included indicator description, age of children in primary schools that was not uniform as most of them were between 10-14, and some 17, 18 and 19 years who qualified to receive messages of AB and OP which needed much caution at primary school level. The population especially at the landing sites always wanted to be facilitated for the time spent with them yet it was not budgeted for. Other challenges included illiterate population that could not write their names on the attendance lists.

In FY 2010, the project will continue implementation of OP activities in Kalangala district. The objectives of this component will be to provide targeted community behavior change communication interventions aimed at stemming HIV transmission among individuals, couples, and families. This activity proposes to reach approximately 10,000 individuals with OP interventions in FY 2010.

Mobilization of communities for prevention programs will be done through radio programs, community meetings, and education sessions at fish landing sites. In other prevention methods, the program will promote correct and consistent condom use for casual relationships as well as dispel myths around condom use. Condoms will be availed through increased number of service outlets through free distribution and social marketing. The program will also support efforts to reduce HIV/AIDS-related stigma and discrimination by providing information and education aimed at changing people's perceptions and attitudes about HIV/AIDS. Through community group meetings and radio talk shows, the program hopes to foster a dialogue among residents, with a view towards reducing negative attitudes about PHAs.

In addition, the program will promote knowledge of and related prevention behaviors including promotion of HIV testing, knowledge of partner HIV status and disclosure of HIV test results. Emphasis will be laid on the importance of couple testing to identify discordant couples, as well as knowledge of the HIV status of biological children for mothers who test HIV positive. Efforts will be made to target commercial sex workers and their clients, as well as addressing excessive alcohol consumption and gender-based violence.

Among HIV-positive individuals, the program will encourage partner testing, promote referral to chronic care centres, and promote STI treatment as well as family planning and PMTCT services for eligible mothers and families.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	156,250	

Narrative:

In FY 09, the project in collaboration with MOH and NMS staff at Kalangala Health Centre IV and lower level health facilities will be supported to plan, forecast and procure drugs and diagnostics to support the scaled up ART services. I

The project will: (1) Provide buffer supplies of ARVs and Septrin while ensuring transportation of drug supplies to the district stores and to the various health facilities. (2) Liaise between the districts and MoH, and SCMS in communicating and following up the facility pharmaceutical supplies while mentoring key pharmacy staff in the districts.
(3) Provide supportive supervision to ensure MoH ARV reports are collected and sent to the necessary authorities. (4) Conduct logistics management training (district-based) targeting HCWs actively involved in procurement, dispensing and storage of drug supplies. (5) Hold meetings with some of the HIV/AIDS partners who are implementing similar services in the two districts while working towards an MoU for

synergistic output rather than duplication. (6) Promote Continuing Medical Education opportunities in the health facilities and deliver MOH LMIS (Logistics Management Information System) tools to enable efficient data capture. (7) Lobby the MoH to increase the medicine credit line budget for the two districts to cater for the increasing number of clients infected with HIV/AIDS and other illnesses that require septrin for instance.

With regard to the three new districts we intend to conduct a needs assessment and rapidly transfer the lessons learnt from the two existing districts to improve systems for accessing MOH drugs while retaining a fund for buffer stocks.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	79,190	

Narrative:

The TB/HIV component of the program was initiated in the second year of the project. Project staff received orientation on planning, implementation and monitoring of the TB/HIV component. This component is led by the Project Laboratory Supervisor in conjunction district TB/Leprosy Officer and with the health facility laboratory staff.

In FY 2009, the program targeted 112 individuals with TB/HIV services at 12 outlets. By 31st August 2009, out of the 147 clients screened for TB on sputum microscopy, 56 clients sputum positive and started on treatment. The number of service outlets providing treatment for TB increased from three to nine. In addition 59 registered TB patients received HCT and received their results. Initially, there was a low turn up for HIV positive clients who needed to be screened for TB at the health facility and this prompted the program to change strategy as detailed; (1) Two health facility staff were identified and facilitated to conduct TB/HIV related activities. (2) Active involvement of the Basic /Palliative care team in TB case finding and sample collection at field level, a strategy that has minimized the cost of water transport for the vulnerable fishing community. (3) Supporting & encouraging service providers from the rest of the health units to refer TB suspects for sputum microscopy at Kalangala Health IV. Major challenges have included collection of all the three sputum samples from individuals at field level viz-a-viz the costly water transport and high population mobility.

In FY 2010, this activity proposes to reach approximately 255 individuals with TB/HIV interventions at 12 facilities. The project will continue implementation of TB/HIV activities in Kalangala district. The objectives of this component will be to increase TB case finding, improve infection control at health facilities and improve TB treatment completion.

The project will ensure that all identified HIV positive patients are referred to chronic care clinics where TB screening is routinely done. This program will support efforts that provide cross-referral and integrated diagnosis, treatment, and support services for TB and HIV in targeted health facilities in Kalangala. HIV+ patients will be actively screened and treated for TB at initial diagnosis and during follow up at chronic care clinics. HIV counseling and testing will be offered to all patients in the TB clinics. In addition, opportunities will be explored to counsel TB patients under the DOTS program about the importance of HIV testing and treatment adherence for ARVs and TB medication. In collaboration with the PEPFAR laboratory strengthening initiative and national TB and Leprosy Program, this project will contribute to the functionality of health facilities' laboratory capacity for TB and HIV services to ensure timely and accurate TB diagnosis, through staff training, availability of laboratory supplies and reagents and standard operating procedures and support supervision. Finally in working with the district education and communication (IEC) team, the program will provide support for a communications campaign aimed at increasing TB-DOTS and ART literacy in target health facilities and the surrounding communities. Health facility staff will be supported in data management and analysis to enable them to better monitor adherence to relevant treatment regimes and to track progress in the performance of their activities. The Kalangala District Directorate of Health Services will ensure a constant supply of TB drugs, Septrin and ARV's to TB/HIV co-infected patients. Support supervision and on-job training will strengthen TB/HIV integrated services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9169	**Mechanism Name: Improving Service Delivery through mHealth**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Makerere University John Hopkins University Collaboration	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Central Public Health Laboratories	Infectious Disease Institute	Mulago STD unit: Most At risk Populations initiative (MARPI)
National TB Reference Lab		

Overview Narrative

Implementing Mechanism narrative

Makerere University Faculty of Medicine was awarded a 5- year Cooperative Agreement "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at Ugandan teaching hospitals" in 2004. The implementing program was code-named "Mulago-Mbarara Teaching Hospitals' Joint AIDS Program" (MJAP). In June 2006, MJAP received supplemental funding to build capacity of Kampala City Council (KCC) clinics to provide HIV care and treatment.

In August 2006, MJAP was awarded a second grant "Expanding Tuberculosis/HIV Integration Activities" to support the Uganda Ministry of health (MOH) to expand integrated Provider Initiated Counseling Testing (PICT) and TB screening and care to 11 regional referral hospitals (RRHs).

MJAP received funding in February 2008 to strengthen capacity of Mulago STD unit in prevention and control of HIV/STI with particular focus on Most at Risk populations (MARPS) and vulnerable groups.

And recently, July 2008, MJAP received central funds to pilot provision of medical and psychosocial services to survivors of sexual and gender-based violence (SGBV).

The goals of the program were as follows:
1. To develop a national model for providing the full continuum of HIV/ AIDS care
2. To prevent HIV infection and HIV related illness through a continuum of prevention and care
3. To enhance capacity of health providers to deliver comprehensive HIV services

Service coverage: MJAP supports comprehensive HIV prevention, care and treatment services in 9 districts and 19 facilities (2 national referral hospitals of Mulago and Mbarara, 7 RRHs of Kabale, Fortportal, Jinja, Mbale, Soroti, Hoima and Masaka, and 10 HCIVs namely Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi Komamboga, Bwizibwera, Mbarara Municipal Council). MARPI activities are supported in Kampala district. RCT is offered in 63 units including all high HIV prevalence units in Mulago hospital and Mbarara Hospital units.

Services: The RCT program targets adults and children attending out-patient clinics, in-patient wards of facilities for routine medical care. Spouses of RCT recipients are targeted to promote couple testing and identify discordant couples. VCT is extended to household members of clients to promote a family approach to care. HIV care is provided to HIV positive clients identified in RCT. All TB patients are screened for HIV, and all HIV clients screened for TB, and co-infected patients managed for both conditions. Antiretroviral therapy (ART) is provided to eligible clients as per MOH guidelines. Clients in care are provided OI treatment and prophylaxis using cotrimoxazole in addition to positive prevention messages and supplies like condoms. HIV-negative persons are also encouraged to remain negative through behavioral change messages. Children identified to be vulnerable are provided with health care and referred to OVC programs for additional services. MARPI program targets STD clinic clients, commercial sex workers and students in tertiary institutions and provides HIV testing, referral, and prevention interventions. The SGBV program targets survivors of rape and sexual violence, provides testing, counseling, and post –exposure prophylaxis. Training is both for pre and in-service medical and allied workers.

Health systems strengthening supported areas include:
• Human resources for health: MJAP provides training for providers in HIV prevention and care and salary support for some additional staff in the supported facilities. MJAP with MOH conduct regular technical support supervision.
• Laboratory strengthening: This is supported through training, procurement of equipment, ensuring supplies availability, and quality assurance.
• Infrastructure: MJAP has remodeled some facilities to improve waiting space and power solutions.
• Capacity building for HIV care: MJAP supports HC IVs in Kampala and Mbarara to provide care and treatment
• Strengthening Logistics and data management systems: Through training of data staff, support supervision, provision of computers.
• National level contributions: MJAP pioneered PITC and TB/HIV integrated care. MJAP staffs are members of national committees for HCT, ART, and TB/HIV providing guidance on policy development.
• Cross-cutting programs/ key issues: Gender: MJAP provides services to survivors of SGBV in Mulago hospital with referrals to police, legal, spiritual services.
• MJAP has implemented use of drugs and other supplies from other sources when available e.g. NTLP for TB drugs, CHAI for pediatric and 2nd line ARVs, Pfizer for Fluconazole, and ARVs through MOH/GF. The program has moved from brand to generic FDA approved drugs, use of fixed dose combinations (FDC), and piloted clinic models to reduce on staffing requirements e.g. family model, task shifting.
• Monitoring and evaluation: MJAP plans to utilize MOH data collection tools in facilities. This is ongoing and any challenges will be shared with MOH and CDC. Monitoring/ technical support visits to facilities will

continue and reports will be submitted as required.

Major program achievements
Since inception MJAP has provided HIV testing to more than 570,000 individuals, identified over 79,800 HIV-infected individuals, and linked them to care. Over 43,799 HIV-infected have received basic HIV care, over 63,000 screened for TB and 12,734 managed for TB /HIV co-infection. MJAP has over 22,055 patients enrolled on ART and has served more than 9,232 OVCs, trained over 8,545 health care providers in areas of HIV/AIDS and TB.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9172	**Mechanism Name: HIV/AIDS Project**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mildmay International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Reach		

Overview Narrative

Mildmay Uganda (MU) is a faith-based organisation operating under the aegis of the Uganda Ministry of Health since 1998 and managed by Mildmay International. It is recognised internationally as a centre of excellence for comprehensive HIV/AIDS care and training, particularly for children (less than 18 years), who constitute 22% of patients. MU has had a cooperative agreement with CDC Uganda since 2001 to support training in HIV/AIDS care and treatment. From April 2004, the support was expanded to include ART and palliative HIV basic care. MU's central facility is in Wakiso district and serves as a referral centre. In addition, MU supports nine satellite facilities covering nine subcounties in six districts (Kamwenge, Luwero, Mityana, Mpigi, Mukono and Wakiso) to increase access to good quality HIV care in the rural communities. MU has cumulatively registered approximately 25,000 patients, with 20,200 currently in care. Through PEPFAR MU supports 9,270 patients with antiretroviral (ARV) drugs. MU's clients access a free palliative care package which includes provision of the Basic Care Kit (safe water vessel, water purification solution, LLITNs for malaria prevention), laboratory services (CD4 counts and other laboratory tests), Cotrimoxazole prophylaxis and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. Other services offered to the clients include cervical cancer screening and treatment of pre-cancerous lesions with cryotherapy; reproductive health and Family Planning; screening and treatment of HIV related eye diseases; dental care for children; mental health care and rehabilitation services. In order to reduce the cost of access to care, MU has established a network of Community Clinics within Ministry of Health facilities in six subcounties of Wakiso and Kampala districts. Stable clients from the main site are referred to these clinics for their drug refills and routine follow-up.

Training is a key component of the MU programme as a health systems strengthening strategy to scale-up prevention, care and support services. It targets doctors, nurses, counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders, community based volunteers and carers of patients. The training programme reaches participants throughout Uganda through long modular work-based programmes, clinical placements and short courses delivered either at the main site or through Mobile Training Teams (MTT) in the rural districts. Short courses include: ART for Programme Managers; Use of ART in Children and Adults; Management of Paediatric HIV and AIDS; HIV and AIDS Palliative Care; Laboratory Skills in an HIV and AIDS Context; Management of Opportunistic Infections among others. MU offers two 18 months work-based dipolma programmes. One validated by the University of Manchester ('A Health Systems Approach to HIV and AIDS Care and Management') and another by Mbarara University of Science and Technology

in Uganda (Community HIV and AIDS Care and Management'). The Manchester diploma targets senior health managers/policy makers, with an added option of 18 months extension to a degree level while the Mbarara diploma targets clinicians involved in HIV and AIDS management. In response to the need to equip Nursing Assistants (a cadre with basic nursing skills but found to be carrying the bulk of the work at lower health centre levels), MU has developed a 4-module certifcate course, 'HIV and AIDS Palliative Care for Nursing Assistants'.

ReachOut (RO) Mbuya Parish HIV/AIDS initiative, a sub-partner with MU is a community and faith based project under Our Lady of Africa Church, Mbuya Kampala started in 2001. RO provides free medical care, social, spiritual and emotional support to PLHIV in 2 districts; Kampala (Nakawa, Giza-giza, Kinawataka, Acholi quarters and Banda) and Luweero (Kasaala). Currently, RO reaches 3,113 PLHIV in Kampala and 338 in Luweero.

Both MU and RO have electronic monitoring and evaluation systems for data management and analysis. The directorates of resources and quality assurance support the core programme areas

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9174	**Mechanism Name: Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: National Medical Stores	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Joint Medical Stores		

Overview Narrative

National Medical Stores (NMS) is an autonomous government corporation established in 1993 to procure, store and distribute essential medicines and medical supplies to government heath facilities throughout Uganda. National Medical Stores has therefore developed a countrywide distribution supply chain for essential medicines and supplies as well as for the HIV/AIDS-related Laboratory commodities and supplies provided through PEPFAR funding. These project commodities are accessed by health facilities and other HCT testing centres under the established laboratory credit line system at both National Medical Stores and Joint Medical Store (JMS). Following the national credit line for essential medicines that established 20% contribution from Ministry of Health to Joint Medical Store for the faith-based and mission health facilities, NMS continues this proportion of the PEPFAR project funding and commodities to JMS as a sub partner to procure, store and distribute HIV/AIDS-related laboratory commodities and supplies. There is a monitoring and evaluation plan being put in place to closely monitor all procurement,storage and distribution of essential supplies and HIV/AIDS related laboratory commodities. The activities will have a national coverage.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9177	**Mechanism Name: Basic Care Package Procurement/Disemination**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview

Population Services International (PSI) is a private non-profit organization with a mission to improve the health of low income people worldwide through social marketing. PSI-Uganda has grown and matured into a local organization: the Program for Accessible health, Communication and Education (PACE). PACE seeks to measurably improve the health of vulnerable Ugandans using evidence based social marketing and other proven techniques that promote sustained behavior change with added emphasis on rural populations.

PACE is committed to effective collaboration in support of the Ministry of Health's (MOH) priority areas including, but not limited to, HIV/AIDS, malaria, child health and reproductive health. Approximately 1.2 million Ugandans are living with HIV, and AIDS related illnesses are a leading cause of morbidity and mortality, in spite of sufficient evidence that supports simple interventions to prevent opportunistic

infections (OI).

Since September 2004, with funding from PEPFAR through CDC, PACE, has been implementing an HIV Basic Preventive Care Program (BCP) with the goal of reducing HIV-related morbidity and mortality and HIV transmission. Currently, BCP includes identification of PHA through family based counseling and testing; prolonging and improving the quality of their lives by preventing OIs; and prevention with positives interventions (PWP). The PWP aims to avert HIV transmission to sexual partners and unborn children through: screening and management of sexually transmitted infections, family planning, partner testing and supported disclosure, partner discordance counseling, prevention of mother to child transmission of HIV (PMTCT), and safer sex practices including abstinence, and fidelity with correct and consistent use of condoms.

Program implementation has supported a multi-channeled communications campaign that educates PHA on how to prevent OIs, live longer and healthier lives through cotrimoxazole prophylaxis, prevention of diarrheal diseases using household water treatment and safe storage, use of insecticide treated nets (ITN) for malaria prevention, the prevention of HIV transmission to sexual partners and unborn children, get screened for tuberculosis at every visit to the health facility, practice beneficial nutrition habits, manage pain and symptoms, and seek for psychosocial support from friends and family. The campaign includes development and production of information, education and communication (IEC) materials for PHA, health care providers and counselors. These materials include posters, brochures, positive living client guides and stickers in the local languages. In partnership with MOH and Straight Talk Foundation (STF), PACE is producing spots and 'parent talk' programs on radio. In addition, BCP combines key informational messages, training and provision of affordable health commodities with evidence-based health benefits, and simple to implement for PHA and their families. The health commodities include free distribution of a starter kit with two long lasting insecticide treated bed nets, household water treatment chlorine solution, a filter cloth, and water vessel for safe water storage, condoms and important health information on how to prevent HIV transmission. PACE manages the procurement, packaging and distribution of all health commodities to ensure consistent supply of the basic care starter kits and re-supply/refill of the different commodities.

Approximately 1,200,000 Ugandans are living with HIV. According to the 2004/2005 HIV sero-behavioral survey approximately 149,000 new HIV infections occur each year in Uganda. With the introduction of various models to scale up VCT in Uganda including family based CT the number of PHA who know their status and therefore opt to access BCP and other HIV care is increasing. Furthermore, the number of clients accessing care and support at already existing partner sites has increased. This explains why BCP targets are consistently overshot, and suggests that there is an unmet need that did not form part of the initial program projections. The clinical care activity is aimed at expanding access to cotrimoxazole

prophylaxis, long lasting treated bed nets, safe water systems, pain and symptom relief, TB HIV and nutritional IEC and education.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9178	**Mechanism Name: Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Protecting Families Against AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

AMURIA, PALLISA	Arua Regional Referral Hospital,	BUDAKA, SIRONKO

	Uganda	
BUDUDA, SOROTI	BUKEDEA, TORORO	BUKWO, WAKISO
BUSIA, KAYUNGA	BUTALEJA, NAKASONGOLA	INFECTIOUS DISEASES RESEARCH COLLABORATION (IDRC)
Islamic Medical Association of Uganda	KABERAMAIDO, NAKASEKE	KALANGALA, MUBENDE
Kampala Pharmaceutical Industries, Uganda	Kapchorwa District Local Government	Katakwi Egangakinos People Living with HIV/AIDS Association
Kiboga District Local Government	KIBULI MUSLIM HOSPITAL	Kumi Pentecostal Assemblies of God, Uganda
Luwero District Local Government	Manafwa District Local Government	MBALE
Mbale Regional Referral Hospital	Ministry of Health, Uganda	Mityana District HIV/AIDS Committee
SAN RAPHAEL OF ST. FRANCIS HOSPITAL, NSAMBYA	Soroti Regional Referral Hospital, Uganda	

Overview Narrative

Protecting families Against HIV/AIDS (PREFA) is a non-governmental organisation working in collaboration with Ministry of Health (MOH) to improve access to quality HIV and AIDS prevention, care, treatment and support services to families with a focus on prevention of mother-to-child transmission (PMTCT) of HIV services as the entry point. In FY 2008 PREFA using PEPFAR funds initially supported 27 districts namely; Amuria, Budaka, Bududa, Bukedea, Bukwo, Busia, Butaleja, Kaberamaido, Kalangala, Kampala, Kapchorwa, Katakwi, Kiboga, Kumi, Luwero, Manafwa, Mbale, Mityana, Mubende, Nakaseke, Nakasongola, Pallisa, Sironko, Soroti, Tororo, Wakiso and Kayunga. In addition PREFA sub-granted Islamic Medical Association of Uganda (IMAU) and the Infectious Diseases Research Collaboration (IDRC) for PMTCT service provision and Public Health Evaluation (PHE), respectively. In April 2009 PREFA using PEPFAR funds facilitated MOH to scale up PMTCT services to the West Nile Region of the country that comprises of 7 districts of Arua, Adjumani, Nebbi, Maracha-Terego, Moyo, Koboko and Yumbe. Currently PREFA supports 36 districts (Eastern region - 17; Central region – 10; Western region – 2; and West Nile region – 7) of which 34 receive PEPFAR funds

In FY 2009 PREFA and its sub-partners supported PMTCT implementation to 282,498 women at 439 health facilities: 28 hospitals, 55 HC IVs, 319 HC III and 37 HC II in the 29 districts. During this period 259,464 (92%) pregnant women were new ANC. All mothers were counseled for PMTCT, and 245,393 (87%) of these were tested for HIV at antenatal, maternity and post natal care clinics. Among the women

who tested 242,409 (99%) received their test results and 13,595 (6%) were HIV positive. All HIV+ mothers received cotrimoxazole prophylaxis. A total of 13,036 (96%) of those who tested HIV+ received ARV prophylaxis for PMTCT (5,189 received CBV/NVP; 5,270 received NVP only; 1,501 received sd NVP only; and 1,376 were on HAART). A total of 92,916 women delivered of whom 5,131 (38% of all HIV+ mothers) were HIV+ deliveries. A total of 4,733 (92%) newborns received ARV prophylaxis. In addition 21,880 (9%) male partners of the pregnant women were counseled, out of whom 19,781 (90%) were tested and 1,244 (6%) were HIV positive. During this period, PREFA also supported salaries for 30 staff including 3-MOH staff who provide routine monitoring and supervision of PMTCT activities nation-wide. A total of 2000 health workers were trained in various courses; provision of logistics and supplies (7 motorcycles, 3 LCD projectors, 1 generator, 8 computers, 1 public address system, 1 vehicle, 120 Hb Analyser (Hemocues), 903 Hemocue strips, 140 baby weighing scales and 40 delivery beds; and regular support supervision and monitoring of PMTCT services in health facilities by the DHT, MOH and PREFA staff. At the community level, PREFA supported the districts to sensitise the community leaders and members on PMTCT services (17 meetings); trained Community Own Resource Persons (CORPS) on PMTCT issues for referral and follow up at community level (1,058 CCAs); conducted home visits for HIV+ mothers, their children and family members (612 visits/trips) and organized 53 HIV counseling and testing outreaches. PREFA supported districts to emphasize PMTCT promotion in their activities through film shows and radio talk shows (153 events).

Between October 2008 and May 2009, MOH in collaboration with PREFA made preparations to scale up PMTCT services to West Nile Region. These preparations included initiation of annual PMTCT work plans for the District Health Teams which were reviewed by the MOH and completed with technical input from PREFA staff. In addition, the pre-existing 27 Districts prepared new annual work plans and budgets for FY 2010 intra-district scale up of comprehensive PMTCT services. PREFA has signed all the Memoranda of Understanding (MOUs) with the 7 West Nile Districts.

In FY 2010 PREFA plans to scale up the PMTCT program in 36 (up from 27 districts) through sub-granting to Local Governments and to IMAU through 519 health facilities. PREFA will continue to consolidate the achiements registered in FY 2009 and to further collaborate with MOH and the districts in training and updating health workers in PMTCT strategies. In addition PREFA will support the 30 additional staff at the district to address the human resource gap in the short-run. Like in the previous year PREFA will procure essential supplies and equipment as prioritised in the district work-plans. In FY 2010 four main strategies will be used for community mobilisation and sensitisation (mobilisation through radio programs; support to PHA groups; facilitation of CCAs and promotion of community education events). Regarding monitoring and technical support PREFA will continue to work with districts, HSD as well health facilities in areas of data management and reporting; and PREFA's M&E department together with MOH HIV reference laboratory will facilitate and conduct quality assurance HIV tests at facility level, respectively. Finally PREFA will also support the MU-SPH/CDC HIV/AIDS Fellow to finalise her assessment of PREFA's community program and recommend ways of improvement.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9180	**Mechanism Name: National Laboratory System Infrastruture Improvement Initiative**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY2010 a TBD partner will continue to strengthen the national laboratory infrastructure throughout

Uganda. These activities were previously carried out by RPSO and AMREF. REDACTED.

REDACTED.

The infrastructure improvements will ensure that district laboratories, national laboratories, and blood banks meet the national quality standards. The laboratories must be able to support HIV/AIDS care and treatment services, HIV testing to support VCT, TB screening and other key tests to prevent opportunistic infections diagnosis. A portion of this funding will be used for the completion of the Central Public Health Laboratories (CPHL). The CPHL will house the coordination units responsible for different activities in the lab sector. REDACTED.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9180**		
Mechanism Name:	**National Laboratory System Infrastruture Improvement Initiative**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	Redacted	Redacted
Narrative:			
REDACTED.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9181	**Mechanism Name: Expansion of Routine**

	Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Research Triangle International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

AIDS Health Care Foundation		

Overview Narrative

Research Triangle Institute (RTI International) is an international, independent not-for-profit organization dedicated to improving the human condition through multidisciplinary technical assistance, training and research services that meet the highest standards of professional performance. RTI is partnering with AIDS Healthcare Foundation (AHF) to support the Uganda Ministry of Health (MOH) in improving access to and uptake of confidential provider initiated HIV counseling and testing (HCT) services in health care settings within hospitals and clinics that primarily serve rural populations in Kaberamaido, Kasese, Kabarole, Masindi, Mityana, Mubende, Mpigi, Pallisa, Bugiri, Sembabule, Iganga and Kyenjojo districts. This effort is addressing a major service need of many rural Ugandan residents who desire to know their HIV status, a critical factor in inducing and sustaining behavior change necessary to stem the disease. In addition, the project promotes and strengthens referral systems that enable identified HIV-positive (HIV+) persons and their families to access various HIV/AIDS services that include prophylactic treatment; palliative and chronic care; antiretroviral therapy (ART); psychosocial support; and life skills to cope with the impact of the disease. During FY 2008, the program added a program component of prevention education that emphasises abstinence (A), being faithful (B) and prevention with positive (PwP) approaches. Currently, RTI is supporting the implementation of services under this program in 41 district hospitals and health center IVs. Now in this fifth and final year of implementation, the program is consolidating program interventions to ensure that activities and service delivery continue after the end of the project. This narrative summarizes proposed activities for the performance period October 2009 to March 2010, the official end date of the program. Additional details on planned activities are provided

under each budget area. Here below is a highlight of the key accomplishments made on the project to date.

(a) By the end of August 2009, an estimated 330,000 persons had been counseled, tested for HIV and received their results under this program. It is hoped that by the end of FY 2010, more than 400,000 persons will have been provided with CT services under this program. (b) RTI contributed to the development of materials for use in training and implementing RCT activities by health workers in collaboration with several other partners in the country. These materials which include training manuals, provider cue cards, standard operating procedures and implementation protocols have been useful in the harmonization of HCT training programs for health workers around the country. (c) More than 3000 health workers have been trained in RCT/BC implementation since program inception in March 2005; (d) The project has also conducted several Information, education and communication (IEC) activities to increase program awareness. These include IEC materials produced in English and local languages that are distributed and posted in conspicuous places within supported health facilities and sensitization meetings with health facility, district and community leaders, so as to further inform the target audience about the program. (e) The project has adapted MOH health management information (HMIS) tools to generate accurate RCT/BC data.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9183	**Mechanism Name: Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and**

	Treatment Services among People Living with HIV/AIDS
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: The AIDS Support Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 15,257,636	
Funding Source	**Funding Amount**
GHCS (State)	15,257,636

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TASO is the oldest and most experienced non governmental organization (NGO) providing HIV/AIDS services in Uganda. To date, TASO has cumulatively cared for over 200,000 clients of whom over 90,000 are active; while over 30,000 clients cumulatively enrolled on ART. TASO has the widest non-government HIV/AIDS service delivery network in Uganda and directly complements the efforts of Ministry of Health (MoH). TASO has 11 Service Centres located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso in the 4 geo-political regions of Uganda. These Centres provide services for the host districts and 3 to 4 neighboring districts. Although Centers are located in the urban district towns/cities, they have extensive service delivery networks up to grassroots communities. TASO also operates 1 International HIV/AIDS Training Centre and 4 Regional Training Centres. The Training Centres conduct various HIV/AIDS courses for service providers. TASO Head Office is located in Kampala and is in charge of: Finance Management; Human Resources & Administration; Advocacy; Training & Capacity Building; Program Management; Planning & Strategic Information.

TASO provides a continuum of comprehensive HIV/AIDS prevention, care, treatment and related support services to HIV-positive people and their families. TASO activities include provision of antiretroviral therapy; counseling services for empowering PHA and supporting ART adherence; TB screening and treatment services; services for prevention, diagnosis and treatment of OI; PHA with the Basic Care Package (BCP); prevention with positives interventions; confidential Home-Based HIV Counseling and

Testing (HBHCT) services for clients' family members; Home Care services; training and capacity-building of different caliber of staff in HIV/AIDS service delivery; supporting and maintaining linkages and referral mechanisms for expanded access to services. In addition, TASO conducts advocacy on the driving factors of the epidemic, issues inhibiting access to services and addresses stigma due to HIV/AIDS. Each TASO Centre is equipped with pharmacy, adequate storage space for supplies and a laboratory that has capacity for diagnosis of opportunistic infections and HIV disease monitoring.

TASO works closely with MoH, and all its service centres operate within or close to District, Regional Referral and National Referral Hospitals. This facilitates contribution to and strategic collaboration with the public health care system. In many cases the 11 Service Centres serve as specialized HIV/AIDS clinics to the MoH district and regional referral hospitals as well as other lower level government health facilities. TASO maintains a referral mechanism with all levels of government health facilities. As a way of contributing to universal access and equitable service delivery, TASO has also trained and supports 23 peripheral partners to provide TASO-like services in under-served districts; these partners include government hospitals, private-not-for profit hospitals and community-based organizations.

TASO through support of PEPFAR and other funding partners has developed all the 11 Service Centres into leading HIV/AIDS prevention, care, support and treatment provider in the regions of Uganda where they are located. TASO Centres have an experienced, well-qualified and well-trained workforce of over 1,000 personnel, an average of 75 staff per Centre. The Centre teams are multi-disciplinary including Medical Doctors, Counselors, Clinical Officers, Nurses, Pharmacy Technicians, Laboratory Technicians, Data Managers, Social Workers and Support staff. Individual staff have received multi-disciplinary on-job training to facilitate multi-tasking in deployment for service delivery; the workforce is organized in cohesive small teams (departments and sections) under supervisors; the supervisors undergo regular training and mentoring in leadership and supervisory management. All frontline staff are trained, facilitated and motivated to cultivate and maintain personal contact with the clients. Staff are required to be fluent in the local languages of the Centres of their respective deployment. All jobs have comprehensive Job Descriptions (JD) and the Human Resources & Administration Directorate ensures regular update of all JDs. Apart from their formal qualifications (Degrees, Diplomas, etc), TASO requires all job applicants to have undergone robust HIV/AIDS training with a practicum component. TASO also provides regular didactic and experiential training to keep service providers up-to-date. TASO will manage and oversee program activities the following system: -

• Governance: The TASO governance structure includes a national Board of Trustees (BOT), 4 Regional Advisory Councils (RAC), 11 Centre Advisory Committee (CAC) and the Clients' Council. The BOT oversees the TASO program nationally and is the highest decision-making organ; the RAC oversees the TASO program in the 4 Regions of Uganda; the CAC oversee the activities of each of the 11 Centres; and

the Clients' Council advocates for clients' rights, mobilizes clients to exercise their responsibility and advise management on clients' issues. All of these governance structures are periodically elected by the Annual General Assembly.

• Program Leadership & Oversight: Overall management and leadership of the TASO program at national level will be done by the Executive Director. This position is assisted by 2 Deputy Executive Directors (in charge of Program Management, and Support Services) and other Directors oversee Planning & Strategic Information, Training & Capacity Building and Advocacy. All the Directors are highly-trained, highly-skilled and experienced individuals in HIV/AIDS programming.

• Management of Activities: Each of the 11 Centres is headed by a Centre Manager. The 11 Managers in charge of TASO Centres are well-qualified and experienced individuals who have undergone specialized experiential and didactic training in leading HIV/AIDS programming and managing TASO Centres, in addition to other training. The Managers ensure adherence to organizational policies and systems. Each Centre Manager is assisted by 5 heads of department, namely Medical Coordinator, Counseling Coordinator, Accountant, Human Resource Officer, Project Officer and Data Manager. These 5 officers supervise multi-tasked teams of highly motivated frontline staff.

• Service Teams at Centres: TASO has just over 800 frontline staff. All staff are well-qualified, have undergone comprehensive training in their respective responsibilities and undergo regular refresher training to keep up-to-date. Besides their service delivery skills, the frontline staff have other beneficial skills in planning, customer care and teamwork among others. TASO will maintain the existing personnel at Headquarters and Centres to steer the program during FY 2009.

• Quality Assurance: TASO ensures that all service providers and Service Centres adhere to the National Guidelines for delivery of various HIV/AIDS services. TASO has Standard Operating Procedures (SOPs) for all services provided by the 11 Service Centres. The SOPs comply with National Guidelines and are observed by all service providers. These SOPs are regularly reviewed in a participatory manner to match the fast paced developments in HIV care and support technologies. TASO has a comprehensive Quality Assurance Manual spelling out the basic minimum standards to be ensured by all service providers.

• Management Information Systems: TASO with support from partners, has developed robust computer-based management information systems (MIS) for generating strategic information and managing/tracking resource utilization. The key organizational systems include Navision 3.0 Accounting System; the Health Management Information System (HMIS); Appointments Management System; Clients' Identification/Mapping System; Clinical Laboratory Information System; Pharmacy and stores Information Management System; Supply Chain Management System; Fleet Management System and

Human Resources Information System. These systems are integrated in order to maximize the quality and integrity of information produced. TASO regularly updates these systems and re-trains data staff to keep the MIS up-to-date. Updates of the MIS shall continue during FY 2009.

• Organizational Policies: All TASO Centres are managed in accordance with documented organizational policies. TASO policies are developed through an inclusive process that harmonizes the views and interests of all key stakeholders. The policies are in harmony with the laws and guidelines of Government of Uganda and the funding agencies. TASO policies are approved by the TASO Board of Trustees. TASO has policies for Procurement, Human Resource Management, Governance, Financial Accounting and other issues.

• Performance Monitoring: TASO has a comprehensive internal performance monitoring mechanism. The Directorate of Planning & Strategic Information (PSI) at TASO Headquarters leads the performance monitoring function. Annual work plans and targets are developed from the TASO Strategic Plan. Each of the 11 Centres has monthly, quarterly semi-annual and annual targets to achieve. Service providers fill data collection forms that measure the quantity and quality of work. Data personnel manage service data as well as data from other systems. Centres submit monthly programmatic and financial reports to TASO Headquarters based on data, lessons and observations recorded. TASO Headquarters generates regular (monthly, quarterly and annual) reports and adhoc reports, Programmatic and Financial Reports for CDC/HHS, Ministry of Health, and other national partners. The reports are also used internally for reviewing performance and improving quality of service delivery.

• Audit Arrangements: TASO has an elaborate Internal Audit system implemented by the Internal Audit Unit comprising the Chief Internal Auditor and three other Auditors. The Auditors are well-qualified and undertake regular performance enhancement training. The Team conducts comprehensive audit of all TASO Centres twice a year, and also conduct other audits as need arises. The audits include both financial and programmatic reviews. TASO operations are also audited externally by internationally recognized audit firms. Internal Audit Unit reports to the Board of Trustees on a quarterly basis.

• Procurement Procedures: TASO conducts competitive open procurement of drugs, medical supplies, stationary, equipment and other program needs. All Centres adhere to the Procurement Policy. Each of the 11 TASO Centres and other TASO units have a Procurement Committee constituted according to the TASO Procurement Procedures policy. There are clear cross-cutting guidelines for situations where prequalified suppliers such as Medical Access will be used.

• Technical Support: The program will have a three-tier technical support mechanism to the services at the 11 Centres. This will be done by the Program Management Directorate at TASO Headquarters,

Ministry of Health (MoH) and the CDC/PEPFAR Country Team. The teams from MoH and CDC will provide regular support to the Directorates of Program Management and Strategic Information at TASO Headquarters. The Directorates will in turn support the TASO Centres through quarterly support visits. The 11 TASO Centres will also collaborate with MoH in the areas of capacity-building for the Centres, availing of the national guidelines by MoH, provision of supplies for TB management, providing consultancy on ART delivery and providing counseling and psychosocial support at MoH facilities by TASO staff.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	15,000
Water	80,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9183**		
Mechanism Name:	**Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS**		
Prime Partner Name:	**The AIDS Support Organization**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,280,000	
Narrative:			
TASO will continue offering both facility-based and community-based care to clients at the 11 centres, 34 outreach clinics at adjacent Government facilities, client homes and over 900 Community Drug Distribution Points (CDDP). The TASO centres are in 11 districts strategically located in the country and each centre serves clients from the host district and 3 to 4 neighboring districts. Apart from the index clients, services will also target household members and the general community especially in relation to stigma reduction, and adherence to HIV/AIDS care, support and prevention. The services will include both clinical and non-clinical activities.The following will be the key services to be offered:			

• Management of Opportunistic Infections (OI): TASO will provide medical care aimed at early OI diagnosis and management. Medical care will target new and continuing clients registered at the TASO Centres. Major interventions will include: screening and management of common OI; malaria management; STI management; provision of cotrimoxazole prophylaxis and the basic care package; regular follow up of clients in care; referral of clients for specialized care; networking with other partners for quality care; client empowerment activities; and others. Service delivery is provided at TASO centres, client homes and outreach clinics. Medical services conform to national and international quality standards. The quality assurance procedures for medical care will include: refresher trainings, supervision of clinicians, meetings on quality medical care, Continuing Medical Education (CME) sessions, support visits and clients' satisfaction reports.

• Counseling adult clients and family members: Counseling sessions oriented to HIV/AIDS care and support will be conducted for clients. These sessions will focus on HIV prevention, supporting clients to disclose serostatus to sexual partners and significant other persons; and provision of information on STI, FP, PMTCT nutrition, TB/AIDS, cotrimoxazole and safe water vessels. Counseling sessions will be conducted at TASO Centres, Outreach Clinics, Community Drug Distribution Points (CDDP) and client homes. Counseling services will conform to national and international quality standards. Quality assurance procedures for counseling services will include: refresher trainings, counselor supervision, meetings on quality counseling, Continuing Counseling Education (CCE) sessions, support visits and client satisfaction feedback. TASO will continue to address gender-related challenges affecting HIV care and support through messages focusing on male norms and behaviors, gender equity, women's rights, domestic violence and coercion.

• Provision of the Basic Care Package (BCP)
TASO will continue to receive and distribute the BCP in partnership with Program for Accessible Health Communication and Education (PACE). Staff at the 11 Centres will continue to train/retrain clients on the use of the BCP commodities.
Cotrimoxazole Prophylaxis: Has been found to reduce the incidence of OI including malaria among PHA. It has been mainstreamed into the TASO care and support package. TASO will provide cotrimoxazole prophylaxis to all the eligible existing 81,000 adult clients and 18,000 new adult clients. Dapsone will be provided as an alternative for the few clients who are allergic to cotrimoxazole. All TASO clients will be educated and counseled on cotrimoxazole prophylaxis. 95% of all clients on ART will be enrolled on cotrimoxazole prophylaxis and at least 75% of all TASO active clients.
Safe Water System: Clients will be provided with Safe Water Vessels and chlorine water treatment as part of the BCP. This will prevent contamination of drinking water and consequently reduce the spread of water borne diseases, especially diarrhea among PHA at TASO.

Male Condoms: These are provided depending on the age of the client; the BCP would contain condoms for the adult packages and none for children. In addition condoms are distributed at all TASO centers, outreaches, CDDP and by community volunteers; so clients can access condoms whenever they need them.

Long-Lasting Insecticide Treated Nets (LLITN): Clients will be provided with LLITN for malaria prevention. New index clients and their children aged below 5 years will be prioritized.

• Capacity-Building for Adult Care: TASO has over 4,000 community volunteers including 1,000 expert clients. All new staff at the 11 TASO centers will receive training in HIV/AIDS care and support. In addition TASO will train staff at the 21 Mini-TASO/CBO partners and public health facilities with emphasis on hard to reach areas, conflict and post conflict areas. This training will also include the training of clients in the provision of peer support.

• Client Education/Mobilization: TASO will facilitate provision of information to communities through music, dance, drama and giving testimonies. This will be done by 11 PHA groups; each of the 11 Centres has 1 group consisting of 25 people. These groups simplify the messages by presenting them in ways easily understood by the communities and in the local languages. The audience can also easily identify with the experiences shared through the messages.

• Reduction in HIV transmission to spouses and children through PWP interventions including behavioral change communication, provision of condoms, partner reduction, partner testing and disclosure, controlling alcohol use, biomedical interventions like STI care, prevention of unintended pregnancy.

• Other cross cutting issues like gender mainstreaming, linkages between facility and community based care, human resources for health, supply chain management.

• Appropriate Monitoring and Evaluation (M&E) of the quality of care and support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	2,560,000	

Narrative:

TASO programming for FY 2010 will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of Persons with HIV/AIDS (PHA); enhancing partnerships; quality assurance; consolidating the gains of the national response; enhancing comprehensive accountability (financial, programmatic,

governance and cost-effectiveness); ensuring value addition to national programming; addressing key drivers of the epidemic; and supporting efforts towards a strong public health sector. In conflict and post-conflict settings, TASO proactively address challenges faced by refugees and internally displaced persons.

About 81,000 active adult clients were served at various service delivery venues operated by TASO Centres. In FY 2008, the TASO priorities for Adult Care & Treatment were: providing counseling services to clients and their family members; management of opportunistic infections (OI); management of sexually transmitted infections (STI); provision of the basic care package (cotrimoxazole prophylaxis, safe water system, condoms, and information on nutrition, STI, FP, PMTCT, TB/HIV); conducting various courses to train service providers to provide HIV care and treatment.

By the end of FY 2009, TASO will target over 27,000 adult clients on ART at the 11 TASO Centres nationwide. The TASO ART program registered very high levels of adherence. Over 95% of the clients on ART had adherence levels of over 96% using a three-day recall. Service providers continued to support the few clients with low adherence through follow-up. Clients with high adherence were counseled to maintain the good performance. Clients received ARV drugs both through the facility arm (11 TASO Centres) and the community arm (client homes and Community Drug Distribution Points). Field Officers delivered ARV drugs to Community Drug Distribution Points and client homes. TASO continued evolving and supporting delivery models that meaningfully involve PHA. The 1,000 expert clients that had been trained as Community ART Support Agents (CASA) continued playing a grassroots role in supporting ART clients in the community (these TASO trained resource persons support other clients in the community to access treatment from other partners).
The 11 Centres continued running multidisciplinary Case Conferences to: assess eligibility for ART initiation; assess client readiness for ART initiation; and switch clients between the facility and community ARV delivery arms. TASO evaluated the MIS modules for Pharmacy, Laboratory and Stores Management in order to identify and address the gaps in their capacity to support quality assurance, M&E and logistics management. TASO also evaluated the ART Data Management modules to enhance generation of information and knowledge from program data. TASO improved the Clients' Appointment System to ease the pressure of client load on Centre resources through scheduling clients to visit Centres on appointment. The system was also aimed at enhancing the quality of services through adequate preparation by service providers. TASO Centres continued using the Pharmacy Information Management System (PIMS) for facilitating upfront planning of drug refills through providing critical information such as clients who did not pick up drug refills for follow-up. TASO units were supported with refurbishment of the existing infrastructure to improve the environment for service delivery and improve the filing and archive rooms for clients' records. Procurements were made to fill the identified gaps in various program areas. TASO solicited feedback through periodic meetings for various teams of service

providers. Key issues addressed by meetings and workshops included: program guidelines; strategic information and knowledge; capacity-building; strategic planning; service delivery models; ART implementation challenges; and other key issues.

During FY 2010, TASO will provide Adult Care & Treatment services at the 11 Centres located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso. Each of the Centres will directly serve clients from the host district and up to 6 neighboring districts. All the 90,000 active adult clients will be facilitated to access a comprehensive package of high quality adult care and treatment services. The adult care and treatment package will comprise: counseling for clients and family members; provision of antiretroviral therapy (ART); screening and treating opportunistic infections; screening and treating sexually transmitted infections (STI); providing vital information on cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT, TB/HIV; enrolling clients on cotrimoxazole prophylaxis; providing and promoting use of the safe water system; providing LLITN; providing condoms to sexually active clients; conducting various courses to build capacity of service providers to provide HIV/AIDS treatment; and provision of nutritional supplements for clients. In order to reach the targeted beneficiaries, TASO will provide HIV/AIDS treatment services through various venues, using appropriate and proven service delivery models. TASO is a key partner in developing innovative client-friendly and community-friendly service delivery models. The 11 TASO Centres will deliver services to clients through the 11 static outlets, clients' homes and 34 outreach clinics sites (each of the 11 TASO Centres conducts monthly outreach clinics in about 3 public health facilities within 75 km radius). The broad service delivery strategies will include mobilization and sensitization, capacity-building, beneficiary involvement, greater PHA involvement, partnership and collaboration and others. TASO will continue sensitizing clients on the importance of the various care and treatment services in improving the quality of life of clients. Sensitization will be done through counseling, health education talks, music dance and drama performances and IEC materials at all service outlets. Staff at the 11 Centres will educate clients on various Care & Treatment issues through individual and group sessions. The messages delivered to clients also address male norms and behaviors, gender equity, women's rights and gender violence. The various TASO field teams will monitor use of treatment services during regular visits to clients' homes. TASO will provide STI information to all adolescents and adult clients with emphasis on sexually active clients. All sexually active clients will be screened for STI routinely and all clients will be screened for STI at least twice a year. All clients diagnosed with STI will be counseled, treated, helped to mobilize sexual partners for treatment, given condoms and condom education. Teams at the 11 TASO Centres will follow up specific STI cases and refer for specialized care where necessary. STI screening is vital as increasing proportions of clients resume sexual activity as part of the paradigm shift arising from improved health due to ART. During FY 2010, TASO Centres will scale up cervical cancer screening for the female clients above the FY 2009 level. Teams will support clients to uphold the high adherence levels recorded (over 95% of the clients on ART had adherence levels of over 96% using

a three-day recall) and supporting the few clients with low adherence through follow-up. Clients will continue to receive ARV drugs both through the facility arm (i.e. 11 TASO Centres) and the community arm (i.e. Clients' Homes and Community Drug Distribution Points). TASO teams will use experience and program feedback to improve the existing models and explore more client-friendly service delivery models. Gender-related challenges often impede the success of adult treatment services. TASO will continue addressing gender issues affecting HIV/AIDS treatment through messages focusing on male norms and behaviors, gender equity, women's rights, domestic violence and coercion. Messages will be delivered through individual and group sessions to clients that encourage feedback by the recipients and dialogue. Quality assurance will be done through ensuring adherence to national and international standards, conducting regular refresher training for service providers, rigorous support supervision of service providers, technical support visits to service outlets and teams, conducting regular QA meetings in service delivery departments and conducting regular client satisfaction feedback exercises. The Adult Treatment program area is related to the program areas of PMTCT, TB/HIV, Counseling & Testing, ARV Drugs and Services and Laboratory Infrastructure. The activities under Adult Care & Treatment will not be delivered in isolation but the program area will be implemented in an integrated service delivery model bringing together activities under all the above program areas to form a comprehensive service package accessed by TASO clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	986,475	

Narrative:

TASO will continue providing confidential HIV counselling and testing to family members of all registered clients. The focus will be to test all children in households of TASO clients who are aged 5 years and below and spouses/sexual partners of all the registered clients. By the end of June 2009, TASO had cummulatively visited 17,056 homes of clients to conduct Home Based HIV Counselling and Testing (HBHCT) and tested 79,710 household members. Of the household members tested; 14.7% were aged less than 5 years; 36.8% were aged 5 - 15 years and 48.5% were aged over 15 years; 5.2% (4,127) tested HIV positive. For households where there are school going children, TASO teams schedule repeat visits at appropriate times when the children are home such as during school holidays. Alternatively children are given appointments at outreaches or nearby Community Drug Distribution points (CDDP). TASO uses a multi-pronged approach in mobilizing family members for HIV counselling and testing including: health talks to index clients at various service delivery points; drama groups using music, dance, drama and testimonies; home visits through a network of over 4,000 community volunteers; IEC materials; at public eents and using mass media. Testing is done at client homes, TASO centres, outreach clinics, CDDP or referred to other accessible HIV counselling and testing service providers. The testing is conducted using a 3-tier rapid HIV testing algorithm in line with the national HIV counselling and

testing guidelines provided by the MoH. Testing is done by TASO Field Officers, Counsellors or Medical personnel who were all trained in HBHCT using a curriculum developed by Strenthening Counsellor Training in Uganda (SCOT); an organization founded by a consortium of partners including TASO, MoH and other partners to strenthen counsellor training and skills in Uganda. TASO conducts annual refresher training for staff participating in HBHCT to refresh their skills, share experiences and update knowledge. Test samples undergo both internal and external quality assurance at nearby Regional Referral Hospitals. Dry Blood Spots (DBS) samples are taken from children 18 months and below for testing at the Joint Clinical Centre (JCRC) Laboratory. The primary goal of the activty is to: identify people who are HIV positive and refer them for HIV/AIDS prevention, care, support and treatment services; identify discordant couples and refer them for appropriate services; and identify HIV negative persons and reinforce HIV/AIDS prevention messages

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	320,000	

Narrative:

The identification of infants born to HIV-infected women is a necessary step in infant diagnosis. TASO shall continue to use the national ART and PMTCT diagnostic protocols by screening children using Dried Blood Spots (DBS) where HIV is suspected, starting as early as six weeks after birth. DBS will be obtained by finger or heel prick and transported to Regional Referral Laboratories for Virologic Polymerase Chain Reaction (PCR) test. Children under 18 months will be closely monitored. Children under 18 months who are known or suspected to have been exposed to HIV will be closely monitored and early timely interventions including ART instituted to reduce early morbidity and mortality. Children of any age confirmed HIV positive will be counseled and linked to care, treatment and support. All infants once confirmed HIV positive willl be started on ART (Irrespective of CD4/CD4% status).The decision as to when to start ART in children more than 12 months shall be guided by immunologic and clinical staging of thee children.Regimens will be based on the National ART and care guidelines for infants and children.Most of the ARVs available for adults can also be used in children, though not all formulations are suitable for children. History of PMTCT shall be considered in selection of 1st line regimens. Use of Paediatric Fixed Dose Combinations (FDCs) shall be considered. Modification of treatment regimens will be considered for tuberculosis co-infection as there is potential for multiple drug interactions. (Rifampicin plus NNRTIs/PIs). Counselling for ART is crucial ion children. Basic monitoring of children on ARVs shall consist of: clinical examination and WHO staging; immunologic CD4 %/CD4 counts; viral loads will be reserved for complicated management decisions following case conferences and training of TASO staff in Paediatric HIV care, treatment and support will be undertaken. Growth and development monitoring will be done using revised WHO growth charts for early identification of growth faltering and institution of corrective measures including nutritional supplements to promote growth and development. Weighing

scales, Stadiometers and tape measures shall be procured. Infant feeding within the context of HIV shall be done according to National guidelines. Optimal feeding to minimize MTCT, prevent malnutrition and promote growth and development shall be practiced. Cotrimoxazole (CTX) prophylaxis shall be instituted for all HIV exposed and infected children starting at 6 weeks of age and continued until HIV is excluded. For HIV-exposed children of any age that are still breastfeeding, CTX will be continued until HIV is excluded i.e. 12 weeks after complete cessation of breastfeeding. Paediatric-specific adherence issues e.g. availability and palatability of drug formulations, relationship of drug administration to food intake in young infants and dependence on caretakers for administration of drugs shall be considered. Adherence shall be monitored through pharmacy refill records, pill counts and home visits for spot checks. Opportunistic Infections Prevention and Care. Provision of opportunistic infections prevention and care will be based on recommendations contained in the National Guidelines for CTX preventive therapy. All HIV infected children, regardless of CD4%/CD4 count shall receive CTX preventive therapy. All TASO HIV exposed and infected children shall be linked to appropriate specialized health facilities and community care e.g. Immunization clinics. Comprehensive Paediatric HIV care, treatment and support shall be provided according to the Ten-point package of the African Network for the care of children affected by HIV/AIDS (ANNECA) and adapted by the government of Uganda. This includes: confirming HIV infection status as early as possible; monitoring the Childs' growth and development; immunizations according to National guidelines; prophylaxis against OIs particularly Pneumocystis Carina Pneumonia (PCP); treatment of acute infections and other HIV-related conditions; counselling on infant feeding, good personal and food hygiene; conducting disease staging; ART for the infected child if needed; provide psychosocial support for the infected child, mother/caretaker & family and referral to higher levels of specialized care when necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	640,000	

Narrative:

TASO currently takes care of over 6,000 HIV infected childrenages 0 - 18 years at the 10 TASO Centres of Entebbe, Gulu, Jinja, Masaka, Masindi, Mbarara, Mbale, Rukungiri, Soroti and Tororo. TASO runs a collaborative family clinic with Baylor Uganda at TASO Mulago Annex in Kanyanya where TASO reports on psychosocial issues at the site whereas Baylor Uganda reports on medical issues of the children. Baylor Uganda is phasing out from the clinic and the process will be complete by April 2010. TASO will thereafter assume full responsibility of service provision at the clinic. TASO targets to have 10% (3,290) of the total (32,940) benefiting child clients. HIV exposed infants and children will be routinely screened for antiretroviral therapy starting at six weeks of age and following the TASO pediatric ART carepathway through a series of counselling sessions to the caregivers, the children as appropriate, pyschosocial assessment and support to the caregiver, laboratory and clinical evaluations at TASO centres and

outreaches. Antiretroviral drugs will be provided to eligible children at their homes, TASO centres, outreach clinics and at Community Drug Distribution Points (CDDP). Infant diagnosis will be done using the Dried Blood Spot (DBS) for HIV DNA-PCR starting at six weeks. The antiretroviral drugs regimens, pediatric eligibility criteria for ART and other pediatric HIV care guidelines will be as per national guidelines provided by MoH. Pediatric ARV drugs will be procured alongside adult ARV drugs and using the same supply chain processess. In addition it is expected that the UNITAID donation comming through the Clinton Foundation for pediatric ARVs and adult 2nd line ARV drugs will continue comming through for most of 2010. TASO has also adopted the comprehensive African Network for the care of Children affected by AIDS (ANNECA) ten point package for comprehensive pediatric HIV care. Support supervision of the TASO pediatric ART program will be done by a team from TASO headquarters that includes a pediatrician who will conduct bi-annual field visits to all the 11 centres. Support supervision tools developed by the Planning and Strategic Information Directorate will be used in accordance with the ANNECA ten point plan to enable a holistic approach to monitoring of children under care. Clinical and related data on the children will be monitored on a monthly basis by the data team including periodic CD4/CD4%, hemoglobin, occurance of opportunistic infections and drug adherence. Children will be linked to nearby health units for immunization, social/community based programs and specialized care when need a rises. All Monitoring and Evaluation activities will be conducted in accordance with the national Antiretroviral therapy treatment and care guidelines for adults and children. TASO will also provide therapeautic feeding to malnourished children during the first three months of initiating antiretroviral therapy or anti TB treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	395,064	

Narrative:

Mother to Child transmission (MTCT) is the second most common mode of HIV transmission in Uganda accounting for up to 20% of new infections. An estimated 25,000 new HIV infections occur in Uganda each year due to mother to child transmission of HIV (MTCT). Over 67% of the more than 90,000 active TASO clients are females. Of these, an estimated 60% are in the 15 to 49 year reproductive age bracket. Among key paradigm shifts due to improved health status resulting from ART are rebuilding broken relationships and families; and resumption of active sexual activity. Feedback has shown that with restoration of hope due to improved quality of life, clients regard having children as a key part of the plan to rebuild their lives and families. In FY 2010, TASO priorities for PMTCT will include: identification and counseling of pregnant clients; medical examination of identified clients at various points of service; provide information on PMTCT and infant feeding in the context of HIV/AIDS; prioritize pregnant women for ART eligibility screening; scale up combined ART therapy, improve adherence support, monitor pregnant women, nursing mothers and their infants; provide ARV prophylaxis for mothers and their new

born babies; strengthen early infant diagnosis of HIV/AIDS (EID) and linkages to pediatric HIV/AIDS care and treatment; conduct supportive home visits; engage pregnant clients and their sexual partners in counseling sessions and promote greater male involvement by continuous education of the male partners and communities; link pregnant clients to antenatal services as part of a two-way referral mechanism; follow up pregnant clients to support them deliver from health facilities under the care of trained health workers; follow up and test all HIV exposed infants starting 6 weeks of age using Dried Blood Spot (DBS). Infants confirmed to be HIV positive will be started on ART according to current Uganda National ART guidelines. Cotrimoxazole prophylaxis will be provided to all HIV exposed and infected children irrespective of clinical stage or CD4%. Futhermore, TASO will: engage in partnership with other PMTCT stakeholders to promote key issues including the 2 way referral, infant feeding in the context of HIV exposure or infection and essential postnatal care for HIV exposed infants; provide Family Planning information and access commodities for all sexually active clients; provide couple counseling to both HIV concordant and HIV discordant couples; empower sexually active clients to disclose their HIV status to their sexual partners; support discordant couple and concordant positive peer clubs. The activities under PMTCT will be implemented in an integrated service delivery model. This activity is linked to other USG funding through USAID and other non-USG partners including Government of Uganda, DANIDA, DFID, and Irish Aid through the Civil Society Fund (CSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	612,320	

Narrative:

TASO will continue to carry out activities under Laboratory Infrastructure to support service delivery at the 11 Centres located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso and to contract competent companies to conduct periodic servicing and maintence of selected equipment. Each of the Centres will directly serve clients from the host district and up to 6 neighboring districts. The equipment will also be used among public health facilities and other partners in the region. The Laboratory Infrastructure related activities will comprise of: automation of laboratory processes such as hematology and clinical chemistry as a way of improving quality of service by reducing on client waiting time and decreasing staff workload; enhancing quality assurance of laboratory services and linking with reference laboratories for external quality assurance; capacity building for laboratory personnel; ensure steady supply of laboratory reagents and consumables; review laboratory guidelines and standard operating procedures; improve clinical waste management; and enhance Laboratory Information Management System (LIMS). TASO will continue providing testing for HIV, Opportunistic Infections (OI), Sexually Transmitted Infections (STI), Tuberculosis, Malaria, Hemoglobin, white blood cell counts and differentials, CD4 counts, ESR, clinical chemistry tests for clients pre-ART, and monitoring drug toxicities. Clinical chemistry test services will be provided to public

health facilities and other HIV/AIDS care and treatment partner programs. Adequate capacity to cater for requirements of the various partners in the areas where they are located has been developed at TASO Mulago, Kanyanya Annex, Mbarara and Gulu. These centres serve as TASO centres and partners in Central Region, South western region and Northern region respectively. Other tests like DNA-PCR, viral load and resistence testing will be done by TASO partners with the necessary capcity. TASO will continue training and retraining laboratory staff on the use of modern laboratory diagnostic equipment. The Laboratory Infrastructure program area is related to the program areas of PMTCT, Adult Care & Treatment, TB/HIV, Counseling & Testing, ARV Drugs and ARV Services. The activities under Laboratory Infrastructure will not be delivered in isolation but the program area will be implemented in an integrated service delivery model bringing together activities under all the above program areas to form a comprehensive service package accessed by TASO clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	7,780,000	

Narrative:

TASO procures US Food and Drug Administration (USFDA) approved generic ARV or FDA approved branded ARVs. ARV drug procurements are done centrally by TASO Headquarters from Medical Access Uganda Limited (MAUL). MAUL was started under the United Nations Joint Programme on HIV/AIDS (UNAIDS) Drug Access Initiative (DAI). After adjusting forecast estimates using current consumption trends and projected enrollment rates, Headquarters places an order with MAUL for a two-month ARV drugs supply. The Pharmacy Support Officer (PSO) receives and checks requests and consumption reports from all the 11 TASO centres. Requests are then consolidated and a Local Purchase Order (LPO) raised and issued in accordance with TASO procurement guidelines. A distribution schedule is prepared and forwarded to TASO Headquarters Stores copied to all the 11 centres. The order is delivered to TASO Headquarters' controlled stores environment by the supplier under their own insurance cover. The PSO verifies the commodities and a Goods Received Note (GRN) is issued to the vendor. Quarterly 12 months forecasts are prepared and submitted to MAUL to guide the supply chain basing on current and expected client enrollment on ART. The forecasts are updated on a quarterly basis to take care of unforeseen variations during a quarter. Quantification to adjust forecast estimates to suit the replenishment cycle/actual need is done. ARV drug quantification is done based on the actual consumption trend and the projected enrolment at a time. Monthly transactions data from all the 11 centres are collected and compiled by Headquarters. Thereafter at end of a calendar month, the PSO is able to know TASO Global ARV stock status in terms of; physical closing stock, available client months, expenditure in client months, cost per client months, total physical closing stock value in monetary terms, total value of expenditure, number of months the available stock can sustain TASO clients per each individual item and physical stocks and consumption at each ART site. Subsequently decisions such as,

quantity to order, relocation of some items from one center to another that may be in excess, low consumption or reduced consumption of a particular item are made. The ARV drugs buffer is kept in the range of 3 - 4 months worth of stock; its value is not static because of changes in: consumption per item; policy changes such as those regarding switch of clients to other regimens; unit cost at the time; availability of generic alternatives; enrollment trends. Both a manual and a computerized records keeping system are in place to quickly help obtain vital strategic information. However the current Pharmacy Information Management System (PIMS) has some challenges and processes of developing a faster and a more user friendly system to address current shortcomings in order to produce real time data. The PSO checks and receives ARVs from the supplier and distributed basing on the pull system. The schedule of distribution is forwarded to Headquarters' Storekeeper. Communication is sent to Medical Coordinators through Center Managers to come and pick up ARVs. Centers are guided to start the replenishment process when they are left with a 2-month supply. As the ARVs leave headquarters a delivery note is issued and centers issue a GRN in duplicate with both the center and the headquarters retaining a signed copy of each. AT centres, ARVs cage/room with a double lock system is provided for. The Store Keeper and the Pharmacy Technician keep a copy of the key each. A double lock system cabinet is also provided to each center Pharmacy. The center Pharmacy Technician makes weekly requisitions of ARVs from the Center ARV Cage in the store to the cabinet in the pharmacy. As ARVs leave the store, the following signatures are obtained: Store keeper to sign stock out of ARV cage; Pharmacy Technician to sign for stock taken out of center ARV cage. The delivery of drugs to clients is done at three levels: - Pharmacy Technician to Field Officer (FO) for clients that receive their refills at home; Pharmacy Technician signs stock out of DDA to FO; FO signs to acknowledge receipt; FO signs stock brought back into DDA and Pharmacy Technician signs for receipt of the returns. The pharmacy Technician then balances the stock cards. FO and Client: FO signs for delivery; client signs for receipt; client signs in missed doses; FO signs to acknowledge receipt of the missed doses; FO compiles his drug distribution report and Pharmacy Technician compiles FO daily reports into his consolidated daily report. Pharmacy Technician to Client for facility based clients: Pharmacy Technician signs the doses out to the client; client signs for received doses; client signs in returned doses and Pharmacy Technician receives the returned doses. The TASO ARVs tracking system emphasizes documentation at every point the ARVs change hands, from supplier up to the final beneficiary who is the client.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	683,777	

Narrative:

TB management is an integral component of the TASO care and support package due to the high prevalence of TB/HIV co-infection among persons with HIV (PHA) and transmission to close contacts. The TB management component comprises: TB health education for clients and community members;

training of health service providers in management, finance and logistics for TB control; routine TB screening for all clients using an array of methods; TB diagnosis with smear microscopy being the primary diagnostic tool for pulmonary TB; provision of anti-TB drugs and ensuring reliable supply chain for anti-TB drugs to deliver uninterrupted supply of standardized short course chemotherapy (SCC); support for adherence to anti-TB treatment using the Directly Observed Treatment Short course (DOTS) strategy; home visits to clients on TB treatment; follow up of all TB clients notified for treatment until treatment completion and a definitive treatment outcome given for every registered case; support partnerships and linkages for TB treatment; ensure proper record keeping for TB treatment and accountability of every registered case; clinical waste management; referral of TB patients; and advocacy as an integral part of effective TB control. All clients seen at TASO clinics are screened for TB using various methods including history taking, clinical examination, sputum examination, and chest X-ray. Those diagnosed with TB were linked to treatment at TASO Centres and through MoH facilities. TASO will continue to partner in the national Community-Based DOT TB strategy. All TASO Centres are located within government hospitals and provide support to the hospital TB clinics. The TASO Centres get regular technical support from the National TB and Leprosy Program (NTLP). TASO will continue providing TB/HIV services at the 11 Centres located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso using the DOTS Strategy as the gold standard for TB management and control. Each of the 11 TASO Centres will directly serve clients from the host district and up to 6 neighboring districts. All the 100,000 projected active clients will have the opportunity to be screened for TB and access TB/HIV services at least once a year. The broad service delivery strategies will include mobilization and sensitization, capacity-building, beneficiary involvement, health education, partnerships and collaboration. Health education also addresses male norms/behaviors, gender equity, legal rights and gender violence.TB infection control will be an ongoing activity through strategies including: (1) continuous TB education for clients and carers;(2) TB infection control at all client waiting areas and within the clinics;(3) mandatory segregation and appropriate disposal of clinical waste;(4) use of hoods in the laboratories; and (5) proper ventilation of the clinic infrastructure. The TB/HIV program area is related to the program areas of PMTCT, Adult Care & Treatment, Paediatric Care & Treatment, Counseling & Testing, ARV Drugs and Laboratory Infrastructure. The activities under TB/HIV will not be delivered in isolation but the program area will be implemented in an integrated service delivery model bringing together activities under all the above program areas to form a comprehensive service package for TASO clients.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9184	**Mechanism Name: Strengthening HIV Counselor Training**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: The AIDS Support Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Strengthening HIV Counselor training (SCOT) project is a collaboration among organizations with a stake in HIV counselor training in Uganda. The project that was initiated in September 2004 exists to cater for the growing needs of HIV counselors in dealing with complex HIV/AIDS issues through standardizing HIV counselor training curricula and materials, implementing innovative training programs, developing evaluation instruments, strengthening quality assurance measures and promoting coordination of HIV counselors. SCOT is a five year project, with the cooperative agreement expiring by March 31, 2010. SCOT exists to pursue the following objectives;

1. To review, update and develop standardized HIV counseling training curricula that are responsive to the changing needs of HIV prevention, care and treatment.
2. To support HIV counseling training institutions to develop and update the knowledge and skills of trainers and support the implementation of the standardized curricula in order to enhance training ad learning effectiveness.
3. To facilitate the review and development of standardized monitoring and evaluation systems and to enable HIV Counseling training institutions to select, evaluate and follow up individuals involved in counseling training and practice.
4. To support the development of criteria and standards for different cadres of HIV Counselors and the establishment of an accreditation system that regularly evaluates and sets minimum standards for training, certification, practice and self-regulation of HIV counseling in Uganda.
5. To support advocacy for recognition of the counseling profession and establish a coordination mechanism for stakeholders in HIV counseling.

SCOT therefore exists to enhance networking and collaboration among stakeholders involved in the training of counselors and utilization of counseling services in order to collectively develop, strengthen and standardize the practice of HIV counselors in Uganda; so as to empower individuals and improve the quality of lives of PHAs, their families and communities.

SCOT works closely with the Ministry of Health (MoH), Uganda AIDS Commission (UAC), Uganda Counseling Association (UCA), other line ministries, National Forum for people Living with HIV/AIDS (NAFOPHANU), HIV Counselor training institutions and development partners to improve the quality of HIV Counselor training and practice in the country.

SCOT implements activities that cover the whole country geographically. Specific target populations are HIV counselor training organizations, HIV Counseling service organizations, networks of people living with HIV and government policy makers.

SCOT contributes to health systems strengthening through supporting the development of National HIV counseling standards which are used to build the capacities of human resources in both government and non-government health units.

SCOT has used the partnership strategy to leverage resources and ensure cost-efficiency, has used well established procurement systems, has built on existing systems and resources and cost-shared with partners in order to expand the programs.

SCOT has for the years developed and maintained a dynamic comprehensive monitoring and evaluation system that helps to track all project activities.
The planning targets are therefore based on the six months period left to the expiry of the cooperative agreement with CDC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9185	**Mechanism Name: Rapid Strengthening of Blood Transfusion Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Uganda Blood Transfusion Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 218,000	
Funding Source	**Funding Amount**
GHCS (State)	218,000

Sub Partner Name(s)

The Uganda Red Cross Society		

Overview Narrative

Uganda Blood Transfusion Service

Project: Rapid Strengthening of Blood Transfusion Service in Uganda

Background and key activities undertaken in the Past.

The Uganda Blood Transfusion Service (UBTS) is the National Blood Service responsible for all blood safety activities for the entire country. The mission of Uganda Blood Transfusion Services is to achieve a safe, efficient and sustainable national blood transfusion service based on healthy volunteer blood donors and able to meet the needs of Uganda's health care system while promoting a good blood transfusion system.

In pursuit of the mission, the main objective of UBTS is to make available adequate quantities of safe blood and blood products for treatment of patients.
Specific objectives include:
1. To expand the blood transfusion infrastructure to operate adequately within a decentralized health care delivery system.
2. To increase the annual blood collection necessary to meet the blood requirements of all patients in the transfusing health units throughout the whole country.
3. To test all blood for transfusion-transmissible infections (TTIs) and operate an effective, nationwide Quality Assurance Programme that ensures safety of the entire blood transfusion process (from vein to vein).
4. To ensure continuous education and training in Blood Safety.

The UBTS contributes to the fulfilment of Uganda's Health Sector goals and the United Nations Millennium Development Goals [MDG] (in particular MDG4: reduce child mortality, MDG5: combat HIV/AIDS, malaria and other diseases and MDG6: improve maternal health).

The estimated hospital blood requirement is 200,000 units of blood annually to be able to handle all emergencies that need blood. 140,000 units of blood were collected in 2008 and distributed to 220 health facilities. 50% of all these collections were transfused to children; 25% to pregnant women and 25% to accidents and surgical/medical cases.

The UBTS has an important task of meeting the increased demand for safe blood transfusion especially at Health Centre IVs located in rural areas where most of the population lives. The target outputs and realized outputs are per attached.

The Uganda Blood transfusion services operate through a network of seven regional and six blood collection centers. While the national blood bank at Nakasero prepares all blood components including fresh frozen plasma, platelets and cryoprecipitate other blood banks are only able to prepare paediatric packs of blood concentrates and issues all blood for treatment of adult patients.

Blood collection is the main programme activity of UBTS. All blood collection is from voluntary, non-remunerated blood donors. In the previous four months April 2009 –July 2009 57,453 units of blood were collected. In a quality assured manner 100% of collected blood were tested for HIV, hepatitis B surface antigen, hepatitis C antibodies and syphilis.

To support appropriate use of blood clinical guidelines were revised, hospital blood transfusion

committees were appointed and documentation of blood used has been embarked on. Training in all areas of blood safety was another key activity implemented in the past year.

Monitoring & evaluation activities were implemented. National level staff and management offer support supervision and monitor implementation progress through regular visits to regional facilities and collection centres. The use of reports and forms designed to capture required data has been institutionalized. The data management unit at the national office analyses the information and compiles it into a quarterly reporting format. Feed back is provided as basis for subsequent planning and training and implementation

REDACTED.

The UBTS continues to face some challenges, including:
• Relatively high level of TTIs in collected blood especially Hepatitis B and C causing a significant quantity of blood to be discarded.
• Save for two regional blood banks the rest have continued to operate in small, restricted premises that negate efficiency of operates.
• The prices of blood collected supplies, like test kits and collection bags have increased yet funding level has remained constant over time. This has severely restricted our effort to increase collections.

The UBTS has continued to meet safe blood availability expectations of stakeholders. A strong case for additional complimentary funding continues to be made to government.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9185**		
Mechanism Name:	**Rapid Strengthening of Blood Transfusion Services**		
Prime Partner Name:	**Uganda Blood Transfusion Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HMBL	218,000	

Narrative:

The UBTS is a semi-autonomous department of the Ministry of Health with the overall objective "To ensure adequate supplies of safe blood and blood products are available and appropriately used for management of all patients in need throughout Uganda." The organization partners with the Uganda Red Cross Society (URCS) in blood safety activities nationally, with URCS contributing 40% in the area of voluntary blood donor recruitment and retaining. UBTS has a network of 7 Regional Blood Banks (RBB) and 6 blood collection centers which collect, process and distribute safe blood to health facilities countrywide.

The UBTS has received support for the last 5 years from PEPFAR. The objectives of this 5 year program include:

i) Strengthen UBTS infrastructure;

ii) Increase blood collections from voluntary non-remunerated donors;

iii) Improve the quality of blood available for transfusion;

iv) Improve transfusion practices in hospitals;

v) Implement a plan for sustainability.

PEPFAR support has improved infrastructure and blood safety activities. There is a 30% increase in blood collections from a safer donor pool; i.e. reduced prevalence of HIV, Hepatitis B and C. However, this success comes with the challenge of data collection, analysis and use for blood safety activities, more so with expansion of services. A blood banking information system (BBIS) was developed by UBTS and CDC Uganda which can track all steps in production of safe blood products and interface with high-tech lab equipment. This BBIS was piloted in 3 RBB and needs to be rolled out to 4 remaining RBB. This funding will be used to support the roll out and full functioning of the BBIS throughout the UBTS headquarters and RBB. Specifically, the following activities will be done:

• Procurement of hard and soft ware to support the BBIS

• Procurement and installation of Internet and E-mail Connectivity across RBBs

• Orientation of all the UBTS staff and training of relevant staff in use of the BBIS

• Transport for related monitoring and support supervision to the RBB

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9186	**Mechanism Name: Laboratory Quality Assurance-Cooperative Agreement**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Uganda Virus Research Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,215,000	
Funding Source	**Funding Amount**
GHCS (State)	1,215,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Uganda Virus Research Institute (UVRI) is a department of Government of Uganda (GOU), dedicated to conduct research on viral diseases since 1936. UVRI has continued to conduct research in isolation and characterization of HIV strains, understanding better the epidemiology and molecular epidemiology of HIV before and after the introduction of ART, comparing modalities of delivering ART, HIV vaccine and microbicide evaluation, PMTCT, HIV sero-behavioural survey, and provided the Ministry of Health (MOH) with HIV surveillance data from ANC and STI clinics. UVRI is mandated by MOH to provide Quality Assurance/Quality Control (QA/QC) to all HIV serological testing sites both public and private. Building on the experience over the past five years with USG funding, the HIV Reference and Quality Assurance Laboratory at the Uganda Virus Research Institute established a national laboratory quality assurance (QA) program focused specifically on HIV-related testing. This activity focuses on ensuring that the lay and the community health workers in addition to counselors and lab staff that obtain samples and test provide quality service. The goal is provision of quality assurance for HIV in the republic of Uganda.Objective1.Strengthen capacity at UVRI to assure the quality of HIV testing nationwide.2.Scale up rapid HIV testing services accross the country according to national and international standards3.In collaboration with other stakeholders provide support supervision to sites providing HIV, TB and malaria diagnostics.4.Proper management of cooperative agreement funds 5. Preparation of the sustainability of HIV QA/QC services accross the country. 6. Evaluation of the project.UVRI works with other partners in the implimentation of its activities.

The development of HIV drug-resistance (HIVDR) is recognized as a serious threat to the efficacy of current ART, & will compromise PEPFAR efforts to provide long-term treatment in sub-Saharan countries. Drug resistance (DR) is likely to have a greater influence on the long term success of ART programs than

any other single factor. Emergence of resistance to one or more ARV drugs is a reason for therapeutic failure in the treatment of HIV. In addition, resistance to one ARV drug sometimes confers a reduction in or a loss of susceptibility to other or all drugs of the same class. Patients with HIVDR must switch treatment regimens, reducing treatment options & significantly raising medication costs. Resistance is usually the result of sub-optimal regimens, or inconsistent use resulting from poor adherence &/or interrupted drug supply. The optimum time for minimizing the emergence & transmission of resistance is when treatment initiatives are still in the early stages & first-line regimens are widely used. Prevention, surveillance & monitoring of drug resistance are critical to the success of clinical & public health HIV/AIDS programs. WHO has developed standardized strategies, protocols, & guidelines for the prevention of HIVDR in resource-limited settings that are designed to be implemented alongside treatment programs? As part of this strategy, many African countries including Uganda have set up National HIVDR prevention, surveillance & monitoring programs in collaboration with WHO-AFRO. Among others the WHO plan includes periodic evaluations of early warning indicators (EWI) which have been shown to correlate with early emergence of DR. EWIs include poor drug supply continuity, inappropriate prescribing practices, & poor adherence among clients among others.
Objective 1: To continue to support the coordination for HIVDR Prevention, Monitoring and Surveillance at both national and Institutional level.1a) Support the coordinating center for the HIVDR Prevention, Surveillance and Monitoring Programme at UVRI in close collaboration with STD/ACP. 1b) Support the National HIVDR working group. Objective 2: To support and coordinate surveillance of HIVDR transmission in different geographical settings using Threshold Surveys. 2a) Conduct one Threshold transmission surveillance possibly in Mbarara. Objective 3: To Monitor Emerging HIVDR in treatment cohorts in selected sites. 3a) Conduct an HIV DR surveillance in 5 treatment sites (sites will be selected by geographical region, size and service provider). Objective 4: Support in country genotypic laboratories with adequate capacity to support HIVDR surveillance and monitoring activities in the country. 4a) Support UVRI in performing genotyping. 4b) Support the HIVDR resistance specimen collection repository at UVRI and other laboratories. 4c)Support UVRI and other laboratories in provision of internal and external quality control measures for procedures and reagents. 4d) Provide training and other forms of technical assistance to laboratories handling specimens to be genotyped for the HIVDR monitoring and surveillance

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9186		
Mechanism Name:	Laboratory Quality Assurance-Cooperative Agreement		
Prime Partner Name:	Uganda Virus Research Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	400,000	

Narrative:

With USG funding, the HIV Reference and Quality Assurance Laboratory at UVRI has established a national laboratory QA program focused specifically on HIV-related testing. This activity focuses on ensuring that the lay and the community health workers in addition to counselors and lab staff that obtain samples for testing are providing quality service to the client, obtain and provide quality samples following bio-safety guidelines.

During FY 2009, in-service training in QA/QC was provided to 70 lab and non-lab staff from the South West region in addition to staff from 323 other sites. Five SOPs for laboratory safety, sample processing, rapid and Elisa HIV testing, rapid syphilis testing and proficiency panel preparations for HIV were reviewed, updated and distributed to 1085 sites. We prepared and distributed 2835 proficiency testing panels to 476 testing sites PT results and provided corrective action when required. first response HIV test kit for plasma and whole blood was evaluated and disclosed a sensitivity of 97.6% and specificity of 95.6 for plasma and the respective values for whole blood are 97.6% and 98.3%.We compiled an HIV testing inventory, held sensitization meetings with the staff at the sites regarding quality assurance, provided support supervision in collaboration with National and Regional Lab Coordinators and District Lab Focal Persons, distributed SOPs and other information tools, provided formal reports disseminating the findings of support supervision to 476 testing sites both public and private. 222 testing sites employed non lab staff majority of whom were nurses and counselors (only 21 sites had these working without lab trained staff); 53 and 22 testing sites conducted CD4 counts and Viral Loads respectively, while 336 performed TB diagnostics, 396 performed malaria slides, 339 performed syphilis serology, 42 performed renal and liver function tests and 139 performed heamatology including lymphocytes. Adherence to SOPs was assessed; availability of SOPs was at 59.3% accessibility to SOPs was at 69.5%.About half of the sites displayed the SOPs, 67.2% understood them, while 69.7% implemented them. More than 95% of the testing sites implemented the National Testing Algorithms. Sites were further assessed for compliance with good clinical laboratory practice, waste disposal and availability of requirements to

conduct HIV testing. This information was shared with partners and sites during support supervision, workshop and the newsletter.

In FY 2010, UVRI shall ensure quality HIV testing is offered to individuals through training, support supervision and continuous assessment of QA/QC in all laboratories testing for HIV, TB, STI. There is need to scale up HCT services through training of service providers. 723 testing cadres will be trained in different courses- 225 lay and community health care workers trained for 5 days in HIV counseling and quality HIV rapid testing; 93 District Laboratory Focal Persons and Regional Laboratory Coordinators to receive TOT in use and handling of DST and DBS for 5 days; 225 clusters comprising of counselors, phlebotomists and laboratory personnel to be trained for 5 days in the quality assurance in pre analytical, analytical and post analytical aspects of HIV testing;150 staff identified by poor performance in proficiency panels to be given a refresher course in rapid HIV testing for 5 days; 30 Regional Laboratory Coordinators and the In-Charges of National and Regional Referral Hospitals to be trained for 5 days in preparation and characterisation of PTPS.
The training provided to RLCs and DLFPs will include: conducting supervisory visits, preparation and characterization of PT panels, distribution and interpretation of the results. We will work with DFLPs to ensure that their activities especially support supervision visits are incorporated in the annual district plan, and engage with the district leaders on the importance of high quality lab results. While the existing M&E plan drawn on national and USG requirements and tools will guide implementation of activities, more partnerships will be established with government and non government organizations, and, the virtual districts of the army, police and prisons. Support supervision visits, provision of Dried Tube Serum as PT panels and continuous assessment of QA/QC services in laboratories testing for HIV, TB, STI and malaria will continue. HIV serology testing QA/QC project will expand services to all HIV testing sites in the country. Working with MOH, particularly the Quality Assurance Unit, the HIV rapid test training coordination unit at CPHL and regional and district-level laboratory supervisors, we shall identify laboratories currently conducting HIV rapid testing and the tests/algorithm. New kits and algorithms will be evaluated. 1000 labs will be visited, 500 new labs and 500 old labs with poor performance in HIV quality assurance. Emphasis will be placed on the hard-to-reach areas, sites handling small volumes of specimens, private labs and labs where testing is mainly performed by non–lab personnel. We shall develop a quality assurance plan that takes advantage of joint supervisory visits and panel distribution with partners. Accredited labs using national/international standards will be documented and others assisted to get accredited. LIMS shall be linked to databases at CPHL and MOH to facilitate sharing of information including reports, logistics management and training needs. Discordant results will be resolved and external quality assurance done. The SOP for counseling and testing will be integrated for the benefit of the counselors, phlebotomists, and laboratory staff. With help from the Ministry of Education and Sports quality assurance of HIV testing will be taught in all lab training institutions. We shall continue to provide apprenticeship to both counselors and lab trainees at the UVRI clinic. Regular

communication will be provided to labs in Uganda to highlight the role of the National HIV QA Lab, share lessons learned, identify problems/issues for which assistance is required, and allow for dialogue about recent news and innovations in HIV lab services. For efficient and cost-effective management of the program, we shall establish organizational, financial and administrative structures and mechanisms necessary to carry out the program activities. A semi-annual report that disseminates the findings of the support supervision visits, resolution of discordant results, PT and evaluations of performance characteristics will be provided to MOH, implementing partners and testing sites. To achieve this, there is need to task shift by training lay and community health workers in quality HIV testing throughout the country. By maintaining and developing strong linkages with key service providers and trainers, UVRI shall support integrated training especially in the diagnostics of HIV, malaria, syphilis and tuberculosis thus maximizing benefits out of the available resources. The training provided to this cadre of personnel will ensure provision of high quality support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	100,000	

Narrative:

The development of HIV drug-resistance (HIVDR) has been recognized as a serious threat to the efficacy of current antiretroviral therapy (ART), and will compromise the efforts of PEPFAR to provide long term treatment, not only in Uganda but also in other sub-Saharan countries. Drug resistance is likely to have a greater influence on the long term success of ART programs than any other single factor. The emergence of resistance to one or more antiretroviral drugs is one of the more common reasons for therapeutic failure in the treatment of HIV. In addition, the emergence of resistance to one antiretroviral drug sometimes confers a reduction in or a loss of susceptibility to other or all drugs of the same class. Patients with drug resistance must switch treatment regimens, reducing treatment options and significantly raising medication costs, assuming appropriate 2nd line drugs are available at all. Resistance is most often the result of sub-optimal regimens, or inconsistent use due to poor adherence and/or interrupted drug supply. The optimum time for minimizing the emergence and transmission of resistance is when treatment initiatives are still in the early stages and first-line regimens are widely used (WHO,2003). Therefore, prevention, surveillance and monitoring of drug resistance are critical to the success of clinical and public health HIV/AIDS programs. WHO has developed a standardized strategy and protocols for the prevention of HIVDR in resource limited settings, designed to be implemented alongside treatment programs. As part of this strategy and in accordance with WHO guidelines, many African countries including Uganda have set up National HIVDR prevention, surveillance and monitoring programs in collaboration with WHO-AFRO. The major principles of containment of HIVDR include: appropriate ARV drug access, proper prescribing and usage, drug adherence, reduction of HIV transmission, and appropriate programmatic response based on the results of monitoring and

surveillance. The WHO and Uganda HIV DR Monitoring Plan includes periodic evaluations of early warning indicators (EWI) which have been shown to correlate with early emergence of drug resistance. EWI include poor drug supply continuity, inappropriate prescribing practices, poor adherence among clients, among others.

A consensus workshop on prevention of DR was held in Kampala in January 2007. A National HIVDR Monitoring Plan was developed with support from WHO, and has been endorsed by the MOH and Uganda AIDS Commission. Under the plan, the Uganda Virus Research Institute (UVRI), working closely with the MOH-ACP and other partners, was identified to coordinate these activities including: 1) the creation of a National HIV drug resistance Data Center in collaboration with the MOH Resource Center; 2) the establishment of a national drug resistance reference laboratory; 3) the coordination of all activities (program management, data coordination, and administration); 4) the establishment of a National HIVDR working group (HIVDR WG) within the MOH and as part of the National ART Committee. The plan addresses key areas of care and treatment within the National Strategic Plan for HIV/AIDS, 2007/8-2011/12, and is relevant to PEPFAR goals. The national HIVDR WG is comprised of individuals with different expertise and from different organizations including the MOH, CDC, Medical Research Council, WHO, UVRI and PEPFAR-supported treatment partners including JCRC, IDI, Catholic Relief Services, TASO and MJAP. With some funding from WHO, the HIVDR WG conducted a pilot survey in 2007 at 41 treatment sites to collect EWI. The sites were selected from different geographical regions, represented different levels and modes of ART service delivery, and were supported by a range of funders. The indicators included prescribing practices, percentage of patients lost to follow up, patients on first line ART, appointment keeping, adherence, and drug supply continuity. The preliminary findings of this study indicated that 71% of sites started all patients on appropriate first line drugs, 85% of sites had less than 20% loss to follow up during the first year, and 71% retained more than 70% clients on first line ART during the first year. Most worrying, however, was the observation that only 19 sites reported no drug stock outs in any quarter in the previous year. The results of this pilot were presented at the Uganda AIDS Conference (UAC), the WHO-AFRO HIV DR meeting in Namibia, to various key partners, and to the PEPFAR country team. Some funds were also obtained from the UNAIDS to contribute to the dissemination of the EWI surveys. Other funds for dissemination will come from PEPFAR through CDC. More work on EWI was done in 2008 this has allowed us to compare the performance of these facilities after one year which I will describe here. Trained field workers abstracted data from patients' paper-based and electronic medical records in 41 facilities in 2007 and 76 in 2008 where ART had been established for at least one year. Data was obtained for a subset of patients recruited during July-September of 2006 and 2007 respectively. HIVDR-EWI were assessed separately for each facility, with national level analysis comprising of proportion of facilities meeting predetermined targets. About 71% of facilities in 2007 and 74% in 2008 prescribed appropriate standard first-line ARV-regimen to all (100%) their newly enrolled clients at ART-start. The target of < 20% of patients lost-to-follow-up during the first

12-months was met by 85% of facilities in 2007, and 75% in 2008. In 71% of facilities, over 70% of patients started on first-line ART were still on first-line treatment after 12 months in 2007, while all facilities met this target in 2008. Few facilities had at least 80% of patients attending all clinical appointments during a 12-month period in 2007 and 2008. About 17% of facilities reported no ARV drug stock outs over a 12-months period in 2007, but this increased to 26% in 2008. The "ART adherence" indicator i.e. proportion of individuals with =90% adherence by pill count over a 12-month period (target: 80%) was not obtained. Five facilities in 2008 and eight in 2007 didn't meet the minimum targets for at least three HIVDR EWI. In conclusion therefore ART programme practices in several facilities pose a risk for HIVDR. Weaknesses in record keeping, drug supply and client retention require urgent redress. Facilities with weak performance should have focused attention for prevention of HIVDR. We plan to hold workshops to disseminate this information. This work was funded by WHO. UVRI, through support from WHO and MRC, conducted a study in Entebbe to determine whether resistant viruses were transmitted to recently infected individuals. No resistant viruses were identified. The HIVDR WG recommended that this activity be repeated in 2008. In 2008 we initiated a new study funded by PharmaAccess to look at transmitted drug resistance in newly diagnosed individuals in Kampala, at Naguru teenage clinic and at a VCT center at the AIDS Information Center. This is a cross-sectional survey of n=85 consecutively enrolled participants of individuals likely to be recently infected using the PharmAccess African Studies to Evaluate Resistance (PASER). So far 31 individuals have been enrolled and sequencing is underway, a few resistance mutations have been noted. With funding from MRC, the Global Fund and EDCTP, UVRI established the National HIV drug resistance reference laboratory and was accredited by WHO. In 2009, we applied to obtain WHO regional accreditation, and the accrediting team visited UVRI on 10th September 2009. The UVRI laboratory has been expanded and a new wing will be commissioned shortly to allow process more samples. Meanwhile we have been approached to sequence samples from Tanzania and Zimbabwe. In 2009 we developed proposals to look for funds to introduce DBS for resistance testing

Another protocol briefly described below has been developed to be submitted to the IRB to conduct another round of EWI. 150 individuals will be trained for 5 days in HIV drug resistance early warning indicators needed to monitor programme performance. In addition, 15 laboratory staff will be trained for 5 days in processing of samples for HIV drug resistance testing; of these 4 will be trained for 10 days in HIV drug resistance testing and analysis.

Data on EWI will be collected from a sample of 100 facilities, by 10 teams each of 2 trained field workers. Data will again be collected from electronic and paper-based systems. We plan to annually abstract data from selected ART service sites to obtain information on ART programmatic factors and client behavior that may be associated with an increased risk of HIV drug resistance. A purposive sample of facilities that have provided ART for at least one year will be selected each year. Standardized data abstraction forms

will be used to collect information on HIVDR EWI from facility level client data from a minimum of 30 patient medical records per site. Centrally constituted and trained field data collection teams with experience in ART data management will visit sites to abstract routinely collected data from client files, patient registries and/or electronic data bases. The variables of interest include ART regimens prescribed at treatment initiation and at 12 months, loss to follow-up, appointment keeping and ART adherence and facility level drug supply continuity. Abstracted data will be entered into a database centrally at the MOH and cleaned. Descriptive statistics of the variables of interest will be produced separately for each facility. National level analysis will comprise of the proportion of facilities meeting the required standards. The results of the assessment will be provided to the MOH, bilateral and other agencies providing support to ART facilities and to the facilities themselves. This will enable programs and facilities to develop methods to address specific problems identified. Data will also be used to support national decision-making on ART programme planning for HIVDR prevention activities and ART programme performance in the country. Annual reports will be produced and disseminated and results may also be published in medical journals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	715,000	

Narrative:

UVRI is mandated by MOH to provide Quality Assurance/Quality Control (QA/QC) to all HIV serological testing sites both public and private. Building on the experience over the past five years with USG funding, the HIV Reference and QA Laboratory at the UVRI established a national laboratory QA program focused specifically on HIV-related testing to provide quality service to the client, obtain and provide quality samples following bio-safety guidelines. As we role out ARV treatment, we need to ensure that we also prevent development of HIV drug resistance (HIVDR). The development of HIVDR is recognized as a serious threat to the efficacy of current ART, & will compromise PEPFAR efforts to provide long-term treatment in sub-Saharan countries. DR is likely to have a greater influence on the long term success of ART programs than any other single factor. Emergence of resistance to one or more ARV drugs is a reason for therapeutic failure in the treatment of HIV. In addition, resistance to one ARV drug sometimes confers a reduction in or a loss of susceptibility to other or all drugs of the same class. Patients with HIVDR must switch treatment regimens, reducing treatment options & significantly raising medication costs. Resistance is usually the result of sub-optimal regimens, or inconsistent use resulting from poor adherence &/or interrupted drug supply. The optimum time for minimizing the emergence & transmission of resistance is when treatment initiatives are still in the early stages & first-line regimens are widely used. Prevention, surveillance & monitoring of drug resistance are critical to the success of clinical & public health HIV/AIDS programs. WHO has developed standardized strategies, protocols, & guidelines for the prevention of HIVDR in resource-limited settings that are designed to be implemented

alongside treatment programs. As part of this strategy, Uganda has set up National HIVDR prevention, surveillance & monitoring programs in collaboration with WHO-AFRO.

During FY 2009, in-service training was in QA/QC was provided to 70 lab and non-lab staff from the South West region in addition to staff from 323 other sites. Five SOPs for laboratory safety, sample processing, rapid and Elisa HIV testing, rapid syphilis testing and proficiency panel preparations for HIV were reviewed, updated and distributed to 323 sites. We prepared and distributed 2835 proficiency testing panels to 476 testing sites PT results and provided corrective action when required. first response HIV test kit for plasma and whole blood was evaluated and disclosed a sensitivity of 97.6% and specificity of 95.6 for plasma and the respective values for whole blood are 97.6% and 98.3%.We compiled an HIV testing inventory, held sensitization meetings with the staff at the sites regarding quality assurance, provided support supervision in collaboration with National and Regional Lab Coordinators and District Lab Focal Persons, distributed SOPs and other information tools, provided formal reports disseminating the findings of support supervision to 476 testing sites both public and private. 222 testing sites employed non lab staff majority of whom were nurses and counselors (only 21 sites had these working without lab trained staff); 53 and 22 testing sites conducted CD4 counts and Viral Loads respectively, while 336 performed TB diagnostics, 396 performed malaria slides, 339 performed syphilis serology, 42 performed renal and liver function tests and 139 performed heamatology including lymphocytes. Adherence to SOPs was assessed; availability of SOPs was at 59.3% accessibility to SOPs was at 69.5%.About half of the sites displayed the SOPs, 67.2% understood them, while 69.7% implemented them. More than 95% of the testing sites implemented the National Testing Algorithms. Sites were further assessed for compliance with good clinical laboratory practice, waste disposal and availability of requirements to conduct HIV testing. This information was shared with partners and sites during support supervision, workshop and the newsletter.
With funding from WHO, the HIVDR WG conducted a pilot survey in 2007 to collect EWI at 41 treatment sites and in 2008, extended this to cover 76 sites including those surveyed in 2008. The sites were selected from different geographical regions, represented different levels & modes of ART service delivery, & were supported by a range of funders. In 2009, we applied to obtain WHO regional accreditation, and the accrediting team visited UVRI on 10th September 2009. The UVRI lab has been expanded and a new wing will be commissioned shortly to allow us process more samples. In 2009 we developed proposals to look for funds to introduce dried blood spots (DBS) for resistance testing. This proposal to evaluate DBS for HIV-1 drug resistance testing and to prepare for WHO accreditation in using DBS for HIVDR at UVRI is important if we are to scale up our monitoring activities. The advantages of DBS card used (filter paper) is they are easy to obtain and store, although the procedures for preparing DBS must be followed precisely, the training required is less intensive. The DR WG continues to meet regularly and to make efforts to secure funding from other sources to support HIVDR activities. Some members of this committee have presented updates to the National ART committee and we are pleased

to say that the HIVDR WG is the most active subcommittee.
There is need to scale up HCT services through training of service providers. In FY 2010, 723 testing cadres will be trained in different courses- 225 lay and community health care workers trained for 5 days in HIV counseling and quality HIV rapid testing; 93 District Laboratory Focal Persons and Regional Laboratory Coordinators to receive TOT in use and handling of DST and DBS for 5 days; 225 clusters comprising of counselors, phlebotomists and laboratory personnel to be trained for 5 days in the quality assurance in pre analytical, analytical and post analytical aspects of HIV testing;150 staff identified by poor performance in proficiency panels to be given a refresher course in rapid HIV testing for 5 days; 30 Regional Laboratory Coordinators and the In-Charges of National and Regional Referral Hospitals to be trained for 5 days in preparation and characterisation of PTPS.
The training provided to RLCs and DLFPs will include: conducting supervisory visits, preparation and characterization of PT panels, distribution and interpretation of the results. We shall conduct trainings in collaboration with CPHL, MJAPand AMREF to avoid duplication. We will work with DFLPs to ensure that their activities especially support supervision visits are incorporated in the annual district plan, and engage with the district leaders on the importance of high quality lab results. While the existing M&E plan drawn on national and USG requirements and tools will guide implementation of activities, more partnerships will be established with government and non government organizations, and, the virtual districts of the army, police and prisons. Support supervision visits, provision of Dried Tube Serum as PT panels and continuous assessment of QA/QC services in laboratories testing for HIV, TB, STI and malaria will continue. HIV serology testing QA/QC project will expand services to all HIV testing sites in the country. Working with MOH, particularly the Quality Assurance Unit, the HIV rapid test training coordination unit at CPHL and regional and district-level laboratory supervisors, we shall identify laboratories currently conducting HIV rapid testing and the tests/algorithm. New kits and algorithms will be evaluated. 1000 labs will be visited, 500 new labs and 500 old labs with poor performance in HIV quality assurance. Emphasis will be placed on the hard-to-reach areas, sites handling small volumes of specimens, private labs and labs where testing is mainly performed by non–lab personnel. We shall develop a quality assurance plan that takes advantage of joint supervisory visits and panel distribution with partners. Accredited labs using national/international standards will be documented and others assisted to get accredited. LIMS shall be linked to databases at CPHL and MOH to facilitate sharing of information including reports, logistics management and training needs. Discordant results will be resolved and external quality assurance done. With help from the Ministry of Education and Sports quality assurance of HIV testing will be taught in all lab training institutions. We shall continue to provide apprenticeship to both counselors and lab trainees at the UVRI clinic. Regular communication will be provided to labs in Uganda to highlight the role of the National HIV QA Lab, share lessons learned, identify problems/issues for which assistance is required, and allow for dialogue about recent news and innovations in HIV lab services. For efficient and cost-effective management of the program, we shall establish organizational, financial and administrative structures and mechanisms necessary to carry out

the program activities. A semi-annual report that disseminates the findings of the support supervision visits, resolution of discordant results, PT and evaluations of performance characteristics will be provided to MOH, implementing partners and testing sites. We are aiming at having two laboratories accredited by WHO; these are the National HIV Reference Laboratory and the National Drug Resistance Laboratory, both housed at UVRI.

We shall follow the WHO guidelines to have our laboratory accredited in use of DBS for drug resistance genotyping. WHO recommends the shipping of DBS on dry ice to avoid freeze thaw as humidity is a big problem for DBS. However since there is no strong data to support this recommendation, in 2009/10 we plan to conduct a study to further look at the effect of shipping DBS at two different conditions (room temperature versus dry ice) on genotypic results. We plan to collaborate with CDC and WHO to investigate the effect of shipment of DBS on dry ice versus shipment at ambient temperatures

We are working towards operationalizing the HIVDR coordinating center in FY 2010, with PEPFAR funding. A protocol has been developed following the WHO template to be submitted soon to the ethics committee to conduct a monitoring study of emerging ART resistance in 3 pilot facilities. The activity will involve abstraction of baseline data from client medical records and an aliquot of residual plasma from ART naïve clients initiating treatment at these facilities for viral load and genotyping at UVRI laboratories. Non-biological data will also be abstracted from the clinical records of these individuals quarterly using standardized forms. At the end of 12 months, another plasma sample and demographic and treatment related data will also be abstracted for viral load testing and genotyping for individuals that fail to suppress their viral load at 12-months end point.

During 2009, 34,606 infants were tested at 550 facilities. Main challenges are shipping of spxs, results reporting and follow-up of exposed, breast-feeding infants. EID currently uses 8 labs (Mildmay and 7 JCRC labs). All commodities are donated by UNITAID. EID has no secure funding past September 2010, other than UNITAID that will continue through 2011. PEPFAR awards for both JCRC and Mildmay end in September 2010 and follow-on RFAs do not include funds for EID – this is confounded by the ongoing scale-up. By 2014, MOH plans to conduct 100,000 PCR tests pa. If testing continues as is, the cost of the program will increase from $2.0M per year in 2010/2011 to $3.6M in 2013/2014. In total, the EID program will require $11.4M over the next 4 years (if overhead costs remain at $22.20 per spx at JCRC and foc at Mildmay).

Given increasing costs and no secure funding, PCR testing must be made as cost-effective as possible. An analysis conducted by MOH suggests costs can be dramatically reduced by consolidating PCR testing in 2 labs using automated, high-throughput platforms. Overhead costs should reduce to $6-9 per spx, the international benchmark - this will save $3.6M over the next 4 years. Consolidating testing in 2 labs will also improve overall efficiencies, sharing the burden of testing and avoiding delayed reporting. With 2 labs working 10 hours per day in a 5-day week, Uganda has ample capacity for the next 4 years. Cost implications: Both Mildmay and UVRI/CDC would need to hire additional staff; a back-up AmpliPrep-Taqman 96 platform will be provided foc by Roche; SMS-printers will be needed for results reporting.

Regardless of where the automated labs are located, MOH will need to establish a transport network to bring samples to these labs using a simple courier service to transport samples daily from the existing hubs to the testing labs - this is the subject of a 2nd proposal.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9236	**Mechanism Name: Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Integrated Community Based Initiatives	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 720,102	
Funding Source	**Funding Amount**
GHCS (State)	720,102

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Integrated Community Based Initiatives (ICOBI) is an indigenous not for profit NGO founded in 1994 with a mission of improving the quality of life of people living in rural communities. Its head office is located in Kampala, the Capital City of Uganda. It has field liaison offices in the districts where it is operating. ICOBI has implemented several programs with community bias since its inception including; the World Bank STI Project (1995-2000), MAP Project (2001-2006), Nutrition and Early Childhood Development Project (1999-2003). Other projects included; EGPAF supported facility based PMTCT Project (2003-2005) and CDC supported Full Access Door to door home based Voluntary Counseling and Testing (2004-2007). These projects were mainly carried out in Bushenyi district in South Western Uganda. ICOBI has

expanded its services and geographical coverage. Currently, ICOBI is implementing three projects in different parts of the country. It is implementing a three year NPI supported OVC Empower Project in Bushenyi and Mbarara districts (2008-2011). It is also implementing two five year CDC supported projects (July 2008 – June 2013). The Home based Voluntary counseling and testing (HBVCT) project is going on in 6 districts in Mid-central Uganda, while the Community PMTCT project is being implemented in 6 districts in South-western Uganda.

The Community PMTCT Project has a national character with a special focus on 6 districts: Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhuura; with a total population of 2,720,459 people. The expected number of pregnancies is 136,023 annually, of whom 8,161 pregnant women are expected to be living with HIV annually. The main purpose for the community PMTCT project is to contribute towards the improvement of child survival through increasing the uptake of PMTCT interventions in Uganda through appropriate and effective community based approaches which include social mobilisation, local language behavioral change communication and service provision. The project intends to achieve the following objectives;

1. To promote innovative community based primary prevention of HIV through community mobilisation.
2. To prevent un-intended pregnancies among women living with HIV through use of modern family planning methods and other family planning strategies
3. To reduce the transmission of HIV from the pregnant or lactating women living with HIV to their babies by referring them to health units for appropriate ARV prophylaxis for PMTCT as well as for other strategies
4. To promote care, support and treatment for pregnant women living with HIV, their partners and families through active referral networks in the community and health facilities
5. To enhance advocacy, capacity building and behavior change communication for community PMTCT interventions

Implementation strategy: The implementation of the project has been phased; with Bushenyi and Ntungamo in the first year, Mbarara and Ibanda in the second year while Isingiro and Kiruhuura will be in third year. However, during the expansion of the project, the same activities will be maintained in the already implementing districts without interruption. There have been some adjustments in the implementation design after realizing that some of objectives were not going to be achieved as earlier planned. These changes were made in consultation with the CDC technical advisor. For example, the project is now carrying out home based HIV testing targeting male partners having realized that male partners were not taking up referral to health facilities for antenatal care in the company of their pregnant wives. Dry blood spot is being done at home for early infant HIV diagnosis (EID) and mothers encouraged to take their babies to the health facilities for other MCH services. ICOBI is expected to work closely with the existing community structures like the village health teams (VHTs) system for sustainability of the community PMTCT program, but these structures are not yet in place. ICOBI is going to assist these districts to train the VHTs and functionalize them.

Progress: ICOBI has recruited and trained key project staff that includes 44 Community PMTCT Officers (CPOs) and 264 community volunteers for Bushenyi and Ntungamo districts. We are in the expansion phase to Mbarara and Ibanda. We have submitted annual and quarterly progress reports to CDC. The number of pregnant women referred for CT for HIV from the community is 8,490 (41%) and the 137 (8%) male partners have been counseled tested and received results in the community. The number of pregnant women who attended ANC with their partners was 136 (26%).
Activities: Major activities will include identification and training of VHTs in Isingiro and Kiruhuura districts, selection and training one member of the VHT to be in charge of Community PMTCT in each parish in Isingiro and Kiruhuura. Other ongoing activities will include community moblisation and sensitization, identification, referral and follow up of pregnant mothers with their partners for antenatal care including PMTCT services. Other activities include HCT for male partners in the community, infant feeding, early infant diagnosis and family planning. M&E activities will include technical support supervision, data collection,analysis, generating/writing reports and organizing program review meetings.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**9236** **Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies** **Integrated Community Based Initiatives**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	45,062	
Narrative:			
Community PMTCT project is being implemented in six districts of South-western Uganda in a phased manner; scaling up to two new districts every year. We started with Bushenyi and Ntungamo districts. We			

are right now doing preliminary activities for starting implementation in Mbarara and Ibanda in this second year. In third year (April 2010), Isingiro and Kiruhuura will be brought on board. Activities continue uninterrupted in the old districts as we expand to new ones. The Community PMTCT Project has a national character with a special focus on 6 districts: Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhuura; with a total population of 2,720,459 people. The expected number of pregnancies is 136,023 annually, of whom 8,161 pregnant women are expected to be living with HIV.

Program Activities

1. ICOBI will develop and implement a systematic approach of local language community education and participation that will ensure information about ABC strategy on primary prevention of HIV reaches over 50% of women in the reproductive age-group and other people in the community in South Western and Central Uganda and beyond. The key strategies to achieve this will include promotional and motivational activities for ABC through mass media, local language information, education and communication (IEC) or behavior change campaigns (BCC) including use of drama shows, interpersonal channels and community dialogue with small groups of 25-30 people.
a) As part of mass media, ICOBI will use radio programs to disseminate information on ABC. ICOBI has experience using radio as a means of information sharing. We will use two approaches, one will be radio talk shows to be held once every week for 52 weeks in a year; and the other will be using various radio spots promoting ABC. In Uganda, Radio is the major source of HIV/AIDS related information to the public as 65% of Ugandan households own a radio set and only 33% get information by word of mouth according to the 2002 National Census. These programs are aired in Runyankole and the public is given time to call and participate in the program either by asking questions or contributing to the debate. ICOBI is going to support the national community mobilisation activities organized by Ministry Of Health.
b) In year three of project implementation, ICOBI will have built capacity of the community resource persons through training members of the Village Health Teams (VHTs) covering all parishes in this region. These community volunteers together with the health unit staff conduct monthly community dialogue meetings in each parish where they cover topics on HIV, PMTCT, Abstinence, being faithful and other prevention methods (OP).
c) The project will identify other community based structures like the 'mothers' and 'fathers' unions and PHA networks who will provide preventive counseling to women and their spouses for long term risk reduction of HIV transmission; encourage women to disclose their HIV sero-status to their partners. ICOBI will promote faithfulness in marriage (zero grazing) through training of model couples who will be used in sensitizing other couples; promote correct and consistent use of condoms; promote ongoing follow-up counseling and education through established community peer psycho-social support groups. ICOBI is supporting the community psycho-social support groups where they exist and rejuvenating dormant ones while at the same time assisting the formation of new ones. We target to have at least one

group per parish.
d) Music, dance and drama is another powerful strategy for community sensitization on ABC in prevention of HIV. ICOBI has formed a drama group which performs in the communities. During the drama show, a health worker gets an interlude and gives health education talk targeted to the audience. During the drama shows, the public is given opportunity to ask questions and also test for HIV.
e) Targeted health education will be given to the community on condom use. The VHT members will distribute condoms in the community to increase access, consequently reducing the risks of persons engaged in risk behaviors like bar maids, multiple or concurrent sex partners, negative partners in long-term sero-discordant relationships, widows and divorcees and young people especially out of school youth. ICOBI will out source free condoms from the Ministry of Health and the district departments of health. Linkages will also be strengthened with the USAID supported AFFORD (social-marketing) to make condoms available in private sector at a subsidized cost.
f) Monitoring and evaluation (M&E): The project management team will carry out technical support supervision on the health facilities and community based volunteers to ensure proper project implementation. The district based coordinator will supervise the health units on a monthly basis. The health unit based coordinator will supervise the community volunteers on a monthly basis. ICOBI team will support the district coordinator on a monthly basis. Data collection tools will be provided and monthly reports submitted by the community volunteers. Data will be analysed and disseminated in form of reports and review meetings for various stakeholders. There will be monthly meetings for the health unit coordinators and quarterly stakeholders review meetings at district level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	25,040	

Narrative:

ICOBI will develop and implement a systematic approach of local language community education and participation that will ensure information about risk reduction strategies and condom distribution as a contribution to primary prevention of HIV to reach over 50% of women in the reproductive age-group, their spouses and other people in the community in South Western Uganda and beyond. The key strategies to achieve this will include promotional and motivational risk reduction activities through mass media, local language information, education and communication (IEC) or behavior change campaigns (BCC) including use of drama shows, interpersonal channels and community dialogue with small groups of 25-30 people.
a) As part of mass media, ICOBI will use radio programs to disseminate information on ABC including sexual partner reduction, STD/STI management and condom use. ICOBI has experience using radio as a means of information sharing. We will use two approaches, one will be radio talk shows to be held once every week for 52 weeks in a year; and the other will be using various radio spots promoting the relevant

behaviors. In Uganda, Radio is the major source of HIV/AIDS related information to the public as 65% of Ugandan households own a radio set and only 33% get information by word of mouth according to the 2002 National Census. These programs are aired in Runyankole and the public is given time to call and participate in the program either by asking questions or contributing to the debate. ICOBI is going to support the national community mobilisation activities organized by Ministry Of Health.

b) In year three of project implementation, ICOBI will have built capacity of the community resource persons through training members of the Village Health Teams (VHTs) covering all parishes in this region. These community volunteers together with the health unit staff conduct monthly community dialogue meetings in each parish where they cover topics on HIV, PMTCT, Abstinence, being faithful and other prevention methods (OP).

c) The project will identify other community based structures like the 'mothers' and 'fathers' unions and PHA networks who will provide preventive counseling to women and their spouses for long term risk reduction of HIV transmission; encourage women to disclose their HIV sero-status to their partners. ICOBI will promote faithfulness in marriage (zero grazing) through training of model couples who will be used in sensitizing other couples; promote correct and consistent use of condoms; promote ongoing follow-up counseling and education through established community peer psycho-social support groups. ICOBI is supporting the community psycho-social support groups where they exist and rejuvenating dormant ones while at the same time assisting the formation of new ones. We target to have at least one group per parish.

d) Music, dance and drama is another powerful strategy for community sensitization on ABC in prevention of HIV. ICOBI has formed a drama group which performs in the communities. During the drama show, a health worker gets an interlude and gives health education talk targeted to the audience. During the drama shows, the public is given opportunity to ask questions and also test for HIV.

e) Targeted health education will be given to the community on condom use. The VHT members will distribute condoms in the community to increase access, consequently reducing the risks of persons engaged in risk behaviors like bar maids, multiple or concurrent sex partners, negative partners in long-term sero-discordant relationships, widows and divorcees and young people especially out of school youth. ICOBI will out source free condoms from the Ministry of Health and the district departments of health. Linkages will also be strengthened with the USAID supported AFFORD (social-marketing) to make condoms available in private sector at a subsidized cost.

f) Monitoring and evaluation (M&E): The project management team will carry out technical support supervision on the health facilities and community based volunteers to ensure proper project implementation. The district based coordinator will supervise the health units on a monthly basis. The health unit based coordinator will supervise the community volunteers on a monthly basis. ICOBI team will support the district coordinator on a monthly basis. Data collection tools will be provided and monthly reports submitted by the community volunteers. Data will be analysed and disseminated in form of reports and review meetings for various stakeholders. There will be monthly meetings for the health unit

coordinators and quarterly stakeholders review meetings at district level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	650,000	

Narrative:

Community PMTCT project is being implemented in six districts of South-western Uganda in a phased manner by scaling up to two new districts every year. We started with Bushenyi and Ntungamo districts. We are right now doing preliminary activities for starting implementation in Mbarara and Ibanda in this second year. In third year (April 2010), Isingiro and Kiruhuura will be brought on board. Activities continue uninterrupted in the old districts as we expand to new ones. The Community PMTCT Project has a national character with a special focus on 6 districts: Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhuura; with a total population of 2,720,459 people. The expected number of pregnancies is 136,023 annually, of whom 8,161 pregnant women are expected to be living with HIV.

Program activities:

1. The main activity for community PMTCT project is community mobilisation and sensitization through a number of innovative appropriate and effective approaches aimed at fostering behavior change and creating demand for PMTCT interventions including; community dialogue meetings, radio programs, drama shows and home visiting. The project has recruited one community volunteer (Member of VHT) for each parish within the project area who mobilizes his community for PMTCT interventions. By 2010, we expect to have 519 community volunteers in the six districts. The community volunteer links up with the health facility based staff for support in carrying out mobilisation activities like giving health education talks at the community dialogue meeting. There is one such a meeting in every parish every month targeting the general population including pregnant women and their partners, HIV positive or negative people in the community are encouraged to attend and ask questions. ICOBI will carry out 6,228 community dialogue meetings in 2010.

a) Targeted drama shows will be conducted at the parish level to strengthen the mobilisation activities. ICOBI has built up a fully fledged drama group which will show performances in communities where PMTCT services uptake will be low. Drama has been found to attract big gatherings for entertainment. At the same time, the songs and the plays convey meaningful messages. During a drama show, people are put in smaller groups of not more than 25 people according to their age category and given health education on HIV and other health related issues. People are given opportunity to ask questions for clarification. We target to have one drama show per parish for Isingiro and Kiruhuura districts, totaling to 136 drama shows.

b) Radio is an important medium of communicating health messages in Uganda. We will hold one radio talk show every week. Runyankole which is the language understood by majority of the people in the

Ankole region will be used.
c) ICOBI supports the national community mobilisation activities as deemed by Ministry of Health; either radio programs or production and distribution of IEC materials like brochures, calendars, stickers, diaries and booklets in different languages.
d) ICOBI will conduct stakeholders/advocacy meetings at both district and sub-county levels to update the opinion leaders and political leaders on their mobilisation roles in the community. We also build consensus on the implementation of the project with full support of the local communities. We will conduct two introductory district level meetings for Isingiro and Kiruhuura and 25 sub-county level meetings in the same districts.
2. Identification, referral and follow up of pregnant mothers with their partners for MCH services including PMTCT interventions to make at least 4 ANC visits before delivery, delivery in health units under supervision of qualified health worker, infant feeding, early infant diagnosis, family planning and TB services. Community volunteers will identify clients and refer them to the health units and those identified at the health units are referred back to the community volunteers for follow up and compliance issues. ICOBI will identify and follow up 90% of the pregnant mothers in the community, 100% of the HIV positive mothers and their babies, 80% of whom will be enrolled on ARV prophylaxis with their babies. We expect to increase health unit deliveries to 50% and mobilize 90% of the HIV positive couples will be on dual method for family planning.
3. Out-reach programs: ICOBI will carry out community out-reach programs to provide targeted HIV counseling and testing in the community/homes. This came after realizing that male partners were not forthcoming for PMTCT services at the health facilities or community meetings in spite of constant encouragement from the community volunteers. Health workers will be facilitated to carry out community out-reaches. There will be one out-reach per parish per month, totaling to 6,228 out-reaches in a year.
4. Psycho-social support: ICOBI will work with the existing post test clubs or PHA networks to provide psycho-social support to the identified women with their partners in the community. Where such groups do not exist, ICOBI will establish them, one per parish. ICOBI will provide expertise in different fields of psycho-social support including counseling and income generating activities. ICOBI has identified a gap in the leadership for the existing post test clubs which need to be addressed by giving on job training for the leaders in leadership and management. ICOBI will hire experts to do that. Currently, psycho-social support groups are supported by the Community PMTCT Officer based at the sub-county level who is going to be phased out and will be replaced by the health facility based coordinator for sustainability reasons..
5. Capacity building: Identification and training of the community volunteers in Isingiro and Kiruhuura districts and conducting refresher trainings for health workers to orient them on community PMTCT will be conducted. A one week training workshop will be conducted for 519 Community volunteers who will be equipped with knowledge and skills for implementing Community PMTCT. These are members of the VHT as explained in number 1 above. We will conduct refresher training workshops for the health

workers as well. All community volunteers will have refresher training workshops for two days every six months.
6. Monitoring and evaluation (M&E): The project management team will carry out technical support supervision on the health facilities and community based volunteers to ensure proper project implementation. The district based coordinator will supervise the health units on a monthly basis. The health unit based coordinator will supervise the community volunteers on a monthly basis. ICOBI team will support the district coordinator on a monthly basis. Data collection tools will be provided and monthly reports submitted by the community volunteers. Data will be analysed and disseminated in form of reports and review meetings for various stakeholders. There will be monthly meetings for the health unit coordinators and quarterly stakeholders review meetings.
Targets for 2010 and 2011
We expect to achieve the following targets
We expect to reach 108,818 (80%) pregnant women and lactating mothers with ABC messages in 2010 and 119,799 (85%) in 2011.
We expect to distributed condoms among 40,807 (30%) pregnant women, lactating mothers and their partners in the community in 2010 and 56,368 (40%) in 2011
We expect to form 219 active male peer groups in 2010 and 300 in 2011. N.B: Active means trained, holding meetings and participating in community education and any other RH/HIV prevention activities
We target 20,403 (15%) male partners to receive counseling, testing and results at community out-reaches in 2010 and 28,184 (20%) in 2011.
We expect 68,011 (50%) partners to disclose test results to the partners in 2010 and 84,552 (60%) in 2011.
We target to identify 108,818 (80%) mothers and follow them up for a minimum of 2 visits, one during ANC and one in PNC in 2010 and 119,782(85%) in 2011.
We target to train 3,000(100%) VHT members in Kiruhura and Isingiro in 2010.
We expect 2,400(80%) VHT members to be active in 2010 and 2,700 (90%) in 2011.
We expect to train all the 519 peer educators in Kiruhura and isingiro in 2010.
We expect 415(80%) active peer educators in 2010 and 467 (90%) in 2011
We target to refer 108,818(80%) pregnant women for ANC and 28,184(20%) in 2011.
We expect to refer 108,818(80%) pregnant women to deliver from health facilities in 2010 and 126,828 (90%) in 2011.
We target to refer 108,818 (80%) mothers for PNC in 2010 and 119,782 (85%) in 2011
We target to refer 108,818 (80%) mothers for FP in 2010 and 119,782 (85%) in 2011

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9238	**Mechanism Name: Traditional & Modern Health Practitioners**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 720,116	
Funding Source	**Funding Amount**
GHCS (State)	720,116

Sub Partner Name(s)

(No data provided.)

Overview Narrative

THETA is a National NGO committed to improving the health of Ugandans by promoting collaboration between the traditional and biomedical health systems. THETA has over 17 years of experience implementing community-based health activities in 22 districts for underserved populations especially in HIV prevention and care. In each district of operation, THETA has built a health and social services community delivery system that comprises of community lay providers (CLPs), community support team (CST) members and district-based trainers (DBT). THETA received a notice of ward on 8th July 2008 from CDC to implement the "Community-based strategies to expand uptake of Prevention of mother-to-child transmission of HIV (PMTCT) interventions". This project is implementing a model of community support for PMTCT based on an active network of CLPs working in close collaboration with facility-based health workers and in line with Uganda National policy for reduction of Mother-To-Child HIV transmission. Project implementation started in Lira, Kumi, Oyam, Rakai and Tororo districts in the first year. In year two it will be rolled into two new districts of Bukedea and Butaleja. In the third year THETA will consolidate activities in the 7 districts to ensure sustainability.

THETA works through existing district structures which include District Health Educator and District PMTCT focal person at district level, Assistant Community Development Officer and HC III In-charge at sub-county level and CLPs at community level. So far 2,005 CLPs have been training in the first 5 districts and an additional 800 CLPs will be trained in Bukedea and Butaleja districts.

The CLPs provide a linkage between the community and the health facilities through the referral network. They conduct home visits and provide Health education on sexual prevention of HIV transmission and mobilize communities for HIV Counseling and Testing (HCT). They refer clients to health centres for the Goal-oriented antenatal care (ANC), health facility delivery and post-natal care (PNC), family planning with emphasis on male partner and couple involvement. They conduct follow up of clients and mother-baby pairs for early infant diagnosis (EID) as well as discordant and HIV positive couples for recruitment in community support groups.

The CLPs together with CSTs conduct community dialogues during which HCT services are provided in liaison with the biomedical health workers from the health facilities. This is the entry point for the programme and the purpose is to identify HIV positive mothers (including pregnant mothers) and their partners so as to refer them for treatment and care at the health facilities and other implementing partners.

Community dialogues are meant to raise awareness and educate communities using "population-specific interventions i.e. targeting age groups, cultural values and beliefs, gender norms" , abstinence, faithfulness and other sexual prevention (ABOP) messages for PMTCT, inform the community about the availability of PMTCT services and provide opportunities to discuss social and cultural barriers that limit uptake of PMTCT services as well as coming up with action plans to influence positive behavior change using the health belief model.

CLPs also initiate formation of PMTCT community support groups who undergo comprehensive group dynamics and management training so as to provide effective ABOP support to PMTCT clients for increased uptake of the services. THETA will continuously identify and train more groups in these areas in the third year of implementation up to the targeted 100 groups by the fifth year of the project.

THETA will implement the ABOP strategy by emphasizing delay of sexual debut (Primary abstinence) and abstinence until marriage (Secondary abstinence) for youth and upholding social values/benefits attached to virginity and sexuality.

THETA will support testing for HIV and being faithful in marriage and monogamous relationships to minimize sexual networking; correct and consistent use of condoms for those who practice high-risk sexual behaviors, discordant couples, commercial sex workers and their clients, and anyone engaging in sexual activity with partners who may have been exposed to HIV infection. Other sexual prevention approaches will include Family Planning (Duo method recommended in PMTCT).

Support supervision and quality assurance visits to CLPs and CSTs will be done on quarterly basis. This will ensure that the knowledge and skills acquired during trainings are competently applied in the field setting. The trained CLPs were each facilitated with a bicycle to enable them conduct home visits, client follow-up and community mobilization for PMTCT related activities.

This approach of using the existing district structure to implement the community based PMTCT intervention will provide an effective strategy for project and financial sustainability. The district Local government will eventually integrate the project activities in their development plans as the project phases

out. This will be expected to contribute towards the district and national efforts in reduction of MTCT among women and men of child bearing age as well as the general population.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**9238** **Traditional & Modern Health Practitioners** **Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	45,063	

Narrative:

The project coverage in the geographical area will include the districts of Lira, Oyam, Kumi, Rakai, Tororo, Bukedea and Butaleja in totality.

The target population for this mechanism includes pregnant women and lactating mothers and their partners as well as other youths.

• The pregnant women and lactating mothers and their partners will be reached with messages of faithfulness. These are specifically targeted because there has been evidence of multiple sexual partners which is an avenue for HIV transmission within the couple.

Couple counseling: This will be held for married couples or couples intending to marry. During the counseling session's emphasis will be laid on cultural practices related to mutual faithfulness. Sessions will aim at improving marital relationships, sexuality and home management. HIV testing, faithfulness, partner disclosure and discordance shall be emphasized in these counseling sessions.

• The youths (15-24 years) will be reached with abstinence messages. These will be targeted to for

primary prevention. This is to encourage them to abstain until such a time when it is fit for them to engage in sexual activities. The youths will also be sensitized on the dangers of cross generation sex among others.
Quality assurance for CLPs: These visits will be conducted by the District based trainers, the CSTs and THETA's counseling team. The aim is check on the quality of information delivered by the CLPs. This shall be done through quarterly sit-in sessions and monthly support supervision visits. There will be quarterly meetings held at the sub-county level between CLPs of that sub-county and health facility staff to update CLPs on HIV/AIDS issues, give feedback to health facility staff from the community about implementation.
Community dialogues: Community dialogues focusing on cultural issues of faithfulness especially among couples, disclosure and social cultural issues sorrounding faithfulness

Monitoring of CLPs: THETA M&E staff will carry out routine monitoring visits to ensure that the project is running as planned and the set targets are being met. The monitoring visits will check on quality of services provides, proof work done, documentation of work done and completion of monitoring tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	25,053	

Narrative:

The project coverage in the geographical area will include the entire districts of Lira, Oyam, Kumi, Rakai, Tororo, Bukedea and Butaleja.
The target population for this mechanism includes pregnant women and lactating mothers and their partners, discordant couples as well as out of school youths.

• The pregnant women and lactating mothers and their partners will be reached with messages of faithfulness and condom use. This population is reached because there are high chances of infecting the baby in case the mother sero-converts during breastfeeding.
• The discordant couples will be reached with messages of condom use and condoms will be distributed to them. While faithfulness among married couples will be the main focus of our intervention, THETA and partners will procure and distribute condoms to discordant couples. The discordant couples are targeted because they pose a high risk to increasing the number of people infected and affected by HIV.
• The out of school youth (15-24 years) will be reached with ABOP messages and be given a chance to make an informed choice. The youth pose a risk because they are making uninformed choices so with information they can be protected.
All the different groups of target population reached will be encouraged to have HCT either at the community level or through referral to the facility. The reason for encouraging HCT is to have people

knows their status and be able to plan for the future and also reduce the risk of unknowing transmission. Procurement of testing kits: 1,000 HIV test kits will be procured for each of the districts to cater for the expected number of pregnant mothers who will turn up for testing during community dialogues. THETA intends to safeguard against unnecessary stock-out during outreaches which would affect subsequent turn ups.

Conduct Home visits: CLPs working in pairs will health workers will be assigned a parish to map, conduct outreach and household visits as appropriate. 60 visits will be made 12 times in each of the districts. Pregnant women identified during these outreaches and visits will be registered by the CLP teams and provided with a referral form to health facilities together with their spouses for PMTCT services. The registration will provide a basis for follow-up by the CLPs on subsequent visits. Other family and community members will be given information on sexual prevention and also referred for relevant health services in case of need. Whenever possible, the CLPs will accompany their referred clients to the health facility the first time they are referred. During the visits the community will be sensitized on AB/OP and given condoms. - Individual counseling sessions aimed at providing personal and confidential counseling to community members who might have specific problems such marital issues, relationships or stressful situations related or other stressful situations related to HIV, TB, and STI. The sessions shall be conducted at the predisposition of the CLP.

Community dialogues: Community dialogues focusing on cultural issues concerning condom use, male involvement and behavioral change will be conducted in all communities. Dialogues will bring together THPs, BHPs, opinion leaders and community members to freely discuss issues related to community PMTCT and Traditional Medicine and how it relates to the community PMTCT model. Community dialogues will act as an avenue for introducing the program at community level, conducting HCTs, mobilizing communities for referrals of pregnant and non-pregnant women and couples, as well as mobilizing communities to form support groups.

Monitoring of CLPs: THETA M&E staff will carry out routine monitoring visits to ensure that the project is running as planned and the set targets are being met. The monitoring visits will check on quality of services provides, proof work done, documentation of work done and completion of monitoring tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	650,000	

Narrative:

The cross-cutting activities will include community mobilizations so as to attract community attention to the availability of community PMTCT services. We will then sensitize them to influence their attitudes towards seeking PMTCT services at the nearest health facilities.

The project coverage in the geographical area will include the districts of Lira, Oyam, Kumi, Rakai, Tororo, Bukedea and Butaleja districts. The districts will be covered in totality.

The target population for the MTCT mechanism includes pregnant women and lactating mothers plus their partners.

• Pregnant women will be targeted for sensitization on PMTCT: getting tested for HIV and partner disclosure, health facility delivery, ANC attendance and accessing the ARV prophylaxis.

• HIV positive lactating mothers will be educated on feeding options, early infant diagnosis and family planning.

• Partners of pregnant women and lactating mothers will be educated and sensitized on getting HIV testing and partner disclosure.

Training CLPs in PMTCT: THETA will conduct trainings for CLPs using the adopted National PMTCT community manual. 2 training workshops each lasting 5 days will be conducted per district involving 120 CLPs. The 120 participants will be divided into groups of 60 to facilitate the training process. 2 THETA staff and 1 midwife trained and experienced in PMTCT will be co-opted from the H/units to facilitate the training. In each district, THETA will select 2 CLPs per parish in collaboration with the District Health Team, midwives, and community members or leaders. CLPs will be equipped with knowledge and skills on PMTCT and infant feeding counseling, other HIV prevention and basic HIV care, family planning and disclosure. Midwives trained and experienced in PMTCT will be co-opted from the district facilities to help train the CLPs. This will create a forum where health workers and CLPs can start to interact on a professional basis and start to appreciate each other role in caring for their women clients.

Orientation of Biomedical Health Workers in THETA Community PMTCT model: 30 Biomedical Health Workers (BHPs) per district will be targeted for a one day orientation workshop in each district in the THETA PMTCT community model. The rationale is make health workers familiar with socio-cultural issues that influence uptake of PMTCT.

CLPs will conduct home visits to follow up HIV positive mothers and their babies, pregnant women and their spouses. The CLPs are all to be facilitated with bicycles to enable their movement in the community.

Counseling and HCT at the community level will be done at a quarterly basis in every district. This is intended to bring services closer to the people and also reduce on the workload at the health facilities. The CLPs will refer people to health facilities for the PMTCT services, care and support at any identified appropriate service point.

Conduct radio programs: Aimed at educating community members about the importance of PMTCT services; THETA will host 24 radio talk shows on 3 radio stations in each of the three major languages in the western, central and northern regions. The panelists shall include THETA community health workers, a CLP and one district resource person. Community members will write in or call in with their views on the PMTCT services. The shows will be aired in each district on a monthly basis.

Community dialogue will be held. This is an activity intended to raise awareness and educate community

about PMTCT. These will involve informing community about the availability of PMTCT services and to enroll for the services. Communities will be encouraged to discuss social and cultural barriers that limit PMTCT services and come up with action plans. Together with the trained CLPs and health workers THETA will facilitate 54 communality dialogues in each of the districts at village level. The dialogues will provide an important avenue to convey appropriate information to pregnant couples before they come to the health facility for ANC and psychologically prepare them to undertake the HIV test. Family support Visits: CLPs will conduct household visits to identify pregnant mothers and refer them to the health units and later do subsequent visits as follow ups. The CLPs will put emphasis on HIV positive mothers. The negative mothers will also be supported to maintain their status Training and support male peer groups: Male peers will play a particularly important role in mobilizing male partners to go for HIV testing with their spouses through use of male peer approaches at relevant community venues and events preferred by men. There will be two trainings of 42 male peer group members in each of the five districts. Training and support Mothers-To-Mothers (m2m) groups: A total of 120 groups of HIV positive mothers operating at parish levels in all the districts will work as volunteers but will be enabled to identify mothers and couples for the PMTCT programme and ensure follow up of cases after their training is completed. The support will be for all the different groups including those created earlier. This approach is aimed at providing psychosocial support for women who have learned they are HIV-positive so they can both accept their HIV status and adhere to medical recommendations for the prevention of mother-to-child transmission. The m2m groups will minimize fear of stigma, lack of information among HIV positive mothers, and the effects of work overload of the health providers in offering counseling and support services. They will also support follow-up of mothers in the postpartum period to support them and their children get postnatal services focusing on family planning, infant feeding and adherence among others. The groups will further support mothers to adopt good practices in home hygiene and positive health seeking behaviors. Monitoring of CLPs: THETA M&E staff will carry out routine quarterly monitoring visits to ensure that the project is running as planned and the set targets are being met. The monitoring visits will check on quality of services provides, proof work done, documentation of work done and completion of monitoring tools.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9239	**Mechanism Name: PEPFAR/PMI Collaboration**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: The AIDS Support Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 490,000	
Funding Source	**Funding Amount**
GHCS (State)	490,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TASO works closely with MoH. Since inception TASO Service Centres operate within or close to District, Regional Referral and National Referral Hospitals. This facilitates contribution to and strategic collaboration with the public health care system. In many cases the 11 Service Centres serve as specialized HIV/AIDS clinics to the MoH district and regional referral hospitals and other lower level government health facilities. TASO maintains a referral mechanism with all levels of government health facilities. As a way of contributing to universal access and equitable service delivery, TASO has also trained and supports 23 peripheral partners to provide TASO-like services in under-served districts; these partners include government hospitals, private-not-for profit hospitals and community-based organizations. TASO through support of PEPFAR and other funding partners has developed all the 11 Service Centres into leading HIV/AIDS care, support and treatment partners in the regions of Uganda where they are located. TASO Centres have an experienced, well-qualified and well-trained workforce of over 1,000 personnel, an average of 75 staffs per Centre. The Centre teams are multi-disciplinary including Medical Doctors, Counselors, Clinical Officers, Nurses, Pharmacy Technicians, Laboratory Technicians, Data Managers, Social Workers and Support staff. Individual staffs have received multi-disciplinary on-job training to facilitate multi-tasking in deployment for service delivery; the workforce is organized in cohesive small teams (departments and sections) under supervisors; the supervisors undergo regular training and mentoring in leadership and supervisory management. All frontline staff are trained, facilitated and motivated to cultivate and maintain personal contact with the clients. Staffs are required to be fluent in the local languages of the Centres of their respective deployment. All jobs have comprehensive Job Descriptions (JD) and the Human Resources & Administration Directorate ensures regular update of all JDs. Apart from their formal qualifications (Degrees, Diplomas, etc), TASO requires all job applicants to have undergone robust HIV/AIDS training with a practicum component. TASO also provides regular didactic and experiential training to keep service providers up-to-date. TASO will manage

and oversee all program activities through the following system: -

• Governance: The TASO governance structure includes a national Board of Trustees (BOT), 4 Regional Advisory Councils (RAC), 11 Centre Advisory Committee (CAC) and the Clients' Council. The BOT oversees the TASO program nationally and is the highest decision-making organ; the RAC oversees the TASO program in the 4 Regions of Uganda; the CAC oversee the activities of each of the 11 Centres; and the Clients' Council advocates for clients' rights, mobilizes clients to exercise their responsibility and advise management on clients' issues. All of these governance structures are elected by the Annual General Assembly periodically.

• Program Leadership & Oversight: Overall management and leadership of the TASO program at national level will be done by Mr. Robert Ochai the Executive Director. The Executive Director is assisted by a Deputy Executive Director and other Directors in charge of Planning & Strategic Information, Training & Capacity Building and Advocacy. All the Directors are highly-trained, highly-skilled and experienced individuals in HIV/AIDS programming.

• Management of Apac Project: The project will be headed by a Project Coordinator who is a well-qualified and experienced individual who will have undergone specialized experiential and didactic training in leading and managing HIV/AIDS programming in addition to other training. The Project Coordinator will ensure adherence to organizational policies and systems. The Project Coordinator will be assisted by 3 County Coordinators, Accountant, an Administrative Assistant, and a Data Manager. The Project Coordinator will also be supported by public health structures in the district.

• Quality Assurance: TASO ensures that all service providers and Service Centres adhere to the National Guidelines for delivery of various HIV/AIDS services. TASO has Standard Operating Procedures (SOPs) for all services provided. The SOPs comply with National Guidelines and are observed by all service providers. These SOPs are regularly reviewed in a participatory manner to match the fast paced developments in HIV care and support technologies. TASO has a comprehensive Quality Assurance Manual spelling out the basic minimum standards to be ensured by all service providers.

• Management Information Systems: TASO, with support from partners, has developed robust computer-based management information systems (MIS) for generating strategic information and managing/tracking resource utilization. The key organizational systems include Navision 3.0 Accounting System; the Health Management Information System (HMIS); Appointments Management System; Clients' Identification/Mapping System; Clinical Laboratory Information System; Pharmacy and stores Information Management System; Supply Chain Management System; Fleet Management System and Human Resources Information System. These systems are integrated in order to maximize the quality and integrity of information produced. TASO regularly updates these systems and re-trains data staff to keep the MIS up-to-date. Update of the MIS shall continue during FY 2010.

• Organizational Policies: All TASO facilities are managed in accordance with documented organizational policies. TASO policies are developed through an inclusive process that harmonizes the views and interests of all key stakeholders. The policies are in harmony with the laws and regulations of the

Government of Uganda and the funding agencies. TASO policies are approved by the TASO Board of Trustees. TASO has policies for Procurement, Human Resource Management, Governance, Financial Accounting and other issues.

• Performance Monitoring: TASO has a comprehensive internal performance monitoring mechanism. The Directorate of Planning & Strategic Information (PSI) at TASO Headquarters leads the performance monitoring function. Annual work plans and targets are developed from the TASO Strategic Plan. Each facility has monthly, quarterly semi-annual and annual targets to achieve. Service providers fill data collection forms that measure the quantity and quality of work. Data personnel manage service data (data entry, data cleaning, data storage, data analysis) together with data for other systems. Facilities submit monthly Programmatic and Financial Reports to TASO Headquarters based on data, lessons and observations recorded. TASO Headquarters generates regular (monthly, quarterly and annual) reports and adhoc reports, Programmatic and Financial Reports for CDC/HHS, Ministry of Health, and other national partners. The reports are also used internally for reviewing performance and improving quality of service delivery.

• Audit Arrangements: TASO has an elaborate Internal Audit system implemented by the Internal Audit Unit comprising the Chief Internal Auditor and three other Auditors. The Auditors are well-qualified and undertake regular performance enhancement training. The Team conducts comprehensive audit of all TASO units twice a year, and also conduct other audits as need arises. The audits will include both Financial Reviews and Programmatic Reviews. TASO operations are also audited externally by internationally recognized audit firms. Internal Audit Unit reports to the Board of Trustees on a quarterly basis.

• Procurement Procedures: TASO conducts competitive open procurement for drugs, medical supplies, stationery, equipment and other program needs. All facilities adhere to the Procurement Policy. Each facility has a Procurement Committee constituted according to the TASO Procurement Procedures policy. There are clear cross-cutting guidelines for situations where prequalified suppliers such as Medical Access will be used.

• Technical Support: The project will have a three-tier technical support mechanism to the services provided in Apac district. This will be done by the Program Management Directorate at TASO Headquarters, Ministry of Health (MoH) and the CDC/PEPFAR Country Team. The teams from MoH and CDC will provide regular support to the Directorates of Program Management and Strategic Information at TASO Headquarters. The Directorates will in turn support the project through quarterly support visits. The project will also collaborate with MoH in the areas of capacity-building, availing of the national guidelines by MoH, supply chain management, referral among others.

Cross-Cutting Budget Attribution(s)

Water	30,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9239		
Mechanism Name:	PEPFAR/PMI Collaboration		
Prime Partner Name:	The AIDS Support Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	120,000	

Narrative:

TASO project team will refer for care and treatment people who are diagnosed with HIV during testing in the district. All the project 6,400 HIV positive persons facilitated through referral to access a comprehensive package of high quality Adult Care & Treatment services from the district comprising of counseling for clients and family members; antiretroviral therapy (ART) as appropriate; screening and treating opportunistic infections; screening and treating sexually transmitted infections (STI); providing vital information on cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT; enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing LLITN and promoting malaria prevention; providing condoms to sexually active clients; conducting various courses to train service providers to provide HIV care and support;
The support will include mobilization and sensitization, capacity-building, beneficiary involvement, greater PHA involvement, partnership and collaboration and others. In partnership with the district, TASO will support provision of a basic care starter kit consisting of safe water vessels and chlorine solution (Water guard®), LLITN (bed nets) for prevention of mosquito bites, cotrimoxazole prophylaxis and condoms to sexually active clients. All adult clients will have the option to access condoms as part of their kits and the sexually active clients will be empowered to appreciate access and use condoms correctly and consistently; all HIV positive persons will be targeted for cotrimoxazole prophylaxis and Dapsone will be provided as alternative medicine for a few clients that are allergic to cotrimoxazole. The project will continue sensitizing clients on the importance of the various Care & Treatment services in improving the quality of clients' lives. Sensitization will be done through counseling, health education talks, MDD performances and IEC materials at service outlets. The various TASO field teams will monitor use of Care & Treatment services during visits to clients' homes. TASO will provide STI information to all

adolescents and adult clients with emphasis on sexually active clients. Quality assurance will be done through ensuring adherence to national and international standards, conducting regular refresher training for service providers, rigorous support supervision of service providers, technical support visits to service outlets and teams, conducting regular QA meetings in service delivery departments and conducting regular client satisfaction feedback exercises.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	270,000	

Narrative:

During the second year of Apac project implementation, TASO will continue providing full access home based confidential HIV counselling and testing to all individuals in Apac district who will have not taken the tests during the first year of project implementation. HIV antibody testing will be done alongside Malaria testing using the same blood samples. Testing for malaria will be done using the rapid paracheck test. All persons tested, will receive their test results. The testing will be done at respective homes. Apac district has one of the highest malaria infectivity in the world with 1,564 bites per person per year. Testing for HIV and Malaria will serve as an entry point to prevention of both conditions and referral for care. HIV testing will be done using a-three tier rapid test algorithm as approved by the MoH. The approach will integrate both HIV and Malaria initiatives with a strategic focus on sustainable strengthening of health systems. For households where there are school going children, project team members will schedule to make repeat visits to such households at appropriate times when the children are at home such as afternoons for children that attend half day school time; during school holidays when children who spend full working days at school and those in boarding schools are back for vacation. TASO will use a multi – pronged approach in mobilizing family members for HIV counselling and testing including. The Village health Teams (VHTs) will constitute key local resource persons in mobilizing community members and guiding the field teams. The approaches to mobilization will include: meetings with various stakeholders, collaboration with health facilities in the district to provide health talks at various service delivery points, use of existing drama groups in music, dance, drama and testimony giving presentations, working through PHA and AIDS service organizations net works, through community development initiatives, IEC materials, during public functions, Civil Society Organizations (CSOs), TASO and partners' organized events and the mass media. Testing will be done at each of the 15 sub-counties by a team consisting of a County Coordinator who supervises a team of 15 people (three per Sub-County i.e. 2 HCT Counsellors and 1 Laboratory Assistant). All field team members will have undergone specialized training in conducting rapid HIV and Malaria tests. TASO will conduct annual refresher training for project staff to renew their skills in HBHCT and Malaria testing, share experiences and receive updates. Blood samples for children aged below 18 months will be processed for DNA-PCR testing using the Dry Blood Spot (DBS) technique and transported using existing mechanisms to Joint Clinical Research Centre (JCRC)

Laboratory or other laboratory with facilities for doing DNA-PCR. Samples of rapid HIV and Malaria tests will be submitted for both internal and external quality control at nearby Regional Referral Hospitals or any other certified Laboratories. The Primary goal of the activity is to identify people who are HIV positive and those with malaria and refer them for HIV and malaria care services and prevention including the Basic Care Package (BCP), PMTCT and ART. Those who are HIV negative will be given support on how to prevent HIV infection and to remain sero-negative. The project will also support health systems strengthening in Apac district.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	30,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	20,000	

Narrative:

TASO AB interventions in Apac will aim at addresssing the key HIV driversthe epidemic by discouraging high risk behaviors and practices such as; early sex, premarital sex, casual sex, multiple sexual partnerships and extramarital sex. The program will also highlight other social economic factors that increase vulnerablity to HIV infection including; the plight of OVC and child-headed households; domestic violence and sexual abuse, human rights abuses; excessive consumption of alcohol and negative gender norms underlying male behavior.

Abstinence interventions will target youths and/or young people in and out of school. The interventions will empower male and female youth in Apac district with life skills to prevent HIV infection through abstaining from sex. Service providers will be empowered with appropriate communication skills and facilities to support abstinence issues among youth. TASO will develop and implement effective IEC interventions for addressing abstinence issues among the youth in Apac district. Be Faithful interventions will target people engaging in marital sex and/or sex in stable ongoing relationships such as married couples and cohabiting couples (these will mostly comprise of adult community members). The interventions will empower adult male and female community members to prevent HIV infection by practicing mutual faithfulness in their sexual relationships. Service providers dealing with adults will be empowered with appropriate communication skills and facilities to support this target group. TASO will develop and implement effective IEC interventions for addressing "be faithful" issues among sexually active adult community members in Apac.

Sexual Prevention (AB) activities during FY2010 will include: building capacity of local communities and indigenous organizations in AB; supporting AB partnerships, networks and linkages; conducting AB outreach activities in communities; providing technical support to identified local AB partners; conducting group and/or individual counseling sessions in the communities; conducting health talks on AB issues; mobilizing and empowering community structures such as cultural, social, economic and political entities to promote/advocate for AB. These interventions have been selected because they align the TASO AB approach to the National HIV/AIDS Strategic Plan (NSP) 2007/08-2011/12. The interventions also respond to the gaps in the national HIV response as identified by the UHSBS and other key studies. The interventions are also backed with evidence of their effectiveness. The TASO-supported AB activities will have partnership and referral linkages to other services/platforms in health service delivery in Apac district. AB activities will also promote other HIV Prevention approaches, HIV Care/Support and HIV Treatment services by partners in the district.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	

Narrative:

Activities will be implemented with full consciousness of gender disparities and vulnerability to infection; appropriate messages will be passed on. The barriers to prevention efforts paused by stigma and discrimination issues will be addressed. TASO will work with the office of the DHO, Ministry of Health and social marketing organizations.

This activity will target prevention of HIV/AIDS through interventions that promote consistent condom use and other prevention methods as appropriate to enable adults access a variety of complimentary approaches to prevent HIV infection in any given situation. In particular, this approach will be used to strengthen "Prevention with Positives' for cleints identified in the home based counselling and testing program especially the sexually active clients and discordant couples. TASO will also make targeted interventions for at-risk populations, including but not limited to boda boda riders, truck drivers, mobile populations, commercial sex workers, plantation workers, and others to whom abstinence and faithfulness are difficult options. Project staff will reach these populations by organizing educational events within their respective communities. Through collaboration with the District, TASO will access free condoms for distribution amongst the population including discordant couples. These condoms will be available with the field staff. Trained project staff will provide appropriate information assisting clients to consider condom use as an appropriate option to avoid further transmission of HIV. Particular effort will be taken to ensure that target audiences are all adults and exclude children.

The second component of this activity is staging Drama Group performances in the community. The

program will train PHA net works and community residents to utilise music and drama to pass on HIV prevention messages in the rural communities, institutional settings and other venues. Drama Groups convey their messages through singing, dancing, acting plays, sharing personal HIV/AIDS testimonies and providing HIV/AIDS information. Through these drama performances the audiences will be able to ask questions and also relate their own experiences. These discussions will lead to recommendations for prevention activities beyond abstinence and faithfulness. TASO will ensure prevention message conveyed through Music and drama performamces are reinforced by age appropriate small group discussions facilitated by trained counsellors. In addition, TASO will also provide various training programmes to promote condom use and other prevention methods using a variety of adult learning methods.

The third component of this activity is staging community education and action through peer groups who, among other roles, will carry out HIV/AIDS education including the promotion of prevention activities beyond A&B in different venues in the community. The community workers will mobilize community residents to come together to attend HIV/AIDS talks, drama shows and other events aimed at providing HIV/AIDS information to the residents. The community workers will be trained in community facilitation skills and promotion of HIV/AIDS prevention through behavior change beyond A&B. Community workers will also inform community members where free condoms can be accessed.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9240	**Mechanism Name: HIV/AIDS Prison Survey**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Uganda Prisons Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 320,000	
Funding Source	**Funding Amount**
GHCS (State)	320,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

• Goal: To improve the health status of prisoners, staff and their families by strengthening the Uganda Prison Service (UPS) capacity to provide comprehensive prevention, treatment, care and support services for HIV/AIDS and related opportunitic infections, STDs, TB and malaria equivalent to those available in the community and consistent with the National policies within 5 years. Objectives: (a) To document HIV/STD/TB prevalence, incidence and related risky behaviours among prisoners and staff to inform health planning and services delivery in the UPS by 2010. (b) To promote HIV prevention strategies for the prisons community. (c) To provide comprehensive HIV/STD/TB continum of care (including HCT, clinical care and social support) to 16,875 prisoners, 2605 staff and 4,704 familiy members by 2014. (d) To develop and strengthen HIV/AIDS policies, operational guidelines and administartive instructions for the UPS by 2014.

• Geographic coverage of the mechanism is National because it includes prisons all over the country: 222 prisons. Target population: prisoners (30,000 with an annual turnover rate of 60,000), prison staff (3,000) and their family members (12,000). The mechanism intends to target 112 prisons in the 11 administative regions of the UPS.

• The mechanism has been mainstreamed into the Prisons Health Service System and thus will build capacities in the areas of clinical care, HRH, infrastuture, cordination mechanisms and diagnostic services.

•The mechanism belongs to the Prevention Working Group. However, it provides cross cutting programs in the areas of Clinical Care, Treatment and Health System Strengthening .

•Further mainstream the mechanism's activities into the existent systems of the Prisons Health Service as part of a sustainability plan. Under procurement, the mechanism follows the GoU Public Procurement and Disposal Act. UPS intends to estabilish an inter-agency coordinating body composed of private and public partners of the UPS in collaboration with the Prisons AIDS Control Program to provide an over sight function and harmonize activities of UPS partners to avoid duplication of services.

• A monitoring and evaluation framework for the mechanisms' activities is being developed.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9240		
Mechanism Name:	HIV/AIDS Prison Survey		
Prime Partner Name:	Uganda Prisons Services		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	320,000	

Narrative:

Condoms:
• Population: Male and female prison staff and their family members aged above 18 years, PLUS prisoners on release.
• Prison staff and their family members will be able to access condoms from community condom distributors and the health facilities of the Prisons Health Service. The prisoners will access the condoms from the reception on release from the prison. This is because condoms are not accepted by law to be given to prisoners while in confinement. This service will be provided in the second half of the fiscal year during the time of sero-behavioral survey.
•Geographic coverage: all the 222 prisons can access condoms through the UPS Medical stores as part of their drugs consignment under the Prisons Health Service. Population coverage: all prisoners, prison staff and their family members will be able to access condoms.
• Quality assurance mechanisms will include training of condom distributors, identify startegic condom distribution points, record and report on condom distribution.
• Condom distribution will be conducted within the strutures of the UPS as described above.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9246	**Mechanism Name: Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Makerere University School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,736,015	
Funding Source	**Funding Amount**
GHCS (State)	4,736,015

Sub Partner Name(s)

Global Health Education	Johns Hopkins University Center for Clinical	Rakai Health Sciences Program

Overview Narrative

Makerere University School of Public Health (MUSPH) is located within the Mulago National Teaching and Referral Hospital in Uganda. The mission of MUSPH is to improve the attainment of better health for people of Uganda through public health training, research and community service. In December 2007, Makerere University School of Public Health (MUSPH) and the Centers for Disease Control and Prevention (CDC) renewed their commitment to develop human resource capacity for management of HIV/AIDS programs in Uganda, and continue to collaborate with Rakai Health Sciences Project (RHSP) to deliver comprehensive community based HIV/AIDS prevention, care and treatment services to over 5000 HIV infected persons and their family members in Rakai and surrounding districts. This is a five year grants that carries forward lessons learnt in phase1. The grant has four major programming components that are addressed in this narrative.

1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. The focus is this program is to provide comprehensive HIV/AIDS prevention, care and treatment to over 5000 HIV positive clients in Rakai and neighboring districts. RHSP implements programs under 12 budget codes including: i) Prevention of mother to child HIV transmission (PMTCT), ii) HIV prevention – AB (Abstinence and being faithful), iii) Other sexual prevention, iv) Biomedical prevention – male circumcision, v) HIV testing and counseling, vi) Adult care and support, vii)Adult treatment, viii) Pediatric care and support, ix) Pediatric treatment, x)ARV drugs, xi) Laboratory infrastructure, and xii) TB-HIV care. Details of the activities under RHSP are described under the respective budget code narratives.

2) The SPH-CDC HIV/AIDS Fellowship Program is a capacity building and training program implemented

by Makerere School of Public Health to strengthen the leadership and management of HIV/AIDS programs in Uganda. The Program aims at building competencies of professionals and health care workers in HIV/AIDS program leadership, management, and comprehensive HIV prevention, care and treatment through hands-on apprenticeships, technical placements, and offsite training. The overall aim of the Program is to build capacity for high quality HIV/AIDS prevention, care, and treatment and support services in Uganda.

3) The internet based distance learning program to support the training of PEPFAR partners is implemented by Johns Hopkins University Center for Clinical Global Health Education (CCGHE). This is a public-private partnership that has the following goals:
- Establish a Project Coordinating Center in Kampala, which will train and employ Ugandan nationals to lead and sustain this initiative over the long term.
- Establish free connectivity for Ugandan PEPFAR partners to a new national high-band internet network supported by RENU, UTL and a large multinational business consortium that will link the Ugandan network to a submarine cable landing site in Mombasa, Kenya.
- Develop a web-based "portal for this initiative, located in Uganda, to support multiple distance learning tools/functionality for the PEPFAR program
- Develop initial priority distance learning programs, defined by key PEPFAR partners
- Initiate an ongoing program evaluation to document the impact of this initiative
- Initiate discussions with local and international business interests, in order to develop a long-term sustainable business plan for this initiative.

The progress, approach of implementation and targets of each area are described under each of the 13 budget code narratives

4) The Crane Survey is a Public Health Evaluation (PHE) among Most at-risk population (MARP). The survey employs surveillance methods for high-risk groups including men having sex with men, female sex workers, non-paying partners of sex workers, paying clients of sex workers, non-paying partners of clients of sex workers, university students, and transport workers in Kampala, Uganda. These surveys will be conducted annually among various groups deemed to be at higher risk for HIV and other STI acquisition

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9246
Mechanism Name:	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District
Prime Partner Name:	Makerere University School of Public Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	120,000	

Narrative:

ADULT CARE AND SUPPORT (HBHC)

The Rakai Health Sciences Program provides HIV care and support services to HIV positive adults residing in Rakai, Lyantonde and a few from the surrounding districts of Masaka, Mbarara and Sembabule. Services provided include both clinical and non-clinical care and support services. Non clinical services include health education and prevention of domestic violence while clinical care services include post-test counseling and linkage to care, treatment and prophylaxis for opportunistic infections especially cotrimoxazole prophylaxis for prevention of respiratory and gastro-intestinal infections, provision of basic care package for prevention of malaria and diarrheal diseases, tuberculosis screening and treatment, general health education, nutritional counseling, prevention of mother to child transmission, reproductive health services like provision of contraception, prevention, screening and treatment of sexually transmitted infections and on-going HIV counseling and support. Condom use is encouraged as a method of contraception and as a method for prevention of STI spread and acquisition. Condoms are distributed by peer educators and clinicians during all clinic days.

To address patient nutrition issues, the program has introduced food preparation demonstration sessions to accompany the nutrition education sessions. In these sessions, patients are practically educated on how to use locally available foods to prepare nutritious meals. This is a sustainable and affordable way to empower patients and prevent malnutrition. This intervention will be evaluated in due course, to assess its impact on the nutritional status of our clients.

Clinical services are provided and will continue to be provided to patients both at home and at facilities.

The program operates a total of 17 clinics located at already existing government health centers within Rakai and Lyantonde districts. Locating the clinics at government health units has facilitated integration into the district health system. The clinics are run on a bi-monthly basis where patients are given drug refill appointments but are free to walk-in on any of the clinic days, if they require care for any illness.

Health education is provided through both community meetings like village meetings and at the clinics. Community health education jointly targets both HIV positive and non-infected individuals. In this, health talks, video shows, drama are used. The clinic health education sessions focus on the HIV positive patient health needs, and cover a variety of topics including; positive prevention, use of condoms, nutrition, PMTCT, emphasis on testing children, adherence to care, use of clean water, etc.

Patient monitoring: The program will continuously assess the well-being of patients enrolled on the program through scheduled clinical and laboratory patient assessments. Patients not yet on ART will receive two monthly cotrimoxazole refills and have their CD4 cell counts re-assessed at least once every six months. Diagnosis and treatment for opportunistic infections will be offered as provided.

Reduction of HIV transmission: In addition to the general health education and distribution of condoms for prevention of HIV transmission, particularly attention will be paid to discordant couple through establishment of discordant couple clubs. This group will receive special education and support to prevent transmission of HIV to uninfected spouses. Couples will be encouraged to share their challenges during the quarterly meetings and access counseling. Uninfected spouses will also be offered repeat HIV testing every three months.

Patient retention: Patients who receive a positive HIV diagnosis through the counseling and testing (CT) program are linked to care through referral chits given by the counselors. Patient who miss their clinic appointments are traced by the resident counselors in their communities and reminded to attend the clinic.

In the past 5 years of HIV care provision, the program has experienced some challenges in the provision of care and support to HIV positive patients. These have included timely enrolment of patients referred from the Counseling and Testing (CT) program, adherence to both ART and non-ART care. Various interventions have been designed to address the issue of early entry into care, adherence to and retention in care. These have included use of the community resident HIV counselor home visits to clients who have received HIV positive results to ensure entry into care. Among patients already enrolled into HIV clinics, adherence to care has been greatly improved by use of the home visiting team that consists of nurses who make impromptu home visits to both patients on ART and those not yet eligible for ART to check on adherence to treatment as well as follow up patients who have missed their clinic

visits. The program has also trained patient peers to follow up fellow patients, reminding them of clinic visits, and this has greatly improved patient clinic attendance. One of the main reasons for falling out of care has been identified as patient feeling unwell. We have provided a pre-paid telephone line which patients call to notify the clinicians of their ill health. These patients are then actively followed up by the home visiting teams. All patient deaths are documented through administration of verbal autopsy. This has helped us keep track of the death rate on the program.

Patient referral: Patients in need of specialist services like chemotherapy or in need of hospitalization are referred to places with the available resources. With separate funding (Suubi fund), the very needy patients receive financial assistance to cater for their upkeep while in hospital.

Quality control and assurance: The program is closely monitored to ensure all clinicians provide quality care. All HIV care providers have been trained in comprehensive delivery of care services. In addition, we provide continuing medical education to further equip the health care providers with skills to provide care. Staff trained in health quality control and assurance provide support to the program by identifying areas where the clinicians need to perform better and recommend any required training to bridge the gap. Editors review all patient files to ensure completeness and correctness of clinic records.

Monitoring and evaluation: The adult care and support program is monitored through MOH, PEPFAR and Rakai program generated indicators. These are derived from the data collected and reports are routinely generated to inform the program performance.

As of the 30 June 2009, approximately 4,906 patients over 14 years of age were receiving care. In FY 2010, the program targets to provide care to 6,500 HIV positive patients and 7200 patients in FY2011. This will greatly contribute to the PEPFAR target of providing care for 12 million people living with or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	320,000	

Narrative:

ADULT TREATMENT (HTXS)

The RHSP provides antiretroviral therapy (ART) to patients whose CD4 counts are 250 cells/ul or with WHO stage is IV. For HIV-infected pregnant women and patient co-infected with TB and HIV, ART is initiated at CD4 below 350. ART is provided via 17 outreach clinics, 16 of which are located in the communities at already existing government centers. Patients are screened for eligibility for ART through

clinical evaluation and laboratory evaluation. Through the clinical evaluation, all morbidities are identified and patient WHO staging noted. Blood is drawn for CD4 cell, liver and renal function tests. These are carried out, to evaluate eligibility for ART as well as establish the capability of the liver and kidneys to handle antiretroviral drugs.

Once identified as eligible for ART, a patient is assessed for readiness to initiate ART, both medically and socially. Medically, the status of the liver and kidney are assessed based on the chemistry results, as well as assessment for any co-morbidity like tuberculosis that may prevent immediate initiation of ART. Prior to ART, the patient's social situation is also assessed so as to prepare adequate support once started on treatment. For some, a home visit may be arranged. A patient is requested to bring along a treatment buddy who will also be educated on ARV drug use. The primary role of this buddy is to remind the patient to take his ARV drugs properly. This extra step taken in assessing the patient social circumstances has greatly helped us identify patients in need of extra help to facilitate adherence to treatment. Quite often, socially challenged patients initiating ART are linked to a resident HIV counselor and peer educator located within their geographical region, who subsequently offer additional adherence support.

Once initiated on treatment, the patient is monitored both clinically and through laboratory indicators to assess improvement. Clinically, a patient is assessed every two weeks for the first three months on ART, then monthly until one year. After one year on treatment, if the patient is fully adherent to his treatment, he/she starts receiving 2 monthly drug refills. Patients' CD4 cell counts and viral loads are monitored every six months. (NB. Viral load monitoring is supported by the National Institutes of Health).

Adherence monitoring and support: Patients on ART receive comprehensive adherence support at the clinics through focused adherence counseling sessions and at home through impromptu adherence checks. Adherence is assessed by self report and by spot check pill counts. Currently, at least 95% of the total ART patient population have 100% adherence.

Role of peer educators: Peer educators are experienced ART patients who have been trained to offer adherence support to fellow patients on ART. They conduct home visits at least 2 weekly and document adherence by pill count. They also take note of the patients' general state of health and inform the clinicians via a pre-paid telephone line, if there is need to urgently review the patient. The peer educator adherence records are filed on the patient records folder to supplement the self report adherence.

Monitoring clinical outcomes: Patient routine data is analyzed to assess the clinical, immunological and virological outcomes of individual patients. Most importantly, we use viral load monitoring to guide decisions to switch patients from first to second line regimens

Patient failure discussions: Lists of patients with have virological failure are periodically generated from the database and discussed during the patient failure discussions held weekly. Each patient is carefully assessed and the reasons for failure documented. When poor adherence is suspected, a spot adherence check is conducted by an adherence nurse and counseling given. In the past year, approximately 50% of patients with virological failure who received additional adherence counseling were able to attain an undetectable viral load within the subsequent six months, therefore delaying switch to the more expensive second line ART regimens.

Training of health care providers in provision of ART care and monitoring.
Adult treatment is provided by personnel trained in comprehensive HIV care and treatment. Also, personnel involved in patient support and monitoring for example the HIV and adherence counselors, laboratory personnel, peer educators, data managers, monitoring and evaluation personnel, are trained to offer quality services. In an effort to strengthen the capacity of the district health workers to provide care to patients on ART, even when the Rakai program clinics are not in session, we have previously supported the training of district health care providers in provision of comprehensive HIV care.

The program targets to provide a comprehensive care and treatment package, including ART to 2500 patients in FY2010 and 2700 in FY2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	150,000	

Narrative:

HIV CONSELING AND TESTING

The Rakai Health Sciences Program provides testing and counseling to clients residing in Rakai and Lyantonde districts. This service will build on the existing HIV testing program where HIV testing is provided through three main avenues:
1. Community HIV testing and counseling. All year round, health education and mobilization will be provided to the Rakai and Lyantonde communities in preparation for community testing and counseling. Different households will be notified by community educators about their respective testing days. Community HIV testing targets people in the 15-49 year age group. At the testing and counseling venues, individuals will be counseled and blood drawn for HIV testing. The blood will be transported for testing at central laboratory in Kalisizo using ELISA therefore results will not be provided at the same sitting, as would be the case with Rapid HIV testing. The program will maintain HIV counselors in the communities, who will return HIV results to clients tested at community level.
2. Testing and counseling through the male circumcision service: Clients seeking medical male

circumcision will be offered voluntary counseling and testing during the pre-surgery counseling.
3. Testing and counseling at the HIV clinics: At each clinic, VCT will be offered especially for the spouse and children of the index client. The HIV negative partners will be followed up for re-testing and referred to discordant couple clubs for continued support and HIV prevention initiatives.

The number of children tested for HIV has been observed to be low in the program. The program plans to work hand in hand with the district health units, to target HIV positive mothers bringing their babies for post-natal clinics like immunization days. These mothers will be counseled to have their babies tested for HIV. This will provide us with the opportunity to identify HIV positive infants and link them into care early. The early infant diagnosis will be implemented in collaboration with the MOH nation-wide program. Infants confirmed to be HIV-infected will initiated on ART as per national HIV treatment guidelines.

Because the Rakai program does not provide rapid HIV testing, there will be no counseling and testing provided at campaigns or special events, where clients need to receive their results immediately. Failure to return results immediately may seem like a missed opportunity, however, the program has used HIV rapid tests before at the beginning of one of RHSP's trials and found that rapid tests generated inaccurate results with an unacceptable number of false positives (see publication: BMJ published online June 1, 2007, doi:10.1136/bmj.39210.582801.BE). Based on this information, RHSP decided to drop rapid testing and continue using double EIAs and Western blot confirmation for discordant EIAs as had previously been done for all research studies and services provided.

Supportive supervision, quality assurance, and M&E: Delivery of quality services will be assured through provision of support supervision for all testing and counseling teams, and resident HIV counselors. Support supervision and quality assurance and control will be provided by staff trained in counseling, testing and HIV quality control. Like all other program areas, the outputs of the testing and counseling program will be closely monitored by a monitoring and evaluation team that captures data on various indicators. Regular progress and scientific reports will be generated on a monthly basis and quarterly reports submitted to CDC, PEPFAR, and MOH.

Referral and linkage to care, treatment, and prevention services: Clients who test HIV positive will be referred to any of the 17 HIV clinics of their choice but will preferably be referred to the clinic nearest to their home. Periodically (approximately monthly), referral data will be examined to determine numbers linked to care.

The program targets to provide testing and counseling to approximately 13,000 individuals in FY2010 and about 14,000 in FY2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	80,000	

Narrative:

PEDIATRIC CARE, SUPPORT AND TREATMENT

Pediatric care is provided for all HIV positive children ages 0-14 years, who reside in the districts of Rakai, Lyantonde and the surrounding districts of Mbarara and Masaka. Entry into pediatric care starts with HIV testing. This may be through the PMTCT program, the Early Infant Diagnosis Program, or HIV testing and counseling at the facilities for in and out patients. At the community meetings, participants are educated about the advantages of having the children under their care tested for HIV.

At the HIV clinics, HIV positive children are provided with a wide range of services including clinical and non-clinical services like health education for the older children, on-going counseling, cotrimoxazole prophylaxis, treatment of opportunistic infections, provision of basic care package for prevention of malaria and diarrheal diseases tuberculosis screening and treatment, general health education, nutritional counseling for child care takers,.

To address patient nutrition issues, we have introduced food preparation demonstration sessions to accompany the nutrition education sessions given to the children's caretakers. In these, caretakers of HIV positive children are educated on how to use locally available foods to prepare nutritious meals, so as to prevent malnutrition among the HIV positive children under their care.

Clinical services are provided to patients both at home and at facilities. The program operates a total of 17 clinics located at already existing government health centers within Rakai and Lyantonde districts. The clinics are run on a bi-monthly basis and although patients are given drug refill appointments, they are free to walk-in on any of the clinic days, if they need care for any illness.

Patient monitoring: The program continuously assesses the wellbeing of these children enrolled on the program through scheduled clinical and laboratory assessments. Children not on ART are seen monthly for cotrimoxazole refills and have their CD4 cell counts re-assessed at least once every three months.

Scaling up pediatric care: Poor uptake of pediatric services still remains a challenge in the program. Strategies to increase awareness about the availability of these services will be implemented like community health education and sensitization meetings and clients will be urged to bring children for HIV testing so that those that are HIV positive receive care. The program will also incorporate HIV testing services for infants into childhood immunization days. It's hoped that this strategy will help identify HIV infected infants early.

Supervision, improved quality of care and strengthening of health services: The program is closely monitored to ensure all clinicians provide quality care. All providers receive support supervision from well trained medical officers. All HIV care providers have been trained in comprehensive delivery of care services. In addition, the program will provide continuing medical education to further equip the health care providers with skills to provide pediatric care. Editors will continue to review all patient files to ensure completeness and correctness of clinic records. In order to strengthen health services, the program will continue to provide training to staff offering pediatric care services in all relevant HIV pediatric care.

Integration with routine pediatric care, nutrition services and maternal health services: The program currently provides nutritional education and food demonstrations to address the children's nutritional needs. In FY 2010 the program will partner with organizations like Uganda Women's Efforts to Save Orphans, to provide skills in sustainable food security to caretakers of HIV positive children, and also link with programs like Nulife, that are already providing nutritional interventions especially to malnourished children.

Activities to strengthen laboratory support and diagnostics for pediatric clients:
The RHSP has partnered with the Uganda Ministry of Health to provide reliable HIV testing for pediatric patients. Samples are collected and transported to the Joint Clinical Research Center laboratory. The program will continue working with the Ministry of Health to ensure provision of diagnosis for pediatric patients. The Rakai program laboratory will also continue to support patient monitoring and diagnosis for opportunistic infections.

In FY2010, the program targets to provide pediatric care to 400 children and 500 in FY2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	80,000	

Narrative:

PEDIATRIC TREATMENT

Pediatric treatment is provided to children residing in the districts of Lyantonde, Rakai and the surrounding districts of Masaka and Mbarara. Antiretroviral therapy (ART) is provided to all HIV positive children <2yrs irrespective of CD4.
ART for pediatrics is provided via 17 outreach clinics, 16 of which are located in the communities at already existing government centers. Children are screened for eligibility for ART through clinical

evaluation and laboratory evaluation. Once identified as eligible for ART, a child is assessed for readiness to initiate ART, both medically and socially. Medically, the status of the liver and kidney are assessed based on the chemistry results, as well as assessment for any co-morbidity like tuberculosis that may prevent immediate initiation of ART. Prior to ART, the child's caretaker's ability to support the child on treatment is assessed and any special needs identified addressed prior to ART initiation. A home visit may be arranged if thought necessary. It is greatly encouraged that both parents of the child participate in the support of a child on ART. The caretaker is thoroughly educated about ARV drugs and all questions arising are answered.

Once initiated on treatment, the patient is monitored both clinically and through laboratory indicators to assess improvement. Clinically, a patient is assessed every two weeks for the first three months on ART, then monthly. Patients' CD4 cell counts and viral loads are monitoring is done every six months (NB. Viral load monitoring is supported by the National Institutes of Health).

Adherence monitoring and support:

Children on ART receive comprehensive adherence support at the clinics through focused adherence counseling sessions and at home through impromptu adherence checks. Adherence is assessed by caretaker report.

Role of peer educators:

Peer educators are experienced ART patients who have been trained to offer adherence support to fellow patients on ART. They conduct home visits at least 2 weekly and document patient adherence to treatment. They also take note of the patients' general state of health and inform the clinicians via a pre-paid warm line, if there is need to urgently review the patient. The peer educator adherence records are filed on the patient records folder to supplement the self report adherence.

Monitoring clinical outcomes:
Patient routine data is analyzed to assess the clinical, immunological and virological outcomes of individual patients. Most importantly, we use viral load monitoring to guide decisions to switch patients from first to second line regimens

Patient failure discussions
Lists of patients with have virological failure are periodically generated from the database and discussed during the patient failure discussions held weekly. Each patient is carefully assessed and the reasons for failure documented. When poor adherence is suspected, a spot adherence check is conducted by an

adherence nurse and counseling given.

Supervision, improved quality of care and strengthening of health services: The program is closely monitored to ensure all clinicians provide quality pediatric treatment. All providers receive support supervision from well trained medical officers. All HIV care providers have been trained in comprehensive delivery of care services. In addition, the program provides continuing medical education to further equip the health care providers with skills to provide pediatric treatment. Staff trained in health quality control and assurance provide support to the program by identifying areas where the clinicians need to perform better and recommend any required training to bridge the gap. Editors review all patient files to ensure completeness and correctness of clinic records. In order to strengthen health services, the program provides training to staff offering pediatric treatment services in all relevant HIV pediatric care.

Monitoring and evaluation: The pediatric care and support program will be monitored through PEPFAR and Rakai program generated indicators. These will be derived from the data collected and reports will be routinely generated to inform program performance.

Integration with routine pediatric care, nutrition services and maternal health services: The program currently provides nutritional education and food demonstrations to address the children's nutritional needs. In FY 2010 the program plans to partner with organizations like Uganda Women's Efforts to Save Orphans, to provide skills in sustainable food security to caretakers of HIV positive children on the program, and also link with programs like Nulife, that are already providing nutritional interventions especially to malnourished children.

In FY2010 the program, we shall provide treatment to 150 children and 200 in FY2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	354,150	

Narrative:

MARPS study: This is an ongoing surveillance activity (dubbed "Crane Survey"). The survey's 1st phase was successfully completed in 2009 (sampling female sex workers and their male partners, men having sex with men, university students, and motorcycle taxi drivers), enrolling more than 3,000 survey participants. SPH staff (~20) included data and coupon managers, administrative assistants, counselors and laboratory technicians. Current activities include data cleaning and analysis as well as preparing for the next phase that will survey school students, drug users and high risk heterosexuals. Field activities are currently paused due to ongoing IRB review of the protocol amendment, unexpected cost increases, and the necessity of finding a new survey office in downtown Kampala. This 2nd phase of field activities

will commence in the 1st half of 2010. We anticipate training for approximately 15 staff on protocol adherence, IT training (ACASI), possible also on VCT. This collaborative activity between CDC, MOH, and Makerere University (School of Public Health, SPH) mostly involves SPH staff, thereby greatly expanding SPH's technical capacity and skills and will inform Uganda's HIV/AIDS stakeholders about high risk populations and their needs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,526,994	

Narrative:

The SPH-CDC Fellowship program currently has four major training activities: 1) the two-year: i) the two-year (long-term) fellowship which has been implemented for the last six-seven years, ii) the eight month (medium-term) fellowship, iii) off-site short courses, and iv) the technical placements which started at the end of FY 2008.

A) Long-term (two year) Fellowships
This is a 2-year, fulltime, non-degree training program, open to Ugandan nationals with a postgraduate degree in a health-related discipline such as: Medicine, Nursing, Social Sciences, Statistics, and Journalism. Enrolled Fellows are attached to host institutions involved in HIV/AIDS activities, and placed under the supervision of host institution and academic mentors. Fellows spend 75% of their apprenticeship at the host institution while the remaining 25% is dedicated to short courses conducted at the MUSPH. Currently, the program has 19 long-term Fellows; 9 enrolled in FY 2008 and 10 enrolled in FY 2009. The Fellows who were enrolled in FY 2008 are scheduled to complete their training in March 2010, and in April 2010 the program will enroll 10 new Fellows. A total of 45 long-term Fellows have so far graduated from the program and are occupying leadership positions in leading HIV/AIDS organizations in Uganda and the region. Host institutions have benefitted through staff training, development and implementation of innovative pilot programs as well as through operations research conducted by Fellows at their institutions.

B) Medium-term Fellowships
Medium-term Fellowships are offered for a period of eight months to middle- and senior-level managers who may not be able to leave their employment for the long-term Fellowships. The purpose of medium-term Fellowships is to improve identified systemic gaps within institutions. Trainees undergo six weeks didactic modular training course spread over duration of eight months. Fellows undertake three distinct but inter-related modules, and after each module, they return to their institutions. This training approach allows them to take the course while continuing with their employment. Two medium-term Fellowships have been implemented since 2008, one in Continuous Quality Improvement (CQI) and the other in

Monitoring and Evaluation (M&E) of HIV/AIDS programs.
To date, 30 medium-term Fellows from 17 institutions have completed the course while 37 individuals from 21 institutions are still undergoing training. Fellows implemented a broad range of CQI activities including improvement of efficiency of clinic systems and reduction in waiting time for patients, increasing enrollment of patients on ART and patient retention, and improvement of logistics management systems at their institutions. Fellows also developed and enhanced M&E systems within their organizations. A number of the institutions have started scaling up these activities to other sites with the programs and districts.

C) Offsite short courses
Offsite short courses are provided to individuals and institutions to enhance their capacity to lead and manage HIV/AIDS programs. Over 2,000 individuals have been trained to date; 519 of these in the past one year. About half of the individuals trained in the past year were from upcountry programs.

D) Technical Placements
Technical placements are offered to individuals working with HIV/AIDS programs. Under these placements, selected individuals are assisted to visit other HIV/AIDS organizations to learn and document best practices for replication within their respective institutions. This is the most recent addition to the Program activities, with the first three trainees completing their placement in April 2009.

FY 2010 plans for MUSPH-CDC Fellowship
In FY 2009, MUSPH fellowship program will support a total of 580 individuals. We will support 20 long-term fellows (10 fellows continuing and 10 new fellows admitted in FY 2010). Two medium term-fellowships will be conducted, each with 24 fellows; a total of 48 medium-term fellows from 24 institutions in the year. In addition to these, short courses will be provided for 500 individuals and technical placements for 12 individuals. Through the medium-term fellowships the program will support the individuals and institutions to improve on identified systemic gaps within their organizations. Within the medium-term fellowships, the short courses at MUSPH will be delivered in three modules, in a staggered manner, for a period of 4 weeks. Through the Fellows apprenticeship attachments 44 organizations will be supported (20 through long-term and 24 through medium-term fellowships). More institutions will be reached through the short courses. These will include public and private organizations (CBOs, FBOs, NGOs etc). The institutions will cut across several districts within the country. Deliberate efforts will be made to reach the rural districts; the program has started regional sensitization meetings to ensure that eligible institutions and individuals throughout the country are aware of the capacity building opportunities available at MUSPH. Varied range of beneficiaries and stakeholders associated with organizations that will be hosting the fellows and receiving short courses will therefore be reached indirectly. These may include people affected by HIV/AIDS as well as special populations such military and refugees.

2. Progress of the JHU-CCGHE initiative
The CCGHE Distance Learning initiative has established a local in-country Project office and Management Team (PMT); Project Manager, Technical Assistant, and Project Administrator. Equipment and software has been installed and IT specifications and setup of the server are complete. The PMT have received extensive training in video capture, editing, lighting, and filming of live conferences/lectures. The IT assessment (network topographies) defining partner IT infrastructure equipment and connectivity requirements continue for the PEPFAR partners; a total of 18 partners have been contacted. Fifteen implementing partners including; (MUWRP, IAVI, TASO, IKI, NIH, MUFOM, MUSPH, PIDC, MUJHU, RO, TMC, UVRI, MJAP) have undertaken the assessment exercise and 5 (CDC, JCRC, MOH/ACP, AID & CPHL) are still to provide the required information. Geographical maps have been generated showing physical location of sites/buildings in Mulago, as well as connections to the backbone and/or MU fiber, and where fiber or copper wiring to connect is currently missing.
In June, the first Infectious Disease Grand Rounds event took place between IDI and Johns Hopkins. IDI presented 3 cases for discussion. Archived recordings were created. A GPS-enabled Patient Tracking Tool and an Educational Training System have been designed, developed and programmed for smart phone deployment. A working demo was created which transfers data via the UTL mobile network to a database on a local server. These tools will allow providers of our PEPFAR partners in remote settings to capture patient information and to receive educational training from our educational portal via a mobile device. A Circumcision Procedural training video (online/DVD) script has been completed and videotaping of the procedure was done in June. Initial meetings were held in June to discuss evaluation of the final training video. The Infectious Diseases Summit 2009 conference, co-sponsored with the Accordia Foundation and held in Kampala April 20-22 was digitally captured and recordings made available to sponsors and for network distribution. A two-day training course held in January by the NIH was digitally captured for network distribution when available and produced on DVD for immediate distribution. The course provided participants with the knowledge and skills on Good Clinical Practice (GCP) regulatory requirements in order to carry out their research within a well structured framework.

FY 2010 plans for CCGHE initiative
Prepare IT Departments of "Second Phase" PEPFAR partners for connectivity to the new network (Kampala-Entebbe-Rakai). The Ugandan PMT will work with key PEPFAR partners on purchasing equipment required for network connectivity based on IT infrastructure needs discerned from network topographies. Connectivity to the new GMRE/RENU national network in Uganda will be complete.
A plan for wireless connectivity for remote clinics of key PEPFAR partners will be completed. Assistance with connectivity from the Ugandan PMT will be available. A web-based platform ("portal") to support multiple distance learning tools/functionality will be completed and intranet access available. Webcasting,

digital recording and archiving of key PEPFAR training programs conducted by PEPFAR partners in Kampala, Entebbe and possibly Rakai for distribution to PEPFAR partners will be available. The video training program for male circumcision will be available and evaluation will begin. Population of a digital library of key educational resources by PEPFAR partners will be available.
Initiate an ongoing program evaluation plan, which could include data collected on an ongoing basis, by the Project Management Team on the impact of the program, including numbers of trainees, numbers and types of training content provided, knowledge and skill assessments and feedback from the participating PEPFAR partners. Grand Rounds will take place on a regular basis and archived for access from the portal. All programs captured in FY2009 will be available within the portal to all connected PEPFAR partners.
Mobile technology platform will be finalized and a pilot project will be initiated for testing and feedback of the device. Both data capture of patient assessments will be 'pulled' from the phone as well as relevant provider training will be 'pushed' to the phone.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	935,200	

Narrative:

The RHSP will continue to promote and provide Medical Male Circumcision as part of a comprehensive prevention package. The program will continue promoting the ABC strategy at all mobilization meetings in the community, in schools and out of school to cover both school going and out of school adolescents and adults. ABC will also be emphasized as part of the package at group and individual counseling sessions, during operation, recovery and at follow up visits.
The program will also continue providing MC skills training to teams of providers; a total of 105 MC providers will be trained in FY 2010 and these will include 35 MC counselors, 35 theater assistants and 35 surgeons (including Medical and clinical officers).
We plan to implement the following strategies in order to make the MC skills training program even more user friendly: Making practice in skills more beneficial by providing video guides for all short procedures, Availing more clinical rooms for pre operative assessment, post operative assessment, and follow ups, Implementing a timely evaluation of the on-line didactic phase of the circumcision skills course, Making monitoring and support supervision visits to trainees. In order to support service providers at government health units, District officials including district medical directors, Nursing officers and health educators will be invited to attend a circumcision awareness course at the program.
Current status: The program had conducted 1200 surgeries by the end of August 2009 (40% of FY 09 target). The program has been able to provide post operative follow up to ~90% of the men we circumcised during this period. Adverse event rates continued to be low during this period (< 2%). Consenting for minors before surgery continues to be a challenge given the fact that parents/guardians

are not readily available. The influx of clients from far locations has increasingly delayed surgery as this is not done immediately thereby increasing the cost per circumcision done. The Rakai MC program will set up at least 2 satellite MC provision centers one in Lyantonde district and another one in Masaka district to overcome this problem. These centers will be routinely supervised by staff from the Rakai MC program.

Post training follow up for trainees: The program will continue to conduct post training follow-up and support supervision to Kalisizo hospital, Kakuuto Hospital, Kayunga Hospital and Kiruhura. This will ensure that supervised units are conducting their MMC activities in accordance with the WHO guidelines and are satisfactorily providing MC services.

IN FY 2010, up to 3300 men will be offered MC services through surgeries at the RHSP center and 2 satellite MC centers, the program will target males 13 years or older in Rakai and neighboring districts of Lyantonde, Sembabule, Kiruhura and Masaka. It will also cover rural communities and high risk communities such as landing sites of Malembo, Kasensero and Kacheera and higher institutions of learning, police and military barracks. All men who report for surgery at the RHSP centre will be offered HIV counseling and testing. Those who test HIV positive and are ready to continue with circumcision will have a sample drawn for CD4 testing to help them accesses ART care and support will be provided to all identified HIV positive clients

To ensure good quality of circumcision services, the program plans to set up constant supervisory strategies at various stages of service provision. These measures will be aimed at ensuring that the health workers offer standard quality of care as well as ensuring that the recipients of these services follow guidelines as prescribed. The Rakai MC program is the only program providing training to MC providers in Uganda. RHSP will follow up a sub sample of trainees to monitor their performance and productivity following receipt of the MC training. This activity will inform programs on issues that need to be addressed to enable easy and smooth integration of MC services into existing private and public health units. Finances allowing, we will do monitoring and evaluation (and support supervision) to at least 10 units in Rakia and neighboring districts.

Communications activities for male circumcision as they relate to males and females will be delivered to the population through a number of channels; namely community health education sessions for ABC that include male circumcision, in schools where teachers, students, school counselors, student leaders and school heads will be equipped with information about MC; drama and film shows addressing circumcision messages, Mass media including news papers and radios; MC brochures to clients and household members.

Male Circumcision service - FY2010

Number of male circumcisions to be performed.

We plan to offer service circumcision to 3300 men during FY 2010 and 3300 in 2011. This is estimated to be achieved by conducting surgeries at the RHSP center and 2 satellite MC centers.

Coverage either in the geographic area or among the target population
We will target males 13 years or older in Rakai and neighboring districts of Lyantonde, Sembabule, Kiruhura and Masaka.. We plan to cover rural communities and high risk communities such as landing sites of Malembo, Kasensero and Kacheera. We also plan to target higher institutions of learning, police and military barracks.

Activities for supportive supervision and quality assurance
To ensure good quality of circumcision services, we plan to setup constant supervisory strategies at various stages of service provision. These measures are aimed at both ensuring that the health workers offer standard quality of care as well as ensuring that the recipients of these services follow guidelines as prescribed.
The Rakai MC program is providing training to MC providers in Uganda. RHSP will follow up a sub sample of trainees to monitor their performance and productivity following receipt of the MC training. This activity will inform programs on issues that need to be addressed to enable easy and smooth integration of MC services into existing private and public health units. Finances allowing, we will do monitoring and evaluation (and support supervision) to at least 10 units in Rakia and neighboring districts.

The Rakai MC program is hoping to set up at least 2 satellite MC provision centers one in Lyantonde district and another one in Masaka district. These centers will need routine support supervision which will be provided by staff from the Rakai MC program.

Routine training, re-training and refresher training sessions for counselors, theater assistants, surgeons and MC trainers will be organized when ever necessary. During these sessions, issues that will have been identified through interaction with providers, clients and trainers will be addressed.
Over the shoulder observation and review of service records will be done to assess provider and trainer competency. Any gaps identified will be addressed through individual and/or group re-training seminars.

Communications activities for male circumcision as they relate to males and females
Information will be delivered to the population through a number of channels;
Community health education sessions will be conducted in groups of about twenty men and women. Issues including ABC, male circumcision and family health will be addressed.
In schools, we plan to equip teachers, students, school counselors, student leaders and school heads with information about MC through targeted school meetings.
Drama and film shows addressing circumcision messages will also be conducted.
Mass media including news papers and radio will be used to disseminate MC messages.
Brochures carrying information about male circumcision will be given to clients together with post

operative wound care instructions. This will act as an easy means of providing MC information to the rest of the members in the household.

Provision of Testing and Counseling onsite

All men who report for surgery at the RHSP centre will be given chance to receive VCT. The following procedure will be followed;

• Men will be given proper pretest counseling at first contact.
• A blood draw will be done for all men who accept to have an HIV test.
• Testing will be done at the Kalisizo lab or hospital lab if available
• HIV results will be provided to all men who are willing to receive them.
• All HIV positive men who receive results and are ready to continue with circumcision will have a sample drawn for CD4 testing to help them accesses ART care.
• Support will be given to all HIV positive clients through discordant couple clubs. Men who are willing to disclose their HIV status to their partners will be provided with counselor facilitate disclosure.
• HIV positive clients will be referred for ART care.

Inclusion of Medical Male Circumcision as part of a comprehensive prevention package

The program will continue to promote and provide MC as part of a comprehensive prevention package. We shall continue promoting ABC at all mobilization meetings in the community, in schools and out of school to cover both school going and out of school adolescents and adults. ABC will also be emphasized at group and individual counseling sessions, during operation, recovery and at follow up visits.

Training programs and materials being used

We will continue providing MC skills training to teams of providers. We will provide training to 105 MC providers. These will include 35 MC counselors, 35 theater assistants and 35 surgeons (including Medical and clinical officers).

We plan to implement the following strategies in order to make the MC skills training program even more user friendly.

• Making practice in skills lab more beneficial by providing video guides for all short procedures
• Availing more clinical rooms for pre operative assessment, post operative assessment, and follow ups
• Implement and make timely evaluation of the on-line didactic phase of the circumcision skills course.
• Make monitoring and support supervision visits to trainees.
• In order to support service providers at government health units, District officials including district medical directors, Nursing officers and health educators will be invited to attend a circumcision awareness course at the program.

A recently concluded in-country review of PEPFAR prevention portfolio recommended the need to scale-up Medical Male Circumcision. Rakai Health science Project (RHSP) is a WHO accredited site for training trainers and service providers in safe medical male circumcision for Uganda and other countries in the region. In FY 2009, Rakai trained over 120 service providers (including Medical officers,

clinical officers, Nurses and counselors) from various programs in the public and private sector. Wiith PEPFAR support Rakai HSP provided MMC services to over 3000 men in Rakai and the surrounding districts. To increase capacity for training and service delivery, Rakai has expanded services to Lyantonde District Hospital and Kakuuto Health Center IV. Through this expansion, Rakai has not only brought services closer to rural communities but also demonstrated models for integration of MMC services in public health facilities.

Initially MUSPH- Rakai received $535,200 in COP 2010 in MMC technical area to continue implementing training and service delivery at Rakai HSP and for supporting the two satellite site at Kakuuto and Lyantonde. With additional $400,000, Rakai HSP will increase the number service provider s trained from 15 per month to 30. The Training Center has position itself to double its training out in order to meeting the increasing demand for trained service providers and trainers. In addition, Rakai will expand services to an additional two new health facilities in the surrounding districts, most likely Masaka and Isingiro. Selection of health facilities will be done after conducting a needs assessment and discussions with the local authorities. REDACTED.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	44,823	

Narrative:

ABSTINENCE/BE FAITHFUL

Abstinence:

The Abstinence education program will target school-age children and youth below 18 years; a group which is considered not yet prepared to make responsible, healthy decisions about sex; to promote abstinence from sexual activity until marriage. The program shall provide abstinence messages to youth both in and out of school, male and female ages 10-24 years. Youth will be supported and encouraged to avoid risky behaviors. Young people will be reached with messages about abstinence and fidelity. They will be urged to choose abstinence before marriage and faithfulness in marriage as the best prevention against HIV and other sexually transmitted diseases.

Abstinence will be promoted particularly among young adolescents who are not yet sexually active. We shall also help "influencers" of youth such as parents, guardians, pastors, teachers, and youth leaders to guide youth to make and sustain wise life choices about their sexual behavior. We shall encourage unmarried youth under the age of 24 to commit to sexual abstinence until marriage. Some young people who may be sexually active shall be convinced to return to abstinence ("secondary abstinence,") but realistic options will be provided for the majority who will not, including information on and access to condoms. Young people will be equipped with life skills to cope with negative peer pressure These will

include skills for building self esteem and skills for being assertive, for example to be able to say 'NO' when one means 'NO'. Education on gender norms, concurrent sexual partnerships, transaction sex, and cross generational sex will also be emphasized.

Messages will be delivered through talks, videos, role plays and group discussions. IEC materials with the relevant messages will also be distributed. At community level and through meetings with opinion leaders like religious leaders, we shall encourage integration of abstinence support programs and HIV/AIDS awareness into their ongoing youth programs

Be Faithful:

Messages to promote perfect fidelity (that is, mutual fidelity with a non-infected partner) as another highly effective method, especially for stable and married couples will be delivered. It shall be emphasized that this strategy works only if both partners are faithful and uninfected. 'Be faithful' messages will be delivered to married persons during their special prevention meetings. Fidelity and reduction of number of sexual partners will be encouraged among both HIV positive and negative persons. The discordant couples will be encouraged to remain faithful to their partners as well as use condoms. Where possible, abstinence will be supported for discordant couples. The younger age groups will be prepared to be faithful when they choose to marry.

Quality assurance and promotion: The Rakai program will ensure quality services are provided to the clients served. Health educator supervisors will directly oversee preparation and delivery of health education sessions and will provide support to staff providing the service. Messages to be discussed will be discussed prior to delivery and will be pre-tested within a representative sample of the targeted population. In addition, the Rakai program's quality control and assurance team will regularly sit in the sessions to provide support supervision, hence ensuring that quality messages are given.

Linkage of Sexual prevention activities to other services/platforms: All sexual prevention activities have been integrated into all services offered in the program, including testing and counseling, where individuals or couples are counseled and educated on the ABC message, the HIV care clinics and sexually transmitted Infection clinics. Sexual prevention activities have also been incorporated in the male circumcision services and the Rakai program research activities like the annual HIV surveillance.

Evaluation and monitoring plan: The sexual prevention program will be monitored through PEPFAR and Rakai program generated indicators. Data on these indicators will be systematically collected by the health educators using data collection tools designed for this purpose. Forms will be entered in electronic databases and periodic reports generated to track program performance as well as meet reporting

requirements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	20,000	

Narrative:

OTHER PREVENTION

Other prevention activities will be conducted in the districts of Rakai and Lyantonde, covering the population of potentially sexually active males and females. Activities will include health education conducted at the general community meetings and through the HIV clinics, condom distribution at the clinics, at community HIV counselor offices and through condom sale agents spread out in the communities.

Health education: The program will conduct 17 Health education clinics on a bi-monthly rotational basis in the HIV clinics. Each clinic session will start with a health education session which lasts about 30 minutes and then a maximum of 30 minutes will be given to questions in small group sessions. In the past, structured community sexual prevention health education messages have been offered through avenues like general village meetings, drama shows, large community meetings, and other crowd pulling events. Different age groups have been targeted including youth in and out of school, married men and women, single parents; these will continue to be used for mobilization of people for the smaller group sessions

Safe Homes and Respect for everyone: The Safe Homes and Respect for Everyone "SHARE" aims at prevention of HIV spread through prevention of domestic violence in the communities. The activities aim at encouraging different groups to focus on prevention of Domestic Violence (DV). The SHARE activities include: village meetings, film shows, drama shows, impromptu discussions, poster exhibitions, booklet clubs, capacity building workshops/ seminars; specialized meetings for youths in and out of school, married adolescents; counseling and referrals., The SHARE project uses volunteers like community volunteers, police officers, health care workers etc to carry out its activities.

Condom distribution: The program receives free condoms from the Population Services International (PSI). These are distributed during clinic sessions by counselors as well as peer educators in the HIV clinic and refills provided as required. In the community, 10 RHSP resident counselors provide points for easy reach. These conduct home visits community members can access free condoms from them. Condom distribution is accompanied by condom use education, addressing issues like proper use, safe storage and disposal after use.
Condom sale agents will also continue to play a key role in distribution of condoms to the Rakai

population. These agents will be supplied with both free and branded condoms for sale. The Rakai program will provide the commercial condoms at a subsidized price, so the agents are able to sell at a subsidized fee to clients who prefer the non-free condom brands. Currently, the program supports 120 condom sale agents.

Special groups: For a long time, the program has continued to recognize the discordant couples as a special group that needs continued support to prevent HIV transmission and marital dissolution. The program sustains discordant couple clubs, through which clients who have been identified as being discordant are enrolled and receive on-going support from counselors and fellow couples. Through this arrangement, couples who are coping well encourage others.
In these clubs, structured health education and condom distribution are also availed. However, the clubs currently have no developed resource materials but hope to adopt already existing discordant couple IEC materials, to avail to these clients. Re-testing for the HIV negative partner in the discordant relationship is also emphasized. The program will provide quarterly HIV re-testing for HIV negative sexual partners of HIV+ persons and a card on which re-test dates are entered will be provided.

In FY2010, the program will continue to provide "other prevention" interventions including health education messages addressing ABC, as well as condom distribution and condom use demonstrations to the population in the Rakai and Lyantonde districts. In addition to the general community health education sessions, the program will provide focused small group (25-30) health education sessions youth, married, discordant couples, and the general population, with messages specially designed to address that group's needs. We hypothesize that in the small group education sessions, the targeted population will be able to clearly understand the information given, ask for any clarifications, and subsequently change behavior. High risk groups like the motor-cyclists and fishermen will specially be targeted. The participants will be invited to the respective meetings at a selected venue, where the sessions will be held. Refreshments will be provided during the meetings.

Intervention(s) for each specific target population will include the following. Discordant couples: These will be educated through health talks from Rakai staff and external facilitators, video shows, facilitated group discussions and client testimonies. The program will ensure use of interventions that maintain the confidentiality of clients. Discordant couple club activities will be held every six months, but on-going counseling and support will be provided by the community resident counselors all year round.

MARPS: Most at risk populations (MARPS) like the motor-cyclists, fishing communities and commercial sex workers will specially be targeted.
These will be educated through health talks from Rakai staff and external facilitators, video shows and facilitated group discussions. The program will ensure use of interventions that maintain the

confidentiality of clients. Special education packages will be identified and used to provide preventive strategies like abstinence, being faithful and consistent and proper condom use, so as to reduce HIV acquisition and transmission within these groups. Education will be delivered through health education talks, drama, video shows and facilitated group discussions. Condom use demonstrations will also be conducted during one on one session, to ensure proper use.

General population: There will be sexual prevention packages particularly delivering messages on abstinence, being faithful to one's sexual partner and consistent use of condoms. These messages will be delivered through workshops of varying durations tailored to the needs of the specific group. Health talks, drama and video shows and small group discussions.

The Rakai program has in place a mechanism to ensure that quality services are provided to the clients. The health education department has supervisors directly responsible for supervising and providing support to staff delivering the "other prevention services to the clients. Messages to be delivered will be discussed prior to delivery and pre-tested within a representative sample of the targeted population. In addition, the Rakai program's quality control and assurance team regularly will sit from time to time in the sessions to provide support supervision, hence ensuring that quality messages are given.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	40,000	

Narrative:

PMTCT

The Rakai Health Sciences Program (RHSP) provides Prevention of Mother to Child Transmission (PMTCT) of HIV to mothers attending the 17 HIV clinics, which cover the geographical regions of Rakai, Lyantonde districts and a few areas in the surrounding districts of Masaka and Mbarara. PMTCT services are provided by the program through the out-patient HIV clinics but this program does not run routine antenatal clinics. PMTCT interventions are aimed at preventing acquisition of HIV by the baby from their HIV infected mother. Activities include antiretroviral prophylaxis for mother and baby, infant feeding education to encourage safe feeding options as well as reproductive health (family planning) services.

Women attending the HIV clinics and are identified as pregnant, receive education on PMTCT, with the aim of ensuring that they deliver an HIV-free baby. These are uniquely identified and flagged to ensure easy identification at the subsequent visits. All pregnant mothers are encouraged to attend antenatal care clinics (from other health care providers) and their antenatal records are reviewed by RHSP clinicians at all visits.

Newly diagnosed pregnant HIV positive mothers are offered PMTCT prophylaxis in accordance to the National guidelines: All mothers are given Nevirapine and Zidovudine syrup with instructions on safe storage and administration of the drug to the infant after delivery. This is given as early as 28 weeks to cater for any premature deliveries, since a relatively large proportion of mothers may deliver at home, where the babies may miss out on PMTCT interventions. On-going health education to all pregnant HIV positive mothers is given during pregnancy emphasizing the importance of delivery in a health center, post-partum hygiene, infant feeding and adherence to ARV prophylaxis for the mother and baby. All the HIV-infected pregnant women are also assessed for ART eligibility and initiated on ART as per national guidelines (i.e. with CD4< 350) if eligible. Mothers that aren't eligible for ART receive combined ARV regimens (commonly AZT/3TC) for prophylaxis. For infected mothers that report very late in pregnancy or in early labor, single dose Nevirapine (SDNVP) is given. The RHSP is working in close collaboration with the district facilities MCH clinics to improve referrals and follow-up and avoid double counting of the clients served.

Infant feeding: The infant feeding option chosen by an HIV infected mother is very critical in further prevention of maternal transmission of HIV to the baby. The RHSP does not provide infant formula to mothers but emphasizes safe feeding practices during the pre-natal health education sessions to ensure that the mothers are adequately prepared for the arrival of the baby. Mothers are educated on all the available methods of infant feeding (exclusive breastfeeding, use of infant formula or alternative feeds, mixed feeding) and the risks involved in each mode. Alternative feeding is only encouraged if it is Affordable, Feasible, Acceptable, Safe and Sustainable (AFASS). Currently, mothers are encouraged to exclusively breastfeed for 6 months post-delivery and wean gradually. Mixed feeding is greatly discouraged as it increases risk of MTCT through breast feeding.

In the FY 2010, in addition to health education, food demonstration sessions will be offered especially to mothers with babies. During these sessions, they will learn to prepare nutritious foods, using foods readily available in their communities.

Reproductive health services: Prevention of pregnancy is the surest way to prevent mother to child transmission of HIV. Therefore, as part of the PMTCT package, RHSP offers reproductive health education and services. Readily available in the clinics are condoms, oral contraceptive pills and Depo-Provera and Intrauterine devices (IUD). The program also plans to explore the possibility of making available long term methods of contraception like Norplant. Patients in need of surgical reproductive health interventions will be referred to the district hospitals.

Patients will be offered family planning counseling and have their knowledge and understanding assessed before selection of a method. Education on possible side effects will be provided and women will be supported to discuss family planning options with their sexual partners and couple family planning counseling will be encouraged.

PMTCT program evaluation: The impact of the use of extended (14 week) Nevirapine prophylaxis to babies born to HIV positive mothers, a practice adopted from the PEPI Malawi PMTCT trial will be evaluated using external funds.
Linkage of babies born to HIV+ mothers into care and treatment will also be evaluated with the aim of improving service quality and program outcomes. All babies born to HIV positive mothers enrolled onto the PMTCT program will be tested for HIV using HIV-1 PCR at 4-6 weeks for both breast-feeding and non-breastfeeding mothers with the aim of early HIV diagnosis among the exposed infants.

All HIV exposed infants will be started on co-trimoxazole at 6 weeks of age and those whose results are positive on DNA PCR will be enrolled for regular HIV care and initiated on HAART. Exposed babies who initially test negative will be followed up for repeat testing until HIV infection is definitely excluded.

Progress: During the first quarter of FY09, 28 pregnant mothers were enrolled into the PMTCT program, bringing the total number of pregnant women active in PMTCT care to 36. Twelve (33.3%) of them were started onto HAART and 24 (66.7%) women were started on a course ARV prophylaxis. There were 14 reported live births, 12 (85.7%) of whom tested for HIV and all these tested HIV negative. There were no reported deaths, stillbirths nor abortions.

In FY2010 and 201, the program targets to provide PMTCT services to at least 150 women. The program will ensure that the HIV infected pregnant women receive the highest level of care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	450,000	

Narrative:

LABORATORY INFRASTRUCTURE

The Rakai Health Sciences Program laboratory supports all HIV testing and monitoring for biological samples collected from the 17 HIV clinics and counseling and testing centers within Rakai and Lyantonde districts. The only exception is the qualitative PCR for infant diagnosis, which is provided by the Joint

Clinical Research center laboratory. The laboratory provides services not only to the Rakai program clinics but also district health centers like Kalisizo hospital and Kitovu mobile, which are supported with CD4 count testing.

Overall, the Rakai program laboratory provides a wide range of testing including: HIV testing, serology like syphilis testing, microbiology testing like TB diagnosis, viral load testing, CD4 count testing, chemistry tests like renal and liver function tests, etc. In FY2009, with PEPFAR funding, RHSP procured a Chemistry machine, therefore increasing the efficiency of running chemistry tests

In FY2010 and FY2011, the program plans to continue providing laboratory support to the district health units in need of testing services and extend support to two other health centers, Rakai hospital and Kakuuto health center IV.

In order to provide quality laboratory services, training of staff has been identified as critical. The laboratory employs well qualified laboratory staffs but these will be provided with additional training to suit the laboratory-specific needs.
The program plans to support training in all laboratory sections of molecular biology, microbiology, chemistry, serology etc. RHSP targets to provide training to at least one staff in each of the laboratory sections; a total of at least 5 laboratory staff will be trained. The laboratory employs two quality control and assurance staff who will continue to move through all the sections to provide support supervision and quality assurance, ensuring accurate performance

In line with the transition process for PEPFAR Track 1.0 implementing partners, the program will transition laboratory services to local in-country partners. In particular, plans and activities that will result in sustainable accredited laboratory programs.

The program plans to build capacity in laboratories in the district health centers so as to build their ability to diagnose opportunistic infections. It will also support the training of laboratory assistants at these health centers through laboratory rotations at the Rakai program laboratory, assist in design of standard operating procedures, training in laboratory safety measures and facilitation with basic laboratory equipment including microscopes and microscope slides.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	600,000	

Narrative:

ARV DRUGS

Rakai program will procure antiretroviral drugs to cover patients on first and second line regimens, for both adult and children in line with recommendations of the National treatment guidelines. Drugs will include zidovudine, lamivudine, nevirapine, efavirenz, alluvia, tenofovir, truvada, and smaller quantities of stavudine for patients who cannot tolerate zidovudine, didanosine and abacavir. Both syrup and tablet formulations will be procured

Prevention of Stock outs:

The program did not experience stock outs in FY 09. To ensure that there are no stock outs in FY2010, the program will continue to submit timely quarterly drug forecasts to our drug suppliers, so as to assist them predict our consumption. In order to prevent stock outs arising from unpredicted drug delivery lead time, we shall include within our drug stock a two months buffer stock.

In FY2010, the program plans to purchase ARV drugs for a total of 2500 patients and for 2700 patients in FY2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	14,848	

Narrative:

TB/HIV

Rakai Health Sciences Program provides TB/HIV care to all clients enrolled in the HIV clinics. All patients are routinely screened for TB and those with signs and symptoms of TB have further testing like sputum examination, Chest x-ray done to make a diagnosis. The program provides tuberculosis care under the guidance of the ministry of health through the Rakai district. We use the district TB registers to capture Ministry of health indicators. Our program works close with the district TB focal person, to whom monthly TB reports and drug forecasts are forwarded. Since the Rakai program was recommended for accreditation as a TB center, the district has provided all the required first line TB treatment. The program receives support supervision from the district focal person and ministry of health TB/leprosy section.

We provide TB/HIV care within the framework of the district set-up, for example referral of patients initiated on TB to the community TB Directly Observed Therapy (DOTS) program, in areas where there are no Rakai program peer educators to reinforce adherence to TB therapy. The Rakai program has continued to support the Rakai district in the diagnosis of TB. Until recently, when the district hospital x-

ray machine broke down, we assisted with supply of both adult and pediatric x-ray films, as well as fixer chemicals. We currently have an agreement to accept referrals from district health units for x-ray at the Rakai program x-ray facilities.

Human Resource Capacity and Sustainability:
The clinical section conducts on-going medical education sessions, covering various topics of which TB management in HIV patients is included. In addition, all the staff currently engaged in TB/HIV care have received training in comprehensive HIV care which covers TB management as well. The TB focal clinicians have received specific training in TB management of HIV positive patients.

Monitoring and Evaluation:
RHSP program gathers data on various indicators. Some of the information is captured in the structured Ministry of Health TB registries while additional PEPFAR program indicator data is collected within the other regular patient clinic forms. TB/HIV is one of the regular program areas on which we report. Data collected is verified by clinically trained editors, who ensure that high data quality is reported. In addition, the quality control and assurance team provides support supervision to the clinicians.

Accomplishments: We have successfully redesigned data collection tools to capture all the required TB/HIV indicator data, including the recent PEPFAR-revised TB indicators. In addition, all staffs have received in-house training on management of TB, in accordance to the ministry of health guidelines. The program has successfully solved the problem of failure of patients to provide all three sputum samples for diagnosis of TB by collecting a spot sample on the first patient visit and leaving the patient with one sputum container to return with an early morning sputum sample on the following clinic day on which a 3rd spot sputum sample is taken, to complete the 3 required samples. This was a compromise between having no follow up sputum samples to complete TB diagnosis since many patients were too poor to bring the subsequent samples to the central laboratory. Reinforcing routine TB screening has seen our program treat more patients than in the previous years, indicating that we might have missed out some infected patients if we screened only patients with suspicious symptoms.

Lessons learnt: We have learnt that it is critical to emphasize routine screening of all HIV positive patients for TB. It is imperative to ensure complete adherence to TB drug therapy so as to prevent development of multi-drug resistant TB, whose treatment is very costly.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9247	**Mechanism Name: Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,019,259	
Funding Source	**Funding Amount**
GHCS (State)	5,019,259

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Uganda Ministry of Health's (MoH) core mandate is formulating national technical policies, guidelines and standards, building the implementation capacity of lower level entities, and tracking the implementation of the policies by the lower level entities, countrywide in line with the national guidelines. The MoH is also responsible for tracking and responding to epidemics. The MoH is expected to provide support and monitor the activities of all health sector implementing entities countrywide including public, private, NGOs as well as district and sub-district health teams.

The MoH conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the public health component of the National HIV/AIDS Strategic Plan (NSP) 2007-2012, aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected/affected individuals and their families. Currently, MoH is engaged in formulation of the national health policy and third Health Sector Strategic Plan that will align with the National Development Plan that is also still under formulation.

Specifically, this cooperative agreement supports the MoH AIDS Control Programme (ACP), Resource Centre, Central Public Health Laboratories (CPHL) and National Tuberculosis and Leprosy Programme (NTLP) to undertake the following: i) HIV Prevention, Palliative Care, Treatment and Support to improve

the quality and scale-up of HIV/AIDS programs including: coordination of local and international partners to increase access to confidential counseling and testing (CT), PMTCT, palliative care and treatment services; improved integration of HIV prevention, care and treatment into comprehensive primary health care; and, support for countrywide access to confidential HCT through provider-initiated and home-based testing approaches; ii) TB/HIV integration to strengthen integrated prevention and clinical management of HIV and TB and increase access to confidential HCT for TB patients and TB diagnosis and treatment for HIV-infected individuals; iii) Policy and Systems Strengthening to identify gaps and develop, revise and update Uganda national policies and technical guidelines for HIV/AIDS related health services and to develop and implement policies and technical guidelines to improve the management of TB/HIV co-infection; iv) Laboratory Infrastructure to support the national CPHL to develop policies, standard operating procedures and quality assurance and quality control process; to conduct training and support supervision to peripheral, district and, regional laboratories; to improve access to early infant HIV diagnosis; and, to develop the capacity for related diagnosis of HIV, TB and OI in health center IVs and IIIs laboratories; v) Strategic Information to implement HIV/TB/STI surveillance activities and support national and decentralized monitoring and evaluation of HIV/TB/STI programmes and population-based studies. In all, 22 technical staff and 30 support staff have been recruited to support the MoH ACP, CPHL, and Resource centre staff to do achieve these objectives.

The activities of the MoH supported under this award aim overall to strengthen health systems in all areas including i) human resources for health through training and skills building, ii) health infrastructure particularly laboratories and equipment, iii) health information systems through the support to the Health Management Information System, HIV/AIDS Surveillance and programme M&E, iv) Logistics management for medical and pharmaceutical supplies, v) policy development for technical interventions and human resources including policies for task shifting, lay counselors and expert patients. Other cross cutting areas that are supported include i) nutrition policies related to safe infant feeding, therapeutic nutrition for ART adherence, TB treatment, and ii) Gender consideration in all HIV/AIDS prevention, care and treatment services.

Under this award, the MoH is progressively implementing cost cutting measures to increase efficiency and gaurantee sustainability. These measures include i) integration of service delivery especially reproductive health and PMTCT, AIDS care / ART and Tuberculosis and PMTCT, STI and reproductive health etc, ii) Integration of activities during implementation such as integrated support supervision involving all technical units, integrated dissemination of policies and guidelines, integrated development of educational materials, etc. iii) the MoH is also planning to integrate M&E activities for various interventions through an integrated M&E plan, iv) the MoH is also considering integrated training through an integrated curricular for various interventions, v) a programme evaluation which will among others, explore other avenues for improving cost-efficiency is also planned.

The activities under this award will be tracked in line with existing monitoring mechanisms. Because the MoH is not a direct service delivery entity, most PEPFAR output level performance measurement indicators do not lend themselves to tracking the performance of this award. Therefore, tracking of performance will be based on performance indicators and targets set out in the budget narrative. Tracking of outcome and impact will be based on the indicators for tracking overall health sector performance in HSSP. This activity will also generate data and capacity for tracking the overall performance of the health sector. Quarterly reports, an interim and final annual report will be prepared in line with the terms of the award, and will report performance against targets.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	50,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9247**		
Mechanism Name:	**Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development**		
Prime Partner Name:	**Ministry of Health and Social Welfare, Tanzania - Zanzibar AIDS Control Program**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	

Narrative:

Ministry of Health strategy is to have a strong HIV care and support programme for HIV clients through out the country, this to be done through the continuum of care approach where village health teams will be trained to offer HIV care through home based care (HBC) programme for HIV clients. The target audience for this care and support are HIV clients.
The continuum of care approach, comprises of various types of HIV care and support which are offered at three main levels namely; health facility, community, and home levels. The various types of HIV care

and support include; counselling and testing for HIV, psychosocial support, adherence counselling, nursing and palliative, provision and monitoring of treatments, nutritional support among others.
The continuum of care approach is arranged in such a way that the HIV clients are identified at the health facility and referred to the community/home or vice versa. This form of referral mechanism ensures that the HIV clients can easily be tracked down the system there by avoiding high rates of loss to follow up for HIV clients in care, especially those on treatments like antiretroviral treatment (ART) and other medications.
The HIV care described above is being strengthened and scaled up throughout the country as part of the response to increasing burden of care for HIV/ AIDS patients in the health care delivery system. The total number of HIV clients who need ART stand at about 350,000 persons and those on ART are more than 180,000 clients and most of these clients require HIV care and support of various types. Because of the chronic nature of HIV/AIDS, the major part of the HIV client's life is spent in the community or home environment where they need a lot of care and support of various forms to enable them have an improved .
Currently, the continuum of care and support for HIV clients is being provided in about 60 out of 80 districts by both public and private partners but this HIV care is not fully offered at all the three levels, the HIV care is relatively strong at the health facility level, where a few health workers have been trained but still weak at community/home level. Because the VHT strategy is relatively new, there is weak link between health facilities and community/home level for HIV care at present which require strengthening. Also the inter linkages between the HIV care sites and others service points providing other forms of essential HIV support like nutrition, reproductive health and family planning services is still weak and all need to be strengthened at all levels.
The home based care policy guidelines and implementation guidelines have been developed and will be printed and disseminated by the end of 2009 to all key partners involved in HIV care provision and these will help in guiding scale up of HIV care and support. The Ministry of Health strategy is to have a strong HIV/AIDS care programme by utilising the VHT strategy to strengthen the home based care programme in the country. The HIV care team members at health facility level will train and supervise the VHT members and these in turn will provide HIV care by working closely with the care givers of HIV clients who stay in close contact with those clients. On average each VHT member will care for at least five to eight HIV clients in the community and the care giver will look after one client in the community. This kind of HIV care program is hoped to reach about 80% of the districts in Uganda by end of 2011.

There will be need to strengthen inter linkages between various programs/key stakeholders in HIV care through out the country by enhancing coordination at national, district and community levels. This will be done through coordination meetings and as well as sharing of information between stakeholders among others.

HIV care and support will be monitored and evaluated through ensuring the client records regarding all HIV care and support are regularly passed on to the nearest health facilities, so that these can be captured in the routine health management information system (HMIS). To ensure uniform implementation of this activity, data collection tools will be developed and availed to all stakeholders to address this issue.

The national level will continue with the following roles in order to address HIV care and support; Updating and availing national guidelines, coordination activities, mobilising resources, support supervision, monitoring and evaluation of the program.
There have been a number of key limiting factors to HIV care and they include lack of guidelines, inadequate coordination at various levels and limited supervision and monitoring of HIV care, plans to minimise these negative factors are underway.
Goal: To strengthen HIV care through home based care programme as a continuum of care for HIV/AIDS in Uganda
Objective: To provide quality HIV/AIDS care and support in all districts both in public and private health sector.
• Performance/effectiveness of HIV/AIDS care will be measured by the number of districts providing quality home based care (HBC) as will be judged from standard supervision and HMIS tools on specific indicators in relation to HIV care.
The support sought under this proposal will address the current existing gaps and the priority activities including i) strengthening capacity building for human resource to enable effective delivery of the services within 20 districts ii) strengthening support supervision, monitoring and evaluation of HIV care and support activities, every quarter iii) strengthening collaboration and coordination of HIV care including HBC activities within both public and private stakeholders , to be held twice a year (iv) provision of essential equipments and supplies to strengthen HIV care and support at various levels, iv capacity development of health care providers on nutrition assessment, management of malnutrition and/or linkage to food support and IGAs services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	600,000	

Narrative:

Antiretroviral drug treatment is the main type of treatment for HIV or AIDS and it falls under the Care and support Unit of the STD/AIDS Control Programme. It was rolled out as a national programme in 2002 after it was successfully piloted under the UNAIDS Drug Access Initiative. Care and support for HIV-infected individuals is a priority programme area of the health sector response to the HIV epidemic in Uganda. The ART Unit is charged with the planning, management and coordination of the scale-up of the

provision of Antiretroviral Therapy in the country.

Uganda adopted the Comprehensive HIV care and treatment training guidelines based on the Integrated Management of Adulthood and Adolescent Illnesses (IMAI) approach for training of its first level health workers. The mandate of the ART Unit is to build the capacity of districts to plan and manage their ART services. This has been done through training of trainers and coordinators for Comprehensive HIV care and treatment at the district and regional level and through supervision of district-based trainings in ART in order to ensure their quality. The ART Unit also carries out accreditation of health facilities for ART and monitoring and evaluation of ART services. Tracking and evaluation of clinical outcomes is conducted through carrying out quarterly cohort analyses of HIV care and treatment data for health facilities providing ART, which activity will be carried out as part of the quarterly support supervision and mentoring for ART sites.

Objective of the National ART Programme
To increase access to ART for those in need to reach 240,000 by 2012

Target: Increase the proportion of health Centre IVs offering comprehensive HIV/AIDS care with ART to 95% by 2011

Core Intervention: Comprehensive HIV/AIDS for both adults and children including access to ART at health Centre IV.

Outcome measures:
• The number of HIV-infected adults and children accessing ART services in the country.
• The proportion of health facilities actively providing ART services in the country.
• Proportion of HIV-infected individuals that are accessing Antiretroviral therapy
• Proportion of HIV-infected individuals that are accessing chronic HIV care including Cotrimoxazole Prophylaxis.

Achievements
The ART Unit has been able to carry out a number of activities over the past one year. These include:

• Increased access of adults to ART in the country from 17,500 in June 2004 to 153,101 by December 2008 and to 180,000 by June 2009; thereby reaching coverage of 50% for those who currently need ART.
• Increased number of health facilities providing ART from 26 in 2004 to 340 by end of December 2008 to the current 355 sites by June 2009.

• Provide support supervision and mentoring of health workers from 100 health facilities in ART data management.
• Accreditation of 50 new health facilities as ART sites.
• Supported the districts of Mukono, Jinja, Bushenyi to train 30 health workers in Pediatric ART.
• Trained 38 health workers from Lira region in patient monitoring for ART.
• Reviewed HIV Care/ART data collection tools to incorporate more data variables for TB, PMTCT, paediatric clinical monitoring and to improve follow up of HIV-exposed infants.
• Validated ART data in all 352 health facilities providing ART in the country
• Revised ART training materials.

Activities planned for 2010/11
The National ART Committee is an important forum of the Ministry of Health for the coordination of partners and stakeholders in ART at the central level. It provides oversight and guidance for implementing ART activities in the country. Quarterly working meetings for the National ART Committee and its constituent eight subcommittees will be facilitated.

The ART Unit plans to carry out accreditation of new health facilities as ART centres in newly-created districts and to cover more of the lower healthy facilities; namely all health centre IVs and some of the health centre IIIs with adequate capacity for ART. Accreditation of lower health facilities is crucial because it will facilitate the decongestion of hospitals that are over-burdened with high HIV patient-loads. In addition, it will bring services nearer to the population that is being served.

District health managers will be empowered through trainings in the District HIV/TB Managers course in order to enable them to plan, manage and coordinate the scale-up and consolidation of ART services within their districts. This will increase their stewardship and ownership for ART activities. The ART unit will support districts to carry-out ongoing training in ART for the hard-to reach regions and also in order to cover training gaps resulting from staff attrition and transfers. A total of 160 health workers from 40 health facilities from the hard-to-reach districts will be identified and from health facilities greatly affected by staff transfers.

The ART Unit will also support districts to hold regional inter-site coordination meetings in order to provide health workers with updates on ART management and to facilitate sharing and learning from each others experiences.

Quarterly support supervision and mentoring in ART logistics and ART data management will also be carried out as an ongoing activity for all health facilities providing ART targeting health facilities that are poorly performing in ART data management and service delivery. Periodic ART data audits will be

carried out in 80 of the health facilities that are providing ART in order to assess and ensure quality of ART data. In addition, cohort analysis for ART services will be carried out during all these data audit visits and during support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	110,000	

Narrative:

HIV counseling and testing (HCT) is the cornerstone and entry point for most HIV interventions globally. In Uganda, the HCT service provision started in 1990 with stand alone VCT services delivery as the only approach. Over the last 19 years the Uganda has scale up of the HCT interventions to include Provider initiated Testing and counseling, and Home based counseling and testing and a number of variations of VCT. The HCT policy was first developed in 2005 and revised in 2007 to cater for all the different approaches of HCT as well as including the national testing algorithms. The UDHS 2006 and UHSBS 2004/5 showed a 70% unmet need for HCT at 70%. The health facility coverage has increased from about 100 sites in 2002 to over 800 in 2008. The population tested increased from 10% in 2000 to about 25% in 2006 and about 38% in 2008. The number of partners supporting HCT also increased from 3 in 2001 to 60 in 2008.
In May 2009, the first Uganda National HCT conference was held in May 2009 and it was proposed that this becomes a two yearly event. Therefore the second HCT conference is planned for 2011. In addition a number of task shifting strategies for delivery of quality HCT are being tried in the country

In order to scale up HIV counseling and testing to facilitate universal access as stated in the National Strategic Plan, the MOH will support the following strategic actions: i) Strengthen capacity for HCT training by increasing the number of trainers and accredited training institutions; ii) Scale up PITC, VCT, and HBCT; iii) Strengthen the management of logistics systems; iv) Scale up HCT support to sero-discordant couples; v) Ensure availability of trained counselors throughout the health care systems; and vi) Enhance coordination support, supervision and quality assurance of HCT.

According to HSSP2, HCT should be expanded to at all HCIIIs by 2010. Currently only 50% of the HCIII are providing HCT. In FY2010, the other 50% will be supported to start testing and the main activities will be training and supervision.

This activity will support the MOH/ACP to meet its mandate of leading the public health response to HIV prevention through coordination, standardization, and training in the area of HCT.

In FY10, we plan to increase HCT coverage by at least 20% given other national efforts. Activities in FY

2010 will be geared towards identification of HIV positive individuals and couples for linkage to care, treatment, strengthen positive prevention among discordant couples; and focus of strategies for HCT in identified most at risk populations (MARPS). We shall strengthen coordination of all the HCT partners through regular quarterly meetings of the HCT national coordination committee and its 5 subcommittees. To further strengthen coordination there will be regional forums where quarterly regional meetings will be held.

In FY09/10 the HCT policy will be reviewed and PITC will be scaled up as one of the most appropriate approaches in identifying HIV infected individuals. There is a need to scale up PITC and the positive prevention. PITC is currently in all regional hospitals and in 20% of general hospitals. In FY09/10 we propose to increase PITC in general hospitals to 50% and are expected to increase to 100% in FY2010. The main activities in scaling up are training of health workers and other service providers followed by focused supervision

Both focused and integrated support supervision will be conducted to ensure quality HCT service delivery given the many HCT actors in the country and those that are using task shifting and therefore support supervision is critical for ensuring quality. All districts will be visited as least twice in a year. We shall provide support supervision to all 42 PNFP facilities and 50% 0f the grade A private for profit facilities

Monitoring and Evaluation: Some of the key indicators for HCT services are already integrated in the MOH HMIS. We propose to continue using data collected under PEPFAR, MEEP that collects data that is not captured in the National HMIS. The new USAID projects implemented during that period of time propose to apply LQAS as an M&E methodology at community level. This data would be useful for community coverage estimates and complements MOH implementation of the VHT strategy. This health facility and community based methods are expected to strengthen the M&E of the HCT intervention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	140,000	

Narrative:

Paediatric treatment falls under the jurisdiction of the ART Unit of the STD/AIDS control Programme and refers to the HIV treatment of children aged 15years and below. Despite increased availability of paediatric ARV formulations and increased access to Early Infant HIV diagnosis in Uganda, improvements in the enrolment of children onto HIV treatment have been slow. Without access to HIV care and treatment, 50% of children infected with HIV will die before their second birthday. There were 20,200 new HIV infections in children in 2008 in Uganda. By end of 2008, 33,151 of the 130,000 children living with HIV were estimated to have advanced HIV disease and are therefore in need of ART.

Only 68% of the 352 active ART sites are currently offering ART to children. Furthermore, linkages between paediatric ART and services for Prevention of Mother-to Child HIV services are still inadequate in many health facilities. Ministry of Health has adopted the IMCI Complementary HIV course for building the capacity of first level health workers in paediatric HIV care and treatment.

The target for Uganda is to put 75% of children with advanced HIV disease on ART. This translates to 25,000 children on ART by end of 2010, and 32,500 by end of 2011.

Achievements

• Increased number of children accessing ART; from 10,418 by December 2007 to 14,297 in December 2008 up to the current 16,000 by June 2009; which is 48% of children with advanced HIV disease.
• Revision of the National ARV guidelines to include Early Infant Treatment (initiation of ART for all children under one year of age diagnosed with HIV, regardless of HIV disease stage or CD4 cell percentage).
• Trained 24 health workers from 12 health facilities performing poorly in Paediatric HIV care, through placements at Mildmay centre and to Baylor Uganda.
• Trained 56 health workers in the IMCI complementary HIV course

In order to avoid overlap and duplication of services, activities to strengthen laboratory support, to improve diagnosis of HIV in children and to promote integration and linkage with routine paediatric care, nutrition and maternal health services have been covered under the section for Early Infant HIV diagnosis (EID). In addition, the activities for improved quality of care will be covered under Quality Improvement activities under the HIVQUAL Program.

In order to coordinate and harmonize contribution of the various stakeholders in paediatric HIV care, quarterly meetings of the national Paediatric ART subcommittee will be supported. This committee has representation of all the major providers and stakeholders in paediatric HIV care in Uganda. Furthermore, regional paediatricians, regional ART coordinators and district health officers will be supported to attend quarterly regional inter-site ART coordination meetings and the annual National Conference for Paediatric HIV care and Treatment.

There is need to train health workers in Paediatric ART while targeting those facilities that are not yet proving ART to children. Training in the IMCI Complementary HIV course will be provided to 120 health workers from 40 of these poorly performing ART sites. The trainings in ART will be followed two-weeks later with a post-training support supervision and accreditation of 40 health facilities as ART sites. Regional paediatricians and regional ART support teams from regions of Uganda with no other partner

support will be facilitated to mentor and supervise quarterly all ART sites that are poorly performing in paediatric treatment. They will support initiation of paediatric ART, paediatric counselling and HIV care/ART data management, which are still weak in many ART sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	1,040,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	779,259	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	100,000	

Narrative:

Uganda has MC prevalence of about 25%, which is still too low to impact on the HIV/AIDS epidemic. Male circumcision is a common traditional practice for Muslims and some cultural groups in the Eastern and West Nile regions and in a few districts in central and mid-western regions of Uganda. In order to popularize the concept to benefit many uncircumcised men in the country it is imperative to disseminate MMC messages to the right target audience and facility based health providers. In view of this, the National Task Force and the MMC Secretariat conducted consultative regional meetings with stakeholders in Eastern, Northern, West Nile and South western regions to solicit support for MMC. A number of stakeholders have been sensitized on MMC. By the end of 2009, 250 (70%) out of the 350 targeted stakeholders country wide had been reached. The sensitizations have resulted in high demand for MMC services. Currently, the MMC Policy guidelines are being developed.

The objectives include:

• To strengthen partnerships for advocacy and mobilization for MMC services in all districts in Uganda
• To scale up MMC services across the country within a comprehensive HIV prevention package
• To ensure standards in the delivery of MMC services

Funds under this budget code will be specifically used for the following activities:

• Conducting meetings with the district political and health leadership to disseminate the MMC policy as well as build partnerships for advocacy and mobilization for MMC services

• Developing training materials and implementation guidelines for MMC
• Training service providers in MMC
• Developing MMC communication strategy
• Conducting support supervision of MMC services
• Conducting monitoring and evaluation of MMC services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	200,000	

Narrative:

Injection Safety is an integral component of Infection Prevention and Control practices which aim at preventing medical transmission of HIV and other blood borne pathogens. The mandate of this area include strengthening district capacity to plan and implement Infection Prevention strategies, and creating mechanisms of promoting safe work practices in the entire health care system. The emphasis areas of this plan have been placed on Standard Precautions, injection safety, health care waste management, Post Exposure Prophylaxis and TB Infection Control. However, successful implementation of infection prevention control still poses a big challenge within the country's health care delivery system, including at the community level.

Some main achievements have been made from implementation of previous work plans. Infection prevention and control guidelines were developed to provide standardized national guidance regarding infection control practices. Infection Control has been institutionalized through formation of Infection Control Committees thus ensuring sustainability of activities. The number of hospitals with committees has steadily increased from 20 to 60. Training of health workers to impart knowledge and skills, and support supervision has been on going.

Despite the above achievements, critical gaps still exist in the area of Infection Control. According to the report on the Implementation of National HIV and AIDS Strategic Plan FY 2007-2008, the coverage of services for injection safety and HIV infection prevention in the health system is still inadequate. Only 52 out of 80 districts have been trained in injection safety and health care waste management. Another gap is the limited interventions addressing HIV medical transmission at community level. This is a critical issue because most of the care givers in communities are informal, and are vulnerable to acquiring and transmitting infections. Medical practitioners in private practice have not been adequately targeted for infection prevention interventions. They need to be brought on board to be able to follow national guidelines for infection control.

During FY 2010 this activity will strengthen and consolidate previous strategies and bring in new areas of

intervention. The activity area will also aim to promote prevention and control of HIV and other infections in the communities through building capacity of districts to support community interventions. This will enable establishment of community strategies aimed at promoting infection control measures, with emphasis on Injection Safety. During FY 2010/11, Health workers in 15 districts will be trained in injection safety in order to increase coverage of services for Injection safety. The training will be preceded by sensitization meetings for district leaders to create awareness of the role of safe injections, in prevention of HIV medical transmission. District leaders will be expected to mobilize communities not to demand for injections and to allocate resources for procurement of injection safety supplies.

To build district capacity, training of trainers in comprehensive infection prevention, targeting 120 members of infection control committees will be conducted. The training covers all infection control components, including Injection Safety, and PEP. To strengthen facility-level infection control committees, 25 hospital committees that were trained previously will be given support supervision to ensure that the training will be translated into practice. Identified gaps, challenges and good practices will be discussed with managers.

The programme area intends to create community awareness on infection prevention and control to contribute to prevention of HIV medical transmission within communities. Initially, six districts will be targeted for this activity. Meetings will be held with the district leaders to empower them to support community infection control interventions. To empower districts to implement community infection interventions, 90 district trainers will be trained. The training will enable trainers to mobilize and sensitize Village Health Teams and other voluntary groups for participating in community infection control interventions.

The program area will conduct TB infection control activities in collaboration with NTLP and other stakeholders. 25 hospitals will be assessed for TB transmission risks factors. Identified gaps will be shared with hospital management teams for possible interventions. 375 health workers will be given on job training in TB infection control (15 per hospital for 25 hospitals).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	

Narrative:

Uganda is committed to re-invigorating HIV prevention to stem the tide of new HIV infections. This is in line with the goal of the second Health Sector Strategic Plan 2006-2010 and the national HIV/AIDS Strategic plan 2007-2012. The Ministry of health by its mandate leads the public health response to HIV prevention, which is the key component of Uganda's multisectoral HIV/AIDS response.

Under previous support to the technical area of other prevention (STD control, condom promotion, focus on most-at-risk population groups, etc) the MoH in collaboration with other partners have initiated activities that address the risk factors and key drivers in the HIV epidemic e.g. HIV discordance, transactional sex, low level or lack of consistent and correct condom use, STI services for Most-at-risk populations etc. Capacity building activities at district, regional and pre-service health training schools were also implemented and support supervision conducted. Some specific achievements include, ongoing efforts to integrate HIV prevention into AIDS care programmes, setting up a dedicated HIV prevention services for sex workers clinic in Kampala and Wakiso for sex workers and other MARPs including condom provision, STI treatment, building STD training capacity in about half of the districts, piloting interventions for most-at-risk populations, IEC materials, developing and implementing a strategy for condom distribution beyond health facilities, pre-service training of health workers has also been conducted.

During FY 2010, support under this technical area will support the MoH to provide technical guidelines and support for STD treatment in primary health care facilities, condom promotion and distribution activities to build on previous efforts, and will support collaboration with other activity areas including AB in order to address the rise in unprotected sexual behavior and the high prevalence of STIs among Most At Risk Populations, cohabiting and married couples. Furthermore, the MoH will also scale up training pre-service and in service health care providers to build their capacity in other HIV prevention activities through training of trainers and mentoring and coaching. Other activities will focus on development/review and updating of tools, policies, guidelines and protocols in the areas of condom and STIs.

Target Population:
Activities under this activity area will mainly target mainly adults, especially those aged over 30 years among whom HIV prevalence and incidence are highest, married and cohabiting couples, urban residents, most-at-risk population groups particularly sex workers and their clients, couples particularly discordant couples, vulnerable populations like students in tertiary institutions, long distance truckers, migrant workers, fish mongers etc. Activities will also target health workers both pre and in service to equip them with skills and knowledge to provide relevant HIV prevention services.

Type of activities:
The specific activities that will be supported under this activity area include: i)Regional Training of Trainers for HIV/ STI prevention and Control among the most at risk populations. This will include district trainers and organizations that offer HIV prevention, development and production of targeted IEC materials for Condom promotion, HIV/ STI prevention for the sexually active agegroups, couples and

MARPs group in central and northern regions and IEC campaigns, to increase comprehensive knowledge on HIV/STI prevention and Condom use; ii) building capacity for HIV prevention through training, mentoring and coaching of pre and in service Providers on STI management where 120 district STD trainers from 20 districts will be trained and 6 pre-service health training schools' tutors will also be trained, iii) training of 300 peer educators for promotion of both male and female condoms and STI treatment for CSWs in two districts of Kampala and Wakiso and 2 hotspots along the northern Kampala Juba route, iii) procurement and setting up 500 Condom dispensers to make condoms more available and accessible to most at risk communities in selected urban centres.

Target Populations:
The target population for this activity will comprise of: i)In the general populations/the sexually active the activities will involve mainly provision of information and messages to increase comprehensive knowledge on HIV/STI prevention and condom use, ii) At district, regional level and pre-service training schools, the activities will focus on building capacity, targeting district trainers and organizations that offer services e.g. NGOs, civil society organizations and tutors in pre-service training schools; iii) Most at risk populations will be specifically targeted with specific interventions like strengthening condom promotion and distribution through production of condom promotion materials, training of peers leaders and condom distributors for both male and female condoms and RH/STI services. Mobilization, sensitization and education of the general population on condom use will also be part of the mix, iv) Development of Policy and guidelines will mainly target central and key stakeholders. I t will involve review of technical guidelines and policies to take care of changing circumstances.

Coverage:
This activity will support the activities of the MoH and will have a nation-wide coverage through provision of capacity building, technical assistance, materials and support supervision. However, here will be particular focus on weak or underserved districts, particularly those with a disproportionate burden of HIV such as districts with high HIV prevalence and concentration of risky behaviours or most-at-risk population groups.

Quality assurance and support supervision
Quality assurance will be ensured through use of standardized training tools, protocols and guidelines. Skills development will be enhanced through capacity building, mentoring and coaching. Technical people in specific areas will be used to deliver capacity building sessions. Support supervision will done using standardized tools approved by Ministry of health. Reference materials will be provided where necessary. Feed back mechanisms will be also put in place.

Integration of activities

Activities will be integrated at district level where applicable. Comprehensive HIV/STI prevention package will be encouraged. Programs and activities like male circumcision, condom programming, RH/STI, PMTCT and others will be implemented with a more integrated approach. For example, ensuring that all mothers who access PMTCT are also screened for syphilis at the same time. Collaboration with partners like UNFPA, WHO, UNAIS etc PACE, Civil society organization, etc will be promoted. Some activities like support supervision will be implemented jointly.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	250,000	

Narrative:

The PMTCT program in Uganda is aimed at achieving an HIV free generation. The services are available in all the districts and in over 68.6% of health facilities. The uptake by June 2009 was 61.1% and out of the 33,523 HIV positive pregnant women who received ARV in FY 2008/09, 53.5% received single dose (sd) Nevirapine, 30.8% for combination regimen and 15.7% for HAART. The Early Infant HIV Diagnosis (EID) programme was started in 2007 with the aim of providing services for early identifications of HIV infected infants so as to guide early interventions. To date, over 400 health facilities (30% of the recommended health facilities) are providing these services in all districts of Uganda. In 2008 alone, over 17,000 (19%) of exposed infants for that year were tested for HIV. From 2007 to date over 36,000 exposed babies have been tested for HIV and over 5,000 have been confirmed HIV positive.

Of the estimated 1,596,400 pregnant women in 2010, the PMTCT programme is targeting 90% of those who will attend the ANC at least once during pregnancy. This is estimated to be 1,200,493 of pregnant women. With the HIV sero-prevalence of 6.5% in pregnancy, about 103,766 pregnant women will be living with HIV in 2010. The PCR programme targets to reach at least 30% of these exposed babies in 2010. To achieve these targets requires the PMTCT services to be provided in over 80% of all the health facilities providing these services. The PMTCT programme also recommends all HIV positive women to receive family planning services to prevent unintended pregnancies and targets to reach at least 50% of the with FP services in 2010. To reach the targets above, the programme will continue to have strong links with other departments in the Ministry notably the Community Health Department, Reproductive health, Child health, nutrition and the health education and promotion. At health unit level (service delivery), the programme will continue to be fully integrated into existing services.

The overall planned activities for FY 10 include; Support refresher training of at least 100 Trainer of Trainers (TOT's) each year on the integrated PMTCT training packages, new policies and guidelines to enable rapid scale up and consolidation of more efficacious regimens that includes ART for eligible women in the ANC care setting. Support updating, printing and dissemination of policies and guidelines

to all stakeholders and implementing partners to ensure quality PMTCT services in the country. Strengthen data management and utilization capacity at all levels and especially at the sub national levels through mentoring and regular technical support supervision. Together with Resource Center and Pharmacy division at MoH, support the Logistics Management Information Systems (LMIS) for PMTCT and EID by printing and disseminating of at least 5000 copies of each the relevant tools. These tools include; Daily Consumption log sheet for ARV's, Bimonthly order and reporting forms for ARVS and PMTCT Monthly summary reporting forms. Support the printing and dissemination of at least 5000 copies of the revised and updated PMTCT policy guidelines of 2010 as well as the development of the related implementation guidelines. The programme will continue to expand the capacity for early treatment for HIV infected infants and children and to retain those started on ART through institutionalizing and operationalising linkages between PMTCT, EID, and HIV care (including co-trimoxazole preventive therapy and treatment programs). Support identification, diagnosis and entry into care for infants and children during the Child Days Plus (CDP) immunization campaigns so as to increase access to EID services by training service providers to conduct DBS collection in immunization outreaches. Coordination of EID services through regional stakeholders meetings will also be strengthened by this support. The programme will continue to review, update, develop and disseminate effective and relevant IEC /BCC interventions, materials, guidelines and job aides for strengthening integration of TB screening in ANC/MCH among others. Promote health facility based education and psychosocial support for PMTCT and paediatric clients. Promote sustainable, coordinated and effective interventions at the community level including community mobilization, promotion of meaningful engagement of PLHIV especially mothers with recent PMTCT experience and the local and national networks of PLHIV in the community response embracing GIPA principles.

Finally, in an effort to foster and promote integration, the PMTCT programme will continue to work closely with other departments and division in the Ministry of Health in particular with Reproductive health, Child health, and Nursing, Nutrition and Clinical services among others. The priority areas will include, but are not limited to advocating for incorporation of MTCT issues in pre-service training, revising, updating and printing the data collection and reporting tools, training packages in line with new international evidence. The integration activities with RH will include among others; FP/HIV integration, integrated support supervision and printing of at least 5000 copies of each of the assorted materials including the integrated antenatal, maternity and postnatal registers .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	1,500,000	

Narrative:

During FY06, the component of laboratory infrastructure was added to the MOH/CDC Co-Ag. The Major activities therein include support to the Central Public Health Laboratories (CPHL), in-service training,

development of guidelines and policies, external quality assessment schemes, coordination of early infant diagnosis of HIV (EID), coordination of logistics and management laboratory information. Training in HIV rapid testing which set out to cover 3500 personnel over 5 years has now reached the 1770 mark. Training in T.B smear microscopy commenced during FY09. Its target is to reach 2 personnel from each of 800 facilities at a rate of 400 personnel per year. The first year of training achieved 90 personnel. CPHL has worked with CDC-Atlanta to pilot a task based approach to training in laboratory management. A total of 19 laboratory personnel were trained during the pilot. The training package shall be used to prepare ground for implementation of the WHO AFRO laboratory accreditation scheme and is now being customized for use in Uganda. Training packages have in the areas of sexually transmitted infection and opportunistic infections, biosafety, logistics management have also been developed. During FY09, the proficiency testing scheme for malaria microscopy, AFB smear microscopy and stool microscopy reached 250 laboratories. Results from the scheme have informed the program on areas of emphasis during support supervision and on identifying training needs. A total of 80 districts have been supported to conduct at least 2 rounds of supervision for each of 703 laboratories while up to 140 laboratories in the 80 districts are visited once from the center. A major milestone has been completion of the Nation Health Laboratories Policy which is due for launching this year. In addition, a 5-year strategic plan for implementation of the policy is in advanced stages of development. The plan is expected to rationalize utilization of resources for laboratory services. To facilitate coordination of laboratory services, the National Health Laboratories Technical Committee (LTC) and its 6 subcommittees are supported to meet periodically. The LTC has played a key role in the development of the National laboratory policy and strategic plan. The committee has also contributed to development/customization of a number of documents including; the HIV rapid testing manual, laboratory SOPs, Safety guidelines, T.B smear microscopy training manual, Laboratory management training manual, laboratory quality assurance guidelines and the laboratory equipment management guidelines. To enhance awareness on laboratory programs and promote networking between laboratories, the CPHL has launched 'Confirm', a newsletter with the first edition being published during FY09. During FY09, CPHL set out to build capacity of regional laboratories to conduct microbial cultures with emphasis on bacterial and fungal infections. As such, laboratory personnel from 6 regional referral laboratories have been supported to rotate in specialized laboratories for 1 month. In addition, basic equipment for installment in one regional laboratory (Jinja regional hospital laboratory) is under procurement. With regards to EID, a total of 403 facilities have been reached with 36,000 infants tested to date. In the area of laboratory logistics and laboratory information management, an evaluation of the laboratory data management needs has been conducted to inform the on going process of review of data management tools. A logistics verification exercise carried out during FY09 has provided data for quantification of reagents and HIV test kits and has helped identify needs of the 40 facilities where automated equipment to be procured under the Global Fund shall be deployed. CPHL is making final preparations to perform viral load monitoring for specimens referred from regional hospitals. Equipment and reagents are under procurement.

The focus of laboratory services and quality improvement activity during FY09/10 shall continue to be in-service training, quality assurance and overall coordination of laboratory activities. Development and implementation of a national accreditation scheme for laboratories as recommended by WHO AFRO shall be an additional area of focus. REDACTED. In the meantime, central coordination functions shall require funds for continued renting premises for CPHL, to support personnel and for transport, communications and utilities. The LTC shall be supported to advise the Ministry on policy and technical matters. A total of 3 editions of the CPHL bulletin shall be published to keep the laboratory and other healthcare professionals abreast with developments in the field. Technical laboratory support supervision shall continue both at district and central level using the network of District laboratory focal persons and personnel from CPHL and other national institutions. A total of 800 labs nationwide shall be targeted, focusing on HIV testing, logistics management and EID in addition to routine laboratory activities. Special attention and mentoring shall be paid to 50 laboratories in 10 districts that have been earmarked for accreditation using the WHO based National accreditation scheme. Development and implementation of the scheme shall require meetings to develop the relevant documents, raise awareness and orient the laboratory personnel. The proficiency testing scheme shall be scaled up to cover 400 laboratories and shall continue to cover malaria, AFB microscopy and stool microscopy. However, its frequency shall be increased from one round to 2 rounds annually and additional tests (HIV and syphilis serology) shall be included for the 50 being prepared for accreditation. Review of data collection shall be completed and the approved tools printed and distributed. Data collection and analysis for quantification of reagents and supplies requirements shall continue. A consultant shall be engaged to establish the best mechanisms for collation and transmission of laboratory data and its integration into the national resource center. CPHL shall be supported to work with the National Medical Store and the Sure Project in coordinating laboratory logistics. One regional laboratory (Soroti Regional Hospital) shall be strengthened to perform microbiological culture through mentoring, training of personnel and provision of essential equipment. Regional laboratories are being strengthened one a year with a selection of those that are not part of the 5 earmarked by an upcoming World Bank project. In-service training shall continue to cover areas of HIV rapid testing, AFB smear microscopy, laboratory management and laboratory quality assurance. HIV rapid testing shall target 400 personnel to build towards the required 3,500 estimated in the initial needs assessment. AFB smear microscopy shall target 150 personnel. The task based laboratory management training though rather costly, shall be implemented to support the National accreditation scheme. As such, the 100 laboratory personnel from the laboratories to be accredited shall be trained. EID shall scale up to an additional 250 sites and plans to test 30,000 babies during FY10/11. Funds shall be required to pa the testing laboratories, courier services and conduct training of the personnel. To ensure continuous function of automated equipment for HIV monitoring, equipment maintenance contract shall be procured for 25 government facilities that have equipment without proper preventive maintenance plans. Monitoring of viral load shall be scaled up from serving 6 regional hospitals to serving 12 regional

hospitals. Implementation of all these activities shall coordinate closely with partners to ensure complementarity. Indicator Target 09/10 Target 10/11 Number of testing facilities (laboratories) that are accredited according to national or international standards 0 50 Number of laboratories with satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program for CD4 (patient monitoring). 74 100 Number of laboratory personnel successfully completing training 900 900 Number of new facilities offering HIV screening among infants 150 250 Number of infants screened for HIV 25,000 30,000

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9297	**Mechanism Name: TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of

Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, and related laboratory services at regional referral and district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner. The mechanism will be responsible for maintaining the delivery of quality HIV/AIDS care and treatment, and related laboratory services to patients previously enrolled in the TREAT program in at least 11 regional referral hospitals and 13 district hospitals. This activity will also implement a phased transition for 22 additional facilities currently supported through the TREAT program. SUSTAIN will devise cost-efficient strategies for sustainable access to ART treatment. SUSTAIN will focus on enhancing the Ministry of Health (MoH) stewardship - including developing innovative means of measuring benchmarks of stewardship—expanding MoH capacity to coordinate, support, deliver and monitor quality HIV/AIDS care, treatment, and laboratory services. SUSTAIN will collaborate with the USAID Health Initiative for the Private Sector (HIPS) project to develop sustainable models of HIV care and treatment. In a global environment of leveling resources for HIV/AIDS programs, the successful offeror will develop a program that innovates and adapts based on principles of cost-efficiency and cost-savings, primarily focuses on maintaining quality services for those who have been reached during the rapid scale-up phase of PEPFAR, and works collaboratively with the GOU, the private sector, and donors to expand sustainable access to services whose needs have not yet been met SUSTAIN will also provide quality HIV/AIDS diagnostic and treatment monitoring laboratory tests, working collaboratively with Central Public Health Laboratory (CPHL), Uganda Virus Research Institute (UVRI) and other stakeholders.

This activity is scheduled to be awarded by January 2010.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	REDACTED.
Human Resources for Health	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9297		
Mechanism Name:	TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional 11 referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner. The activity will also successfully transition 22 current TREAT sites over a period of two years to MoH or other capable partners.

The activity will support approaches that improve the quality of care for patients who are on pre-ART, aiming to delay the onset of ART eligibility and improve quality of life through a variety of innovative care and support strategies. SUSTAIN will provide care services for 120,000 ART and pre-ART patients.

Moreover, this activity will increase stewardship by the MoH in provision of quality HIV/AIDS care and support within the public health system through joint planning and technical assistance with MoH, DHTs, facility managers and other stakeholders. SUSTAIN will build regional capacity building mechanisms which will function as knowledge hubs in HIV/AIDS care and support within the MoH.

This activity will also address the human resource gap by working with the regional referral hospital (RRH authorities and the DHTs. Jointly, they will undertake human resources needs assessments for ART services at the 11 RRHs and 13 district hospitals and identify critical additional staff requirements. SUSTAIN will work with the Capacity Project and other USG projects at district level to help the RRH authorities and DHTs develop realistic human resource plans for recruitment and retention.

This activity supports approaches to provide a variety of services to patients at the 11 regional referral and 13 district hospitals. Major activities in this technical area will include:
• OI management
• Pain and symptom management

• Provision of basic package of preventive care services
• Positive prevention
• Regular clinical mentoring
• TB screening and treatment referrals
• Family Planning services
• Pre-ART care and monitoring
• Referrals to other services at the facility and community-level

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner.

As a first priority, SUSTAIN will aim to build on the successes of the scale-up of the TREAT program by continuing to provide high-quality HIV treatment, care, and lab services to patients that have been served by the TREAT program. The activity will focus on increased consolidation and efficiency, leveraging of resources and capacity building of MoH systems. Also, SUSTAIN will work to build the capacity of Regional Referral and selected district hospitals to serve as knowledge hubs for their geographic area and to provide quality services in a consistent manner.

Moreover, this activity will increase stewardship by the MoH in provision of quality ART services within the public health system through joint planning and technical assistance with MoH, district health teams (DHTs), facility managers and other stakeholders. This activity will also address the human resource gap by working with the regional referral hospitals (RRH) authorities and the DHTs. Jointly, they will undertake human resources needs assessments for ART services at the 11 RRHs and 13 district hospitals and identify critical additional staff requirements. The activity will also successfully transition 22 current TREAT sites over a period of two years to MoH or other capable partners. SUSTAIN will work with the Capacity Project and other USG projects at district level to help the RRH authorities and DHTs develop realistic human resource plans for recruitment and retention.

SUSTAIN will work closely with the MoH at national level and at supported ART sites to facilitate the

development of a chronic care model for HIV/AIDS care and treatment. The model is based on the WHO principles of chronic HIV care and provides patients a holistic range of services, either through direct provision, specific services or through reliable referral networks. The project ensures that emerging issues in HIV/AIDS care and treatment (e.g. care and treatment of adolescents and older persons, HIV/AIDS mental health care) are addressed. This activity will support facilities to implement approaches aimed at organizing client records for rapid identification in active care and follow up on ART services. It will also facilitate the identification of those who fail to attend follow-up and, at high volume sites, the computerization of records as soon as this is feasible.

For holistic care beyond the facility, the project will build and strengthen facility linkages with external partners including the networks of people living with HIV and local community based organizations. In addition to enhancing service quality from a technical/professional perspective within appropriate budgets for Ugandan RRHs and district hospitals, the activity will implement innovative strategies for involving patients in assessing the quality of care and treatment services. SUSTAIN will draw upon existing resources including network support agents, expert clients and other stakeholders.

SUSTAIN will provide TA to improve monitoring of treatment outcomes by enhancing MoH patient and program monitoring systems to inform the roll-out and provision of effective ART services, including:
• Streamlining client record keeping with enhanced client clinical record filing, storage and retrieval;
• Supporting cohort analyses and periodic summaries of treatment outcomes;
• Expanding the co-management capacity of TB/HIV;
• Estimating ART treatment needs and impact of treatment; and
• Monitoring early warning signs of drug resistance

Expected Program Results
• Support of MoH on development and dissemination of standard operation procedures for ART and lab services;
• Supported sites fully adhere to MoH guidelines and SOPs;
• Supported sites implement a comprehensive continuing education program for their health workers;
• Support to MoH to conduct semi-annual supportive supervision to hospitals and lower level facilities within districts hosting SUSTAIN sites;
• Supported sites rated favorably on Early Warning Indicators for ARV resistance surveillance; and
• Supported sites utilizing monitoring systems in accordance with MoH's standard operating procedures.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at 11 regional referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner. The activity will also successfully transition 22 current TREAT sites over a period of two years to MoH or other capable partners.

SUSTAIN will work closely with the MoH at national level and at supported ART sites to facilitate the development of a chronic care model for HIV/AIDS care and treatment, which is based on WHO principles and provides patients a holistic range of services, either through direct provision, specific services or through reliable referral networks. Moreover, SUSTIAN will be building capacity for pediatric health care staff through training, mentorship and supervision. Moreover, it will build capacity of community care groups such as PHA networks, religious leaders and volunteers to assist with pediatric care. The existing prevention with positives (PWP) interventions will be strengthened to enhance disclosure at the family level and support parents and guardians to test children for HIV. TREAT has been the PEPFAR flagship program for supporting the MoH Early Infant Diagnosis (EID) program in Uganda and support will continue under SUSTAIN. The program will introduce innovative approaches and enhance coordination among MoH, PEPFAR partners, referring facilities and testing labs to ensure quick result turnaround so that infected infants are diagnosed and treated in a timely manner. This will significantly reduce mortality among HIV positive infants and increase the number of children and infants identified for HIV care and treatment.

SUSTAIN will support the strengthening the linkage between facilities, which provide pediatric care and support services, and community based organizations providing OVC and youth friendly services. The program will emphasize the importance of improved quality of services for children infected and affected with HIV/AIDS, including adherence counseling, copying, and prevention with positive, and sexual and reproductive health issues among adolescents and young adults.

SUSTAIN will support implementation of nutrition assessment and counseling for infants and children. The program will coordinate with Nulife and other nutrition partners to ensure that infants and eligible children receive therapeutic and nutrition supplementation as per the OGAC and national nutrition guidance.

All infants born to HIV infected mothers at SUSTAIN-supported sites will receive cotrimoxazole

prophylaxis starting at the age of six weeks until HIV infection is excluded after weaning. SUSTAIN will coordinate with the President's Malaria Initiative and PEPFAR supported social marketing partners to ensure that infants and children receive other Basic Care Package (BCP) commodities, such as insecticide treated bed nets, safe water systems, treatment for malaria and other OIs.
SUSTAIN will also ensure that MCH units in the supported facilities provide quality services for HIV/AIDS-infected and exposed infants including: growth monitoring, routine child immunization, de-worming for helminthes, nutrition education and supplementation.

In accordance with WHO/MoH guidelines, all HIV-positive infants will initiate ART. Children above 12 months will be routinely monitored for treatment eligibility using WHO staging and CD4 percentage. SUSTAIN will directly support 35 facilities during FY2010 and FY2011 and transition 11 of them by the end of 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at 11 regional referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner.

SUSTAIN will work closely with the MoH at national level and at supported ART sites to facilitate the development of a chronic care model for HIV/AIDS care and treatment, which is based on WHO principles and provides patients a holistic range of services, either through direct provision, specific services or through reliable referral networks. SUSTAIN will be building capacity for pediatric health care staff through training, mentorship and supervision. Moreover, it will build capacity of community care groups such as PHA networks, religious leaders and volunteers to assist with pediatric ART services. TREAT and Baylor Uganda have been PEPFAR flagship programs for pediatrics ART services in the country. SUSTAIN will build on the achievements of TREAT program in the area of ART services and in supporting the MoH Early Infant Diagnosis (EID) program. SUSTAIN will coordinate with the Health Communication Partnership (HCP) program to ensure that young children and adolescents enrolled in ART programs receive adequate counseling on treatment adherence and on sexual and reproductive health issues. SUSTAIN will follow a family-oriented approach in identifying, counseling, treating, monitoring and tracking children on ART.

This mechanism will procure ARVs for more than 3500 patients currently receiving drugs through the JCRC/TREAT mechanism in addition to providing substantial technical support on pediatric ART to 35 sites directly supported by SUSTAIN (11 of them will transition in FY11). SUSTAIN will enable these sites to support lower level facilities on training and mentoring for pediatric ARV services. This includes patients whose drugs are procured by the Clinton Foundation HIV/AIDS Initiative (CHAI) that ends December 2010.

SUSTAIN will encourage the MoH and other partners to ensure that consistent and adequate quantities of pediatric ARVs drugs are available at supported sites. Facilities that secure consistent supply of pediatric ARV drugs through MoH will receive the necessary technical capacity to enroll more infants and children on ART. Children above 12 months will be routinely monitored for treatment eligibility using WHO staging and CD4 percentage. HIV positive infants less than 12 months will be initiated on ART despite their CD4 levels.

SUTAIN will also ensure that infants and children on ART services access other relevant services including nutrition counseling and treatment, OI prophylaxis, TB screening, OVC support, immunization and growth monitoring among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

SUSTAIN PMTCT

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project hereinafter will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally).The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at 11 regional referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner. To ensure sustainability and partner rationalization, this mechanism will transition 11 lower level health facilities that are currently supported through the TREAT program.

PMTCT services will be a major component of the SUSTAIN program. This mechanism will support the WHO/MOH four-pronged PMTCT approach. SUSTAIN will work with ANC and MCH providers in the regional and district hospitals to ensure that a basic package of essential RH services is available for pregnant women and mothers, including lab tests and equipment, STI screening, iron, multivitamins and

folic acid supplements, intermittent preventive malaria treatment, de-worming and infection control, for all women attending ANC, maternity and post-natal care units. This collaboration with ANC and MCH providers will strengthen SUSTAIN's PMTCT activities including HIV counseling and testing of pregnant women, screening for ART eligibility and the provision of more efficacious ARV regimens including HAART to HIV positive pregnant women and their infants according to national guidelines, and implementing safe early infant feeding practices. HIV positive women and their infants identified through the PMTCT program will be linked to SUSTAIN care and treatment services.
s.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional 11 referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner.

The long term management of HIV disease and monitoring of treatment requires chronic care services including a range of basic laboratory services. Also needed are HIV/AIDS diagnostic and treatment monitoring laboratory tests. However, most hospital laboratories at regional and district-level provide only hemoglobin, ESR and microscopy services.

Most public and private laboratories lack the staff competency, equipment, systems and infrastructure—including reliable power supply—to provide adequate quality services and quality control and assurance. There are significant gaps in the following areas: recording and monitoring storage temperature of laboratory supplies; performing daily internal quality control tests on all laboratory analyzers and tests; and overall documentation. Most laboratories do not operate at good clinical laboratory practice standards, with the exceptions being some PEPFAR-supported laboratories like the JCRC Regional Centers of Excellence.

Analyzers and equipment in MoH and some NGO laboratories are out of service, sometimes because of lack of reagents and often due to lack of maintenance servicing and damage caused by irregular power supplies and fluctuations in voltage. For example, significant number of the MoH/Global Fund purchased CD4 machines are non-functional. There is inadequate utilization and adherence to best practices for

sustainable maintenance of laboratory equipment through service agreements with vendors.

Laboratory related documentation is often inadequate with inconsistently completed request forms that do not include provision for the date and time of sample collection; no laboratory workbooks detailing who undertook which tests when; and sometimes poor turnaround of reports.

This program will ensure that laboratory personnel in regional and district hospitals are capable of providing high-quality lab monitoring and services. SUSTAIN will collaborate with MoH, PEPFAR partners and other relevant stakeholders in developing and updating QA/QC standards for basic hospital laboratory services and HIV diagnosis and treatment monitoring laboratory services. The project will develop a QA/QC strategy and plan for basic hospital laboratory services and HIV/AIDS laboratory services.

In coordination with CDC supported efforts, SUSTAIN will assist CPHL in implementing laboratory support and training activities at SUSTAIN-supported regional and district hospitals. SUSTAIN will coordinate with CPHL to provide any specific technical assistance (TA) to the development/enhancement of HIV/AIDS care and treatment and laboratory policy, service standards, quality assurance, standard operating procedures (SOPs), training curricula and training provisions to the MoH and its national level partners.

Expected Program Results
• Support provided to MoH on development and dissemination of SOPS for ART and lab services;
• Adherence to MoH guidelines and SOPs by supported sites;
• Implementation of a comprehensive continuing education program for their health workers by supported sites;
• Support to MoH to conduct semi-annual supportive supervision to hospitals and lower level facilities within districts hosting SUSTAIN sites;
• Undertaking and recording daily QC for all assays/diagnostic tests by supported laboratories;
• Participating in external Q/A for all major assays/tests;
• Favorable quality standards met through external Q/A by supported laboratories;
• Favorable ratings of supported sites on Early Warning Indicators for ARV resistance surveillance; and
• Utilization of monitoring systems in accordance with MoH's standard operating procedures by supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional 11 referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner. This activity will also transition 22 current TREAT sites to MoH or other partners over a period of two years.

This activity is follow-on to the Time Table for Regional Expansion of ART (TREAT) project which is currently implemented by the Joint Clinical Research Center (JCRC). It is scheduled to be awarded by January 2010. The project is expected to take over more than 32,189 patients. 85% of the patients are on adult 1st line, 9% on pediatric 1st line, 5.6% on adult second line, 0.3% on pediatric second line and 0.1% on salvage therapy. More than 5000 patients will be transitioned to a USAID district based program during the first year of the project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

TB/HIV SUSTAIN

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional referral and 11 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner.

This mechanism will improve quality of TB-HIV/AIDS services in 11 regional referral and 13 district hospital. Facilities will be supported for coordinated and integrated HIV/AIDS services. Sites will be supported to hold regular TB/HIV and meeting where they will discuss and track patient transfer between two programs. Moreover, they will assess quality of services, treatment outcome, and appropriateness of regimen, drug side effects, and major HIV/TB co-management issues during the period.

The implementing partners will support facilities to implement innovative approaches for improving quality TB/HIV services.

The implementing partner will coordinate with NTLP and the AIDS Control program and other lead technical partner to ensure that supported facilities receive timely technical and programmatic guidance on TB/HIV collaboration.

REDACTED. The program will build upon the successes of The Timetable for Regional Expansion of Antiretroviral Therapy (TREAT) project. The new project will be referred to as SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) in this and accompanying documents. The purpose of the project is to provide quality HIV/AIDS care and treatment, PMTCT, TB/HIV and related laboratory services at regional referral and 13 district hospitals in Uganda and to build the capacity of the public and private sector to provide care and treatment in a sustainable manner.

This activity being a comprehensive HIV/AIDS care and treatment project has a unique opportunity to reach TB patients who under HIV/AIDS care and treatment services. In addition this activity will work with TB clinics in supported sites to implement TB/HIV collaborative activities as defined by WHO and the national TB program.

Major focus areas for the mechanism will include
1. Provide HIV Counseling and testing of more than 85% TB patients
2. Provide co-trimoxazole prophylaxis to more than 80% of TB/HIV co-infected clients
3. Provide ARVs to at least 40% of TB/HIV co-infected clients
4. TB screen to >90% of patients on HIV care and treatment at supported sites
5. Support sites to implement TB infection control measures based on the revised WHO guidelines. The partner will support facilities to conduct their own risk assessment for TB transmission
Based on specific assessment finding, sites will be supported to develop and implement TB infection control plans. Which will include but not limited to assigning Infection Control officer, proper design and use of space, improved patient flow minimizing time spent in a health-care facility, personal protective measures; training of providers, patients and community member.

This mechanism being a lead partner for building lab capacity at regional hospital level, will support introduction of improved and cost effective TB diagnostic in selected facilities including introduction fluorescence microscopes with Light-Emitting Diodes in all 11 regional referral hospitals in coordination with other key players in TB diagnostics including the US Center for Disease Control and Prevention (CDC), Foundation for Innovative Diagnostics (FIND) and the Central Public Health Lab (CPHL).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9300	**Mechanism Name: TBD - HCT/AIC Follow on**

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,949,263	
Funding Source	**Funding Amount**
GHCS (State)	3,949,263

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID awarded a five-year award to Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) on August 20th, 2009 to implement the HIV counseling and testing project in 20 underserved districts in Uganda. The goal of the program is to scale up access to and coverage and utilization of quality HIV counseling and testing (HCT) services to populations at risk of HIV infection. The project has four objectives: 1) To increase the number of people accessing and utilizing HIV counseling and testing (HCT) services in Uganda; 2) improve the quality and efficiency of HCT services in Uganda by strengthening the appropriate support systems; 3) strengthen the referral network between the community and health facilities to allow expansion of HCT services and HCT linkage to HIV prevention, care, treatment and support; and 4) increase the demand for HCT services.

The project's strategic approaches to scale up HCT services include: a) Enhancing the capacity of the districts health services delivery system to manage HCT services; b) developing partnerships to facilitate capacity building and provision of HCT services to the private sector and community-based organizations; c) expanding a mix of approaches to increase access to HCT including VCT (facility-based and VCT outreaches), RCT for health facilities, and HBHCT (using index HIV infected individuals to test families and their surrounding communities); and d) enhancing human resource capacity for HCT service delivery through multiple approaches i.e. task shifting approaches to PLHIV, volunteers and other lay providers to alleviate the staffing constraints and creatively bridge human resource gaps.

The project will work closely with local government health delivery systems, the private sector, civil society, networks of people living with HIV, families and communities to achieve the objectives of this proposal. Project activities will be fully integrated into the district health plans to ensure local ownership

and sustainability. Fiscal year 2010 will focus on rolling out HCT and setting up infrastructures and systems to support the program in eight districts namely: Koboko, Kaabong, Nyadri, Arua, Nebbi, Kampala, Mbarara and Mukono. Program year two will focus on the roll out of HCT activities to the remaining fourteen districts guided by experiences gained in year one.

Community outreach programs will also include activities to create awareness and increase demand for HIV testing. The community mobilization plan will include: community mobilization by drama groups; groups will receive training in presenting messages through music, dance, drama and public speaking; and groups will be trained/re-trained in HCT and referral. Available Information, Education and Communication (IEC) materials will be distributed on behalf of the MoH. MJAP will utilize the MoH communication strategy to educate the community about the importance of testing as couples with a focus on male involvement, disclosure, having multiple partners, fear of domestic violence and lack of couple communication. MJAP will build on their experience with discordant couples support to provide post-test support to couples tested through this program.

The Performance Monitoring Plan designed in line with the National HIV/AIDS Strategic Plan and the Health Sector Strategic Plan (HSSP) will be used to track progress towards achievement of project milestones. In keeping with the principles of "Three ones", all information will be available to support national policies and will be reported to the MoH and the Uganda AIDS Commission. The data for this PMP shall be collected using the MoH HMIS and other project specific tools.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9300**		
Mechanism Name:	**TBD - HCT/AIC Follow on**		
Prime Partner Name:	**Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HBHC	535,410	

Narrative:

Program objective three focuses on the strengthening of the referral network between the community and health facilities to allow expansion of HCT services and HCT linkage to HIV prevention, care, treatment and support. Program year one activities will focus on: 1) Mapping of all HIV care and support service providers in the 2o target districts to provide detailed information on where both HIV positive and HIV negative individuals can access the services of all types that they need. The mapping exercise will include Government facilities, CSOs, PLHIV networks, post-test clubs, care and treatment partners, OVC and PWD organizations. Providers will be identified from a range of sources including the Directory of HIV/AIDS Care and Support Agencies in Uganda (produced by TASO). Mapping will include GIS social maps as provided by the Uganda Bureau of Standards and also detailed maps of service providers as developed by MJAP; 2) Existing networks (such as the HIV/AIDS Alliance, The National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) and linkages would be used to the maximum, and reinforced and strengthened as necessary, to forge durable, robust, and above all swift linkages between HCT and other HIV services including prevention, care and treatment programs. Networks and referral arrangements within facilities will be identified so that newly diagnosed HIV positive individuals can be linked to care and support services.

This is a new activity that will focus on increasing access to and utilization of HIV/AIDS Counseling and Testing (HCT) through support to 20 districts in the Uganda. Linkages to care, treatment and support services for the newly diagnosed HIV positive individuals is a key component of the HIV Counseling and testing project that is to be implemented by the Makerere Mbarara Teaching Hospital Joint AIDS Program(MJAP). Project focus will include the following interventions:

• All individuals who will consent for HIV counseling and testing services will receive information on STIs, Family planning, and TB during the pre- and post-test counseling sessions. Newly diagnosed HIV positive patients will be screened for and/or treated for 1) opportunistic infections (OIs) and minor ailments; 2) STD/STIs; and will receive 3) Septrin prophylaxis; 4) pain and symptom management; 5) Family planning services 6) psychosocial support; and 7) on-going counseling. HIV positive clients will receive CD4+ screening to establish eligibility for ART. Other clinical services include related laboratory services, and nutritional assessment and support.
• Provision of support to civil service organizations (CSOs), public and private facilities to strengthen the delivery of comprehensive and integrated services within the network model (management of STIs, malaria, TB, provision of cotrimoxazole prophylaxis and post exposure prophylaxis for health care workers, pain management and symptom control, spiritual and terminal care outside the facility
• Training service providers from CSOs, public and private facilities in the provision of comprehensive palliative care services.

• Promotion of family approach to the delivery of palliative care services through partnerships with CSOs using the HIV+ client as an entry point into the family and community. The family approach will be complemented with the provision of home based care kit through the trained home care givers.
• Support various community based groups in the delivery of care services and referrals at community levels. Groups to be supported will include: post-test clubs, psycho social support groups for HIV+ mothers and spouses, religious leaders, faith-based organizations and volunteers. These groups will address legislative issues such as stigma, discrimination and gender based violence. Part of the 800 trainees (above) will be from these various groups.
• Community mobilization activities to promote positive behaviors such as gender equality, couple dialogue, partners counseling and testing, disclosure and accessing treatment together
• Support linkages that support leveraging other resources to benefit PLHAs in the areas of malaria, TB, family planning and safe motherhood, nutrition and child survival support, and education

Each person who tests positive will be given a referral card with contact details of a health care worker at the referral facility to help the individual register, receive counseling, be screened for TB and other OIs, and then be treated accordingly. If the client is HIV-positive, referral cards will be given to sexual partners and children under 5 to encourage them to access testing. The cards would be collected and analyzed to check whether the referral system is working as intended, and to pinpoint necessary improvements to the design and operation of the referral system (patient follow up and adherence).

Integrated services will be provided in collaboration with other partners such as Population Services International (PSI) to reach an estimated 1,000 HIV-positive clients with comprehensive HIV basic care packages which include mosquito nets, water vessel guards, information, education and communication (IEC) materials on positive living and Septrin prophylaxis, all of which aim to improve the quality of life of PHAs. The HIV+ client will be encouraged to mobilize other family members and communities to access HCT so as to identify infected clients that require ART and other care and support services beyond what they can offer to other agencies such as Joint Clinical Research Center (JCRC), TASO, Mild May and Regional public health facilities. Training and mentoring of care service providers will enhance the quality of care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	2,940,000	

Narrative:

The HCT project will contribute to the national HIV response to scale up HIV counseling and testing to facilitate universal access to treatment by 2012. Despite tremendous achievements registered in the reduction of HIV prevalence in Uganda, only 25% of women and 21% of men reported being previously

tested for HIV and receiving their results. The current HIV/AIDS interventions are not evenly distributed across the country, resulting in some districts being over-served while others are underserved. Investment in HCT programming has focused on development of infrastructure for Voluntary Counseling and Testing (VCT) services at freestanding VCT centers, antenatal care clinics, and sexually transmitted disease clinics. Systematic constraints in HIV services delivery in the target districts are: 1) Inadequate numbers and limited HCT knowledge and skills among the existing staff; 2) Frequent stock outs of essential HIV testing supplies and prophylaxis medicines such as Cotrimoxazole. This is due in part to irregular supplies through MoH/NMS supply channels and to inaccurate forecasting, quantification and ordering by the health workers; 3) in districts with several HCT partners supporting, coordination among the partners is poor. This results in duplication of services and therefore wastage of available resources; and 4) inadequate recording and reporting on their HIV services. Nearly all the districts have less than 10% of the eligible population tested for HIV, with Kaboong in particular having less than 1% of their populations tested for HIV.

This new activity will increase access to, coverage and utilization of HCT services through Routine HIV Counseling and Testing (RCT) in the health care settings, home-based HIV Counseling and Testing (HBHCT) for couples and families, and community outreach VCT for most-at-risk populations. Target beneficiaries for this project are under-served high-prevalence populations, discordant couples, children, and most at risk population e.g. fishermen, motorcycle riders ("boda boda"), internally-displaced persons (IDPs), truckers, commercial sex workers, uniformed personnel and mobile populations.

The project will support health systems strengthening through task-shifting approaches for the lower level health units, technical assistance for HCT supply chain management including forecasting, quantification, ordering, stock taking and recording. The program will provide buffer stocks to the MOH to ensure a constant supply of test kits at the health facilities.

The project will strengthen the monitoring and evaluation (M&E) systems including Health Management Information System (HMIS) capturing the HIV testing in both the public and private sector.

Quality of HCT services is affected by limited skills for providing HCT to children, adolescents and couples, as well as obtaining and documenting informed consent. The limited number of trained personnel and inadequate support supervision in the private sector compromise the quality of HCT in the private sector.

The project will review existing SOPs, guidelines and quality assurance systems for delivery of HCT through internal quality control (IQC) and external quality control for HIV tests and support supervision to facilitate adherence to national HCT policy and the associated guidelines. All testing units in the program

submit 5-10% of positive and negative samples once a week to a local reference laboratory for re-testing and feedback reports are taken to the units. Corrective actions will be taken in case of any identified errors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	133,853	

Narrative:

Program objective three focuses on the strengthening of the referral network between the community and health facilities to allow expansion of HCT services and HCT linkage to HIV prevention, care, treatment and support. Program year one activities will focus on: 1) Mapping of all HIV care and support service providers in the 2o target districts to provide detailed information on where both HIV positive and HIV negative individuals can access the services of all types that they need. The mapping exercise will include Government facilities, CSOs, PLHIV networks, post-test clubs, care and treatment partners, OVC and PWD organizations. Providers will be identified from a range of sources including the Directory of HIV/AIDS Care and Support Agencies in Uganda (produced by TASO). Mapping will include GIS social maps as provided by the Uganda Bureau of Standards and also detailed maps of service providers as developed by MJAP; 2) Existing networks (such as the HIV/AIDS Alliance, The National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) and linkages would be used to the maximum, and reinforced and strengthened as necessary, to forge durable, robust, and above all swift linkages between HCT and other HIV services including prevention, care and treatment programs. Networks and referral arrangements within facilities will be identified so that newly diagnosed HIV positive individuals can be linked to care and support services.

This is a new activity that will focus on increasing access to and utilization of HIV/AIDS Counseling and Testing (HCT) through support to 20 districts in the Uganda. Linkages to care, treatment and support services for the newly diagnosed HIV positive individuals is a key component of the HIV Counseling and testing project that is to be implemented by the Makerere Mbarara Teaching Hospital Joint AIDS Program(MJAP). Project focus will include the following interventions:

• All individuals who will consent for HIV counseling and testing services will receive information on STIs, Family planning, and TB during the pre- and post-test counseling sessions. Newly diagnosed HIV positive patients will be screened for and/or treated for 1) opportunistic infections (OIs) and minor ailments; 2) STD/STIs; and will receive 3) Septrin prophylaxis; 4) pain and symptom management; 5) Family planning services 6) psychosocial support; and 7) on-going counseling. HIV positive clients will receive CD4+ screening to establish eligibility for ART. Other clinical services include related laboratory services, and nutritional assessment and support.

• Provision of support to civil service organizations (CSOs), public and private facilities to strengthen the delivery of comprehensive and integrated services within the network model (management of STIs, malaria, TB, provision of cotrimoxazole prophylaxis and post exposure prophylaxis for health care workers, pain management and symptom control, spiritual and terminal care outside the facility
• Training service providers from CSOs, public and private facilities in the provision of comprehensive palliative care services.
• Promotion of family approach to the delivery of palliative care services through partnerships with CSOs using the HIV+ client as an entry point into the family and community. The family approach will be complemented with the provision of home based care kit through the trained home care givers.
• Support various community based groups in the delivery of care services and referrals at community levels. Groups to be supported will include: post-test clubs, psycho social support groups for HIV+ mothers and spouses, religious leaders, faith-based organizations and volunteers. These groups will address legislative issues such as stigma, discrimination and gender based violence. Part of the 800 trainees (above) will be from these various groups.
• Community mobilization activities to promote positive behaviors such as gender equality, couple dialogue, partners counseling and testing, disclosure and accessing treatment together
• Support linkages that support leveraging other resources to benefit PLHAs in the areas of malaria, TB, family planning and safe motherhood, nutrition and child survival support, and education

Each person who tests positive will be given a referral card with contact details of a health care worker at the referral facility to help the individual register, receive counseling, be screened for TB and other OIs, and then be treated accordingly. If the client is HIV-positive, referral cards will be given to sexual partners and children under 5 to encourage them to access testing. The cards would be collected and analyzed to check whether the referral system is working as intended, and to pinpoint necessary improvements to the design and operation of the referral system (patient follow up and adherence).

Integrated services will be provided in collaboration with other partners such as Population Services International (PSI) to reach an estimated 1,000 HIV-positive clients with comprehensive HIV basic care packages which include mosquito nets, water vessel guards, information, education and communication (IEC) materials on positive living and Septrin prophylaxis, all of which aim to improve the quality of life of PHAs. The HIV+ client will be encouraged to mobilize other family members and communities to access HCT so as to identify infected clients that require ART and other care and support services beyond what they can offer to other agencies such as Joint Clinical Research Center (JCRC), TASO, Mild May and Regional public health facilities. Training and mentoring of care service providers will enhance the quality of care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	200,000	

Narrative:

This is a new activity that will focus on increasing access to and utilization of HIV/AIDS Counseling and Testing (HCT) through support to 20 districts in the Uganda. AB messages will be provided during HCT outreaches at H/C II and the communities in collaboration with existing HCT service providers in order to increase access to most-at-risk populations (the MARP will need more of OP than AB services) and remote areas. The MJAP Regional offices will serve as the focal point for coordination of M&E systems, operational research, external quality assurance, training and mentoring of other HCT service providers within the health system. Special emphasis in AB (school going children of ages 10-14); those aged 15+ should get comprehensive HIV/AIDS information including information regarding condoms) and OP will focus on the Most-at-Risk Populations that will include fisher folk military/police establishments, mobile populations including internally displaced persons (IDPs), truck drivers, CSW institutions of higher learning, as well as People with Disabilities. Peers trained for AB and OP will mobilize for HCT among their peer populations.

AB resources will continue to assist the national response in appropriately addressing the shifting nature of the epidemic, and expand attention to faithfulness and partner reduction initiatives among newly married young couples. In addition, resources will specifically address the vulnerability factors of specific categories of youth such as young people involved in transactional or cross-generational sexual relationships, young people living with HIV, and addressing the underlying causes of the vulnerabilities faced by Uganda's youth that increase their risk of exposure to HIV. Cultural norms and practices, sexual coercion and gender discrimination issues that make youth and in particular young girls at increased risk of exposure will be addressed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	140,000	

Narrative:

This is a new activity that will focus on increasing access to and utilization of HIV/AIDS Counseling and Testing (HCT) through support to 20 districts in the Uganda. Other Prevention (OP) messages will be provided as an integrated component of HCT services at health centre IIIs, IIs and the community levels. The MJAP Regional offices will serve as a focal point for coordination of M&E systems, operational research, external quality assurance, training and mentoring of other HCT service providers within the health system. OP services will focus on the Most at Risk Populations that will include fisher folk military/police establishments, mobile populations including internally displaced persons (IDPs), truck drivers, CSW institutions of higher learning, as well as People with Disabilities. PLWHAs will be trained to offer OP services and will mobilize for HCT among their peer populations.

OP resources will continue to be used to ensure that Uganda's older and at risk youth have access to age and risk appropriate abstinence, faithfulness, behavior change and condom information and services. OP resources will also assist the national response in appropriately addressing the shifting nature of the epidemic, and expand attention to faithfulness and partner reduction initiatives among discordant and married couples. In addition, resources will specifically address the vulnerability factors of specific categories of youth such as young people involved in transactional or cross-generational sexual relationships, young people living with HIV, and addressing the underlying causes of the vulnerabilities faced by Uganda's youth that increase their risk of exposure to HIV. Cultural norms and practices, sexual coercion and gender discrimination issues that make youth and, in particular, young girls increasingly at-risk of exposure will be addressed.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9301	**Mechanism Name: STAR-EC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow Research and Training Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 6,177,011	
Funding Source	**Funding Amount**
GHCS (State)	6,177,011

Sub Partner Name(s)

Communication for Development Foundation Uganda	mothers2mothers (m2m)	Uganda Cares
World Education		

Overview Narrative

STAR-EC covers 6 districts in the East Central region including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba. The main goal of the program is to increase access to, coverage of, and utilization of quality comprehensive HIV&AIDS and TB prevention, care and treatment services within district health facilities and their respective communities. This goal is in line with the national priorities articulated in the National HIV&AIDS Strategic Plan 2007/08 -2011/12. Other specific objectives include:
1. Strengthening decentralized HIV&AIDS and TB service delivery systems with emphasis on health centers (HCs) IV and III and community outreach;
2. Improving quality and efficiency of HIV&AIDS and TB service delivery
3. Strengthening networks and referrals systems
4. Intensifying demand for HIV&AIDS and TB prevention, care and treatment services.

The target population includes the most at risk populations such as commercial sex workers, fisher-folk, migrant workers, boda boda cyclists and long distance truck drivers. Other target populations include pregnant women, HIV positive pregnant women, People living with HIV&AIDS, HIV positive infants, orphans and other vulnerable children, HIV/AIDS affected families, TB patients, adults, out–of-school youth, students in institutions of higher learning and People With Disabilities, With regard to strengthening health systems, STAR-EC provide technical and financial support to District HIV&AIDS Committees, District HIV&AIDS Task forces and other district leadership/management. District performance review meetings will be conducted quarterly. District and CSO personnel will also be trained to improve their monitoring and evaluation skills. An additional 10 new CSOs will be provided with funding through a competitive granting mechanism. STAR-EC will procure supplies including HIV test kits, condoms, Co-trimoxazole, and some laboratory equipment. Ten laboratories will be refurbished.

With regard to human resources for health, STAR-EC will encourage the task shifting for tasks such as community-based client follow-up to ensure adherence, psychosocial support to PLHIV using lay providers such as 'expert patients' and 'mentor mothers. Quality Improvement teams will be trained and established at supported health units. Additionally, pre-service and in-service training will be given to different district and CSO staff across all the technical areas. As regards nutrition, the program will partner with NuLife project to train service providers in nutritional supplementation with ready-to-use therapeutic feeds. Clean and safe water will be provided as part of a Basic Care Package to PLHIV. Health workers in 80 heath facilities will be provided with training, onsite technical support and mentoring on TB/HIV integration and their competence increased in TB/HIV diagnosis and management including pediatric TB/HIV, internal and external referrals for support counseling and ART for eligible individuals, logistics planning and TB/HIV reporting. Screening of all TB patients for HIV and the vice versa will be supported. 10 laboratories will be renovated including portioning available rooms to create space for examining and counseling patients.

Education as one of the cross cutting areas will be promoted through working with institutions of higher learning (since UNITY works with primary and secondary schools) to carry out HIV prevention campaigns and behavior change interventions. Prevention of gender based violence will be supported by training and conducting support supervision of the partner CSOs to conduct action oriented community discourses on issues of gender power relations.

Child survival will be addressed through training 25 health workers in Pediatric care using the Integrated Management of Childhood Illnesses approach. STAR-EC will also support Early Infant Diagnosis of HIV infection through facilitating transportation of dry blood spot samples to referral laboratories. Safe mother hood will be supported through prevention of malaria in pregnancy (IPTp) and. providing safe delivery kits (maama kits), Gender issues will be addressed through CSOs conducting community mobilization activities to promote positive behaviors such as: gender equity; couple dialogue; partner counseling and testing and disclosure. As alluded to above, mobile populations and the workplace (as for the fisher-folk) are targeted with interventions.

STAR-EC will pool together the required items and carry out bulk purchases in order to increase its bargaining power. Procurement will be done through competitive bidding. Partners like Uganda Health Marketing Group and Program for Accessible Health Communication and Education (PACE) will assist STAR-EC to obtain items like condoms and the basic HIV preventive care package from respectively. The program will order ARVs through SURE project and utilize Joint Medical Stores.

Monitoring and evaluation plans include developing a comprehensive electronic data base, up-dating the Performance Monitoring Plan (PMP) in line with the new generation PEPFAR indicators, sharing baseline survey findings with the districts, CSOs and the MoH. We plan to conduct organisational capacity assessments, strengthen data collection at district level through the use of HMIS and improve data quality. The program will conduct the annual Lot Quality Assurance Survey to enable results to be incorporated into Local Government annual planning.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9301		
Mechanism Name:	STAR-EC		
Prime Partner Name:	John Snow Research and Training Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	544,000	

Narrative:

STAR-EC will support health facility-based counselors to provide risk assessments to HIV positive clients and their household members (affected by HIV). HIV clinics are co-located with routine HIV test points, and so early identification of HIV-positive persons will occur followed by their enrollment into chronic care clinics. 7,000 people living with HIV (PLHIV) are targeted for clinical assessments using WHO clinical staging and diagnosing opportunistic infections.

90 health workers shall be trained on management of opportunistic infections and sexually transmitted infections (STIs). Also 40 clinicians will train on palliative care medicine –pain and symptom control in collaboration with Hospice Africa. Clinic workers will be oriented on prevention with positives to enable them to offer family planning/dual protection, treatment of STIs, and behavioral counseling on reduction of sexual partners, disclosure of HIV status plus partner testing.

Care services shall scale up to 80 facilities with support towards ordering medicines for treatment of opportunistic infections and oral morphine from the National Medical Stores. STAR-EC will support access to co-trimoxazole for use during national stock outs often experienced in public facilities. In collaboration with the Program for Accessible Health Communication and Education, the program will provide HIV preventive basic care package kit (BCP) that contains an insecticide treated net, a safe water system, condoms and a guide to positive living.

STAR - EC will conduct bi-monthly support supervision visits to provide technical assistance. The program will use existing data collection and reporting tools to strengthen the existing national monitoring and evaluation system.

Community-based care and support shall be provided by our civil society organizations mainly targeting MARPs. Through outreaches, CSOs will offer co-trimoxazole prophylaxis, home-based care kits, prevention with positives counseling, peer adherence support and psychosocial support. CSO shall train home care givers as trainers on home-based care to emphasize their role in basic nursing care, patient

hygiene and nutrition. Network support agents will be responsible for linkages and referrals from community to health facilities and NGOs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,647,705	

Narrative:

Coverage of antiretroviral therapy (ART) services shall be scaled up from 15 to 19 health facilities targeting provision of treatment to 1,500 new individuals (adults and children). About 100 health workers shall be trained on comprehensive HIV/AIDS treatment including ART. The training aims at expanding the prescriber base and targets workers in the HIV clinic, medical and maternity wards.

To address under-staffing at four hospitals (higher patient volume), the project will facilitate hired labor for extra duties in order to reduce patient waiting time and thus increase utilization of ART. To reduce drop-out and loss to follow-up rates, the project will facilitate hospitals to conduct outreach satellite ART clinics to lower level facilities thus eliminating potential barriers to ART access.

STAR-EC shall facilitate the transportation of blood specimens from 19 ART sites to JCRC laboratory at Kakira for CD4 cell count testing and also pay the test fees. This immunological monitoring shall boost decision making to initiate ART as well as help track clinical outcomes. Various adherence activities such as adherence counseling, pill counting, medication boxes, adherence calendars, and home follow-up when appointments are missed, shall be supported and their outcomes closely monitored.

Health workers will receive on-the-job mentorship on antiretroviral (ARV) logistics management system. We will also facilitate postage of ARV bi-monthly order forms to the district health offices and National Medical Stores and support the distribution of ARV supplies from district stores down to ART sites.

AIDS Control Program will assess four sites, recommend areas that STAR-EC can support to get accredited to provide ART services. Clinics shall be renovated and equipped with furniture to handle bigger client loads. We will support site clinical teams to regularly meet and review clinical care to maintain quality. Further, site captains shall have exchange visits to other ART sites to share challenges and observe best practices.

STAR-EC will provide technical assistance on ART service delivery through regular support supervision visits. Facilities will hold regular continuing medical education sessions to update their knowledge and skills.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVCT	300,000	

Narrative:

STAR-EC will employ the 'know your epidemic, know your response' analogy in scaling up HIV testing and counseling (HTC) to increase knowledge of one's own and partner HIV status. The program will emphasize taking HTC services to institutions of higher learning where cross-generational sex is experienced, road-side truck-stops where multiple concurrent relationships are rampant, and to couples in view of their high vulnerability to HIV infection. Working with the public and civil society, the program will strengthen delivery of HTC services by introducing and supporting Provider Initiated HTC (PITC) at 80 health units. Other innovative community models such as home-to-home HTC, family-based HTC, index-client-based HTC, community camping, mobile HTC and moonlight HTC will be supported. Emphasis will be placed on couple HTC using 'counselor assisted mutual disclosure' to strengthen knowledge of partner HIV. STAR-EC will support HTC during commemoration of World AIDS day and World TB day.

STAR-EC will train 50 health workers in pediatric counseling and testing and 150 health workers and lay providers in rapid HIV testing techniques to provide both static and outreach HTC services. 30 health facilities will be supported to conduct regular outreaches to communities and lower level health units; CSOs will access funds to conduct additional outreaches in hard-to-reach areas. Bicycles will be procured for service providers to reach difficult terrains inaccessible by vehicles. STAR-EC will support training of 'model couples' and facilitate them to conduct couple dialogue sessions to increase couple uptake of HTC.

STAR-EC will procure buffer stocks of HIV test kits and consumables to cover stock out periods often experienced in most of the public health facilities. The project will support community mobilization for HTC services through community-staged music, dance and drama shows and messages through the media especially radio. The quality and progress of HTC services will be regularly monitored through quarterly review meetings and district onsite support supervision visits. The project will also support the reproduction and dissemination of MoH data collection tools such as HTC client cards and registers. Health facilities will be supported to transport samples to reference laboratories for quality control.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	136,000	

Narrative:

STAR-EC will support the early infant diagnosis of HIV infection using the polymerase chain reaction test. In particular, the project will equip facilities to transport dry blood spot samples to Joint Clinical Research

Centre laboratory at Kakira regional centre of excellence. Test results shall be collected at the time of next sample delivery and those infants and children found to be HIV infected shall be enrolled into HIV clinics and initiated on co-trimoxazole therapy (CPT).

CPT shall also be provided to all babies above 6 weeks of age who are HIV exposed (i.e. born to HIV positive mothers) to reduce the risk of developing opportunistic infections and dying prior to their first birth day. Therefore STAR-EC shall procure syrup co-trimoxazole for these babies since government facilities often lack syrup formulations.

Pediatric counseling and support shall be provided by trained pediatric counselors on a routine basis at 40 facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	411,926	

Narrative:

STAR-EC will train 50 health workers on the integrated management of childhood illnesses to build their capacity in providing pediatric care. As part of the training on comprehensive HIV&AIDS treatment including ART, five days shall be dedicated to pediatric ART (theory and practicum) to increase the capacity of health workers to treat HIV&AIDS in children.

The project shall implement the new policy of ministry of health which guides that all infants confirmed to be HIV positive must be initiated on ART immediately irrespective of their CD4 cell count or their clinical staging. This policy shall be disseminated and discussed with health workers to ensure compliance. STAR - EC targets treating at least 280 children while scaling up pediatric ART from 4 hospitals to 19 sites.

A similar laboratory mechanism as for adults shall be employed to provide regular CD4 monitoring of children on anti-retroviral therapy. In addition, health workers shall monitor growth and development, assess nutritional status, provide infant feeding counseling, treat opportunistic infections, and link and refer children to other service centres.

STAR-EC staff shall provide regular monitoring and support supervision in collaboration with the regional hospital Pediatrician.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	300,000	

Narrative:

In order to promote evidence based planning, this activity will support the Government of Uganda to institutionalize the use of the Lots Quality Assurance Sampling (LQAS) and ensure that the data generated is used. The activity will also support the key national HIV/AIDS data use (including reporting) processes and activities taking place at the district in order to build sustainability. These activities will be implemented in 9 districts in the Eastern region of the country, namely: Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutamba. Evidence-based planning and decision making will be achieved through regular measurement of program performance and progress at the districts and lower levels. Regular and timely feedback to the supported local governments, non-governmental organizations ad civil service organizations will be provided through systems strengthening of district-level monitoring and reporting systems including HMIS and PMMP. While the LQAS results will be used to inform district-level work planning in order to identify intervention areas and sub-counties on which to focus in the future, this USG investment goes beyond this and achieves two other objectives. First, the support is intended to build the capacity of the central level GOU to design, plan, manage, coordinate, and institutionalize the use of the LQAS. The other objective of this USG support is to ensure that these district-based programs support the existing national data collection, collation, use, and reporting systems at the district and lower levels for purposes of building sustainability. Increased capacity will improve performance monitoring of service delivery and overall district planning. Coordination at the district also includes ensuring that the existing supply of, and demand for, ICT (information, communication, and technology) and human capital resources are optimized.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	147,030	

Narrative:

Qualitative key informant interviews will be conducted during the first quarter so as to establish gaps in the functionality of District AIDS Committes (DACs), District AIDS Teams (DATs), Health Sub Districts (HSDs) and other district leadership/management structures related to HIV&AIDS and TB. On a quarterly basis, district performance review meetings will be conducted involving different District Health and Management teams as well as CSOs. Action plans will be developed in relation to the reviewed program outputs and outcomes.

STAR-EC's baseline survey information will be used to ascertain the level at which different health facilities possess the capacity to manage HIV&AIDS and TB-related logistics and thereafter develop targeted solutions. Additionally, targeted solutions will be executed through collaboration with the MoH and the SURE project including the training of health facility staff, technical support, on-the-job mentoring and coaching in logistics and supply chain management per district. Facilities will be supported in

preparing and delivering their requisitions for ARVs, other drugs and supplies, HIV test kits and laboratory reagents to the SURE project. A similar arrangement will be made with JMS on proper storage and transportation to the sites.

STAR-EC will issue Request for Applications (RFAs) to CSOs working within East Central districts. Ten new CSO's will be selected to supplement the existing four. A comprehensive organisational capacity assessment for the existing four CSOs and new CSOs will be conducted once they are on board in order to identify gaps and the level of required support. During CSO quarterly finance compliance and technical review meetings, onsite support will be given. District and CSO personnel will also be trained in different M&E applications that will promote data quality and reporting timeliness. A performance-based CSO grants financing mechanism will be adopted.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	850,000	

Narrative:

STAR-EC will promote and support the introduction of MMC as one of the biomedical prevention approaches that have been proven to be effective when combined with other approaches.
STAR - EC preliminary activities will involve holding consultative meetings with MOH on the policy guidelines. The program will receive technical support from partners with the requisite experience in providing MMC services such as the Rakai Health Sciences Project. The technical support will give STAR - EC guidance on initiation of MMC as part of our comprehensive package of HIV prevention. Since MMC does not provide complete protection against HIV, STAR - EC will encourage MMC along with messages promoting the delay of onset of sex, abstinence, mutual faithfulness, reduction in the number of sexual partners, consistent condom use, HIV counseling and testing, and treatment of other sexually transmitted infections.
STAR-EC will support MoH to produce BCC/IEC materials for dissemination and community mobilization for MMC. The program will conduct a site visit to the nearby Kayunga Hospital Project in Kayunga district to learn from their experience with the recently- introduced MMC services.
WHO/UNAIDS recommended MC as part of a comprehensive HIV prevention package in 2007.Uganda endorsed this recommendation and started MMC policy development in 2009. the policy has recently been approved and USG through the Health Communication Partnership, will work with MOH to have a national and dissemination workshops. MMC is however being done in some Public and private health facilities and the demand is increasing. PEPFAR supported pilot MMC projects namely: SPH-Rakai, Walter Reed Kayunga, UPDF and HIPs.
With additional resources, PEPFAR is going to scale up provision of Safe Male Circumcision (SMC). This will be contributing to the NSP goal of reducing HIV incidence rate by 40% by 2012.

The key target groups for Safe Male Circumcision are: HIV negative males including older adolescents and sexually active men; older men at particularly high risk (truck drivers, uniformed services, STI patients, and uninfected men in HIV discordant couples and in the long term, Neonatal male circumcision.

With the additional funding, both HIPS and STAR- EC will undertake HU assessments to determine the human resource and infrastructure needs. The needed personnel will be trained by either Rakai or Walter reed training centers. Both projects will, working hand in hand with HCP, will undertake IEC and BCC activities with the aim of creating demand but also increasing correct and appropriate knowledge about SMC in particular and HIV prevention in general. HIPS will extend to 10 new health units while STAR – EC will be in 8 health units at both level IV and III .

The Key activities will include :

• Developing a plan to provide Voluntary Safe Male Circumcision services as a minimum package alongside other known HIV prevention interventions

• Supporting the rapid scale up of facility based VMMC services in Government, Private, FBO and community based health facilities

• Supporting the provision of outreach (temporary or mobile) Voluntary Safe Male Circumcision services to increase access, particularly in remote areas.

• Undertaking advocacy, community sensitization/mobilization, and education to create informed demand for VMMC services,

• Undertaking in-service training of service providers in public, Private, Faith based and community health facilities. At least 3 training centers will be supported

• Long-term sustainable and integrated VMMC capacity in health facilities including capacity for provision of neo-natal and pediatric MC services

• Facilitate referrals and linkages of VMMC services to other HIV/AIDS prevention, care and treatment services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	238,888	

Narrative:

STAR-EC will support "Highly Active HIV Prevention" with a multiple of interventions including: behavioral, biomedical, treatment and structural prevention. STAR-EC will tailor the project HIV prevention response to the locally known drivers of the epidemic. Our interventions will promote abstinence, including delay of sexual activity or secondary abstinence, fidelity, reducing multiple and concurrent partners, and related social and community norms that impact these behaviors.

STAR-EC will adopt 'Value for Life' training program commonly used by our partner Youth Alive, to train

Abstinence and Be-faithful promoters. Behavior Change Communication Programs (BCPs) will be supported to equip youth with knowledge and skills to enable them appreciate causes of HIV&AIDS; assess personal risk; set personal goals and plans of achieving them. We will support positive peer group/club formation and equip them with play-kits for 'edutainment' as a sustainability strategy for positive behavior amongst peers with activities including 'peer-to-peer' education; sports outreaches; games; and small group discussions.

STAR-EC will support CSOs to train individuals and married couples in 'Couples-on-the Way' and 'Couples United' programs who will train and support their peers and conduct door-to-door activities. STAR - EC will support community drama, 'Faithful House' seminars and group discussions on parent-child dialogue sessions. STAR - EC will train peers to address gender issues pertaining to HIV infection.

STAR-EC will train CSOs in the 'men and HIV&AIDS curriculum', the sexual network game, alcohol and how to use some trigger videos in community settings. STAR-EC will support religious leaders as AB promotional outlets to offer premarital and marital counseling. They will support Young Marrieds, Fathers and Mothers and Unions against the tide of HIV acquisition. STAR-EC will support 'be faithful' radio talk shows and radio spots in the main local languages. We will orient radio presenters on communicating concepts and benefits of being faithful, prevention of stigma and discrimination.

STAR - EC estimates to train 400 individuals and reach 76,000 individuals with HIV preventive interventions focused on abstinence and/or being faithful.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	316,666	

Narrative:

STAR-EC will accelerate the prevention of sexual transmission of HIV through targeted interventions focused on most-at-risk populations (MARPs); one of the notable drivers of the HIV epidemic in the region. The MARPs will include; migrant workers, distance truck drivers, 'boda boda' cyclists, transactional sex workers, bar and lodge attendants, fisherfolk and persons in multiple or concurrent sex partnerships.

STAR-EC will support CSOs to map "hot spots" of underserved and/or hard-to-reach areas and areas likely to put people at high risk of HIV transmission like bars and lodges as well as local video halls commonly known as 'bibandas' and prioritize these sites for HIV prevention interventions. STAR-EC will support beach management units (locally known as 'Gabungas') to mobilize residents to attend outreach services.

STAR - EC will target an estimated 50,000 MARPs to be reached with individual and/or small group level HIV preventive interventions mainly through peer-to-peer interactions and community outreach programs. STAR-EC in collaboration with targeted audiences, will identify peers to be trained and oriented in basic counseling skills on correct condom use, recording and reporting. STAR-EC will facilitate peer educators to deliver other HIV prevention messages and distribute of condoms.

STAR-EC will support condom education and distribution at HTC, PMTCT, ART and palliative care sites and ensure that counsellors provide prevention education to all clients. Partner CSOs will also be mapped as targeted condom outlets. STAR-EC will support mapping of other community distribution points by community members and CSOs. PTCs will be used to promote prevention messages with a focus on correct and consistent use of condoms by the targeted audiences. STAR-EC will collaborate with MoH and social marketing organizations like UHMG to procure and distribute condoms to targeted vulnerable populations including MARPs.

STAR-EC will support the Ministry of Health to produce context specific IEC materials on ABC including posters, cue cards, calendars and leaflets to reinforce messages in the radio programmes and information passed on by the community volunteers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	851,000	

Narrative:

STAR-EC will support 34 public health units in Bugiri, Iganga, Kamuli, Kaliro, Mayuge, and Namutumba districts to provide PMTCT services. The target population includes pregnant women and their spouses, HIV positive pregnant women, infants of HIV positive women, and heath workers providing PMTCT services. An estimated 900 HIV positive pregnant women will receive prophylactic ARV regimens. 100 health workers will be trained to provide ARV prophylactic regimen according to the Ministry of Health (MoH) PMTCT guidelines. Experienced teams from hospitals and HCIVs will be facilitated to conduct PMTCT outreaches to lower health units. Additional 40 'mentor mothers'- mothers who are already utilizing PMTCT services and have gone ahead to give public testimonies about their experience- and 20 family support groups will be trained to counsel mothers, trace defaulters; to ensure adherence to therapy and the chosen method of Infant and Young Child Feeding.

Routine Testing and Counseling will be promoted in maternal and child health clinics, maternity and postnatal wards. Family planning and prevention of malaria in pregnancy will be integrated in PMTCT through routine delivery of goal oriented antenatal care. Safe delivery kits will be distributed to ensure a

clean delivery environment. The program will obtain long lasting insecticide treated nets from President's Malaria Initiative and distribute them to pregnant mothers. Laboratory personnel will receive funds to physically transport blood samples to referral laboratories at Kakira, Buluba and Kamuli Mission hospitals for CD4 testing. PMTCT mothers will be provided with cotrimoxazole preventive therapy and TB screening and management. Eligible clients (i.e.: CD4 count of <350) will be counseled and enrolled into the HIV clinics to initiate Highly Active Anti-retroviral Therapy. Through home visits, mothers will be utilized as index clients to extend family centred care. Pre-packaged regimen for babies will be accessed to facilities through working with the National PMTCT program. The program shall link mothers and babies to nutrition programs at community level through the networks and the NuLife project. Support supervisory visits will enhance quality assurance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	153,333	

Narrative:

STAR-EC is targeting to have 25% of facilities with functional, accredited laboratories for key tests by the end of the first year of implementation. Support to laboratories will involve training laboratory personnel at two levels. The first level will be an in-service training of laboratory assistants and microscopists on sputum ZN staining and microscopy, then followed by training on laboratory principles practices plus diagnostic methods for other diseases. The second level will be a pre-service training of existing microscopists to upgrade to laboratory assistants' cadre by undertaking a certificate course in medical laboratory technology offered at Jinja Laboratory Training School. As part of improvements to the health work force in the East Central region, STAR-EC will fully sponsor six microscopists selected by the District Laboratory Focal Persons to undertake this course.

The project will procure laboratory equipment ranging from 20 microscopes to 2 Flow Cytometers (CD4 machines) in consultation with the Central Public Health Laboratory (CPHL) and the National Tuberculosis Reference Laboratory (NTRL). Laboratory reagents for the above equipments will also be procured. STAR-EC will support refurbishment of laboratories at 10 facilities (HCIV and HCIII level) to create a safe working environment. The refurbishment will be undertaken in collaboration with Health Infrastructure Department of the Ministry of Health, Distrcit Health Office (DHOs) and Chief Administrative Office (CAOs).

District Laboratory Focal Persons (DLFPs) will be facilitated by STAR-EC to provide regular technical assistance and support supervision together with STAR-EC's Laboratory Services Advisor. The project intends to strengthen the HIV proficiency testing and External Quality Assurance (EQA) by reference laboratories (such as NTRL, Uganda Virus Research Institute (UVRI), JCRC) on a wide range of tests

including HTC, sputum ZN staining, DNA-PCR, CD4, rapid protein reagent (RPR) and blood smears.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	280,463	

Narrative:

STAR-EC will facilitate district and health sub-district level joint TB and HIV&AIDS coordination and review meetings, district planning workshops, and fund M&E activities related to TB/HIV.

The project target is to identify and treat 400 PLHIV for TB disease. Health workers will be trained on TB/HIV collaborative activities, and will receive on-job mentorship on conducting routine screening for TB among PLHIV using intensified case finding tools. The program will facilitate home visits to actively trace contacts of index TB cases.

The Tuberculosis Control Assistance Program (TB CAP) will assist the project to conduct risk assessments for TB infection control in facility departments and to institute administrative and environmental control measures in clinics e.g.: patient triage and separate waiting areas. The project refurbish laboratories, TB clinic & HIV clinic rooms in order to improve air flow.

STAR-EC will facilitate the testing of 600 TB patients for HIV infection and appropriately treat those co-infected. Test points shall be set up in TB clinics to provide diagnostic HTC on-site by procuring additional furniture, HIV test kits and related supplies. Health workers will be trained to use the provider-initiated HTC approach. On job mentorship will be provided on data recording and reporting for co-trimoxazole preventive therapy (CPT), and on how to expedite the enrollment of TB/HIV patients into HIV clinics to access CD4 testing, ARVs and nutritional supplements.

The National TB and Leprosy program (NTLP), and Buluba Hospital shall be supported to train nurses on TB diagnosis, treatment and case management, to train laboratory personnel on sputum staining and microscopy, and to train sub-county health workers (SCHW) on CB DOTS strategy.

STAR-EC shall procure 12 motorcycles and 65 bicycles for SCHW, 2 X-ray machines for Iganga and Bugiri hospitals, and 18 microscopes for HCIIIs. In addition, we will contribute towards repairs and maintenance of existing equipments.

STAR - EC will support the NTLP structures such as Zonal TB and Leprosy Supervisors (ZTLS), District TB and Leprosy Supervisors (DTLS), and SCHW to function as supervisors through providing activity specific funds for technical support supervision and program monitoring.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9303	**Mechanism Name:**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: DOD-UPDF	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,942,837	
Funding Source	**Funding Amount**
GHCS (State)	1,942,837

Sub Partner Name(s)

National Medical Research Unit (NAMERU)	Research Triangle Institute, South Africa	University of Connecticut

Overview Narrative

The military populations, to which Uganda People's Defense Forces (UPDF) belongs, have been identified among the Most at risk populations to HIV transmission. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. They mostly reside in and/or around military bases that are widely distributed all over the country. The majority are young, energetic men and women in the 18-45 age-group that is well known to be sexually actives. While all recruits undergo an HIV test and only HIV negative persons are conscripted, the HIV/AIDS scourge has not spared the military populations. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4%, it could be as high as 15% in the military.

The UPDF HIV/AIDS Control program started way back in 1988 when the President of Uganda, as commander in chief of the armed forces mandated the UPDF's AIDS Control Program to oversee and manage prevention, care, and treatment programs throughout the forces and their families. It is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family

members. Additionally, an increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions; up to 50% of outpatient visits are by non-military.

The Goal of DoD-UPDF HIV/AIDS Prevention Program (DHAPP) in Uganda is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military populations. Specifically, DHAPP's objectives are;

• To increase awareness about HIV prevention, care and treatment services among military community.
• To increase access to and utilization by military personnel and their family members, of;
– Prevention of mother-to-child transmission (PMTCT)
– Prevention (AB and ABC)
– HIV Counseling and testing
– Basic and specialized HIV care and treatment
– Diagnosis and management of TB-HIV co-infection
– Services for orphans and vulnerable children (OVC).
– Sexual and Gender Based Violence services and now
– Medical Male Circumcision
• To strengthen the monitoring and evaluation systems of the UPDF HIV/AIDS Control Program
• To support injection safety initiatives in the military health facilities.

PMTCT: The goal for this performance period is to reach 80% of pregnant women and 25% of spouses and partners of the targeted pregnant women with PMTCT services and reaching 80% with prophylaxis and treatment according to Ministry of Health Guidelines.

The DoD-UPDF implementing mechanism supports Uganda People's Defense Forces (UPDF), a Government institution with mandate to defend and protest the people and territorial integrity of Uganda. Implementation is based on the UPDF HIV/AIDS strategic plan-2007-2012, which was developed in accordance with the National HIV/AIDS Strategic Plan 2007-2012. Therefore, the mechanism fits within the "3-ones" approach namely; one strategic framework, one performance measurement and management plan and one monitoring and evaluation framework. The mechanism mainly adopts and uses the Ministry of Health and WHO recommendations, guidelines and standard Operating Procedures (SOPs). The DoD-UPDF mechanism sub-contracted three partners; Research Triangle Institute (RTI) International; National Medical Research Unit (NAMERU) and University of Connecticut (U-Conn), to strengthen the support to this unique military population. Furthermore, whenever possible, DoD-UPDF partners with other local implementers with comparative advantage in specific implementation areas, to further increase efficiency and cost-effectiveness.

The DoD-UPDF mechanism delivers HIV/AIDS care and treatment services through strategy of integrated

clinical care service delivery; (2) with the exception of specific target populations, health education messages are integrated, and delivered through Behavioural Change Communication (BCC) outreaches; (3) Wherever minor infrastructural, logistical and technical capacity is built, the benefits go beyond the specific implementation area that has contributed the budget, and at times beyond PEPFAR supported services. For example procurement of theatre equipment for the MMC program is accomplished using MMC funds but serves all patients.

The DoD-UPDF mechanism was created out of collaboration between the USG and Ugandan Government to build the latter's capacity, and therefore has high sustainability chances. One of the challenges faced by the implementing mechanism is poor distribution systems and working with Supplies chain Management Systems (SCMS), logistics management trainings will be conducted for UPDF health workers and drugs storekeepers as a way of minimizing stock-outs and expiry, thereby improving efficiency.

A comprehensive and integrated Monitoring and Evaluation system is an important tool in the management of any programme, because it helps to focus implementers and hence contributes to causing impact. For DoD-UPDF, this integrated Monitoring and Evaluation plan will generate information on HIV/AIDS Care and Treatment from the implementing sites to the national level.
The overall objective of the M&E plan is to generate comprehensive and timely information for use in decision making, learning, effective planning and implementation of HIV/AIDS prevention control interventions in all implementation sites. DoD-UPDF in collaboration with NAMERU will achieved through strengthening the capacity of the military facilities to collect and use data, developing/modifying data collection tools to capture MEEPP and military specific indicators, routinely collecting data from military clinics, compiling, analysing and preparing reports for dissemination to key stakeholders.

For the upcountry military bases, the key strategies will include use of existing Ministry of Defense reporting structures and channels. A participatory approach is employed in the planning, designing, implementation and subsequent reviews of the plan which are deemed relevant to HIV/AIDS care. The indicators closely relate with the National Monitoring and evaluation framework as well as FY 2010 PEPFAR indicator guidance.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Education	5,000
Food and Nutrition: Policy, Tools, and Service	15,000

Delivery	
Gender: Reducing Violence and Coercion	45,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9303		
Mechanism Name:			
Prime Partner Name:	DOD-UPDF		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	40,000	

Narrative:

Budget Code Narrative – Adult Care and Support
The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military. It is estimated that about 10,000 military are living with HIV and up to an additional 10,000 HIV infected family members and surrounding community. An increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions with up to 50% of outpatient visits being by non-military.

The goal of the adult care and support program area is to extend and optimize quality life for HIV infected clients and their families, through the continuum of illness through provision of clinical, psychological, spiritual, social and prevention services. The services are provided using mainly the facility based approach, in 12 ART accredited centres. They are; Bombo, Gulu, Acholi Pii, Moroto, Rubongi, Kakiri, Nakasongola, Katabi, Makindye, Mbuya, Mbarara and Mubende.
The DoD-UPDF mechanism employs the Ministry of Health guidelines for comprehensive management of PHAs. In FY 2010, the DoD-UPDF will expand its support to provision of comprehensive HIV care services to an additional 2 facilities and facilitate their accreditation as ART centres making a total of 14

ART facilities. Basing on the results of the needs assessment Research Triangle Institute (RTI) International conducted at the beginning of this year, there is great need for basic patient care commodities and quality gaps in services currently delivered at a number of facilities. In view of that, we propose to; i) strengthen linkage between diagnosis and chronic care through improved patient referral. The referrals will be made primarily to the 14 chronic care clinics. A total of 2,400 patients will be newly enrolled into chronic care clinics to bring the total enrolled to 15,000. In addition, 1,000 adults and children with advanced HIV will be newly enrolled on ART; ii) REDACTED. iii) Sponsor medical, clinical officers and senior nurses teams for short courses in HIV chronic care management-pediatric HIV care will be given special emphasis. These courses will be provided at nationally recognized training institutions like Infectious Disease Institute and of course by our partners like RTI and University of Connecticut. A total of 75 health workers will be trained in comprehensive HIV care and treatment. To further bridge the existing human resource gaps in the facilities, volunteer health workers and/or PHAs will be trained to support the provision of on-going counseling, psychosocial support and helping patients to develop sexual behavior, care and treatment plans in order to prevent HIV transmission and improve adherence – at least 4 volunteers per facility; iv) support quality control measures like conducting basic hematological tests for patient monitoring. We will also promote CME meetings and on job training during technical support supervision to bridge the existing quality gaps; v) Work in collaboration with the MOH-ACP to distribute the revised standard operating procedures, protocols and job aids on HIV patients' care; vi) In order to improve patient adherence, DoD-UPDF will work in collaboration with University of Connecticut to develop client education materials that can be used in group and individual counseling sessions and orient health workers in effective counseling skills.

. In addition, working with University of Connecticut, DoD-UPDF will support the Prevention with Positives (PwP) program, which is modeled on the South African Options for Health Program in Bombo and Nakasongola, and where possible scale it up. A master trainer course will be organized to cater for transfers and new facilities we bring on board. The program will also distribute MOH standard operating procedures, protocols and job aids on Palliative Care to all supported health facilities. In order to minimize stock-outs for drugs used in prophylaxis, DoD-UPDF, in collaboration with SCMS, will train health unit staff in forecasting and requisition for the right amounts of drugs and other basic care supplies.

In collaboration with PACE, all families of HIV positive military persons will be provided with a Safe Water Vessel (20 liter) and insecticide treated bed nets. All HIV positive persons attending chronic care HIV clinics will be screened for TB and treated accordingly.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	150,000	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people.

The goal of the OVC program is to increase access and utilization of comprehensive quality services for most vulnerable children and their households. An Orphan and Vulnerable Child (OVC) in the military is defined as a child below 18 years who has lost a parent/s or affected or infected by HIV residing within or in close proximity to the military facility/barracks. It includes: all HIV positive children; children affected by HIV i.e. parent/s or guardian is HIV infected and unable to adequately support them; children lacking protection, education, adequate nutrition, access to health, accommodation, clothing, legal redress and psychosocial (parental /guardian) support; and children unable to have the basic necessities of life due to long time absence of the parent/s or guardian, including children whose earning parent is deployed to an operational area for prolonged periods.

With the DoD/PEPFAR support, Uganda People's Defense Forces, together with Research Triangle Institute (RTI) International held a series of stakeholder meetings to build consensus on military OVC definition and strategies for identifying them. A customized military OVC program framework was formulated. Consequently, RTI is in the process of developing OVC implementing guidelines. Coordinators were indentified for every ART centre, to coordinate and report on OVC activities. A total of 958 orphans were provided with education, medical care and psychosocial services. Other services include mitigation of the impact of conflicts provided to children in northern Uganda. In addition, AIDS Alliance trained OVC providers in Bugema and provided OVC data capture tools.

However, a lot still needs to be done. Basing on the 2004/05 National HIV/AIDS sero-behavioral survey, only 23% of OVCs receive some form of external assistance in Uganda. This could be worse for OVCs in military populations, considered to be hard to reach by civilian providers. The UPDF OVC program specifically lacks adequate human resource to provide technical supports and there are as yet no system at community level for identification, planning and support of beneficiaries for OVC services.

During FY 2010, the DoD-UPDF program will focus more on completing military specific OVC implementation guidelines and disseminate them to stakeholders. We acknowledge the fact that military facilities provide services to the civilians but our primary target will be the OVCs within the facilities and those of patients attending the chronic care clinics at the facilities. The DoD-UPDF program targets to

reach 1,000 military OVCs with at least one OVC need. However, only 600 eligible OVC (presumed to have the most pressing needs) will be provided in 3 or more OVC core program areas beyond psychosocial support. The program will train 50 service providers from the 14 ART centers, on OVC service delivery and comprehensive HIV management. The program actual support packed will be determined at a later date guided by the needs assessment results that is to be conducted in September 2009.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	193,000	

Narrative:

Budget Code Narrative – Adult treatment

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military. It is estimated that about 10,000 military are living with HIV and up to an additional 10,000 HIV infected family members and surrounding community. An increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions with up to 50% of outpatient visits being by non-military.

The goal of the adult treatment program area is to extend and optimize quality life for HIV infected clients and their families, through management of common illnesses, improving clinical infrastructure and provision of monitoring laboratory tests. The services are provided at the 12 ART accredited centres. They are; Bombo, Gulu, Acholi Pii, Moroto, Rubongi, Kakiri, Nakasongola, Katabi, Makindye, Mbuya, Mbarara and Mubende.

The DoD-UPDF mechanism employs the Ministry of Health guidelines for comprehensive management of PHAs. In FY 2010, the DoD-UPDF will expand its support to provision of comprehensive HIV care services to an additional 2 facilities and facilitate their accreditation as ART centres bringing the total ART facilities to14. Basing on the results of the needs assessment Research Triangle Institute (RTI) International conducted at the beginning of this year, there is great need for basic patient care commodities and quality gaps in services currently delivered at a number of facilities. in addition, the University of Connecticut conducted focus group discussions with UPDF health workers in Mbuya, Bombo and Nakasongola. They identified informational and behavioural issues preventing clients from consistently adhering to ART. In view of these facts, we propose to; i) strengthen patient adherence to

medications. Working with University of Connecticut, job aids will be developed to facilitate health workers to give adherence support services to all the clients in care; ii) REDACTED; iii) Support counselor, clinical officers and nurses teams for short courses in HIV chronic care management including adherence support. These courses will be provided by our partners RTI and University of Connecticut. A total of 30 health workers will be trained in Art adherence support skills. To further bridge the existing human resource gaps in the facilities, volunteer health workers and/or PHAs will be trained to support the provision of on-going counseling, psychosocial support and helping patients to develop sexual behavior, care and treatment plans in order to prevent HIV transmission and improve adherence – at least 4 volunteers per facility; iv) develop client education materials for both group and individual counseling sessions; v) Work in collaboration with the MOH-ACP to distribute the revised standard operating procedures, protocols and job aids on HIV patients' treatment; vi) In order to improve patient adherence, DoD-UPDF will work in collaboration with University of Connecticut to develop client education materials that can be used in group and individual counseling sessions and orient health workers in effective counseling skills.

. In addition, working with University of Connecticut, DoD-UPDF will support the Prevention with Positives (PwP) program, which is modeled on the South African Options for Health Program in Bombo and Nakasongola, and where possible scale it up. A master trainer course will be organized to cater for transfers and new facilities we bring on board. The program will also distribute MOH standard operating procedures, protocols and job aids on Palliative Care to all supported health facilities. In order to minimize stock-outs for drugs used in prophylaxis, DoD-UPDF, in collaboration with SCMS, will train health unit staff in forecasting and requisition for the right amounts of drugs and other basic care supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	130,000	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military.

The UPDF employs the following HIV testing models; 1) Voluntary Counseling and Testing (VCT); 2)

Provider Initiated HIV Testing and Counseling (PITC) and where appropriate 3) Mandatory HIV Testing and Counseling (for persons selected for external military training). The DoD-UPDF mechanism contributes over 60% of the HIV test kits used in military populations.

During FY 2010, the program will focus more on PICT, in line with Ministry of Health guidelines. Every opportunity will be employed to reach soldiers who have not been tested. The program has targeted to reach 29,130 unique persons with HCT services, using the above named strategies. Services will be provided at 20 static facilities and through community outreaches. Additionally, HCT services will be offered at all Military gatherings where the leaders are encouraged to test and act as role models to their subordinates. In order to minimize double reporting, the monitoring and evaluation system, will be strengthened through our partner; National Medical Research Unit (NAMERU). NAMERU will ensure all testing centres are provided with HIV test registers and are regularly reporting to UPDF headquarters. There will be cross-referral between this crucial service and others like Medical Male Circumcision, TB/HIV co-infection, HIV prevention outreaches (health talks, film and drama shows).

To further build capacity for sustainability and to ensure quality of CT, in-service training and technical support supervision will be provided to health workers by the project technical staff and external facilitators with specialized skills. To further enhance quality of counseling and testing, external quality control for HIV testing will be conducted. Proficiency testing for health care workers involved in HIV rapid testing will be periodically conducted and blood samples from field tests will be re-tested at a reference laboratory at least once every quarter. The project will facilitate the collection and transportation of blood samples for re-testing from the facilities to the reference laboratory and pay for analysis when need be. Commodities like; tables, chairs working tops, timers, testing protocols and SOPs will be provided to the established testing points. Internal referral mechanisms will be built where all newly diagnosed HIV-positive patients will be immediately linked to care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	115,200	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high

as 15% in the military. It is estimated that about 10,000 military are living with HIV and up to an additional 10,000 HIV infected family members and surrounding community. An increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions with up to 50% of outpatient visits being by non-military. Assuming the WHO proportions apply in military populations, there are about 2000 children aged 0-14 years living with HIV/AIDS.

The goal of the pediatric HIV care and support program is to extend and optimize quality life for HIV infected children of military families and surrounding communities, through the continuum of illness by provision of clinical, psychological, spiritual, social and prevention services. The services are provided using mainly the facility based approach, in 12 ART accredited centres. They are; Bombo, Gulu, Acholi Pii, Moroto, Rubongi, Kakiri, Nakasongola, Katabi, Makindye, Mbuya, Mbarara and Mubende. Employing the Ministry of Health guidelines for comprehensive management of PHAs, the DoD-UPDF mechanism supports pediatric HIV care and support services in 3 facilities of Bombo, Kakiri and Nakasongola. Basing on the results of the needs assessment Research Triangle Institute (RTI) International conducted at the beginning of this year, there is great need for basic patient care commodities and quality gaps in services currently delivered at a number of facilities. In FY 2010, the DoD-UPDF will expand its support to provision of comprehensive pediatric HIV care services to an additional 3 facilities among the Ministry of Health accredited ART centres. We propose to do the following; i) strengthen linkage between diagnosis and chronic care through improved patient referral. We will support collection of DBS samples and their transportation to testing centres and returning of results to referring facilities; ii) routine provision of services to children. A total of 2,250 HIV positive children have been targeted to receive care and support service through the DoD-UPDF mechanism. Using the same referral mechanism as for DBS, the program will support referral of blood samples for HIV positive children for CD4 testing and timely return of results, for patient monitoring. In addition, ii) All clinics will be provided with basic commodities like Septrin buffer stock (including pediatric formulations); iii) Sponsor medical, clinical officers and senior nurses teams for short courses in HIV chronic care management and pediatric HIV care will be given special emphasis. These courses will be provided at nationally recognized training institutions like Mildmay or Baylor-Uganda and of course by our partners RTI. A total of 50 health workers will be specifically trained in pediatric HIV care and treatment. We will also promote CME meetings and on job training during technical support supervision to bridge the existing quality gaps; V) Work in collaboration with the MOH-ACP to distribute the pediatric HIV care and treatment guidelines and job aids; vi) In order to improve program monitoring, DoD-UPDF will work in collaboration with NAMERU and MOH-ACP care and treatment team to provide and orient health workers to the MoH standard data collection tools and to provide regular technical support to enhance knowledge and skills.

All new health care workers in the supported health facilities and in the two new facilities will be trained to

provide facility-based palliative care and /or referral for further assessment and specialized care for HIV+ patients. Refresher training and technical support supervision will be provided as needed to ensure quality delivery of Palliative Care services for children. In order to minimize stock-outs, DoD-UPDF will support health unit staff in forecasting and requisition for the right amounts of drugs and other basic care supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	48,250	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military. It is estimated that about 10,000 military are living with HIV and up to an additional 10,000 HIV infected family members and surrounding community. An increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions with up to 50% of outpatient visits being by non-military. Assuming the WHO proportions apply in military populations, there are about 2000 children aged 0-14 years living with HIV/AIDS.

The goal of the pediatric HIV care and support program is to extend and optimize quality life for HIV infected children of military families and surrounding communities, through the continuum of illness by provision of clinical, psychological, spiritual, social and prevention services. The services are provided using mainly the facility based approach, in 12 ART accredited centres. They are; Bombo, Gulu, Acholi Pii, Moroto, Rubongi, Kakiri, Nakasongola, Katabi, Makindye, Mbuya, Mbarara and Mubende. Employing the Ministry of Health guidelines for comprehensive management of PHAs, the DoD-UPDF mechanism supports pediatric HIV care and support services in 3 facilities of Bombo, Kakiri and Nakasongola. Basing on the results of the needs assessment Research Triangle Institute (RTI) International conducted at the beginning of this year, there is great need for basic patient care commodities and quality gaps in services currently delivered at a number of facilities. In FY 2010, the DoD-UPDF will expand its support to provision of comprehensive pediatric HIV care services to an additional 3 facilities among the Ministry of Health accredited ART centres. We propose to do the following; i) strengthen linkage between diagnosis and chronic care through improved patient referral. We will support collection of DBS samples and their transportation to testing centres and returning of results to referring facilities; ii) routine provision of services to children. A total of 2,250 HIV positive children have been targeted to receive care and support

service through the DoD-UPDF mechanism. Using the same referral mechanism as for DBS, the program will support referral of blood samples for HIV positive children for CD4 testing and timely return of results, for patient monitoring. In addition, ii) All clinics will be provided with basic commodities like Septrin buffer stock (including pediatric formulations); iii) Sponsor medical, clinical officers and senior nurses teams for short courses in HIV chronic care management and pediatric HIV care will be given special emphasis. These courses will be provided at nationally recognized training institutions like Mildmay or Baylor-Uganda and of course by our partners RTI. A total of 50 health workers will be specifically trained in pediatric HIV care and treatment. We will also promote CME meetings and on job training during technical support supervision to bridge the existing quality gaps; V) Work in collaboration with the MOH-ACP to distribute the pediatric HIV care and treatment guidelines and job aids; vi) In order to improve program monitoring, DoD-UPDF will work in collaboration with NAMERU and MOH-ACP care and treatment team to provide and orient health workers to the MoH standard data collection tools and to provide regular technical support to enhance knowledge and skills.

All new health care workers in the supported health facilities and in the two new facilities will be trained to provide facility-based palliative care and /or referral for further assessment and specialized care for HIV+ patients. Refresher training and technical support supervision will be provided as needed to ensure quality delivery of Palliative Care services for children. In order to minimize stock-outs, DoD-UPDF will support health unit staff in forecasting and requisition for the right amounts of drugs and other basic care supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	100,000	

Narrative:

The DoD-UPDF HIV/AIDS Other Prevention program target population is the soldiers, their spouses and adults in the surrounding communities. The military population is estimated to be 200,000, residing in military barracks all over Uganda. The DoD-UPDF mechanism provides a comprehensive package of HIV services in over 20 military health facilities and military bases, ranging from prevention, counseling and testing, clinical care and OVC. The goal of SI program is to have a vibrant monitoring and evaluation system, able to provide up to date information to program managers and timely reports for stakeholders (ministry of health, ministry of defense and MEEPP). The SI component of PEPFAR support is implemented in collaboration with National Medical Research Unit (NAMERU), a local NGO with experience of Ugandan healthcare system.

During FY 2010, the Strategic information program will focus on: training a critical mass of health workers

in UPDF health facilities in data management and reporting skills; 1) continue to support the UPDF M&E Officer and HMIS Focal Persons with on-job training and technical support. In this regard, 100 health workers will be trained; 2) in collaboration with ministry of health, procure data capture tools and distribute them to UPDF health facilities; 3) equip 14 HIV clinics with physical and electronic data storage facilities including computers, internet, filing cabinets and book-shelves; 4) transform the paper-based HMIS into a computerized system and promote internet-based reporting; and in collaboration with NAMERU and Ministry of Defense, conduct quarterly technical support supervision to all implementing facilities.

The SI program will be guided by the National "three ones" strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	542,400	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military. Medical Male Circumcision has been proven to be effective in reducing the risk of heterosexual HIV transmission. The DoD-UPDF mechanism started supporting this intervention in FY 2009, with central funding from OGAC, with the goal of increasing access to MMC services. Achievements included: 1) sensitization of the top and mid level military leadership regarding the benefits of male circumcision on HIV prevention. Fifty military leaders were reached, and advocacy is still ongoing; 2) equipping theatres at 04 health facilities; the equipment were procured basing on a checklist developed from the WHO MMC training manual. 3) Procurement of supplies; this was again guided by the WHO training manual and health workers' experience. 4) Training of health workers by Rakai Health Sciences Program; 5) sensitization for over 12,000 soldiers on the benefits of MMC and 6) UPDF leadership supported to conduct site visit to Kayunga Walter Reed Project. UPDF is working with Ministry of Health to develop appropriate IEC materials and orient VCT counselors (including the post-test club counselors), peer educators and health care personnel to provide appropriate health education. Over 100 MMC circumcisions have been performed.

In FY 2010, the DoD-UPDF mechanism will employ the following strategies in an inter-linked approach: (1) make MMC services available through a strategy of integrated clinical care service delivery; (2)

mobilize communities, especially young newly recruited uniformed officers, for services utilization through Behavioural Change Communication (BCC) strategy; (3) ensure that there is an infrastructural, logistical and technical capacity to provide the MMC minimum package; (4) intensify advocacy to secure support; and (5) conduct operational research to provide evidence & document lessons learned. The DoD-UPDF mechanism will scale up MMC services from the current 4 facilities to an additional 2 that are considered to be distant from the existing sites. Bombo General Military Hospital will be equipped as a COE to provide training to health professionals and support supervision to lower facilities. MMC clinic outreaches and special day clinics on weekends will be organized so as to cater for busy officers and also overcome the inadequate staffing shortage. Additional surgeons will be recruited and supported to provide the services, alongside the existing staff.

A total of 1,500 MMC operations will be performed at the supported military hospitals. In addition, 5,000 clients will be provided HCT services and screening for STIs. All supported facilities will be provided with basic MMC equipment and supplies. REDACTED. New equipment will be procured for the 2 new facilities, while for the facilities already supported; only equipment to replace damaged items will be procured. Bombo General Military Hospital will be fully equipped and strengthened to work as a centre of excellence for mentoring healthcare providers and hosting key experts for technical support supervision of lower facilities. A total of 50 health workers will be trained in delivery of MMC minimum package and an additional 300 peer educators and community groups oriented in delivery of appropriate MMC messages. To further bridge the existing human resource gaps in the facilities, 2 clinical officers will be recruited and trained as MMC surgeons to support heavy

Safe Male Circumcision (SMC) has been scientifically proven to reduce the risk to HIV infection by 40-60%, making it the most plausible prevention strategy in generalized epidemics. SMC can synergistically work with other prevention strategies. However, in Uganda where the bulk of HIV infections are through heterosexual transmission, no program has been able to implement a circumcision program at a scale that would have an appreciable effect on HIV incidence. The military attracts mainly energetic sexually active young men, who are HIV negative at recruitment. The military SMC program offers an easy opportunity to reach, and as respected members of society, these could potentially serve as agents of change in their traditionally non circumcising communities.

The military population, the constituent group served by the DoD-UPDF mechanism, comprises; uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The current number of males not circumcised in the military population is not known. However, assuming the 2002 National Housing and Population Census circumcision rates of 25% of males, and the fact the Ugandan security forces are male dominated, over 50,000 people could be un-circumcised in the military population. On the other hand, while the HIV prevalence in this population is not known, it is widely believed to be higher than the 6.4% for the general population. The high HIV burden is widely believed to be driven by a mostly young people who want to experiment; the highly mobile nature of the

occupation and long spells they stay away from their families; the risk taking culture their training inculcates in them; the redundancy in between tours of duty; and alcohol abuse (MARPS study).
The uniformed forces in Uganda have been identified among Most at Risk Populations, mainly acquiring HIV through the heterosexual mode of transmission, for which Medical Male Circumcision has been proven to be effective. In addition, although uniformed forces are an organized group, they are hard to reach by civilian health services. They can best be reached through their institutionalized health services. The SMC program will be an opportunity to further strengthen and improve these health facilities. Furthermore, roll out of SMC will provide a platform for more comprehensive HIV prevention service for this elusive group.

Goal: To reduce the incidence of HIV among military populations in Uganda, through increased utilization of quality Medical Male Circumcision services in the broader HIV prevention program.
Program purpose: To strengthen the capacity of UPDF, health facilities for provision of a minimum package of Medical Male Circumcision services integrated into routine clinical care.
Specific Objectives: By the end of the 5 years:
1. To increase by 50% from 2010 figures, the prevalence of male circumcision among military populations in Uganda.
2. To strengthen the capacity of UPDF health facilities to provide a minimum package of SMC integrated into existing health care services.
3. To raise to 80% among uniformed communities the awareness about SMC services and its benefits, in relation to HIV/AIDS preventions.

Accomplishments since last COP
In FY 2009, the DoD-UPDF mechanism supported: 1) sensitization of the top and mid level military leadership regarding the benefits of male circumcision on HIV prevention. Fifty military leaders were reached, and advocacy is still ongoing; 2) equipping theatres at 04 health facilities; the equipment were procured basing on a checklist developed from the WHO SMC training manual. Equipment for an additional 2 facilities will be procured soon; 3) Procurement of supplies; this was again guided by the WHO training manual and health workers' experience. 4) Training of health workers by Rakai Health Sciences Program (16 health professionals have undergone this training; 5) sensitization for over 12,000 soldiers on the benefits of SMC and 6) UPDF leadership supported to conduct site visit to Kayunga Walter Reed Project. UPDF is working with Ministry of Health to develop appropriate IEC materials and orient VCT counselors (including the post-test club counselors), peer educators and health care personnel to provide appropriate health education. Over 300 SMC circumcisions have been performed (report to be compiled by end of March). Using FY 2010 funds, an additional 2 sites will be established, where all the above activities will be implemented.
Identified gaps, which need immediate intervention

• There is overwhelming competition for theatre space in UPDF health facilities, making it impossible to increase SMC days to more than once a week.
• Understaffing within UPDF makes it almost impossible to have a complete team for SMC service provision.
• There is frequent transfer of uniformed personnel including healthcare workers, mostly basing on security rather than health reasons.
• Establishment of an M&E system for the SMC program that generates information for program management and reporting requirements.
Areas to be addressed with supplemental funding
The additional funding will specifically address;
• Identify and renovate 2 rooms in each of the already existing SMC centres, to work as theatre and recovery rooms
• Hire additional staff and enroll volunteers to establish self-reliant SMC clinics alongside the UPDF established theatre infrastructure.
• Additional supplies to meet the increased demand for SMC services
Expected outputs
• Six theatre rooms renovated
• Fifteen (15) health workers recruited and supported
• Daily Safe Medical Circumcision services introduced in the 6 MC centres
• 3,000 safe male circumcisions performed/year, 800 by September 2010
• Increased capacity of supported health facilities to perform surgical operations
• Improved quality of surgical services in the supported health facilities

Assumptions:
Each facility will be conducting 50 circumcisions per week (10/day), hence a total of 3,000 circumcisions in a year. However, since for this year, the intensive program is likely to start in June, only 800 circumcisions can be done by 30th September 2010.
Less than 5% experience moderate or severe adverse events following a MMC procedure will be experienced.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	50,000	

Narrative:

Blood-borne infections such as HBV, HCV and HIV constitute a major occupational hazard for health care workers. The greatest threat in the military health facility setting is accidental injury with contaminated needles or other sharp objects. The gaps identified in these facilities include; lack of

injection safety supplies like safety boxes, single use syringes, needle cutters and others. In addition, there is high demand for unnecessary injections and the health worker injection safety practices are wanting. The DoD-UPDF mechanism, in collaboration with National Medical Research Unit (NAMERU), a local non-governmental organization, is implementing the injection safety program in Uganda People's Defense Forces (UPDF) health facilities. The goal of this program is to reduce HIV transmission through unsafe injections. Specifically the program will build the capacity of health workers in military health facilities in management of safe injections; support the military medical procurement and supply chain; and support behavior change and advocacy campaigns. The program is currently implemented in three Military Hospitals; Rubongi, Mbarara and Kakiri.

FY 2010 Activities will include: 1) Scaling-up the program to 3 more health facilities; 2) training of health workers on the standards for safe injection use, healthcare waste management and PEP; 3) print and distribute National Policy, National Guidelines on Injection Safety and medical waste management, SOPs and related IEC materials; 4) construct 2 incinerators (at Bombo and Gulu Military Hospitals); 5) procure and distribute to UPDF health facilities injection safety materials like auto-destruct syringes, safety boxes, protective gear, colour-coded medical waste disposal bins; 6) ensure availability of and accessibility to PEP services at UPDF health facilities; 7) community sensitization about dangers of unnecessary injections; 8) developing injection safety checklists/guidelines for UPDF HIV managers to use while conducting support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	50,000	

Narrative:

Target population: The DoD-UPDF HIV/AIDS program target population is the children in 30 primary, 4 secondary (Nakasongola Tororo, Mbarara & Entebbe) and 2 Polytechnic (Mbarara & Mubende) schools, with an estimated population of 12,000 youths. The out of school youths and married couples will be given comprehensive prevention messages including condom use and so will not be counted under AB. Most children who live in military barracks commonly face inadequate parental guidance. Their parents are deployed at short notice; they stay in congested residences; with people from mixed cultural background and with no coherent family structures. They are hence regarded as vulnerable to HIV.

During FY 2010, the AB program will focus on reaching small groups and individuals with consistent messages on abstinence, delays of sexual activity and/or secondary abstinence as well as related community and social norms that impact these behaviors. A total 5,000 children have been targeted to be reached with these messages. To achieve this, school teachers will be equipped with current knowledge about HIV/AIDS and skills to pass on this message to children. The UPDF health educators too will be

conduct monthly health education outreaches to schools to address more technical questions.

The specific activities to be implemented by DoD-UPDF in include: 1) training of 120 school teachers and health educators in AB messages; 2) monthly health education outreaches to schools; 3) IEC materials developed by Ministry of Education and Sports will adopted to suit the military environment, and massively produced; 4) Support children's clubs/associations to hold and debate on HIV/AIDS issues; 5) Support drama and film shows with appropriate content for children in schools; 6) Support assay writing competitions and present awards to winners.

The DoD-UPDF mechanism will also identify children with good oratory to make inspiring speeches or poetry about the virtues of abstinence, delayed sexual activity and secondary abstinence. Where applicable, health education outreaches will be integrated with HIV counseling and testing to identify infected children and link them to care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	325,000	

Narrative:

The DoD-UPDF HIV/AIDS Other Prevention program target population is the soldiers, their spouses and adults in the surrounding communities. The military population is estimated to be 200,000, residing in military barracks all over Uganda, majority of which are in the 15-49 sexually active age group. While all recruits undergo an HIV test and only HIV negative persons are conscripted, the HIV/AIDS scourge has not spared the military. The HIV prevalence is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Heterosexual intercourse is the main mode of HIV transmission. Drivers of the epidemic have been identified as; the young sexually active age; the frequent transfers to different stations and being separated from their main sexual partner and family for long spells of time; alcohol abuse and having a regular income while serving vulnerable communities.

During FY 2010, the other sexual prevention program will focus on increasing access to condoms by the military community. This will be achieved through increasing condom outlets to 30 and orienting community resource persons like peer educators and counselors in condom distribution skills. Condoms will primarily be obtained from the national Ministry of Health procurement system. Other activities will include health education/film shows/drama show outreaches integrated with HIV Counseling and Testing outreaches, health talks at military parades and training institutions, all which will be entry points before peer educators and counselors engage clients in small groups and individual discussions. Similar groups meetings will be organized for soldiers' spouses. The DoD-UPDF mechanism will support 5 drama groups to prepare and stage shows in various military bases. In addition, we shall facilitate teams to go

out for monthly outreach visits. 20 Film show equipment (TV sets, DVD players and tapes/DVDs) will be procured and distributed to brigades to support film shows. Peer educators will be engaged in quarterly review meetings to keep track of their performance. Seminars will be held targeting 100 military leaders with correct HIV prevention messages. Messages will be tailored to influence soldiers' perceptions about heroism in regard to HIV infection and alcohol abuse. The ministry of health communication strategy will be adopted to suit the military environment and copies printed and distributed to all levels, as a way of standardizing the delivered messages. We shall also massively produce and distribute army conceptualized IEC materials including posters, leaflets, to re-enforce the messages. UPDF will take advantage of every social event like football shows, army week, world AIDS day to show case for HIV prevention, like supporting a popular commander to address the participants, facilitating PHAs to give testimonies and others.

Where applicable, health education outreaches will be integrated with HIV counseling and testing to identify infected individuals and link them to care. People counseling will be encouraged go for HIV counseling and testing as a couple. Risky behaviors like having multiple sexual partners, transactional sex and trans-generational sex will be discouraged. Peer educators will refer clients for other reproductive health services like family planning.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	100,000	

Narrative:

Target population: The DoD-UPDF HIV/AIDS program target population is the military personnel, their family members and surrounding communities, totaling well above 200,000 people. Given that military populations are male dominated the population of pregnant women is less than the 5%, expected in the general population. During FY 2010, the program will focus on increasing the coverage of women receiving PMTCT services in the 09 PEPFAR supported military facilities; namely Bombo, Gulu, Lubongi, Mbarara, Jinja, Katabi, Kakiri, Nakasongola and Moroto. A total 2,000 mothers are expected to attend ANC in these health facilities, representing 40-50% of the expected number in the population and of these 300 are expected to be HIV positive.

The activities to be implemented by DoD-UPDF in collaboration with Research Triangle International (RTI), a sub-partner include: 1) sensitization and increased awareness for pregnant women to access services; 2) Conduct an assessment to estimate the coverage of counseling and testing of pregnant women and linkage to ART services; 3) training of midwives and nurses in provision of PMTC services according to Uganda WHO and MOH guidelines; 4) procure delivery equipment for supported health facilities; 5) procure protective wear for healthcare providers; support referral of CD4 count samples to

testing centres and receipt of results to enhance screening for HAART eligibility; 6) support peer mothers/expert clients to provide psychosocial support to newly diagnosed HIV positive pregnant mothers; 7) procure a buffer stock of HIV test kits to supplement those supplied through the Ministry of health system; and 8) support tracking infants of HIV positive mothers after delivery.

The DoD-UPDF mechanism will also use the pregnant women as index contacts to support the involvement of partners in the PMTCT program by promoting HIV testing for family members, couple counseling, disclosure of sero-status and support for discordant couples. The program will also promote the integration of PMTCT activities within the routine maternal and child health services at the target facilities. Working with RTI, links between community and facility services will be enhanced to complement and reinforce each other for maximum impact on PMTCT and on the health of mothers. DoD-UPDF will also use the pregnant women as index contacts to support the involvement of partners in the PMTCT program by promoting HIV testing for family members, couple counseling, disclosure of sero-status and support for discordant couples.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	98,987	

Narrative:

The Goal of DoD-UPDF HIV/AIDS program is to increase access to and utilization of HIV/AIDS prevention, care and treatment services among the military population in Uganda. The UPDF is comprised of uniformed personnel, their family members and surrounding communities, totaling well above 200,000 people. The HIV prevalence, though not officially known, is believed to be similar to that of the other African militaries estimated at 2-3 times that in the general population. Given that the Ugandan National HIV prevalence stands at 6.4% (National sero-behavioral survey), it could be as high as 15% in the military. It is estimated that about 10,000 military are living with HIV and up to an additional 10,000 HIV infected family members and surrounding community. An increasing proportion of military clinics and hospital attendees are civilians not affiliated to the military institutions with up to 50% of outpatient visits being by non-military.

With the widespread use of cotrimoxazole prophylaxis, TB has become the commonest HIV associated opportunistic infections and the leading cause of death PHAs in the Ugandan military population. The goal of the TB/HIV program is to reduce the burden of TB among HIV patients and reduce the burden of HIV among TB patients. The services are provided using mainly the facility based approach, in 12 ART accredited centres. They are; Bombo, Gulu, Acholi Pii, Moroto, Rubongi, Kakiri, Nakasongola, Katabi, Makindye, Mbuya, Mbarara and Mubende.
The DoD-UPDF mechanism employs the WHO and Ministry of Health guidelines for TB/HIV collaborative

activities. In FY 2010, the DoD-UPDF mechanism has targeted to screen 15,000 HIV positive patients for active TB and all those diagnosed to have active TB will be started on treatment. In addition, we targeted to treat 800 TB patients in our supported facilities and using the strategy of Provider Initiated HIV testing and counseling, we will screen all that will accept to test for HIV and whoever tests HIV positive will immediately be linked to chronic HIV clinics for care. We therefore propose to; i) strengthen laboratory services through support to procurement of buffer laboratory reagents and supplies. All supported health units will have functional laboratory services with capacity to conduct a sputum examination. In a few selected cases, we shall pay for X-ray services obtained from private providers. A total of 400 patients are estimated to be present as incident TB patients and these will be given priority. ii) Patients with TB/HIV co-infection will be index patients and their families members will be followed-up and screened for both HIV and TB. Children and infants will be given special consideration; iii) Together with our partners RTI, UPDF health workers will be supported to attend short courses in management of TB/HIV co-infections-using WHO and Ministry of Health recommended curriculum. At least 75 health workers will be trained in this aspect of HIV care and treatment. Some CME sessions will be provided specifically focusing TB/HIV co-infection. To further bridge the existing human resource gaps in the facilities, The Ministry of Health DOTS strategy will continue to be supported due to its proven improvement on drug efficacy; iv) In order to improve program monitoring, DoD-UPDF will work in collaboration with NAMERU and MOH-NTLP team to provide and orient health workers to the standard data collection tools and to provide regular technical support to enhance knowledge and skills. The MoH quality assessment quality control program will be supported.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9325	**Mechanism Name: The Capacity Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,226,477	
Funding Source	**Funding Amount**
GHCS (State)	1,226,477

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,226,477

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9325**		
Mechanism Name:	**The Capacity Project**		
Prime Partner Name:	**IntraHealth International, Inc**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	1,226,477	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9326	**Mechanism Name: John Snow, Inc./Injection Safety/country funded**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract

Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 370,000	
Funding Source	**Funding Amount**
Central GHCS (State)	370,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

JSI/AIDSTAR-one Injection Safety and Waste Disposal

AIDSTAR-One will provide technical assistance in Health Care Waste Management (HCWM) to USG implementing partners with the aim of reducing medical transmission of HIV through unsafe HCWM practices. The project will build capacity among partners to assess, evaluate and plan for HCWM as well as analyze outcomes of implemented activities. The planned activities will be implemented in 30 partner districts namely; Kampala, Wakiso, Mukono, Kayunga, Kasese, Jinja, Mbarara, Kabaale, Rakai, Rukungiri, Hoima, Kyenjojo, Mubende, Tororo, Mbale, Manafwa, Gulu, Soroti, Amolatar, Kitgum, Nebbi, Kalangala, Ibanda, Isingiro, and Kamuli.

Recent assessments show that health units are failing to cope with increasing volumes of infectious waste due to; inadequate planning, low level of awareness among health managers, poor waste segregation habits making HCWM unnecessarily expensive, and inadequate coordination especially at district level. As part of health systems strengthening, MMIS in conjunction with the MoH and development partners in health, developed policies and guidelines on HCWM. The developed documents will be widely disseminated during training, supervision, and during review meetings. AIDSTAR-one will create awareness among health managers on the need to plan for HCWM and efforts will be made to get HCWM incorporated into ongoing budgeting processes. The project will instill among service providers a culture of segregating waste and coordination mechanisms among development partners in health will be strengthened.

For the purpose of sustainability, a team of 30 central trainers composed of MoH staff, representatives from District Health Teams (DHTs), representatives from Health Training Institutions (HTIs) and partner staff will be established. This team will be instrumental in training lead partner staff that will be in-charge

of HCWM, and will also train district focal persons who will liaise between partner organizations and the individual districts. To support training and to enhance the health workers' understanding of HCWM concepts like segregation and final disposal; educational materials and job aids will be developed or where necessary updated and disseminated. The job aids will be posted as reference material at all areas where waste is generated.The project will facilitate 40 training sessions of partner staff in safe phlebotomy and HCWM. Fifteen organizations will benefit including 10 new and 5 - 8 old partner groups. The project will ensure that each group trained is competent in supervising service providers, collecting data on HCWM practices, and selecting priority areas for action basing on the prevailing risks. The project will follow up the trained health workers and will provide technical support during the training of partner operational level health workers. It is estimated that 1000 health workers including waste handlers will be trained.

Improper final waste disposal contributes to biomedical transmission of HIV and other blood borne pathogens. Members of the community are likely to get in contact with hazardous waste if it's indiscriminately damped in areas where it is not expected to be or is disposed of in open areas that are not restricted to the general public. In an effort to improve final waste disposal, MMIS will work with USG partners to install environmentally friendly final disposal facilities. Options to be installed will depend on the prevailing situations at the specific sites.

Health facilities where the USG works will be encouraged to incorporate HCWM requirements into their annual plans and budgets. The project will work closely with the MoH to get reliable funding for HCW from the Ministry of Finance. In addition, mechanisms will be put in place to promote more stakeholder buy-in at all levels.

Pre-visits will be made to partner organizations to discuss how the HCWM collaboration will be effected. Visits will be made to targeted districts to gain insight into the range of services provided and the different categories of waste generated. AIDSTAR-ONE will assess the working environment and the HCWM practices at the partner implementing sites. Data collected will be analyzed and findings will be presented to USG partners and stakeholders in the districts. Efforts will be made to establish district coordination committees in 10 areas where such structures do not exist. Review meetings will organized to evaluate progress made by the HCWM coordinating committees in implementing HCWM plans. Following the training, the project will provide on job support supervision to the staff at the partner implementing sites. In order to build capacity in problem solving among health facility based supervisors, mutually beneficial exchange visits will be organized between districts. Criteria for selecting participating health units will depend on the matters arising.Information collected including lessons learned will be shared in a national stakeholders meeting.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9326**		
Mechanism Name:	**John Snow, Inc./Injection Safety/country funded**		
Prime Partner Name:	**John Snow, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	370,000	

Narrative:

AIDSTAR-One will provide technical assistance in health care waste management (HCWM) to USG HIV/AIDS implementing partners with the aim of reducing medical transmission of HIV through unsafe HCWM practices. The project will build capacity among partners to assess, evaluate and plan for HCWM as well as analyze outcomes of implemented activities.

Improper final waste disposal contributes to biomedical transmission of HIV and other blood borne pathogens. In an effort to improve final waste disposal, MMIS will work with USG partners to install environmentally friendly final disposal facilities. Options to be installed will depend on the prevailing situations at the specific sites. Health facilities where the USG works will be encouraged to incorporate HCWM requirements into their annual plans and budgets. The project will work closely with the MoH to get reliable funding for HCW from the Ministry of Finance. In addition, mechanisms will be put in place to promote more stakeholder buy-in at all levels. Efforts will be made to establish district coordination committees in 10 areas where such structures do not exist. Review meetings will organized to evaluate progress made by the HCWM coordinating committees in implementing HCWM plans. Information collected including lessons learned will be shared in a national stakeholders meeting.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9327	Mechanism Name: NUMAT
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 6,087,561	
Funding Source	**Funding Amount**
GHCS (State)	6,087,561

Sub Partner Name(s)

AIC (VCT Lira Apac)	Associazione Volontari per il Servizio Internazionale, Italy	World Vision

Overview Narrative

NUMAT is a cooperative agreement implemented by John Snow Research and Training Institute, Inc. (JSI) and its partner organizations (AIC and World Vision). It was awarded in August 2006 as a program - Expanding HIV/AIDS, Tuberculosis, and Malaria Services to Northern Central Uganda which later came to be known as Northern Uganda Malaria AIDS and TB Program (or "NUMAT"). NUMAT works in 3 broad areas: HIV/AIDS, Tuberculosis and Malaria with an overall goal of expanding access to and utilization of HIV, TB and malaria prevention, treatment, care and support activities in the nine districts of North Central Uganda region (Lira, Apac, Dokolo, Amolatar, Gulu, Amuru, Kitgum and Pader). NUMAT places emphasis on strengthening capacity and utilization of HIV/AIDS/TB and malaria services at all the different levels of service delivery with special focus on HC IV and III which are close to where the formerly displaced population has returned. The objectives of the project are:

1. Improved coordination of HIV/AIDS and TB responses. NUMAT's emphasis is on strengthening decentralized coordination at lower local government levels at districts, sub-counties, parishes and villages. NUMAT also recognizes that local government support must be complemented with national technical support and working in partnership with others. Thus NUMAT works with Uganda AIDS Commission and members of Decentralized Response Self Coordinating Entity (DR-SCE) including UNAIDS. NUMAT also works with other NGOs, UN agencies and donors that are supporting coordination of MAT response in the nine NUMAT supported districts.

2. Increased access to and utilization of quality HIV/AIDS, tuberculosis and malaria prevention, care and treatment services.This objective strives to ensure that communities and individuals in the Program area can access and utilize quality services in an integrated manner, both in their communities and from the health facilities. It includes all the three key program areas of HIV, TB and Malaria. As for HIV the purpose is to ensure that the supported services focus on identifying HIV-positive individuals and facilitating access to networked care and treatment services.
The key HIV services include: HIV counselling and testing (HCT), Prevention of Mother to Child transmission of HIV (PMTCT), palliative care for HIV including but not limited to facility-based chronic care and ART provision both for treatment and prevention where indicated. As for Tuberculosis, the key program components included scaling up and strengthening TB CB-DOTS services and making sure that TB and HIV services are integrated through support to TB/HIV collaborative activities. For all the three program areas to be supported it was important to have a functional laboratory system in order to improve access to the other services. Human resources for health is another key area that NUMAT has put in resources to achieve this objective.

3. Decreased vulnerabilities for specific groups to HIV/AIDS and other infectious diseases.The NUMAT Program prevention strategy primarily targets the following groups for HIV prevention: girls and women at risk of survival sex, Discordant couples,Uniformed service members/mobile male populations, PHA (for positive prevention), young married women, orphans and other vulnerable children, youth aged 10-24 years, men including fishing communities, long distance truck drivers farmers groups, boda boda and commercial sex workers. NUMAT uses the ABC strategy and is working closely with other partners to roll out key elements of a comprehensive strategy for balanced and targeted prevention. The key elements of the NUMAT strategy are: to strengthen district capacity and linkages to coordinate prevention activities; to plan and implement message dissemination; to improve prevention component of clinical services; and to establish and strengthen community-based groups to reinforce messages and provide ongoing support to most-at-risk populations.

4. Increased access of PHAs and their families to wrap-around services (care and support).NUMAT seeks to strengthen systems and mechanisms to increase access of PHAs to care and support services not provided directly by the NUMAT programme. These wrap around services include: access to nutrition and food support, family planning, water and sanitation, orphans and vulnerable children (OVC) support, spiritual and psychosocial support, counseling, non-food item distribution, income generating activities, legal assistance, and human rights protections. The programme works with partners to build and strengthen collaboration with USAID and non- USAID implementing partners, local government, FBO/CSOs, other NGOs, PHA networks and the private sector operating in the region to create effective linkages to these essential wrap around services. The NUMAT approach has also involved capacity

building of PHA networks/groups to ensure active participation in and promotion of access to wrap around services through advocacy. PHA volunteers are supported to serve as service navigators, connecting fellow PHAs and their families to wrap around services support. The third approach has involved strengthening of referral networks in the region.

5. Improved use of Strategic Information.NUMAT has been building its own monitoring and evaluation system in partnership with the district focal persons for HMIS, in order to compare the raw data and disseminate analysed information. Additionally, the program's main approach is to support districts to provide timely and quality information for their planning and decision making.

NUMAT's Guiding Principles:
? Scaling up service provision within existing framework and policies. NUMAT works with the local governments and existing service providers to improve and expand service delivery through providing a variety of inputs. Al this is done within existing national guidelines and policies.
? Ensuring District involvement and ownership of the supported services. All NUMAT's support is aimed at complementing what the Government is doing. And all activities are supported with the involvement and blessing of the districts l under a partnership agreement between NUMAT and each of the nine District local governments.
? Strengthening services in peripheral areas beyond towns and municipalities. Emphasis is put to strengthen services at lower level facilities HC IVs and HC IIIs with specific emphasis on those sites which are beyond municipalities and towns.

Overall strategies
? Strengthening existing service provision sites to increase on coverage and quality of services offered;
? Supporting new sites in peripheral areas to offer comprehensive services;
? Strengthening integrated outreach and service delivery;
? Strengthening existing local structures to coordinate and integrate services;
? Addressing critical human resource needs; and
? Involving beneficiaries in planning and delivering of services (including PHAs).

Overall Inputs
? Training: in-service and pre-service TOTs and direct service providers (mainly by the districts);
? Direct Technical assistance through support supervision and mentoring (central, district or NUMAT); Districts are always involved;
? Infrastructure development – mainly in lab sector (targeting 27 labs);
? Equipment support (labs, PTCs, ANC, FSGs);
? Supplies and reagents – test kits and other lab consumables;

? IEC/BCC materials (print, audio & video);
? Medicines – ARVs; and
? Direct funding to districts/sites and community groups – through grants & other mechanisms.

NUMAT contributes to the health system strengthening through several programme components namely: Infrastructural development - The programme has supported districts to renovate laboratories and counseling rooms at HCIII level. In 2010 laboratories and counseling will be refurbished and equipped with basic lab equipment to improve the diagnostic capacities of the units.
Capacity building - NUMAT works closely with local governmemet to build their capacity in planning, management and delivery of HIV/AIDS, TB and malaria services. Four NUMAT supported districts have been supported to develop and put in place HIV/AIDS strategic plans. An additional four districts will be supported to develop their plans which would help them strengthen coordination of HIV activities and also help the districts rationalize allocation of resources to HIV/AIDS acivities.

NUMAT supports in service training for health workers. Given the high attrition rate of health workers, NUMAT will train more health workers in different program areas. Support supervision will continue being strengthened through providing logistical and financial support to the District health offices, supporting MoH technical staff to conduct supervision visits and through NUMAT staff conducting their own independent support supervision visits to the service delivery sites.

NUMAT will continue helping districts to address the critical Human Resource constraints facing them by providing resources and technical assistance to districts to conduct exhaustive staffing needs assessments, putting in place functional Human Resources information systems, advertising vacant positions and supporting district health service commissions to shortlist and interview candidates. Support will also be provided to districts for orientation of newly recruited staff as well as training district human resource managers in support supervision and performance management.

NUMAT has partnered with Baylor College of Medicine to leverage resources for pediatric HIV Care. Through this partnership ART sites jointly supported by NUMAT and Baylor have benefitted from ARV pediatric formulations, Capacity building initiatives including didactic training of health workers in pediatric care, establishment of ART databases, recruitment of additional support and technical staff in ART clinics and increased HIV lab monitoring tests. This partnership will continue in FY2010 and will be expanded to another 20 sites.

In the last two years NUMAT has continued to support free CD4 and CBC outreach testing through a partnership with two organizations - JCRC and CNAPSIS for a fixed quota of samples per month. In FY2010 the number of CD4 and CBC tests performed will increase at no direct cost to NUMAT as other

partners like Baylor College and AIC start conducting tests at no cost for NUMAT. There are also plans by the MoH to procure CD4 machines for several sites in the nine districts – this will go a long way in increasing coverage of this vital activity at a low marginal cost for NUMAT.

As mentioned above, NUMAT will train more health workers in FY2010, but more focus will placed on skills and confidence building through a mentorship of health workers at their work places by experienced and more senior collegues from the cntre or within the region. District based trainers will facilitate the bulk of the trainings in FY 2010 to ensure relevance, sustainability and local support of the trainings conducted.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Food and Nutrition: Commodities	20,000
Gender: Reducing Violence and Coercion	250,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9327**		
Mechanism Name:	**NUMAT**		
Prime Partner Name:	**John Snow, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	800,000	
Narrative:			
NUMAT supports health facilities and community-based service providers to increase access and utilization of care and support services for HIV infected adult individuals and their families. NUMAT addresses support and care by strengthening psychosocial support, establishment of referral networks to link PHA to HIV/AIDS and other wrap-around services. These services include: home-based care services and the provision of essential drugs for OI prophylaxis and ART, pain and symptom management and psychosocial support. The NUMAT support also includes technical capacity building of			

health workers, community-based providers, PHA groups and community volunteers to offer quality care and support for PHAs and their families.

Psychosocial support in the region was promoted when NUMAT trained 140 counselors from 40 health facilities in Northern Uganda to provide counseling on disclosure to spouses and significant others, ongoing counseling, therapeutic counseling and bereavement counseling.

In FY2010 an additional 120 counselors will be trained; these will mainly be drawn from health centre III's and IV's in the Acholi sub region. Majority of those previously trained hailed from the Lango sub region. The counselors will be followed up on a quarterly basis by MoH mentors to ensure adherence to set standards.

In FY2009, NUMAT supported 28,000 PHAs with basic chronic care services including Cotrimoxazole for primary prophylaxis and screening for tuberculosis. An adequate supply of Cotrimoxazole for patients assessing care at the supported sites has been made possible through the auspices of the NMS/JMS/MoH/CDC Laboratory supplies project, leaving NUMAT to concentrate on providing new ART clinics with antiretroviral drugs. Co-trimoxazole has been availed to all clients at all NUMAT supported ART sites which include two hospitals, 12 health centre IVs and 14 health centre III's. In PY2010 five more sites will be added, bringing the total of NUMAT-supported sites to 33. This will contribute to bringing comprehensive care to an additional 5000 PHA in the nine districts, as they are targeted for various forms of treatment. In addition to supporting the provision of cotrimoxazole, NUMAT will also support the mechanisms to ensure the supply of oral morphine and other pain relieving drugs to support pain and symptom management at the supported sites. This however will require working with MoH, Palliative Care Association of Uganda and Hospice Uganda to support training of Palliative care specialists and nurse prescribers for oral morphine for the sites.

People living with HIV/AIDS in the sub-region are provided home-based care services by a team of 1,100 home visitors trained by NUMAT. These are volunteers, often PHA peers, drawn from within the community. The home visitors visit clients in their home environments, providing basic nursing care, psychosocial support, on going counseling, prevention care services and referrals for other services. In FY 2010 therefore, there will be additional 80 home visitors trained as replacements of drop outs. This will bring the number of home visitors trained to 1,180. CBOs, FBOs, NGOs and PHA networks will be strengthened through mentorship and support supervision of home visitors to provide quality home-based care services. Home-based care implementation guidelines and policies shall be given to the home visitors to use and guide the activities implemented. Replenishment of supplies such as soap, ORS, monitoring notebooks and referral forms will continually be provided as required.

The program engages individuals openly living with HIV/AIDS as service providers. These are referred to as Network Support Agents (NSAs). The Network Support Agents are a link between communities, health facilities and the direct service providers. To date, there are 140 Network Support Agents working as navigators of HIV/AIDS/TB services including provision of clear information on ART treatment, making it more understandable by not only those living with HIV/AIDS, but also their immediate families and communities. In FY2010, the role of NSAs will further be strengthened.
The wrap around services needed by PHA and their families are many and diverse. However, NUMAT program does not directly provide these services but it coordinates with providers of these services to ensure linkages. In this context, NUMAT collaborates with of these services to increase their access by PHAs and their families. Such collaboration with Population Services International (PSI) has enabled 5500 PHA households to access basic care commodities (BCP).

In FY2010 NUMAT will continue partnering with Program for Accessible Health Communication and Education (PACE) to enable an additional 5,000 PHA access the BCP commodities. NUMAT will also develop a working relationship with ACDI VOCA Project to ensure that the registered PHA access food nutrition and security support. The National Agricultural advisory services (NAADS) programme will also be engaged to empower PHA households to grow their own food. NUMAT will continue to strengthen collaboration and partnerships with various implementing partners and services providers to expand access to wrap around services by PHA and their families. New partners will be identified and brought on board to provide wrap around services. Where possible, small grants will be provided to some selected CBOs and NGOs providing critical wrap around services to scale up these services. A key strategy is for NUMAT to continue supporting the active participation and capacity building of PHA networks to serve as service navigators, connecting PHA between direct HIV services and wrap around support. The program will continue strengthening the roles of PHA networks and groups in increasing access and utilization of these services. Evaluating NUMAT's activities will include an evaluation of the referral mechanisms and access to wrap around services.

Quarterly referral coordination meetings to improve referrals mechanism between service providers (facility and community-based) from health sub district and or sub county level will be held in all the nine districts. Referral forms and tracking tools will be developed, printed and distributed to community-based HIV/AIDS service providers to track and record clients for services. A key strategy is for NUMAT to continue supporting the active participation and capacity building of PHA networks to serve as service navigators, connecting PHA between direct HIV services and wrap around support. CBOs providing services will be brought together at the health sub district or sub county level to support referrals between community and clinical services. NUMAT will continue to strengthen PHA Networks to perform referral and linkage functions.

Involvement of the PHA networks in patient care and support will continually be enhanced. At the health facility, PHA as network support agents will be engaged in supporting menial tasks at the clinic and in maintaining PHA registers. At the community, the role of the sub county PHA groups will be expanded to include providing patient follow up and defaulter tracing. These activities will support retention of patients in the ART programs run in the region. Data captured in the PHA registers, defaulters traced and loss to follow-up verified through the PHA activities will enrich the monitoring and evaluation processes that the NUMAT program has to undertake.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	617,600	

Narrative:

NUMAT supports capacity building for health workers at the supported sites in the nine supported districts of Northern Uganda. In FY2009, through collaboration with the World Health Organization (WHO), the AIDS Control Programme and the MoH, NUMAT supported the training of 160 health workers in Adult Comprehensive HIV care. This course also called the Integrated Management of Adult Infectious Diseases (IMAI) has been offered to health workers constituting ART teams in 28 supported health facilities in the nine districts of Northern Uganda. Training has also been provided in various aspects of palliative care. In collaboration with the Palliative Care Association of Uganda (PCAU), NUMAT trained and mentored 55 health workers from 17 NUMAT-supported ART sites. Other trainings held include one in opportunistic infectious diseases. Held in collaboration with the AIDS control program, it trained 35 health workers in advanced management of HIV and AIDS-related diseases. In FY2010, NUMAT is to facilitate two more IMAI trainings for ART teams from five new ART sites. Additional didactic training will be required in pain and symptom management. This will be made possible by teaming up with PCAU and Mildmay Uganda. This will address critical gaps in pain and symptom management and terminal care recognized in some of the more rural districts of the region. This includes Apac, Pader, Oyam, Amolatar and Dokolo districts.

In FY2009, 72 health workers from ten newly-accredited ART sites were mentored and provided guidance in adult HIV management, ARV drug logistics, data management and nursing care. Mentorship will be a prominent feature of capacity building for health workers supporting the ART clinics in FY2010. Mentors will include clinicians, nurse specialists and pharmacists. Curricula to guide and standardize the different mentorship areas will be developed with the support of HIV training experts.

NUMAT has endeavored to monitor clinical outcomes of therapy. Through a contract arrangement with Joint Clinical Research Center (JCRC) and CNAPSIS, a CD4 lymphocyte outreach testing project is supporting treatment at the ART sites. In FY2009, 11,880 CD4 and 2,378 full hemogram tests were

provided to PHA at the supported sites. Average CD4 level for patients increased by 91.8%, from 158.8 cells/ul at initiation to 304.7 cells/ul after six months of follow up. This evaluation was undertaken during an HIV adherence and retention survey completed in FY2009. The Survey also established that there was a nominal increase in weight gain of 6.2%. In regard to health facilities supported by the project, had two year retention of patients on ART of 51.1% at baseline when support had just commenced. In additional to CD4 monitoring, HIV surveillance testing will commence in FY2010 so that the efficacy of ART drugs provided through the NUMAT program, in accordance with the National ART guidelines remain appropriate.

NUMAT supports adherence activities at the health facility through technical supervision and mentoring for health facility staff, enhancing recording of patient self report, pill counting and the use of appointment registers to detect default and loss to follow up. NUMAT also strengthens adherence activities at community level by utilizing PHA peers and volunteer home visitors. The stakeholders supporting HIV treatment at the NUMAT sites are facilitated to have monthly meetings were default, loss to follow up, transfer and death amongst the clients is discussed. The review meetings enabled health workers and community workers to improve the continuum of care. In FY2010 the meetings will continue and will expand their scope to address linkages for TB/HIV collaboration and PMTCT.

With a prevalence of 8.2%, about 220,000 adults in this project area are HIV positive and in need of various forms of treatment. In FY2009 NUMAT supported 28,000 PHAs with basic chronic care services including cotrimoxazole for primary prophylaxis and screening for tuberculosis. In FY2010 by adding 5 more sites, NUMAT will be supporting 33 ART clinics. This will contribute to bringing comprehensive care to an additional 5,000 PHA in the nine districts, as they are targeted for various forms treatment. Specifically, an additional 878 persons will be initiated onto antiretroviral treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	560,000	

Narrative:

In FY 2009, NUMAT, like in the previous year, collaborated with various partners to support HCT services in the nine Northern Uganda districts. The partners include the nine districts: AIDS Information Centre (AIC), the NUMAT sub-partner; Straight Talk Foundation through Gulu Youth Centre (GYC) and Kitgum Youth Center (KYC). These partners helped to roll out HCT services using the voluntary Counseling and Testing model.

Through partnership with AIC, NUMAT was able to conduct HCT outreaches to the most at risk population (MARPS), namely internally-displaced persons in camps, youth, prison inmates, uniformed personnel, and fishing communities and over 2,500 MARPS were reached with HCT services

In addition to the outreaches, NUMAT supported a total of 100 health facilities including hospitals, health center IVs, health center IIIs and selected health centrer IIs supported to provide HCT. This support was in the form of technical support supervision; capacity building/ training; and the provision of logistics tools, registers, cards and HIV test kits to facilities without these commodities. In FY2009, NUMAT, in partnership with MOH and AIC, trained 150 health workers as VCT counselors drawn from 40 lower level health facilities and 399 health workers from the district hospitals of Kitgum and St Josephs were trained in provider-initiated testing and counseling (PITC), in addition to the 404 health workers from Gulu and Lira regional referral hospitals trained in PITC in FY2008. As a result of the above mentioned support, over 180,000 clients were counseled, tested and received results with an HIV prevalence of 11%. These were linked to preventive and treatment services including wrap-around services

In FY2009, ten Post-Test Clubs (PTC) were enabled to conduct activities for positive living. These were in the districts of Amuru, Amolatar, Apac, Dokolo and Oyam .With this support, over 5,000 HIV positive and negative individuals have benefited from PTC activities including psycho-social support meetings; educational talks; and music, dance and drama activities. Working with PTCs and through strengthening referral mechanisms, those who test positive at the HCT sites will be supported and linked to a wide range of palliative care, ART and other wrap-around services.
During FY2010, NUMAT will consolidate and build on the achievements made in the past two years, while working closely with the districts, AIC and other partners to continue provision of HCT outreached to the communities and MARPS. The HCT outreach will mainly be focused on the far/hard-to-reach and the returning communities.
NUMAT will also consolidate and strengthen existing facilities, where HCT services are provided and support the establishment of new HCT service delivery points. Furthermore, health facilities will be supported to conduct HCT outreach. This will be done in order to increase geographical and population coverage.
In order to increase demand for testing, targeted HCT promotion and community mobilization as well as distribution of IEC materials in all communities will be given due attention. Targeted populations will include groups at most risk like discordant couples and those engaged in transactional sex. Where appropriate materials do not exist for certain populations or language groups, either existing materials will be translated and/or adapted or new materials will be developed using a participatory process.
Also in FY2010, support to PTC activities will be strengthened and in addition, NUMAT will support discordant couple clubs so that discordant clubs are able to meet monthly and offer each other psycho-social support and can benefit from counselor-led health education session.
To ensure the smooth flow of supplies for uninterrupted service delivery, NUMAT will invest in logistics training of the concerned health workers with support from MOH. The project will also support the District health managers of HCT access to supplies and test kits from National Medical Stores. The project will

continue to support procurement of US and Ugandan government-approved buffer test kits and work with the existing distribution systems to ensure their constant availability at all supported sites.
NUMAT will yet again enhance capacity building by training 120 health workers as VCT counselors. These will be drawn from lower health facilities from the Acholi sub-region districts where populations have just returned.

In FY009, NUMAT supported a team from MOH to conduct second-round (bi-annual) support supervision to the HCT implementing health facilities. The MOH team patterned with other HCT stakeholders in the region to conduct this exercise. Emphasis was put on logistical management, data management, infection control and adherence of the service providers to the nationally recommended testing algorithms.
NUMAT supported sites using the nationally-recommended testing algorithms i.e. serial algorithm for rapid HIV testing and in partnership with MOH reproduced the standard operating procedures (SOPs) for testing and these were distributed during the supervision. The health workers were trained in the use of SOPs
For purposes of quality control and quality assurance, at least 3% of the tested blood samples from health facilities and the outreaches were sent to a reference laboratory at Uganda Virus Research Institute for re-testing.
These activities will again be supported in FY2010. In addition, NUMAT will facilitate the MOH team to mentor the district and health sub-district (HSD) teams, which will be supported to conduct quarterly support supervision to the sites. Quality assurance and quality control will again be conducted to promote provision of quality services.

In the previous two years, NUMAT main approach of HCT provision was the voluntary counseling and testing (VCT) which was offered at the NUMAT HCT supported sites and through the outreaches. In FY2009, health workers from the two regional hospitals of Gulu and Lira were trained in PITC and implementation began. NUMAT, in partnership with AIC and MOH, trained 400 health workers from the district hospitals of Kitgum government hospital and St Josephs Hospital in PITC and implementation has began
In 2010, NUMAT will strengthen the PITC approach in the implementing health facilities. All hospitals will be supported to conduct PITC. In addition, two HCIVs from the districts without hospitals will be trained and supported in implementation of PITC
NUMAT will in 2010 partner with more sub-grantees in HCT services delivery in the districts of Amuru, Gulu, Kitgum and pader. In Kilak County (Amuru district), the approach will be through home-based HCT so as to reach majority of the returning population. The program will continue to hold integrated outreaches as work camps with HCT as one of the service areas among others. This outreach activity, which started in FY2009 brings together a "cocktail" of NUMAT services (HCT, PMTCT, ART, Malaria,

T.B, Palliative, Prevention a services) under one umbrella at specific sites. The work camps have the advantage of immediate linkage to the needed care and prevention services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	200,000	

Narrative:

NUMAT began its support to health facilities after establishing that less than 6% of patients assessing care and support were children. There was lack of knowledge in pediatric counseling. Health workers generally considered care for children to be the exclusive domain of the pediatric specialist. The HIV clinics did not prioritize the care of children at the clinic. In all the clinics visited, children spent long hours in the waiting queues alongside the adult patients.

As a strategy to address care and support for children, NUMAT considered it essential to co-opt the skills of a partner specialized in the care of children to kick-start appropriate pediatric HIV care services in the region. This culminated into the signing of a partnership agreement with Baylor College of Medicine Pediatric Foundation, (BCM) which in turn led to activities that raised recruitment levels for care and support for children at an initial eight health facilities supported by NUMAT. The activities included didactic training for health workers in comprehensive pediatric care, training in pediatric specialized psychosocial support, regular mentoring and technical support. Assistance was offered to respective district local governments to recruit and retain pediatric nurses, clinicians, social workers and data clerks. BCM also provided drugs for treatment of opportunistic diseases as well as cotrimoxazole for prophylaxis. NUMAT, on the other hand, afforded the sites CD4 lymphocyte monitoring for initiation and clinical follow-up of children on ART. In addition NUMAT supports the community follow-up of children on treatment.

In FY2010, an additional 17 NUMAT-supported sites will receive the full range of support stipulated by the partnership agreement akin to the support provided to the 8 initial sites. An additional 8 sites that NUMAT intends to support may not benefit from the agreement with BCM. As a solution NUMAT will work closely with MOH, scaling up provision of pediatric formulations of OI drugs for treatment and prophylaxis to these sites through strengthening essential drug logistics centrally and at the sites. NUMAT will also work with WHO and the AIDS Control Programme to build the capacities of health workers in pediatric counseling and support. NUMAT will also partner with ACDI-VOCA, and the Nu-Life project to provide nutritional supplements for these children.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	154,400	

Narrative:

Pediatric treatment has been inadequately addressed in Northern Uganda. Less than 3% of patients accessing ART were children. The initiation of HIV-infected infants was virtually non-existent in HIV clinics in the lower level health facilities-there was lack of knowledge in pediatric counseling. Health workers generally considered care for children to be the exclusive domain of the pediatric specialist. The HIV clinics did not prioritize the care of children at the clinic. The needs of both children and their caregivers that affected adherence were poorly addressed and led to significant levels of loss to follow-up and death amongst the few children initiated on treatment. In literally all the clinics, children spent extended hours waiting to be attended to alongside the adult patients.

MoH made an attempt, though inadequate, to improve treatment for the HIV infected child in HIV clinics in the region. There was the provision of pediatric formulations to the sites. However, on many occasions the drugs were provided through a push system and had a limited shelf life, often expiring before children could access from the drugs. There was a lack of laboratory backup to help determine eligibility for ART amongst the children, lack of knowledge and functional equipment for weight and growth monitoring. In this regard, there was no demand for health workers to make fresh orders for more pediatric formulation.

NUMAT has partnered with the Baylor College of medicine, Pediatric foundation (BCM) to develop a strategy to improve treatment for children. By these efforts, BCM is now providing pediatric formulations to children at 25 of the NUMAT-supported sites. Another eight HIV clinics supported by NUMAT in FY2010 may not benefit from the arrangement with BCM. NUMAT will address this gap by working closely with MOH, scaling up provision of pediatric ARV formulations and strengthening ART logistics centrally and at the sites. NUMAT will also work with WHO and the AIDS Control Programme to build the capacities of health workers in the provision of pediatric ART formulations. This will increase the number of children on ART at the sites to 428 individuals in FY2010; representing almost 10% of all the HIV patients on antiretroviral therapy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	400,000	

Narrative:

The overall goal of the Northern Uganda Malaria AIDS & Tuberculosis (NUMAT) Strategic Information (SI) activities is to provide greater support to the national capacity building in the collection, management, analysis and utilization of health data. NUMAT's specific support to this mechanism falls under the following three broad areas:

1. Support to the National Health Management Information System (HMIS):

NUMAT has been supporting the HMIS through building the technical capacity of district biostatisticians to manage data collection from the lower level health units and facilitate analysis, reporting, dissemination and utilization of data. Record assistants at health facilities are also being equipped with skills and trained to extract data from service registers and enter into the HMIS summary forms—the emphasis being on HIV/AIDS, tuberculosis and malaria data. As necessary, NUMAT has also been supporting the procurement of equipment like computers and internet modems to facilitate collection, analysis, storage and timely reporting of data at district, regional and national levels. NUMAT has also supported the scale-up of the Ministry of Health-led Web Enabled HMIS system to facilitate timely reporting of data. NUMAT was part of the technical review of the newly-revised HMIS forms & data collection registers by the Ministry of Health and in the next year, will facilitate the dissemination and utilization of these in the health facilities and the districts.

This year, NUMAT will embark on a process of coaching/mentorship and intense support supervision in HMIS data management. This process is intended to be a milestone activity in building the capacity of biostatisticians & record clerks by improving their knowledge, skills, and experience in data management. As much as possible, this process will be practical and on-the-job to ensure maximum attainment of skills in data collection, detailed analysis and data utilization. This coaching will be complemented by quarterly meetings of biostatisticians aimed at discussing key topics to strengthen their capacity in the execution of their day-to-day tasks. District health officials will also be supported to monitor progress on critical health indicators, and to routinely utilize data for their planning purposes and supporting service delivery. This support will be through quarterly data review meetings to allow the sharing of practices, challenges, lessons and review of service data. In addition, NUMAT will continue providing equipment and stationary including HMIS forms to the districts to facilitate data management.
The above will all be done with and through partnership the Ministry of Health, Uganda AIDS Commission, World Health Organization and other UN agencies, the American Refugee Council, AIDS Capacity Enhancement Project and the network of People living with HIV/AIDS.

2. Surveys
LQAS & HFA: As a program, NUMAT supports the systematic collection, analysis and interpretation of data through the execution of surveys. To date, NUMAT has conducted two Lot Quality Assurance Surveys (LQAS) and one Health Facility Assessment (HFA). These are being used as rapid cost effective sampling methodologies used to measure coverage of key indicators while identifying service related gaps. Overall, over 140 participants from the nine districts have been trained on both methodologies. This coming year, NUMAT will do the same and conduct another LQAS survey and HFA.
Geographical Information System (GIS) Mapping: NUMAT will use GIS as a tool to turn data from these surveys on the location of health facilities, populations, and other variables into maps that can visually display the availability and distribution of health services in the region. This is meant to go a long way in

guiding districts and other stakeholders in the allocation and targeting of resources.

3. Monitoring and Evaluation

NUMAT's M&E strategy aims to provide reliable & quality information to satisfy the strategic needs of the district, national and also Program M&E efforts as well as our donors. NUMAT is doing this through building the technical capacity of both the district leadership and organizations to ensure sustainability into the overall national system as discussed below:

District & Grantee M&E Capacity: NUMAT has built the capacity of the districts and local organizations to design M&E plans as tools to monitor and evaluate their outputs and outcomes of their HIV & AIDS activities. To date, NUMAT has supported four out of its nine districts to develop M&E plans. This coming year, NUMAT will support the remaining five districts to develop M&E plans. NUMAT will also build the technical capacity of grantees in M&E.

Data Quality: NUMAT is constantly evaluating the quality of data reported through conducting Data Quality Assessments (DQA). This year, NUMAT will continue these assessments, in partnership with other USG partners such as USAID/Uganda Monitoring & Evaluation Management Services (UMEMS) and Monitoring and Evaluation of the Emergency Plan Project (MEEPP) project.

Data dissemination: Focused documents aimed at informing decision makers such as comprehensive reports, brochures and journal articles will continue to be produced, and meetings and workshops to discuss data will be supported. To share lessons learned and ensure exposure to practices, NUMAT will support staff and partners' participation at national, regional or international conferences. NUMAT will also organize a regional conference in Northern Uganda to share lessons learned with a variety of stakeholders

Project M&E: NUMAT as a program is routinely involved in monitoring and evaluating the implementation of its activities. The program has been engaged in conducting several evaluative studies. This year, NUMAT will continue to conduct these, to evaluate program's performance, share findings and inform strategic decision-making regarding specific programmatic areas. NUMAT will also invest in ensuring that accurate data is reported on its activities and results as per its mandate to the President's Emergency Plan for AIDS Relief (PEPFAR).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	191,139	

Narrative:

The Government of Uganda recently developed the National HIV/AIDS Strategic Plan (NSP) 2007/8-2011/12. Goal 4 of the NSP aims at building an effective system that ensures quality, equitable and timely delivery of HIV/AIDS services for all intended beneficiaries. In line with this goal, NUMAT's emphasis has been to shift the focus of HIV decision-making closer to the lowest decentralized level of government. At the district and sub-county local government level, emphasis has been on strengthening

and building the capacities of HIV/AIDS coordination structures that had hitherto been dormant due to conflict. Other forms of leadership and governance issues were supported by the project in the context of the health system as enshrined in the health sector strategic plan. The main focus was on improving the capacities and capabilities of districts to plan, manage, implement and supervise health activities at the district, health sub-district and health facility level.

Apart from working within established government structures, the program also specifically addressed leadership and governance issues within civil society organizations, especially those involved in HIV/AIDS responses. Technical assistance, training, financing and equipment were provided in order to address institutional and organizational gaps.

In terms of supporting human resources for health, the program has mainly focused on the following areas: a) partnering with health training institutions for field attachment of medical students(nurses, pharmacists, medicine and radiology students) to work in peripheral health units with in-adequate staffing; b) supporting districts to advertise, recruit and induct health workers to fill staffing gaps; c) working jointly with Capacity Project and Ministry of Health to improve staff performance and training in various aspects of HRM; d) supporting pre-service and in-service training of health workers; e) strengthening continuing professional development (CPD) of health workers; and finally f) supporting districts to set up human resources information systems for planning and decision-making on human resources for health.

Accomplishments

The program provided technical support and funding for the development of nine district plans and five district HIV/AIDS strategic plans. The funded activities were: support towards functionality of coordination structures (meetings, field monitoring and reporting); functionality of health structures at the district and health sub-district levels (in the form of monthly/quarterly meetings, support supervision and training of health unit management committees).Civil society partners were provided funding and technical support to develop their strategic and operational work-plans.

In terms of human resources for health, 187 undergraduate medical students were attracted to work in 11 health units. Their presence reduced workload for the few health workers within these facilities. Patient waiting time was reduced and demand for health services from the communities increased. Two post-graduate students from Makerere University school of Public Health were also brought in to work at the Apac district hospital. They were able to undertake operational research on malaria and their findings were used by the District Health Management Team (DHTM) for planning; 242 health workers of various cadres were recruited, inducted and deployed in three districts (Gulu, Pader and Kitgum). The program supported 26 health workers for pre-service training in a laboratory assistants course, and out of these, eight health workers have completed and 18 will complete in FY2010. The eight who have completed will

be tracked in their respective district to ensure they are re-absorbed as Laboratory assistants, a critically lacking cadre of staff in most project districts. Various in-service trainings were done for health workers in the various program areas notably PMTCT, HCT, TB, ART, RCT and Malaria. Performance improvement focusing on reproductive health and PMTCT services was undertaken in health units offering RH services in all the nine districts. The findings were disseminated in the respective districts and action plans drawn for each of the health units. Human Resource Information System (HRIS) was set in three districts (Gulu, Pader and Kitgum) and Gulu regional referral hospital. The database will be used for planning and making decisions on staff recruitment, deployment, retention and management. A number of advocacy activities were undertaken including meetings with partners such as Capacity Project, Ministry of Health, Ministry of Finance and above all, organizing a regional conference on attraction and retention of health workers in Northern Uganda that attracted stakeholders from the region and the national level.

Barriers:
Meeting the expectations and demands of the communities and the Local Government in the region given the enormous rehabilitation and development needs caused by the 20-year conflict needs a holistic approach that not only address the issues of leadership and governance but also other underlying causes of poverty. The impact of conflict is still evident in the weak government structures characterized by in adequate staffing, poor compensation, absenteeism, poor working and living conditions. Because of these needs and weaknesses the health systems and government structures still need enormous technical and financial support.
Despite the support to districts to recruit health staff, attraction of key cadres of health staff such as medical officers, Orthopedics, Public Health Nurses, Laboratory Assistants, Nursing Officers (Nursing) and Laboratory Technologists, Pharmacists and Public Health Dental staff has continued to be problematic. The lengthy and bureaucratic recruitment process does not adequately address staffing gaps within districts. Even after recruiting health workers, drop-out rates have been alarming due to delayed access to payroll, lack of housing, social amenities and inadequate supplies and equipments in most health units. Other factors include poor remuneration and cross-overs of health staff to NGOs. Inequitable and erratic transfers of health workers to areas where their skills might not be required is also cited as a case for poor retention and morale of health workers. NUMAT was not able to implement distance education due to the lengthy consultation and negotiation process for accreditation with different directorates within the Ministry of Health (MoH) and health professional bodies, not to mention that it is also a rather expensive undertaking.

Rationale for focus:
Due to inadequate capacity of the coordination structures, limited funding, low capacity of civil society organizations, duplication and multiplicity of actors, the need for ensuring effective coordination for quality, equitable and timely delivery of HIV/AIDS services is paramount in NUMAT's operational context.

And also, as populations move back to their original homes and social services such as curative and primary health care gets re-established at new and formerly abandoned health facilities, there is need to revamp community oversight structures such as health unit management committees.

HIV/AIDS response in the communities is evident by among other things the proliferation of Civil Society Organizations (CSO). Much of these CSOs are doing commendable work in HIV/AIDS prevention, care, treatment and support for their communities. Most are still organizationally and institutionally weak and hence, the need for external intervention to build their capacity and capability.

NUMAT can only effectively contribute to the achievement of Uganda National Minimum Health Care Package (UNMHCP) if the districts in which it is operating in have the required quality and quantity of health staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	382,500	

Narrative:

Injection safety and waste disposal.

In the course of provision of health services, different types of waste are generated. NUMAT will support the nine districts of Gulu, Amuru, Kitgum, Pader, Oyam , Lira, Apac, Dokolo and Amolatar to roll out training of health workers, waste handlers and community sensitization on HCWM to ensure safe and appropriate disposal of health care waste. Health workers will be encouraged to include HCWM activities during CME sessions. With these activities supported, it is expected that all health service providers will be trained in HCWM, communities will be sensitized on HCWM and there will be improvement in safe and appropriate disposal of health care waste. It is also expected that during this period, NUMAT will have built capacity of the nine districts to assess, evaluate and plan for HCWM, as well as analyze outcomes of implemented activities. In FY2009, NUMAT, with support from the MMIS project, conducted an assessment on waste management and safe injection practices in selected sites in the nine districts. In FY2010, the activities to be supported will respond to the findings of this assessment. The assessment discovered that health units are failing to cope with increasing volumes of infectious waste due to: inadequate planning, low level of awareness among health managers, poor waste segregation habits making HCWM unnecessarily expensive, and inadequate coordination especially at district level.

To address these findings, NUMAT plans to do the following.

Training of service providers:

NUMAT will facilitate training sessions of service providers in safe phlebotomy and HCWM. All the nine districts will have teams trained, which will include members of the DHT. NUMAT will support each district team to have competencies in supervising service providers, collecting data on HCWM practices, and selecting priority areas for action basing on the prevailing risks. The district teams will be responsible with support from NUMAT to train operational health workers including waste handlers. NUMAT anticipates teaming up with National trainers whose capacity has been built by MMIS to conduct the initial district level trainings.

Dissemination of HCWM policies and guidelines:
Policies and guidelines on HCWM have been developed by MoH with support from MMIS. NUMAT will support MoH to disseminate these policies and guidelines in all nine districts. NUMAT plans to utilize existing opportunities like trainings, review meetings and support supervision to have this done. At selected facilities, NUMAT will support CMEs specifically on HCWM.

Production and dissemination of educational materials on HCWM:
To support training and to enhance the health workers' understanding of HCWM, concepts like segregation and final disposal, educational materials and job aides will be reproduced and disseminated. The assumption is that these have already been developed at the national level. The job aids will be posted as reference material at all areas where waste is generated.

Supporting waste disposal:
NUMAT will support selected facilities in their waste disposal. Support will range from activities targeting waste generation reduction, waste segregation and final waste disposal. NUMAT will support selected facilities with waste bins and bin liners and personal protection equipment for those handling waste. NUMAT will also support final waste disposal. Improper final waste disposal contributes to biomedical transmission of HIV and other blood borne pathogens. Members of the community are likely to get in contact with hazardous waste if it's indiscriminately discarded in areas where it is not expected to be or is disposed of in open areas that are not restricted to the general public. In an effort to improve final waste disposal, NUMAT will work with District partners to install environmentally friendly final disposal facilities in selected facilities. Options to be installed will depend on the prevailing situations at the specific sites. The options to be supported will include waste pits and incinerators. Where incinerators will be installed NUMAT will support the training of incinerator operators.

Protection of Health workers:
In the ART supported NUMAT sites, PEP is one of the supported services though information about this service is not universally available in these sites. There are also more non ART sites supported by NUMAT where this service is not available. In FY2010 NUMAT, plans to reproduce/disseminate available

IEC materials on PEP in the supported health units. Where there is need, the various health workers will be re-oriented through CMEs. Arrangements will also be put in place for those non ART sites to have in stock ARV necessary for PEP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	500,000	

Narrative:

Incidence modeling reveals that of all new infections in adults 15-45 years in 2008, 43% were among people in discordant monogamous relationship in the past 12 months (UNAIDS Country Report 2009). NUMAT recognizes that more married couples are becoming infected with HIV and therefore the need for targeted messages aimed at enabling married couples to demystify their risk perceptions, and seek HCT, PMTCT and ART services. In FY2010, NUMAT will strengthen prevention messages among couples in monogamous relationships, support discordant couples, mobilize mothers and women for PMTCT services, and reach out to adults involved in multiple and concurrent sexual partnerships through couples seminars and men's and women's groups in both the villages and workplaces. NUMAT will also continue to work with MARPs such as CSWs, bar and lodge attendants, young women, fishing communities and others to respond to HIV/AIDS by dealing with factors that make these populations vulnerable to HIV. As per MTR recommendations, NUMAT will also expand coverage of prevention activities by training CORPs in areas of new settlements. NUMAT's interventions with adults will aim at increasing risk perception through HIV education and self-assessments, with the aim of partner reduction and utilization of risk-reduction techniques such as consistent and correct condom use and skills such as condom negotiation. In FY2010 focus will also be placed on male involvement, continuing couples seminars, and increasing access to HCT services through non-traditional outlets such as moonlight camps for MARPs.

Most at risk groups in the Lango and Acholi region comprise of commercial sex workers, fishing communities (in lango sub region), young wives clubs, drinking clubs, truck drivers, boda boda riders, women's groups and men's groups. Messages disseminated will be tailored to the BCA tool specifically adapted to address HIV prevention issues and vulnerabilities among MARPs in northern Uganda and will be used to disseminate targeted messages. Messages will emphasize partner reduction and utilization of risk-reduction techniques such as consistent and correct condom use and skills such as condom negotiation and strengthening linkages to ART, PMTCT and TB services. To strengthen message dissemination among couples, NUMAT will train 150 couple BCA. 500 couples will be reached with prevention messages integrated with HIV counseling and testing services. Eighteen HCT outreaches will be conducted through the FBOs reaching 500 couples with HIV counseling and testing services.

NUMAT underscores the importance of male involvement in responding to HIV/AIDS, and therefore

engage mobile men with money through workplaces and drinking clubs. NUMAT will try to reach adult men's groups such as truck drivers and boda boda riders with messages on partner reduction, mutual faithfulness, secondary abstinence, correct and consistent condom use and access to testing and treatment services. Fathers' unions provide a platform to reach more adult males within the community with messages on the significant role they can play in reversing the trend of infections through testing, mutual faithfulness and becoming role models to younger men. Through this intervention, NUMAT will address both poverty and wealthy as drivers of the epidemic, and alcohol and drug abuse as factors that increase the ones rick to HIV infection. Forty-five workplace meetings and 250 drinking club discussions will be conducted to reach men with HIV prevention messages with focus on multiple reduction and faithfulness.

NUMAT will strengthen prevention for occupationally based MARPs. Men and women working in the region are occupationally associated with high-risk behavior due to factors like extended time away from families, disposable income (and the associated purchasing power to engage in commercial/transactional sex), and alcohol. All of these factors influence high-risk behavior such as multiple and concurrent sexual relationships. NUMAT will engage these MARPs near their workplaces through BCAs, equip BCAs/CORPs with IEC/BCC materials, and make HCT more accessible to these groups. Occupationally-based MARPs include teachers, Uniformed Forces, Boda-Boda drivers, hotel & lodge workers, fishing communities, CSW, and others. To reach fishing communities NUMAT will facilitate "moonlight" HCT outreaches in the night to increase access to testing and treatment services for fishing communities. Targets for activities include: 300 BCAs trained among Boda Boda, Fishing communities, CSW, drinking clubs, and other adult groups to roll out HIV prevention activities among their peers; 46,800 MARPs reached with HIV prevention messages at their workplaces.

Another occupationally-related MARP group is teachers and Uniformed Forces, who also face extended deployments away from home and have income. Joint efforts with SPEAR will engage this target population in behavioral risk assessments and negotiated personalized risk-reduction plan (which include abstinence, partner reduction, correct and consistent condom use, partner testing for HIV, and other risk reducing behaviors as goals). NUMAT will also equip BCAs with condom demonstration tools so that participants can practice risk reduction skills, such as condom negotiation and correct condom use. With SPEAR, NUMAT will identify opportunities for HCT among these workers and services will be provided. NUMAT BCAs & PEs will lay the groundwork for UF and teachers to access VCT and those testing positive will be referred for wrap-around services and positive living skills. 360 teachers/ UF identified by NUMAT to be trained as BCAs by SPEAR. 56,160 UF, teachers and their families reached with HIV prevention messages by NUMAT's existing BCAs

In FY2010, NUMAT will continue to strengthen and sensitize women's groups and young women's

groups by training BCAs to reach their peers with mutual faithfulness and OP messages. Community-led dialogues for couples in monogamous relationships, clients of sex workers, persons engaged in causal sexual relationships and women groups to emphasize AB/OP messages and RH/FP will be conducted. NUMAT will strengthen mobilization of expecting mothers and women of reproductive age to access PMTCT services. Messages on benefits of HCT & PMTCT will be disseminated during the integrated work camps and community awareness campaigns Linked with Objective 1, these groups will be supported with kits that will enable them conduct official savings and credit transactions. Targets include: 117,000 women reached with Be Faithful and correct and consistent condom use messages, 60 older women groups supported to practice ASCAs/VSLAs, 14,040 young wives/mothers reached with Be Faithful & Correct and Consistent condom use messages, negotiation skills and family planning, 15 young wives/mothers clubs trained in business development skills training and in-kind support.

In FY2010, NUMAT will support MARP CORPs (BCAs/Master Trainers), other MARPs and adult groups to register as Community Based Organizations (CBOs), and train them in proposal writing, project monitoring and evaluation (linking with Objective 1: capacity building). 9 MARPs/Adults groups supported to register as Business Entities.

In FY2010, NUMAT will support the office of the DHO to distribute condoms to the health centers and equip BCAs with condom demonstration tools (dildos) to implement and support condom promotion and distribution. NUMAT will support establishment of national traditional outlets to increase access to condom supplies during non-working hours for health centres.50 non-traditional condom outlets (bars, lodges, workplaces) and 115 HCs supported to provide condoms; 300 dildos procured and distributed to the BCAs for condom education.

NUMAT will engage community leaders on prevention and response to SGBV and encourage empowering women to speak out and report instances of SGBV and ensure that those who are survivors of SGBV receive appropriate response (health, psycho social, safety/protection and legal/justice). SGBV issues integrated into NUMAT trainings on prevention, discussions, and drama and radio talk shows for the MARPs, CHATTs, Youth, PHA groups, PMTCT counselors, Village Health Teams and all other NUMAT activities. NUMAT will train 450 in basic skills as SGBV community animators in 15 sub counties.

Health workers are vital in the response to sexual and gender-based violence. NUMAT will train 70 health workers on how to respond to cases of sexual violence, provide emergency post exposure prophylaxis and document evidence that is crucial in prosecuting offenders. Health workers will also be trained in counseling and how they can integrate it into their services.

Through faith leaders, NUMAT will continue to advocate for the rights of PHA to access services and live

a life free from stigma and discrimination. PHA will be involved in service provision and advocacy activities.

NUMAT will facilitate support supervision visits by TOT every 2 months to check progress of activities and document impact. Quarterly review meetings will be supported to collect data and report. NUMAT will support the CDO to provide on-going support meetings with the MARP/Adult groups and the CORPs to ensure their participation and involvement in HIV prevention activities as one of the ways for sustaining the prevention activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	550,000	

Narrative:

Youth in Northern Uganda face high unemployment, breakdown of family and traditional structures, inadequate health facilities and have grown up in constant instability due to conflict and resettlement. These factors, as well as others make youth more likely to engage in risky behaviors such as multiple sexual partnerships, transactional sex, and drug and alcohol abuse, making them at-risk for HIV/AIDS. In PY3, NUMAT youth prevention activities focused on strengthening existing structures to support HIV prevention at community level. Youth prevention approaches include integrated prevention for young positives, advocacy against SGBV, addressing alcohol and drug abuse, supporting young people with disabilities in accessing HIV information and services, and strengthening linkages to HCT, ART, PMTCT, malaria and TB services, as well as youth-friendly RH and STI services. The target group is comprised of both male and females aged 10-24 years. The youth in higher institutions of learning are associated with many risk factors and drivers of the epidemic like casual sex, transactional sex, and multiple concurrent sexual partners. The out of school youth are involved in drug and substance abuse, they are unemployed, some are heading child families, the returnees have been sexually abused, casual and transactional sex is one of their characteristics with many being forced into early marriages. The young positives have long suffered psychological trauma, stigma and discrimination, they have been orphaned, and many have dropped out of school and are faced with challenges of adherences to ART

In FY2010, NUMAT prevention activities will focus on strengthening community structures and building capacities of youth Community Resource Persons (CORPS) as an exit strategy to ensure sustainability. Furthermore, NUMAT will also build on the innovative new program started in PY3 of reaching out to young HIV-positive students and teachers in collaboration with SPEAR, and also begin outreach to students in university/tertiary institutions.

University students, both male and female, are a risk group engaged in casual sex, transactional sex and

multiple partnerships. Such behaviors render these young people vulnerable to HIV infection. NUMAT will train selected students as peer educators (PEs) to share risk reduction information with their friends and classmates. Therefore, in FY2010, NUMAT will train students as PEs using the MOH-standardized Peer Education Manual to offer information and services on issues of sexual and reproductive health in universities and tertiary institutions. NUMAT will work in collaboration with Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICCAL) for purposes of sustainability. This will serve as an avenue to advocate for municipalities' inclusion of universities/tertiary institutions into their HIV/AIDS response plans. Targets include:180 peer educators trained in 6 universities and colleges, 120 peer learning sessions conducted to reach 6000 students with AB and OP messages, and1000 students tested for HIV & supported appropriately for continuity of care.

In FY2010, NUMAT will continue to partner with YEAH to train existing Master Trainers and PEs in value-added skills such as the YEAH curriculum (incorporating topics such as PMTCT, malaria and TB prevention) and ARK (Abstinence and Risk Avoidance) supplemental materials (which address higher risk behaviors for youth and young adults including multiple concurrent partnerships, inter-generational sex, transactional sex, gender-based violence, drug and alcohol abuse, as well as risk reduction strategies such as condom use and male circumcision).YEAH and ARK programs are specifically tailored to meet the health needs and aspirations of both sexually active and not-yet sexually active out-of-school youth age 15-24 years. In PY3 300 peer educators receive updated training for risk reduction and value-added skills. In PY4, NUMAT will support these resource persons to reach their peers with life planning skills as part of AB & OP. Targets include: 90, 000 out-of-school youth reached with AB or OP messages; using the sports and recreation the 18 sports tournaments for out-of-school youth conducted; 72 focus group discussions (25 or less people per FGD) conducted during tournaments, benefiting 1800 out-of-school youth.

In FY2010, NUMAT will support existing 'Young Positives' clubs, ensure enrolment and retention of young positives in schools and provide access to community-based services for positive living, such as counseling, nutrition and referral to young persons living with HIV/AIDS. So far, 9 post test clubs have been established (1 per district).

YAGs, SACs and PAGs are at various life-stages of self-functionality and thus, in PY4, NUMAT will continue to strengthen these established groups so they can sustainably conduct youth prevention & stakeholder coordination. Having had their inter-generational communication skills built, teams of these trained PAG and YAG members will be equipped to lead Parent-to-Youth and Common Ground Melting Pot meetings. Targets include: 1890 PAG members will be trained (210 per district) and 540 dialogue meetings held (270 youth-youth and 270 parent-youth)

Common Ground Melting Pot (CGMP) meetings are the culmination of the series of dialogue meetings occurring within a community (including the above mentioned dialogue meetings), where groups of parents and youth have been meeting and documenting issues of concern that they would like to address in a safe, mediated forum such as a CGMP. At these meetings, the groups aim to reach consensus on unresolved and controversial issues and chart the way forward on how to handle them . Thus, this forum is often used as an opportunity to address socio-cultural issues, such as norms which negatively affect youth behaviour. As such, these meetings often invite an expert from the community such as a Legal Advocate, faith leader, or Probation or Gender Officer to support the trained facilitation team. Targets include: 90 common ground meetings will be facilitated.

NUMAT will support YAGs and PAGS to work with local institutions to conduct holiday youth camps. These activities are aimed at equipping young people with correct information so they can make informed and responsible decisions. Through AIC, on-site HCT is available at these camps. Targets include: Eighteen integrated youth camps will be conducted reaching 1800 young people with HIV testing and counseling services and 3600 youth reached with messages.

NUMAT will also continue to work with out-of-school drama groups to stage HIV/AIDS prevention theatre productions. Targets include: 240 interactive drama shows/outreach and 12 radio talk shows supported reaching 12,000 young people; NUMAT will partner with NUTI to disseminate messages to out-of-school youth groups; 10,000 IEC materials will be adapted, printed and disseminated.

In FY2010, NUMAT will train teachers in essential support for young positive students including psychosocial support and coping mechanisms, creating a conducive learning environment, increasing enrolment and retention of young positive students, improving school-based services such as counseling and nutrition, helping young positives to understand their status and work towards achieving their dreams and ambitions.10 HIV anti stigma trainings will conducted reaching 300 PHA Leaders/teachers who will in turn reach.500 young positives in schools will be linked to Baylor-Uganda to provide pediatric HIV/AIDS care & treatment and other wrap-around services.

Sexual prevention activities will be integrated and linked to other services. During integrated HCT work camps small group discussions for young people are carried out with the aim of motivating them have an HIV test. Young positives are linked to PHA networks where they are educated on use of condoms; in palliative care, use of condoms is emphasized. During training of PHA, abstinence, faithfulness and use of condoms messages to reduce re-infection are emphasized. Condom use is part of the BCP package for PHAs. Under PMTCT for young pregnant mothers and their partners, condom education is essential. At the ART sites, young positives are educated on safer sexual practices to avoid re-infection. The TB campaign in decreasing the burden of TB in HIV patients revolves around the preventative message

under the ABC strategy. The integration of malaria lies in the IEC, BCC strategy like use of nets, early treatment and use of VHTs to provide information on malaria and HIV prevention

Promotion of quality assurance will be done through routine support supervision, link CORPS to the local governments and institutions, Quarterly review meetings and technical assistance to CORPS , M&E trainings and documentation of case studies. At various youth meetings, NUMAT will invite an expert from the community such as a Legal Advocate, faith leader, or Probation or Gender Officer to support the trained facilitation team.

The monitoring and evaluation plan will include the Quarterly review meetings, documentation and validation exercises, and special studies to assess impact and technical dissemination forums. NUMAT will continue to strengthen these established groups so they can sustainably conduct youth prevention & stakeholder coordination. This supervision will take the form of increased spot-visits at events and the presence of NUMAT Specialists, DTO's, as well as members of the SAC, at monthly meetings. NUMAT in collaboration with ADCO will review and strengthen the youth group capacity to plan, document and capture data and also provide TA to this group and also help to link them to the village health teams (VHTs) to ensure continuity beyond NUMAT project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	838,000	

Narrative:

In FY2009, NUMAT PMTCT support in Northern Uganda, which is district wide, increased to 100 PMTCT sites from 80. This scale-up helped increase geographical access to PMTCT services in the 9 districts. The NUMAT support was mainly through the provision of Technical Assistance (TA). The TA was in the form of support supervision to the sites where NUMAT partners with MOH to conduct bi-annual visits to the sites. Through the supervision visits, health workers were oriented on the new PMTCT national guidelines to ensure adherence to standards, mentored on the use of the standard operating procedures (SOPs) and use of logistical management information systems (LMIS).

In FY2010, this support will continue and will be done at 3 levels:
1) Central-led support supervision: This will still be an MOH led activity, conducted bi-annually, which will involve other partners/NGOs involved in PMTCT service provision in Northern Uganda and regional and district supervisors. During this exercise, the MOH team mentors district supervision teams. This team will also provide mentorship to newly recruited staff and will kick-start new PMTCT sites.
2) District-led support supervision: This will be conducted on quarterly basis and will follow up on issues raised by the central (MOH) team. It will be conducted by the district supervisors.

3) HSD-led support supervision: This will be conducted on monthly basis by the HSD team, concentrating on PMTCT site specific issues that are raised by the national and the district supervision teams.

Following the centrally-led supervision, NUMAT will have bi-annual coordination meetings which are used to disseminate the supervision findings and draw action plans for each of the stakeholders with feasible recommendations. NUMAT also continues to enhance capacity building through trainings of health workers. In FY2009, NUMAT conducted several trainings of health workers on different aspects of PMTCT: Orientation of 319 health workers on the new PMTCT policy guidelines; 580 health workers trained in early infant diagnosis (EID); 88 health workers trained in the implementation of the family support groups so that HIV+ mothers and their families are offered psychosocial support; 40 health workers trained in infant and young child feeding counseling and 40 trained as PMTCT counselors. In FY2010, the program will concentrate on job mentoring of health workers. Trainings will specifically target the newly-recruited staffs and those from the newly accredited PMTCT sites.

In FY2010, NUMAT will continue to scale up PMTCT services through partnerships with sub-grantees. In the districts of Kitgum and Pader, NUMAT will yet again work through partnership with AVSI to scale up PMTCT services to reach 19 sites in the two districts. The program also intends to have more sub-grantees for the districts of Gulu and Amuru.

Previously through the direct district grants, health sub-districts were able carry out PMTCT outreaches to the internally displaced people (IDP) camps and the lower health facilities. The situation in the region has normalized and majority of the people have returned to their homes, however these are usually far from health facilities. Putting this into consideration, NUMAT will intensify support for integrated PMTCT outreaches from hospitals, and health sub-districts to lower health facilities mainly targeting the returning and far away communities.

In FY2010, emphasis will again be put on supporting the sites and districts in supply chain management using the "pull system" so that health facilities are able to get supplies from the national medical stores/ MOH. Additionally, NUMAT will procure ARV drugs for PMTCT prophylaxis which will help as buffer stocks to sites experiencing shortages and stock-outs. The ARV drugs will be Nevirapine tablets and Syrup, Zidovudine and Lamivudine (Combivir), Zidovudine Syrup, and Zidovudine Tablets. Emphasis will again be put on supporting the sites and Districts in supply chain management using the "pull system". The buffer stocks will take care of un-foreseeable circumstances like delays in delivery resulting in stock-outs.

In FY2009, IEC/BCC materials were produced and distributed to the PMTCT sites. Also, health equipment in form of video/television sets and tapes for PMTCT sites were procured and distributed to PMTCT sites and as a result, 15 sites got generators, 30 sites got T.V sets and 31 sites received Video decks. PMTCT talk shows on Radio Wa and Mega FM were carried out.

To further increase demand and therefore access for PMTCT, in FY2010 NUMAT will again work with MOH and AIC to review and translate IEC/BCC materials on male involvement in PMTCT, benefits of

PMTCT, infant feeding and early infant diagnosis. These will be distributed to the health facilities and the communities. In addition, the program will strengthen radio talk shows on weekly basis and these will focus on PMTCT related issues among other areas. Moreover, the program will again procure health education equipment in form of T.V. screens, video decks and tapes to be used in the PMTCT setting to educate mothers and their spouses for the regional hospitals and the district hospitals of Anaka in Amuru and Apac in Apac.

Through FY2009, NUMAT has supported a cumulative total of 45 family support groups (FSGs) according to MOH guidelines. The FSG groups helped mothers, their partners and their infants access and adhere to ARV and infant feeding regimens. Over 1000 pregnant women were able to access psycho-social support through the FSG and 800 babies followed up. The members were also linked to 'wrap-around' services such as home-based care, family planning, food and nutrition support.

The program will, in FY2010, strengthen psycho-social support to the HIV+ pregnant mothers, and their spouses, identified in a PMTCT setting through the FSGs. Through the FSG, where HIV+ mothers will be able to meet twice a month, and a continuum of services will be offered; health education, ART adherence counseling, EID for the exposed infants, WHO clinical staging, and linkage to prevention and treatment services.

In FY2009, NUMAT supported early infant diagnosis (EID) in the 9 districts. A total of 580 health workers from 7 districts were, in partnership with MOH, oriented in EID. This is in addition to the 230 who had trained in FY2008 in the two districts of Apac and Amuru. Consequently 80% of the PMTCT sites are now able to offer EID service. As a result of this support, a total of 4,321 DBS samples from HIV exposed babies were tested of which 382 (11%) were positive. Those who tested positive were linked to care and treatment services.

In FY2010, NUMAT will work with MOH to ensure functional EID services in all the PMTCT sites. The program will also facilitate the district laboratory focal persons of the respective districts, twice a month, to collect the dry blood spots (DBS) samples from the health facilities and transport them to the regional laboratory for PCR testing. The DLFPs will in turn take the results back to the sites. Trained health workers will be followed up through support supervision.

In FY2009, efforts were made to strengthen PMTCT-ART linkages mainly in the areas of septrin prophylaxis, CD4 testing, WHO clinical staging and HAART initiation for eligible HIV positive pregnant women. NUMAT was able to carry out CME at the sites in this aspect.

In FY2010, the PMTCT –ART linkages will further be strengthened in all NUMAT supported ART sites. NUMAT will procure infection control materials for the PMTCT sites to be used in MCH/ reproductive health set up i.e. Antenatal care clinic, labor and delivery and the post natal clinic. These are Gloves (surgical and disposables), Jik, Aprons, face masks, Gumboots, caps, Mackintosh, Buckets and soap. The project will reproduce, and distribute to the facilities, the MOH reproductive health integrated registers (ANC, maternity, and the PNC) to be used as data tools. Additionally, all the reporting and the logistical management tool are to be reproduced and distributed to the facilities. Upon distribution, Health

workers are to be mentored on the use of the tools. The program will also produce the SOPs to aide the health workers adhere to the standards according to national guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	300,000	

Narrative:

The NUMAT project, which is being implemented in the sub-regions of Acholi and Lango, covers nine districts in the post-conflict region of Northern Uganda with an overall goal of expanding access to and utilization of HIV, TB and malaria prevention, treatment, care and support activities in Northern Uganda. With the relative return of peace in the region, most of the populations have returned to their homes. The districts have re-opened health facilities closer to the homes of the returning populations that were closed due to insurgency. NUMAT is working within the existing health structure and, in collaboration with other partners in the region, will continue supporting delivery of quality laboratory services to populations both in the peripheral camps and to those who have returned home. Laboratory services are central in the diagnosis, management and prevention of HIV/AIDS, TB and malaria.

Accomplishments since COP 09:

In FY09, NUMAT completed refurbishment of 12 laboratories at HC III in the districts of Amuru, Gulu, Dokolo and Amolatar, and is in the process of procuring refurbishment services for 16 laboratories in the districts of Apac, Lira, Oyam, Pader and Kitgum, and Dokolo HCIV. Following an in-service training curriculum developed by NUMAT in conjunction with the Ministry of Health and other partners, the project provided refresher training to 49 (cumulative total of 133) practicing laboratory personnel on tests for diagnosis and management of HIV/AIDS/TB and malaria, Disease Surveillance and Laboratory Management; 60 clinicians were re-oriented on rational utilization of laboratory services; twenty six (26) students from the project districts were sponsored for a two-year Laboratory Assistants' course in various laboratory training schools of whom eight sat for end-of-course national examinations; select equipment such as microscopes, manual centrifuges, refrigerators, colorimeters, water filters, microlitre pipettes, counting chambers, tally counters were provided to a total 59 health facilities based on needs; a total of 93 health unit laboratories were visited and 171 laboratory personnel supervised by District Laboratory Focal Persons (DLFPs), national trainers/supervisors and Central Public Health Laboratories (CPHL) staff. Laminated Standard Operating Procedures (SOPs) were provided to 75 health facilities laboratories. Making Medical Injections Safer (MMIS), Ministry of Health and NUMAT trained 159 District Health Team members and health unit in-charges from the districts of Oyam, Amuru, Gulu, Dokolo and Amolatar on Health Care Waste Management, planning and budgeting for HCWM activities. Colour coded bins and bin linners were procured for 74 health facilities. To disseminate innovative approaches;

an abstract "Quality assurance in scaling up of HIV testing using rapid tests, NUMAT'S experience was presented as a poster during the HIV Implementers Meeting in Windhoek, Namibia.

Challenges in FY 09:
• Stock-outs of laboratory supplies such as reagents, test kits, specimen containers, specimen packaging materials at the facilities.
• Inadequate health facility staffing at both clinical and laboratory levels and yet the demand for services is ever increasing.
• Increase in the costs for refurbishment – prices of fuel, steel products went up; the scope of works therefore had to be scaled down to fit within the budget.
• Weak system of equipment maintenance and repair
Ministry of Health with partners and stakeholders finalized the National Laboratory Policy during FY 09 and a three year Strategic Plan for laboratory services is being drawn.
In FY 2010, working in line with the National Laboratory Policy and strategic plan, NUMAT will continue building on the achievements gained through the joined efforts of partners and agencies supporting the laboratory sector in the region and nationally. The central role of districts in implementation of activities to ensure ownership and sustainability will be emphasized. Activities will be directed at further improving the capacity and quality of the laboratory services in the diagnosis and management of HIV, TB, malaria, Opportunistic Infections associated with HIV infection, other Sexually Transmitted Infections; strengthening specimen/patient referral for specialized tests. Laboratory Information Systems and Supply Chain Management Services that form the core for planning for laboratory services will also be emphasized. Support will be targeting 95 health facility laboratories (HCIII through to hospitals) in the region. The main activities will be:
1. Renovating infrastructure of laboratories and counseling rooms to meet the minimum standards set by Ministry of Health. The laboratories to be refurbished are closer to the resettling communities. This will reduce distances traveled by the population to access laboratory services and also increase the population served. The laboratories to be refurbished were selected by the districts authorities and NUMAT following a logical assessment of where the most need was. REDACTED. NUMAT will provide select supplementary equipment and supplies, required in the provision of laboratory services for the management of HIV, TB, malaria, OI's, STIs based on the gaps identified during performance monitoring visits. The equipment will include but not be limited to Microscopes, Autoclaves, Counting chambers, Cool boxes, accessories, spare parts and supplies. Working closely with the ministry of health, partners and stakeholders, NUMAT will strengthen capacity for equipment maintenance and repair (training and mentorship).
2. Training - 30 laboratory staff with formal training that are yet to receive refresher training will undergo a two-week in-service training in HIV rapid tests, sputum smears microscopy, total and differential white blood cell counting, hemoglobin estimation, blood smear examination for malaria parasites and other

haemoparasites, diagnosis of other opportunistic infections common in HIV/AIDS, Laboratory management and Laboratory disease surveillance. The training will follow an in-service training curriculum that was developed by NUMAT, Ministry of Health and other partners. Laboratory service providers without formal laboratory training (Microscopists) continue providing laboratory services with minimal supervision due to shortage of laboratory personnel. NUMAT will support a specially tailored training to 35 microscopists currently providing services in the region. One hundred (100) clinicians will receive re-orientation in best practices in utilization of laboratory services, this activity will be conducted by the trainers in the districts. In line with the Ministry of Health's Human Resource Development strategy of increasing availability of qualified laboratory personnel at the health facilities, NUMAT will continue sponsorship of the 18 students in the laboratory training school and also follow up with the districts the deployment of the eight that completed the Laboratory Assistants' course. Laboratories are a big source of health waste. NUMAT project will assist districts in rolling out trainings for all health workers and waste handlers, while conducting community sensitization on health care waste management.
3. Quality Assurance – The training will be followed by support supervision visits during which mentorship, quality control activities, re-checking of stored slides/samples and on-site training will be conducted. A team of trainers/supervisors from the ministry of health will be facilitated to conduct quarterly supportive supervision for all laboratory service providers in the project districts. District Laboratory Focal Persons are part of the team of supervisors to further strengthen their supervisory skills. Examined stored slides and samples will be re-read during support supervision and a proportion taken to a reference laboratory for re-reading as part of quality control. Proficiency panels (samples/slides of known results) will be given to participating laboratories to read and immediate feedback provided. Staff from CPHL will be trained to supervise, mentor and provide on-the-job training for DLFPs bi-annually to strengthen their competencies to manage laboratory services in the districts. Laboratory management that includes data management, supply chain management; report writing and dissemination will remain the areas of focus. DLFPs will be facilitated to conduct supervision in the district every two months.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	593,922	

Narrative:

TB/HIV (HVTB)

NUMAT supported the nine districts in the north zone to continue strengthening TB management using community-based directly observed treatment short course (CB-DOTS). TB/HIV collaborative activities were supported to decrease the burden of TB in PHAs and decrease the burden of HIV in TB patients.

Partly as a result of NUMAT's support to CB-DOTS and TB/HIV activities, 2008 NTLP report the North

Zone surpassed national and WHO recommended target of case detection rate of 70% by achieving a case detection rate of 75.6% but the 85% treatment success rate target was slightly missed as the zone achieved a treatment success rate of 84.9%. For TB/HIV collaborative activities, 83.7% of all TB patients were counseled for HIV testing while 59.1% were tested for HIV. And 54.6% were HIV-positive of which 78% were put on septrin and 19.5% were put on ART.

CB-DOTS

Community-based TB care using the community based directly observed therapy-short course (CB-DOTS) strategy was adopted by the Uganda's ministry of health as the best way to control and treat tuberculosis.

In this strategy, the sub county health worker (SCHW) links the health facility to the community where the TB patient lives.

NUMAT will continue to work towards improving and maintaining the case detection and treatment success by supporting activities that will empower the community and TB patients to get involved in TB activities in all sub-counties. CB-DOTS will be strengthened at facility and community levels through training of community members and health workers including the prisons, army and police health workers in all the districts. NUMAT will continue to support volunteers for CB-DOTS through the transportation of drugs and other logistics from the health centers to the community volunteers by sub county health workers (SCHWS), supporting their supervision and logistical support by SCHWS, health sub district TB focal persons (HSD TB FPs), district TB and leprosy supervisors (DTLS) and zonal TB and leprosy supervisor (ZTLS).

NUMAT will continue supporting the districts to provide sub-county health workers with allowances and other logistics to conduct support supervision and take TB drugs and other logistics to the community or family volunteers.

District TB and Leprosy Supervisors (DTLS) together with health sub district TB focal persons (HSD TB-FPs) will continue to be supported to conduct support supervision to the SCHWs and community volunteers on a monthly basis. These district officers will be facilitated with allowances and transport to reach the SCHWs. The clients together with the care givers are advised on sputum follow-ups at months two, five and eight. This is essential on improving treatment success rate and hence controlling development of MDR TB. NUMAT will continue supporting the districts and NTLP to contribute to the control of MDR by:

• Intensified case finding through improved laboratory coverage and increasing TB and TB/HIV awareness through IEC/BCC messages.

• Proper treatment of TB by improving CB-DOTS coverage so as to increase treatment success rate.

• Supporting the districts and NTLP in diagnosis and treatment of MDR.

• Support the transportation of sputum samples from the districts to the NTLP reference Laboratory for Culture and Sensitivity tests.

• Support the district and NTLP in transportation of patients to Mulago National Referral Hospital.

The ZTLS will be facilitated to conduct support supervision to the District TB and Leprosy supervisors (DTLS) and health sub district TB focal persons (HSD TB-FPs) in the nine districts. Support will mainly include travel allowances, stationery and other supplies to effectively run the zonal office.
NUMAT will also support four quarterly TB zonal meetings to discuss TB and TB/HIV implementation in the region.
TB/HIV Collaborative Activities:
TB/HIV collaborative activities will continue to be supported as per the National policy guidelines for TB/HIV collaborative activities in Uganda. The supported activities will revolve around the three areas of:
• Establishing mechanisms for sharing information and collaboration
• Decrease the burden of TB in people living with HIV/AIDS
• Decrease the burden of HIV in TB patients

During FY09 a total of 118 Health workers were trained in TB/HIV collaborative activities including being able to screen HIV patients for TB and provide TB treatment to HIV-infected individuals plus infection control measures. These health workers will be able to counsel and test TB patients for HIV and provide HIV and TB treatment plus infection control according to national guidelines.
In addition, NUMAT supported the dissemination of TB/HIV policy and communication strategy guidelines to district stakeholders in the nine districts. Lower level dissemination to sub counties was done in five of the nine districts.

Coordination across Partners:
NUMAT has been collaborating with the ministry of health from the national level to the health facility level through National TB and Leprosy Programme (NTLP), AIDS Control Programme (ACP), the zonal TB and leprosy supervisor (ZTLS), the district health officers (DHOs), health facility workers and the community through SCHWs. Collaboration with other partners involved in TB control such as WHO, AIC, HCP, MC, ICRC , PHA fora, the uniformed group (Army, Police and prisons) etc has been taking place through planning meetings, trainings and implementation. This has contributed to the combined effort towards TB and TB/HIV control activities.
NUMAT will continue to engage in activities that support collaboration with other stake holders involved in TB control activities. This will be at the National, Zonal, District, Facility and community levels.
During FY10, NUMAT will provide technical assistance and funding for quarterly meetings at the health sub-district level for review and planning of collaborative activities including data management and referral issues. Participants for these planning meetings will include those in charge of the TB treatment facilities and the HSD, as well as the HSD TB and HIV focal persons and the sub county health workers.

In supporting IEC/BCC activities, NUMAT will continue working with the districts through the IEC/BCC working groups, NTLP, WHO and HCP. The focus for IEC/BCC materials will be infection control both to the communities and health facilities. NUMAT will continue to work with religious leaders and preachers to include TB and TB/HIV control messages in their programs.

Human Resource Capacity and Sustainability:
During FY09, NUMAT trained 80 newly recruited health workers on CB-DOTS in all the districts. During FY10, no health workers will be trained on CB-DOTS and instead the focus will now be on training on TB/HIV collaborative activities and infection control.

In addition in FY10, NUMAT will continue supporting training/sensitization of volunteers in TB control and care. These volunteers are village health team (VHT) members will be sensitized on TB and TB/HIV co-infection control using CB-DOTS strategy and infection control measures. The same volunteers have been and will continue to be crucial for successful implementation of other program areas including ART adherence, malaria control and home based care activities

Monitoring and Evaluation:
NUMAT staff, in collaboration with the ZTLS and respective DTLS, have been providing technical assistance on records management, data collection and reporting to district staff in sites rendering TB/HIV services .The DTLS's and HSD TB focal persons were supported on a quarterly basis to collect and analyze TB and TB/HIV data using the national TB and leprosy quarterly reporting forms so as to improve data quality and reporting time.
During FY10 NUMAT will continue supporting the districts in record management by mentoring the district staff in data collection, recording and reporting. The project in collaboration with NTLP will continue providing registers, referral slips and other materials as needed. At the end of each quarter, NUMAT will support TB/HIV planning meetings from the health sub district level through district and zonal levels up to the national level. At every level, the recorded data on the input and out put indicators are reviewed against the set objectives and targets. It is at the zonal level that NUMAT gets the analyzed data to report on. This information is the same as the zonal TB and leprosy supervisor reports to the national program in the MOH. All revised TB/HIV and TB indicators are being catered for and NUMAT will be reporting on them during each reporting time.
In order to continue getting credible and early information, NUMAT will continue facilitating all the districts' TB and leprosy Supervisors (DTLS) and HSD TB focal persons with allowances and fuel to quickly collect TB/HIV quarterly data during the first week of the next quarter to minimize delays in reporting

Accomplishments in FY09: NUMAT supported TB management using community-based directly observed therapy-short course (CB-DOTS) in all NUMAT 9 districts. This was through the following ways: • Supporting the sub county health workers to carry out CB-DOTS activities. The SCHWs were supported by giving them bicycles and allowance to facilitate them do CB-DOTS activities which include taking drugs from the health facility to the community volunteers who observe patients taking drugs. Also the SCHWs are important in mobilizing the community to select the volunteers for the patients. They also supervise the treatment and advise both the volunteers and the patients on sputum follow ups. • NUMAT technically and logistically supported the ZTLS and all the district TB and leprosy supervisors together with HSD TB focal persons to carry out support supervision to the sub county health workers. • Supporting the TB Zonal office to distribute TB drugs, reagents and other supplies. The ZTLS was supported to distribute drugs to the districts. This was mainly by directly involving NUMAT district drivers to help deliver drugs faster in the districts which ensured a continuous drug supply to the districts except for a short time when the country had no Anti TB drugs. • Proper education messages through IEC/BCC working groups. NUMAT supported dissemination of health education messages on control of TB using CB-DOTS and TB/HIV collaborative activities. The messages were disseminated by the technical people in the IEC/BCC working group. • Also supported TB/HIV collaborative activities whereby a total of 118 Health workers were trained in TB/HIV collaborative activities including being able to screen HIV patients for TB and provide TB treatment to HIV-infected individuals plus infection control measures. • NUMAT supported the dissemination of TB/HIV policy and communication strategy guidelines to the districts' TB/HIV stakeholders. The dissemination of the guidelines to the lower structures in the district down to the sub county level was supported by NUMAT in the districts of Lira, Dokolo, Amolatar, Amuru and Oyam.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9334	**Mechanism Name: Roads to a Healthy Future/ROADS II-SafeTStop Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,010,000	
Funding Source	**Funding Amount**
GHCS (State)	2,010,000

Sub Partner Name(s)

BUSIA LIW CLUSTER (BAMACODA + 3 CBOS)	BUSIA OVC CLUSTER (BWOA + 8 CBOS)	BUSIA PLHA CLUSTER (FOCREV + 6 CBOS)
BUSIA YOUTH CLUSTER (URCS + 8 CBOS)	Dai Welfare Society	Howard University/PACE Center
JHPIEGO	Johns Hopkins University Center for Communication Programs	KATUNA LIW CLUSTER (KBTG + 14 CBOS)
KATUNA PLHA CLUSTER (KPSG + 3 CBOS)	Katuna Youth	KOBOKO LIW CLUSTER (KUWA + 6 CBOS)
KOBOKO PLHA CLUSTER (FECHA-K + 7 CBOS)	KOBOKO YOUTH CLUSTER (KOYID + 6 CBOS)	MALABA LIW CLUSTER (MAKACODA + 4 CBOS)
MALABA PLHA CUSTER (TONASO + 4 CBOS)	MALABA YOUTH CLUSTER (FASNET + 9 CBOS)	North Star Foundation
PATH	Solidarity Centre	Voice for Humanity

Overview Narrative

Despite important gains in health and development in Uganda, gaps in HIV and AIDS services persist in many settings. Poor communities along Uganda's major transport corridors, including border towns, are particularly underserved with prevention, care, support and treatment services. Morbidity and mortality rates tend to be relatively high in these communities, where HIV prevalence is often significantly higher than national estimates. The combination of poverty, concentration of transient workers, preponderance of multiple concurrent partnerships (MCP), heavy alcohol consumption, widespread sexual and gender-based violence (SGBV), and poor access to health services create an environment of elevated risk. These communities remain, in effect, incubators of HIV, driving HIV transmission in areas well beyond their geographic location.

The Roads to a Healthy Future (ROADS II) Project—a five-year Leader With Associate award managed by Family Health International and funded by the U.S. Agency for International Development (USAID)—extends HIV prevention, care and support services to most-at-risk populations in these underserved, often remote communities. The project currently works in four Ugandan corridor communities, Busia, Katuna,

Koboko and Malaba, with plans to establish an additional site in FY 2010 (pending available funding) based on team assessments to be conducted in September 2009.

Like ROADS I, ROADS II utilizes the cluster community organizing model, which maximizes program reach by expanding participation and collective action of small, sustainable, indigenous volunteer groups with similar focus and interests. Through 11 clusters, ROADS is building the capacity of 65 such groups in Uganda with a combined membership of more than 10,767. Project partners implement HIV and AIDS prevention, care and support programming of their own design, and are introducing such wrap-around programming as community-based alcohol counseling and interventions to address SGBV (based on Busia and Malaba innovations).

In addition to skills-building in these areas, ROADS II strengthens skills in monitoring and evaluation, program and financial management, leadership, conflict resolution and governance. To raise the visibility of clusters and signal availability of quality services, including those provided through private drug shops and pharmacies, ROADS II continues to socially market the SafeTStop concept, which uses consistent but adapted strategies, branding and materials across countries.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	400,000
Food and Nutrition: Commodities	175,000
Food and Nutrition: Policy, Tools, and Service Delivery	30,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9334**		
Mechanism Name:	**Roads to a Healthy Future/ROADS II-SafeTStop Project**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HBHC	400,000	

Narrative:

Target populations: 1) PLHIV (all ages); 2) family members of PLHIV (all ages); 3) PLHIV caregivers (15+). Promoting gender equity and male involvement cut across all ROAD II program elements.

Program description: With COP FY 2010 funds (programming year 2011), ROADS II/Uganda will expand HBHC in existing SafeTStop sites (Busia, Katuna, Koboko, Malaba, and another TBD in FY 2010), plus at least one additional site to be established in FY 2011 if funds are available. ROADS II will reach 3,330 eligible adults and children with a minimum of one care service (Next Generation Indicator C1.1.D). The basis for programming will be existing ROADS mapping, assessments and evaluations plus new participatory assessments to be conducted in FY 2010. ROADS II/Uganda will link with a range of partners in the outreach and bi-directional referral system, including CBOs, FBOs, NGOs, government and private businesses, to ensure PLHIV and their families can access all needed services, including FP/RH, malaria, MCH and TB.
With the MOH, ROADS II will ensure that sufficient numbers of community and para-social health workers are trained in comprehensive HIV management with skills to address palliative and terminal care at the household level. Services of HBHC workers will include prevention for positives, including distribution of condoms and demonstration of correct use. ROADS II will provide appropriate home-based care kits including gloves, cotton wool, disinfectant, and basic medicines to enable them perform their work; ROADS II will also provide PLHIV a Basic Care Package including a water vessel, CTX prophylaxis (prescribed and received), long-lasting insecticide-treated net, water purification tablets, liniment, pain medication, condoms, filter cloth, multi-vitamins, de-wormers, disinfectants, cotton wool, gloves, etc. ROADS II will utilize a non-monetary incentive package that includes a bicycle, identifying clothing, and such professional development opportunities as advanced training, exchange visits and references.

ROADS II will provide counseling and spiritual care by training community volunteers as psychosocial support counselors. The PSS counselors will be selected from the existing HBHC workers that have already undergone training on all other aspects of care. The PSS counselors, some of whom are trained in child counseling, will be given further training in trauma identification and counseling, especially for children, and thus be able to provide emotional and spiritual counseling. The PSS counselors will hold sessions with their clients on a regular basis at household level to help them deal with bereavement, and provide end-of-life care to the client and family when needed. They will also assist them to cope with issues around stigma and discrimination, counsel them on positive living, and offer spiritual support.

ROADS II will work with PLHIV "clusters" at each site to enhance LifeWorks Partnership Trust economic strengthening strategies for PLHIV, their family members and caregivers. This will build on food-security strategies introduce by ROADS II/Uganda in FY 2010. Through a demonstration farm in Busia (to be

established in FY 2010), ROADS II will ensure PLHIV and dependents have access to nutritious food. Food/nutrition support will be targeted to stage of disease, particularly for those on antiretroviral therapy. PLHIV and family members who receive support will also be provided skills in modern agricultural techniques that they can use at home. All PLHIV in the program will have the opportunity to participate in support groups in their area, focusing on positive living. Social support services will also include shelter, protection, and access to health services.

ROADS II will continue upgrading pharmacy/drug shop providers' skills in palliative care, including counseling on OIs and ART, including adherence. The project will integrate alcohol counseling and treatment options for PLHIV, particularly ART patients, linking alcohol counseling groups with public health facilities.

Recognizing the importance of proper monitoring and evaluation, ROADS II will engage the HBHC workers at the lowest level of care (household) to provide weekly reports to their supervisors. Monthly assessments of PLHIV by health workers will be essential to ensure care received by clients is indeed what they need. Healthy facility staff will meet quarterly with HBHC workers to discuss progress and address barriers to effective care at the household level. Cluster and ROADS II Site Coordinators will compile the data collected weekly to produce a monthly report that will inform on progress and provide information on how to improve current programming. ROADS II will also conduct quarterly program reviews to assess the effectiveness of the program, particularly the outreach and bi-direction referral system. Annual evaluations will be conducted to assess the impact of the program.

The main oversight structures at the site level are the Cluster Steering Committees, which include representatives from all groups belonging to respective clusters. Steering committee members communicate routinely with the ROADS Site Coordinators and meet formally once per month. At the monthly meetings, the Committees and Site Coordinators review monthly data reports against targets, ensure activities are on track and focused on agreed target audiences, identify programming impediments, and resolve issues in a timely manner. The Site Coordinators report directly to the Kampala-based Country Manager, who has overall responsibility for achieving country program targets, ensuring ongoing quality assurance/quality improvement, and managing the day-to-day relationship with USAID/Uganda, in liaison with the ROADS II management team in Nairobi. The Country Manager will visit each site at least once per quarter to ensure all project activities are on track, and will convene in-country quarterly staff/partner meetings with Site Coordinators and implementing partners. ROADS II will strengthen the technical skills of our local partners and site staff, drawing on our strategic partners for technical assistance in support.

The ROADS II/Uganda M&E system is based on national monitoring and evaluation (M&E) requirements

and responds to the needs of the Government of Uganda, PEPFAR, USAID/Uganda and ROADS II. The project will continue to strengthen its M&E system building on existing systems to guide participatory, coordinated and efficient collection, analysis, use and provision of information to track achievement of project objectives and inform decision-making at all levels. This will include the Kampala-based M&E Officer, who will continue to strengthen the capacity of the clusters to collect, manage, report and utilize data. The system will use targeted and special evaluations to establish the project's contribution to selected outcomes, to monitor quality and performance, and measure program results and contribution to achievement of outcomes. Using realistic methodologies and through collation and analysis of service statistics, an estimation of key socio-demographic indicators at project sites will be made to provide important denominator information. Documentation of changes over time will be conducted for comparison with the baseline assessment data to establish the project's contribution to any observed changes at community and individual targets populations. This will include use of inexpensive and quick evaluations using appropriate methodologies to measure its contribution to the target population's quality of life at the household and individual levels. These assessments will provide answers to the questions about the extent to which the project resulted in behavior change at the individual, family, and community levels as well as answers to the contribution support for those infected and affected by HIV/AIDS. A Quality Assurance and Quality Improvement strategy will be implemented to ensure high quality of services provided. The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data and strengthen the M&E system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	200,000	

Narrative:

Target populations: 1) orphans and vulnerable children (<18); 2) OVC caregivers (15+). Promoting gender equity and male involvement, including prevention of sexual and gender-based violence, cut across all ROADS II programming.

Program description: With COP FY 2010 funds (programming year 2011), ROADS II/Uganda will expand OVC programming in existing two SafeTStop sites (Busia and Katuna) and potentially other sites if funding is available. ROADS II will reach 1,650 eligible OVC with three or more OVC core program areas beyond psychosocial/spiritual support (Next Generation Indicator C5.0.D.); to achieve this result, ROADS II will train 220 caregivers in comprehensive HIV management (NGI C5.0.D). ROADS II programming will address four of the five priority areas for OVC: community support and coordination; family household strengthening; improving quality service delivery; and increased data development and use for strategic planning. Services will be linked closely through a strong referral network including health facilities and

CBO, FBO, NGO and private sector partners.

ROADS II will continue working with the Ministry of Gender, Labor and Social Welfare, CBOs, FBOs, NGOs and the private sector to meet the daily needs of OVC. The platform for delivering services will continue to be the cluster model, which has successfully brought together community-based partners in a coordinated response, with joint capacity building, to care for vulnerable children. The focus of OVC programming will be at the family/household level. All services will be provided within the national OVC policy framework.

A major challenge has been enumerating OVC in target communities. ROADS II has conducted OVC censuses in Busia and Katuna to guide programming. ROADS II will conduct additional child-focused needs assessments to identify where and how services will be provided, including shelter and care-giving, health care per the national OVC policy, education and/or vocational training, food and/or other nutrition services, protection and legal aid services, psychological/ social/spiritual services, and economic strengthening. ROADS II will continue to work with the private sector through public-private partnerships. In FY 2010, ROADS will continue programming for orphan-headed households, recognizing their unique vulnerability and needs. To address the long-term needs of orphan-headed households, ROADS' LifeWorks Partnership Trust will conduct job training and job creation, and develop other economic opportunities for OVC caregivers. The project will also continue supporting HIV risk-reduction and care strategies specifically for OVC who are heads of households, linking them with sexual prevention messaging, HVCT, and STI diagnosis and treatment. ROADS will also facilitate care in cases of rape and sexual assault. ROADS II will introduce programming specifically to address the needs of OVC caregivers by providing counseling, education/training in nutrition and parenting, medical and social services; access to economic strengthening through agriculture and other business development; and community-sharing of child support.

The main oversight structures at the site level are the Cluster Steering Committees, which include representatives from all groups belonging to respective clusters. Steering committee members communicate routinely with the ROADS Site Coordinators and meet formally once per month. At the monthly meetings, the Committees and Site Coordinators review monthly data reports against targets, ensure activities are on track and focused on agreed target audiences, identify programming impediments, and resolve issues in a timely manner. The Site Coordinators report directly to the Kampala-based Country Manager, who has overall responsibility for achieving country program targets, ensuring ongoing quality assurance/quality improvement, and managing the day-to-day relationship with USAID/Uganda, in liaison with the ROADS II management team in Nairobi. The Country Manager will visit each site at least once per quarter to ensure all project activities are on track, and will convene in-country quarterly staff/partner meetings with Site Coordinators and implementing partners. ROADS II will

strengthen the technical skills of our local partners and site staff, drawing on our strategic partners for technical assistance in support.

The ROADS II/Uganda M&E system is based on national monitoring and evaluation (M&E) requirements and responds to the needs of the Government of Uganda, PEPFAR, USAID/Uganda and ROADS II. The project will continue to strengthen its M&E system building on existing systems to guide participatory, coordinated and efficient collection, analysis, use and provision of information to track achievement of project objectives and inform decision-making at all levels. This will include the Kampala-based M&E Officer, who will continue to strengthen the capacity of the clusters to collect, manage, report and utilize data. The system will use targeted and special evaluations to establish the project's contribution to selected outcomes, to monitor quality and performance, and measure program results and contribution to achievement of outcomes. Using realistic methodologies and through collation and analysis of service statistics, an estimation of key socio-demographic indicators at project sites will be made to provide important denominator information. Documentation of changes over time will be conducted for comparison with the baseline assessment data to establish the project's contribution to any observed changes at community and individual targets populations. This will include use of inexpensive and quick evaluations using appropriate methodologies to measure its contribution to the target population's quality of life at the household and individual levels. These assessments will provide answers to the questions about the extent to which the project resulted in behavior change at the individual, family, and community levels as well as answers to the contribution support for those infected and affected by HIV/AIDS. A Quality Assurance and Quality Improvement strategy will be implemented to ensure high quality of services provided. The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data and strengthen the M&E system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	360,000	

Narrative:

Target populations: 1) family members of PLHIV; 2) males and females (15+) involved in multiple concurrent sexual partnerships; 3) females and males (15+ years) engaged in commercial and transactional sex, including those working in bars, guest houses and other local hotspots, as well as community members who do not self identify as a sex worker; 4) mobile workers (18+ years) including truck drivers, driver assistants, traders (e.g., fish mongers in Busia), and businesspeople; 5) out-of-school youth (15+ years) including money changers, boda boda riders, loaders, etc.; 6) sexually active in-school youth (15+) where they are not being reached by another program; 7) 1) males and females (15+ years) in stable relationships; 8) members of faith-based groups (10+ years); and 9) OVC (15+). Promoting

gender equity and male involvement, including prevention of sexual and gender-based violence, cut across all ROAD II program elements.

Program description: With COP FY 2010 funds (programming year 2011), ROADS II/Uganda will expand HVCT in existing SafeTStop sites (Busia, Katuna, Koboko, Malaba, and another TBD in FY 2010), plus at least one additional site to be established in FY 2011 if funds are available. ROADS II will support 40 outlets (staff, supervision, supplies and equipment, infrastructure upgrading) to provide counseling, testing and results for 8,860 individuals (Next Generation Indicators P11.0.D and P11.1.D., respectively). To achieve these results ROADS II will provide pre-service HVCT training for 35 individuals—counselors, counselor supervisors, lab technicians—and in-service training in the same categories for another 100. (HVCT volunteers do not work on a full-time basis, as they balance volunteering with livelihood.) The basis for programming will be existing ROADS mapping, assessments and evaluations plus new participatory assessments to be conducted in FY 2010.We will follow Uganda's national HVCT algorithm in all sites. Special focus will continue to be on counseling discordant couples including positive prevention, identifying and counseling clients with hazardous drinking behavior, and promoting and referring for family planning. ROADS will continue promoting testing to all family members where the index patient is found to be positive. Testing all family members will be the entry point for referral to the full menu of health services, including child survival, family planning/reproductive health, malaria prevention and treatment, PMTCT, TB and pediatric care and treatment. In FY 2010 ROADS will support fixed outreach outlets in program sites with hours and locations appropriate for key target audiences, including couples, mobile workers and their sexual partners. Sites will include the SafeTStop Recreation and HIV Resource Centers, which serve as alcohol-free recreation sites and a venue for a range of HIV services. Beyond client-initiated HVCT, ROADS II/Uganda will work with local health facilities to strengthen provider-initiated testing and counseling (PITC). Importantly, ROADS II will organize meetings between HTC staff, health providers and community caregivers to ensure HTC clients and family members are referred to and from services. ROADS II will conduct quarterly evaluations of the referral system to ensure the linkages are functioning efficiently and effectively. As a wrap-around to HTC, the project will address gender barriers to uptake of HTC at health facilities, fixed outreach sites or the home, safe disclosure of results and training of HTC counselors to identify and refer clients who may be suffering from alcohol abuse.

Community-based mobilization complemented by targeted local radio will be the cornerstone of our HVCT promotion strategy. Community "clusters" will be supported through funding and training to encourage peers in their immediate social networks to present for HVCT. Promotional channels will include peer education, interactive drama, community campaigns and special events. Clusters will be linked in a strong referral system with district health teams, local government, the private sector and the faith-based community.

ROADS II will provide ongoing QA/QI to HVCT sites, including periodic site visits, to existing and new HVCT sites. Linking with the MOH, counselor supervisors will be trained to monitor quality of services provided by each site. Quarterly meetings of all counselor supervisors will ensure that the same standard of services is provided in all sites. The Kampala-based Technical Officer in liaison with local MOH will mentor the counselor supervisors. QA/QI under ROADS will be applied to monitor and improve services in all HVCT sites. Exit interviews, monthly summary sheets and counselor self-assessment checklists will be used to ensure high-quality services. Every six months counselors will be involved in a quality assurance cycle. For quality control of HIV testing, dry blood spots will continue to be collected for every tenth client. These will be sent to a reference laboratory for validation of results given to clients. Lab supervisors will be trained to ensure quality of testing.

The main oversight structures at the site level are the Cluster Steering Committees, which include representatives from all groups belonging to respective clusters. Steering committee members communicate routinely with the ROADS Site Coordinators and meet formally once per month. At the monthly meetings, the Committees and Site Coordinators review monthly data reports against targets, ensure activities are on track and focused on agreed target audiences, identify programming impediments, and resolve issues in a timely manner. The Site Coordinators report directly to the Kampala-based Country Manager, who has overall responsibility for achieving country program targets, ensuring ongoing quality assurance/quality improvement, and managing the day-to-day relationship with USAID/Uganda, in liaison with the ROADS II management team in Nairobi. The Country Manager will visit each site at least once per quarter to ensure all project activities are on track, and will convene in-country quarterly staff/partner meetings with Site Coordinators and implementing partners. ROADS II will strengthen the technical skills of our local partners and site staff, drawing on our strategic partners for technical assistance in support.

The ROADS II/Uganda M&E system is based on national monitoring and evaluation (M&E) requirements and responds to the needs of the Government of Uganda, PEPFAR, USAID/Uganda and ROAD II. The project will continue to strengthen its M&E system building on existing systems to guide participatory, coordinated and efficient collection, analysis, use and provision of information to track achievement of project objectives and inform decision-making at all levels. This will include the Kampala-based M&E Officer, who will continue to strengthen the capacity of the clusters to collect, manage, report and utilize data. The system will use targeted and special evaluations to establish the project's contribution to selected outcomes, to monitor quality and performance, and measure program results and contribution to achievement of outcomes. Using realistic methodologies and through collation and analysis of service statistics, an estimation of key socio-demographic indicators at project sites will be made to provide important denominator information. Documentation of changes over time will be conducted for

comparison with the baseline assessment data to establish the project's contribution to any observed changes at community and individual targets populations. This will include use of inexpensive and quick evaluations using appropriate methodologies to measure its contribution to the target population's quality of life at the household and individual levels. These assessments will provide answers to the questions about the extent to which the project resulted in behavior change at the individual, family, and community levels as well as answers to the contribution support for those infected and affected by HIV/AIDS. A Quality Assurance and Quality Improvement strategy will be implemented to ensure high quality of services provided. The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data and strengthen the M&E system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	300,000	

Narrative:

Target populations: 1) males and females (15+ years) in stable relationships; 2) members of faith-based groups (10+ years); and 3) OVC (10+ years). Promoting gender equity and male involvement, including prevention of sexual and gender-based violence, cut across all ROAD II program elements.

Program description: With COP FY 2010 funds (programming year 2011), ROADS II/Uganda will expand HVAB programming in existing SafeTStop sites (Busia, Katuna, Koboko, Malaba, and another TBD in FY 2010), plus at least one additional site to be established in FY 2011 if funds are available. ROADS II will reach 44,000 individuals under Next Generation Indicator (NGI) P8.2.D. To achieve this target, ROADS II will provide pre-service training for 1,130 community health and para-social workers (NGI H2.2.D), and in-service training for an additional 1,350, using standardized materials (individuals are trained in HVAB and HVOP simultaneously). The basis for programming will be existing ROADS mapping, assessments and evaluations plus new participatory assessments to be conducted in FY 2010. Community-based interventions will continue to be the cornerstone of our strategic communication strategy in program sites. Community "clusters" will be supported through funding and training to implement evidence-based community outreach interventions that utilize simple, robust, participatory approaches to provide HVAB messages. Approaches will include twice-weekly peer education, weekly interactive drama, monthly special events, and community-developed branding and messaging. Clusters will be linked in a strong referral system with district health teams, local government, the private sector and the faith-based community.

In all community outreach, ROADS II will promote routine interaction among trusted individuals, which our experience shows is more effective than infrequent information-exchanges with strangers in their

communities. ROADS II will continue to strengthen and expand an immediate social network (ISN) approach to maximize the quality and frequency of interaction among trusted individuals, be they transport workers or community residents. Under this approach we broaden "peer" to include not only people in an educator's age cohort, but also those older or younger with whom s/he has a trusted relationship (e.g., family members, neighbors, customers, health workers and faith leaders). This approach is highly responsive to the reality of residents in ROADS II/Uganda sites, where most residents are faced with the choice between volunteering and making ends meet. Through these networks, peer educators will promote risk-reduction behaviors and HIV services, with a major focus on faithfulness, partner reduction and HVCT. Our experience with this model indicates peer educators identify up to 150 people in their immediate social networks. They enumerate them during training, which forms the basis of a simplified M&E tool to track interactions and expand the networks.

ROADS II will strengthen peer education and community outreach to examine barriers to abstinence and being faithful to target audiences, including truck drivers, who spend much of their lives away from home. ROADS II will also help youth and OVC to develop more positive, safe sexual behaviors and norms (including secondary abstinence for youth). Where they are not reached by other programs, ROADS II will expand programming into schools, particularly focusing on creating positive gender norms through extra-curricular programming such as creating positive self-images through art and other forms of expression, healthy attitudes, and safe behaviors. ROADS II will continue to link prevention activities with such HIV-related services as HVCT (MOH, fixed outreach), PMTCT, ART and pediatric AIDS, including those supported by other USG partners. We will also refer clients for other district health services, such as family planning/reproductive health, malaria, MCH and TB. ROADS II will work with transport workers to create opportunities to strengthen family ties while the men are on the road (e.g., through email linkages at resource centers) and to provide alcohol-free programming and venues (e.g., adult learning activities, men's discussion groups, and sports activities linked to the SafeTStop Recreation and HIV Resource Centers) to provide safer alternatives. ROADS II will continue working with the faith-based community and youth groups to promote HVAB, including partner reduction for truck drivers, community men and women, and sexually active youth. The project will reinforce HVAB prevention programming for military personnel near Koboko, particularly at sites where they congregate off base. Finally, ROADS II will expand dissemination of the MP4 device with HVAB content for use by drivers on the road and discussion groups where they stop.

The main oversight structures at the site level are the Cluster Steering Committees, which include representatives from all groups belonging to respective clusters. Steering committee members communicate routinely with the ROADS Site Coordinators and meet formally once per month. At the monthly meetings, the Committees and Site Coordinators review monthly data reports against targets, ensure activities are on track and focused on agreed target audiences, identify programming

impediments, and resolve issues in a timely manner. The Site Coordinators report directly to the Kampala-based Country Manager, who has overall responsibility for achieving country program targets, ensuring ongoing quality assurance/quality improvement, and managing the day-to-day relationship with USAID/Uganda, in liaison with the ROADS II management team in Nairobi. The Country Manager will visit each site at least once per quarter to ensure all project activities are on track, and will convene in-country quarterly staff/partner meetings with Site Coordinators and implementing partners. ROADS II will strengthen the technical skills of our local partners and site staff, drawing on our strategic partners for technical assistance in support.

The ROADS II/Uganda M&E system is based on national monitoring and evaluation (M&E) requirements and responds to the needs of the Government of Uganda, PEPFAR, USAID/The project will continue to strengthen its M&E system building on existing systems to guide participatory, coordinated and efficient collection, analysis, use and provision of information to track achievement of project objectives and inform decision-making at all levels. This will include the Kampala-based M&E Officer, who will continue to strengthen the capacity of the clusters to collect, manage, report and utilize data. The system will use targeted and special evaluations to establish the project's contribution to selected outcomes, to monitor quality and performance, and measure program results and contribution to achievement of outcomes. Using realistic methodologies and through collation and analysis of service statistics, an estimation of key socio-demographic indicators at project sites will be made to provide important denominator information. Documentation of changes over time will be conducted for comparison with the baseline assessment data to establish the project's contribution to any observed changes at community and individual targets populations. This will include use of inexpensive and quick evaluations using appropriate methodologies to measure its contribution to the target population's quality of life at the household and individual levels. These assessments will provide answers to the questions about the extent to which the project resulted in behavior change at the individual, family, and community levels as well as answers to the contribution support for those infected and affected by HIV/AIDS. A Quality Assurance and Quality Improvement strategy will be implemented to ensure high quality of services provided. The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data and strengthen the M&E system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	750,000	

Narrative:

Target populations: 1) males and females (15+) involved in multiple concurrent sexual partnerships; 2) females and males (15+ years) engaged in commercial and transactional sex, including those working in

bars, guest houses and other local hotspots, as well as community members who do not self identify as a sex worker; 3) mobile workers (18+ years) including truck drivers, driver assistants, traders (e.g., fish mongers in Busia), and businesspeople; 4) couples in union (15+ years) who lack skills to introduce condoms into their relationships; 5) out-of-school youth (15+ years) including money changers, boda boda riders, loaders, etc.; 6) sexually active in-school youth (15+) where they are not being reached by another program; 7) PLHIV (15+ years) for positive prevention; 8) chronically underemployed male and female youth (15+); 7) widows (18+ years) and OVC (15+ years) heading households; and 9) individuals abusing alcohol and other substances (15-49 years) as well as local brewers. Promoting gender equity and male involvement, including prevention of sexual and gender-based violence, cuts across all ROAD II program elements. Based on our experience programming for MARPs, ROADS II/Uganda will explore opportunities to share technical expertise with other USG-funded programs targeting, potentially organizing a Technical Working Group to facilitate exchange of lessons learned and promising/best practices.

Program description: With COP FY 2010 funds (programming year 2011), ROADS II/Uganda will expand HVOP programming in existing SafeTStop sites (Busia, Katuna, Koboko, Malaba, and another TBD in FY 2010), plus at least one additional site to be established in FY 2011 if funds are available. ROADS II will reach 88,000 individuals under Next Generation Indicator (NGI) P8.1.D. and 27,500 individuals under NGI P8.3.D. To achieve these targets, ROADS II will provide pre-service training for 1,130 community health and para-social workers (NGI H2.2.D), and in-service training for an additional 1,350, using standardized materials (individuals are trained in HVOP and HVAB simultaneously). In addition, ROADS II will establish 350 targeted condom service outlets in SafeTStop communities (NGI 8.4.D), focusing on easy access for MARPs. The basis for programming will be existing ROADS mapping, assessments and evaluations plus new participatory assessments to be conducted in FY 2010. Community-based interventions will continue to be the cornerstone of our strategic communication strategy in program sites. Community "clusters" will be supported through funding and training to implement evidence-based community outreach interventions that utilize simple, robust, participatory approaches to provide HVOP messages. Approaches will include twice-weekly peer education, weekly interactive drama, monthly special events, and community-developed branding and messaging. Clusters will be linked in a strong referral system with district health teams, local government, the private sector and the faith-based community.

In all community outreach, ROADS II will promote routine interaction among trusted individuals, which our experience shows is more effective than infrequent information-exchanges with strangers in their communities. ROADS II will continue to strengthen and expand an immediate social network (ISN) approach to maximize the quality and frequency of interaction among trusted individuals, be they transport workers or community residents. Under this approach we broaden "peer" to include not only

people in an educator's age cohort, but also those older or younger with whom s/he has a trusted relationship (e.g., family members, neighbors, customers, health workers and faith leaders). This approach is highly responsive to the reality of residents in ROADS II/Uganda sites, where most residents are faced with the choice between volunteering and making ends meet. Through these networks, peer educators will promote risk-reduction behaviors and HIV services, with a major focus on correct and consistent condom use, partner reduction and HVCT. Our experience with this model indicates peer educators identify up to 150 people in their immediate social networks. They enumerate them during training, which forms the basis of a simplified M&E tool to track interactions and expand the networks.

The SafeTStop Recreation and HIV Resource Centers in Busia, Katuna, Koboko and Malaba, with integrated Wellness Centres (primary health services), will continue to be the focus of programming for MARPs, providing mobile workers (Ugandan and non-Ugandan), their sexual partners and other vulnerable community members with HVCT, STI treatment and other services at convenient hours; HIV peer education; condom distribution; adult education on life and job skills; psychosocial and spiritual services; men's discussion groups on male social norms; and internet services to help truckers stay in contact with family members while away from home. Focusing on MARPs, ROADS II will continue to distribute an innovative MP4 audio device with prevention content for use by drivers on the road and discussion groups where they stop. ROADS II will continue to link prevention activities with such HIV-related services as STI diagnosis and treatment, HVCT (MOH, fixed outreach), PMTCT, ART and pediatric AIDS, including those supported by other USG partners. We will also refer clients for other district health services, such as family planning/ reproductive health, malaria, MCH and TB. ROADS II will mobilize the private sector, especially brothel/bar/guest house owners, and promote joint action to reduce risk for bargirls and patrons. To enhance the community education effort, local pharmacists/drug shop providers will receive expanded training in managing STIs, condom promotion and referral for HVCT.

Based on lessons learned around the region, ROADS II will continue its programming to address root causes of HIV risk, including gender norms that perpetuate SGBV, abuse of alcohol and other substances, and economic inequity. (Though economic strengthening is listed under palliative care and OVC under the Next Generation indicators, we see a role for this in sexual prevention as well given the need for alternatives to high-risk survival strategies.) Alcohol programming will be based on the cost-effective community alcohol counseling methodology developed by ROADS clusters in Busia, Kenya and launched in Uganda in FY 2009. Additional community Alcohol/GBV Task Teams will be established by ROADS clusters. These will refer survivors to health facilities for post-rape services, including post-exposure prophylaxis. The project will continue expanding food/nutrition support to reduce reliance on high-risk survival strategies, building on a promising community food-banking strategies and kitchen gardening techniques established in other ROADS sites.

The main oversight structures at the site level are the Cluster Steering Committees, which include representatives from all groups belonging to respective clusters. Steering committee members communicate routinely with the ROADS Site Coordinators and meet formally once per month. At the monthly meetings, the Committees and Site Coordinators review monthly data reports against targets, ensure activities are on track and focused on agreed target audiences, identify programming impediments, and resolve issues in a timely manner. The Site Coordinators report directly to the Kampala-based Country Manager, who has overall responsibility for achieving country program targets, ensuring ongoing quality assurance/quality improvement, and managing the day-to-day relationship with USAID/Uganda, in liaison with the ROADS II management team in Nairobi. The Country Manager will visit each site at least once per quarter to ensure all project activities are on track, and will convene in-country quarterly staff/partner meetings with Site Coordinators and implementing partners. ROADS II will strengthen the technical skills of our local partners and site staff, drawing on our strategic partners for technical assistance in support.

The ROADS II/Uganda M&E system is based on national monitoring and evaluation (M&E) requirements and responds to the needs of the Government of Uganda, PEPFAR, USAID/Uganda and ROADS II. The project will continue to strengthen its M&E system building on existing systems to guide participatory, coordinated and efficient collection, analysis, use and provision of information to track achievement of project objectives and inform decision-making at all levels. This will include the Kampala-based M&E Officer, who will continue to strengthen the capacity of the clusters to collect, manage, report and utilize data. The system will use targeted and special evaluations to establish the project's contribution to selected outcomes, to monitor quality and performance, and measure program results and contribution to achievement of outcomes. Using realistic methodologies and through collation and analysis of service statistics, an estimation of key socio-demographic indicators at project sites will be made to provide important denominator information. Documentation of changes over time will be conducted for comparison with the baseline assessment data to establish the project's contribution to any observed changes at community and individual targets populations. This will include use of inexpensive and quick evaluations using appropriate methodologies to measure its contribution to the target population's quality of life at the household and individual levels. These assessments will provide answers to the questions about the extent to which the project resulted in behavior change at the individual, family, and community levels as well as answers to the contribution support for those infected and affected by HIV/AIDS. A Quality Assurance and Quality Improvement strategy will be implemented to ensure high quality of services provided. The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data and strengthen the M&E system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9335	**Mechanism Name: HOSPICE**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: HOSPICE AFRICA, Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,386,000	
Funding Source	**Funding Amount**
GHCS (State)	1,386,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9335**
Mechanism Name:	**HOSPICE**
Prime Partner Name:	**HOSPICE AFRICA, Uganda**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,386,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9338	**Mechanism Name: Community-based Care and Support/TASO Follow on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: The AIDS Support Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,261,000	
Funding Source	**Funding Amount**
GHCS (State)	3,261,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TASO is the oldest and most experienced NGO providing HIV/AIDS services in Uganda. To date, TASO has cumulatively cared for over 200,000 clients of whom over 90,000 are active with over 30,000 clients cumulatively enrolled on ART. TASO has the widest non-government HIV/AIDS service delivery network in Uganda and directly complements the efforts of MoH. TASO has 11 Service Centres located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso in the 4 geo-political regions of Uganda. Each TASO Centre [equipped with pharmacy, a laboratory that has capacity to provide tests for malaria, TB, STI and other OI, and also for basic HIV disease monitoring, and adequate storage space for supplies]. These Centres provide services for the host districts and 3 to 4 neighboring districts. Although Centers are located in the urban district towns/cities, they have extensive

service delivery networks up to grassroots communities. TASO also operates 1 International HIV/AIDS Training Centre and 4 Regional Training Centres. The Training Centres conduct various HIV/AIDS courses for service providers. TASO Head Office is located in Kampala and is in charge of: Finance Management; Human Resources & Administration; Advocacy; Training & Capacity Building; Program Management; Planning & Strategic Information.

TASO provides a continuum of comprehensive HIV/AIDS prevention, care, treatment and related support services to HIV-positive people and their families. TASO activities include provision of antiretroviral therapy; counseling services for empowering PHA and supporting ART adherence; providing TB screening and treatment services; providing services for prevention, diagnosis and treatment of OI; providing PHA with the Basic Care Package (BCP); providing services for prevention-with-positives; providing confidential Home-Based HIV Counseling and Testing (HBHCT) services for clients' family members; providing Home Care for the sick; training and capacity-building of different calibers of staff in HIV/AIDS service delivery; supporting and maintaining linkages and referral mechanisms for expanded access to services; and conducting advocacy on the driving factors of the epidemic, issues inhibiting access to services and addressing stigma due to HIV/AIDS.

TASO works closely with Ministry of Health (MoH). Since inception TASO Service Centres operate within or close to District, Regional Referral and National Referral Hospitals. This facilitates contribution to and strategic collaboration with the public health care system. In many cases the 11 Service Centres serve as specialized HIV/AIDS clinics to the MoH district and regional referral hospitals and other lower level government health facilities. TASO maintains a referral mechanism with all levels of government health facilities. As a way of contributing to universal access and equitable service delivery, TASO has also trained and supports 23 peripheral partners to provide TASO-like services in under-served districts; these partners include government hospitals, private-not-for profit hospitals and community-based organizations.

TASO through support of PEPFAR and other funding partners has developed all the 11 Service Centres into leading HIV/AIDS care, support and treatment partners in the regions of Uganda where they are located. TASO Centres have an experienced, well-qualified and well-trained workforce of over 1,000 personnel, an average of 75 staffs per Centre. The Centre teams are multi-disciplinary including Medical Doctors, Counselors, Clinical Officers, Nurses, Pharmacy Technicians, Laboratory Technicians, Data Managers, Social Workers and Support staff. Individual staff have received multi-disciplinary on-job training to facilitate multi-tasking in deployment for service delivery; the workforce is organized in cohesive small teams (departments and sections) under supervisors; the supervisors undergo regular training and mentoring in leadership and supervisory management. All frontline staff are trained, facilitated and motivated to cultivate and maintain personal contact with the clients. Staff are required to

be fluent in the local languages of the Centres of their respective deployment. All jobs have comprehensive Job Descriptions (JD) and the Human Resources & Administration Directorate ensures regular update of all JDs. Apart from their formal qualifications (Degrees, Diplomas, etc), TASO requires all job applicants to have undergone robust HIV/AIDS training with a practicum component. TASO also provides regular didactic and experiential training to keep service providers up-to-date. TASO will manage and oversee program activities the following system: -

• Governance: The TASO governance structure includes a national Board of Trustees (BOT), 4 Regional Advisory Councils (RAC), 11 Centre Advisory Committee (CAC) and the Clients' Council. The BOT oversees the TASO program nationally and is the highest decision-making organ; the RAC oversees the TASO program in the 4 Regions of Uganda; the CAC oversee the activities of each of the 11 Centres; and the Clients' Council advocates for clients' rights, mobilizes clients to exercise their responsibility and advise management on clients' issues. All of these governance structures are elected by the Annual General Assembly periodically.

• Program Leadership & Oversight: Overall management and leadership of the TASO program at national level will be done by the Mr. Robert Ochai the Executive Director. The Executive Director is assisted by 2 Deputy Executive Directors (one in charge of Program Management and the other in charge of Support Services) and other Directors in charge of Planning & Strategic Information, Training & Capacity Building and Advocacy. All the Directors are highly-trained, highly-skilled and experienced individuals in HIV/AIDS programming.

• Management of Activities: Each of the 11 Centres is headed by a Centre Manager. The 11 Managers in charge of TASO Centres are well-qualified and experienced individuals who have undergone specialized experiential and didactic training in leading HIV/AIDS programming and managing TASO Centres, in addition to other training. The Managers ensure adherence to organizational policies and systems. Each Centre Manager is assisted by 5 heads of department, namely Medical Coordinator, Counseling Coordinator, Accountant, Human Resource Officer, Project Officer and Data Manager (these 5 officers supervise multi-tasked teams of highly motivated frontline staff).

• Service Teams at Centres: TASO has just over 800 frontline staff. All staff are well-qualified, have undergone comprehensive training in their respective responsibilities and undergo regular refresher training to keep up-to-date. Besides their service delivery skills, the frontline staff have other beneficial skills like planning skills, customer care skills, teamwork skills and others. TASO will maintain the existing personnel at Headquarters and Centres to steer the program during FY 2009.

• Quality Assurance: TASO ensures that all service providers and Service Centres adhere to the National

Guidelines for delivery of various HIV/AIDS services. TASO has Standard Operating Procedures (SOPs) for all services provided by the 11 Service Centres. The SOPs comply with National Guidelines and are observed by all service providers. These SOPs are regularly reviewed in a participatory manner to match the fast paced developments in HIV care and support technologies. TASO has a comprehensive Quality Assurance Manual spelling out the basic minimum standards to be ensured by all service providers.

• Management Information Systems: TASO, with support from partners, has developed robust computer-based management information systems (MIS) for generating strategic information and managing/tracking resource utilization. The key organizational systems include Navision 3.0 Accounting System; the Health Management Information System (HMIS); Appointments Management System; Clients' Identification/Mapping System; Clinical Laboratory Information System; Pharmacy and stores Information Management System; Supply Chain Management System; Fleet Management System and Human Resources Information System. These systems are integrated in order to maximize the quality and integrity of information produced. TASO regularly updates these systems and re-trains data staff to keep the MIS up-to-date. Update of the MIS shall continue during FY 2009.

• Organizational Policies: All TASO Centres are managed in accordance with documented organizational policies. TASO policies are developed through an inclusive process that harmonizes the views and interests of all key stakeholders. The policies are in harmony with the laws and guidelines of Government of Uganda and the funding agencies. TASO policies are approved by the TASO Board of Trustees. TASO has policies for Procurement, Human Resource Management, Governance, Financial Accounting and other issues.

• Performance Monitoring: TASO has a comprehensive internal performance monitoring mechanism. The Directorate of Planning & Strategic Information (PSI) at TASO Headquarters leads the performance monitoring function. Annual work plans and targets are developed from the TASO Strategic Plan. Each of the 11 Centres has monthly, quarterly semi-annual and annual targets to achieve. Service providers fill data collection forms that measure the quantity and quality of work. Data personnel manage service data (data entry, data cleaning, data storage, data analysis) together with data for other systems. Centres submit monthly Programmatic and Financial Reports to TASO Headquarters based on data, lessons and observations recorded. TASO Headquarters generates regular (monthly, quarterly and annual) reports and adhoc reports, Programmatic and Financial Reports for CDC/HHS, Ministry of Health, and other national partners. The reports are also used internally for reviewing performance and improving quality of service delivery.

• Audit Arrangements: TASO has an elaborate Internal Audit system implemented by the Internal Audit Unit comprising the Chief Internal Auditor and three other Auditors. The Auditors are well-qualified and

undertake regular performance enhancement training. The Team conducts comprehensive audit of all TASO units twice a year, and also conduct other audits as need arises. The audits will include both Financial Reviews and Programmatic Reviews. TASO operations are also audited externally by internationally recognized audit firms. Internal Audit Unit reports to the Board of Trustees on a quarterly basis.

• Procurement Procedures: TASO conducts competitive open procurement for drugs, medical supplies, stationery, equipment and other program needs. All Centres adhere to the Procurement Policy. Each of the 11 TASO Centres and other TASO units have a Procurement Committee constituted according to the TASO Procurement Procedures policy. There are clear cross-cutting guidelines for situations where prequalified suppliers such as Medical Access will be used.

• Technical Support: The program will have a three-tier technical support mechanism to the services at the 11 Centres. This will be done by the Program Management Directorate at TASO Headquarters, Ministry of Health (MoH) and the CDC/PEPFAR Country Team. The teams from MoH and CDC will provide regular support to the Directorates of Program Management and Strategic Information at TASO Headquarters. The Directorates will in turn support the TASO Centres through quarterly support visits. The 11 TASO Centres will also collaborate with MoH in the areas of capacity-building for the Centres, availing of the national guidelines by MoH, provision of supplies for TB management, providing consultancy on ART delivery and providing counseling and psychosocial support at MoH facilities by TASO staff.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	200,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9338**
Mechanism Name:	**Community-based Care and Support/TASO Follow on**

Prime Partner Name:	The AIDS Support Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	1,571,200	

Narrative:

TASO will continue offering both facility-based and community-based care to adult clients at the 11 service centres, 34 outreach clinics, at adjacent Government Hospitals/Health Centres and at clients' homes. The 11 TASO centres are located at 11 districts strategically located in the country and each centre serves clients from 3 to 4 neighboring districts. Apart from the index clients, services will also be targeted at household members and the general community especially in relation to stigma reduction and adherence to treatment. The services will include both clinical and non-clinical services. TASO will continue to strengthen treatment of opportunistic infections, provision of basic care package consisting of Cotrimoxazole for prophylaxis, Long Lasting Insecticide Treated bed Nets (LLITN), safe water vessels and water guard. TASO will focus on the aspects of improving the quality of life of adult clients by strengthening the aspect of pain management provision of psychosocial, social and spiritual (end of life) care, counseling and nutritional support. TASO medical staff and volunteers will be trained in pain management using the recommended World Health Organization (WHO) analgesic ladder. TASO will work with the Ministry of health to ensure continuous availability of Liquid Oral Morphine (LOM) for management of severe pain.

TASO will also enhance the capacity of indigenous organization in HIV/AIDS care and support. TASO will identify 10 new indigenous organizations for capacity development through a transparent and competitive process. The successful organizations will need to be operating in under-served/under-resourced settings; registered as CBO/NGO with at least 3 years experience; broad-based membership and ownership; pursuing HIV/AIDS-related vision and mission; not-for-profit status; willingness to grow in terms of scope and OD; meaningful and greater PHA involvement in programming; gender sensitive programming and meaningful involvement of women and children; and interested in reaching out to most-at-risk populations. Through these partners, TASO will be able to increase the number of people accessing good quality services. The key activities in increasing access to HIV/AIDS services in under-served areas will comprise:

• Selection of viable Indigenous Organizations: TASO will invite applications from indigenous organizations; review and select successful applicants; orient successful applicants and other stakeholders to the program. Indigenous organizations will be selected on competitive basis. Successful applicants will be those that meet but not limited to the following criteria: operating in high HIV prevalence areas; organizations located in under served districts; previously organizations supported by AIM, UPHOLD and other USAID programmes; organizations whose vision/mission are relevant to NSP;

organizations with clean past record in delivering HIV/AIDS services and resource management; organizations providing comprehensive HIV/AIDS services within a given geographical area; organizations with basic human resource and infrastructural capacity and organizations that work closely with districts in their areas of operation. In addition to the above, TASO, will enhance partnership in HIV/AIDS service delivery with existing partner PHA networks and/or organizations such as Positive Men's Union (POMU) and National Coalition of Women Living with AIDS (NACWOLA).

• Providing Sub-Grants: TASO will provide sub-grants to the selected organizations to finance HIV/AIDS service delivery. The terms for receiving, utilizing, managing and accounting for the funds will be included in the Memoranda of Understanding signed with these organizations. Compliance with the terms in the memoranda will be included in the terms of reference of audit and technical support visits to these organizations.

• Service Delivery by supported Organizations: The supported indigenous organizations will offer a package of services in under-served areas comprising HCT, counseling, medical care, home care, community mobilization/sensitization/education, condom education and promotion and referral for specialized care. Through supporting indigenous organizations, at least 25,000 individuals will be reached with HIV/AIDS services and provided closer to their homes.

TASO will conduct performance enhancement courses for direct service providers of the supported organizations to offer quality, care and support services to PHA. These courses will target direct service providers, PHA networks, clinicians, counsellors, nurses, people with disabilities and religious leaders. The major training interventions will be as follows: -
• HIV/AIDS Counsellor Training: TASO will reach 300 service providers in the selected organizations with this kind of training. The trainees will be prepared to become counsellors capable of meeting the information needs of clients and providing the necessary psychological support towards adopting positive lifestyle. This counselling course will also incorporate appropriate aspects of HIV and Gender issues. Due assessments will be done and where it is deemed necessary, a Basic Peer Counselling Course will be conducted to enable PHA reach out to their peers within the communities served by the supported organisation. Up-to 160 PHA will be trained in basic counselling.

• Child Counsellor Training: TASO will also train some of the counselling in the supported CBOs in child counselling. This course will orient and train individuals working with children affected by HIV/AIDS. The course will enable participants to identify HIV/AIDS-related risks and challenges of children and young adults. Trained people will also support families develop strategies for coping with HIV/AIDS. TASO plans to train 10 counsellors in each supported CBO in child counselling.

• Clinical HIV/AIDS Management: TASO will reach 100 service providers in the selected organizations with this training. This will be a highly practical course, offering a strong hands-on experiential learning at the TASO clinical training facility. The course will target the medical service providers, especially the clinical officers and nurses.

• Home-Based HIV/AIDS Care: TASO will reach 100 service providers in supported organizations with this course. The course will equip participants with skills and knowledge to offer comprehensive HIV/AIDS care to individuals, families and communities, and will target clinicians, HIV/AIDS counsellors and social workers.

The TASO Training Centre will work with the SCOT Consortium, NUDIPU and its partners in the Regional AIDS Training Network (RATN) to develop tailored courses to address competency gaps in various areas including HIV prevention strategies for identified most-at-risk groups such as people with disability (PWD); children and young adults; people living with HIV/AIDS and other current and emerging priorities. TOT courses will also be conducted to cascade training and for sustainability within the supported institutions and districts. TASO will conduct this in collaboration with RATN. Post-training follow-up visits will be done to at least 60% of the trained people. Following implementation of these courses, supported organizations will have capacity to provide quality HIV/AIDS services.

This objective will be achieved through provision of leadership, management governance support: This support will target Management / leadership committees and governance bodies of partnering and supported organizations to offer sound, practical and effective leadership for HIV/AIDS programming. Capacity building for indigenous organizations will focus on the following systems: performance management; strategic planning; program leadership; managing human resources; supply chain management and procurement; stocks management and control including pharmacy; advocacy, networking and partnerships; monitoring and evaluation; resource mobilization; financial accounting; report writing; and governance.
Capacity development will be done using a combinational strategy comprising of didactic teaching; mentoring; experiential placement at TASO Centres; exchange visits; and ongoing technical support supervision. Through this kind of support TASO will reach 218 people (members of management and governance structures of supported organizations). By the end of 5 years, these organizations will be able to: develop short-term and long-term strategic plans, compete for resources from non-US sources and to operate accounting and other systems compliant to USG and in country audit requirements. Support will be geared to enhancing sustainability of the supported indigenous organizations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	375,000	

Narrative:

TASO will provide to OVC a comprehensive package of services comprising of socio-economic security components, food and nutrition security, educational support, health care (targeting uninfected children in targeted households who are not catered for in the CDC mechanism) and child protection services as per the NSPPI and NOP. All the 8,000 supported OVC will, in addition to this package, also access psychosocial support. The services provided to the OVC under the various CPA will be as follows: -

• Socio-Economic Security: TASO will provide these services to benefit 1,000 OVC. Socio-economic security will comprise of provision of small grants for OVC and/or households; counseling OVC and family members about health and socio-economic welfare; apprenticeship training for out-of-school OVC; training in small business management for OVC and/or caregivers; and mobilizing community structures to support community safety nets.

• Food and Nutrition Security: TASO will provide these services to benefit 3,000 OVC. Food and nutrition security interventions will comprise of providing agricultural tools and supplies for vulnerable households; counseling caregivers of chronically ill household members about alternative food security practices; and training households in appropriate nutrition for persons who are chronically ill.

• Educational Support: TASO will provide these services to benefit 1,100 OVC. Educational support will comprise of short-term assistance for needy primary and secondary level students (scholastic materials and uniforms); short-term assistance for vocational school students (tuition fees and materials); training in psychosocial care and support to OVC who are in school, at risk of falling out, or have fallen out; training in the gender impact of HIV/AIDS and innovations to keep girls in school and safe; and school/family-based monitoring of children at risk of dropping out.

• Health Care for under-served OVC: TASO will provide these services to benefit 4,000 children in PHA households in under-served/under-resourced settings. Health care for these children will comprise of preventive health care; referral for hospice care for chronically and terminally ill children in need of specialized care; counseling for chronically ill OVC and caregivers; curative health care for OVC and caregivers; providing information on health, hygiene, nutrition and ARV therapy; procuring manuals and IEC materials for trainers of caregivers of the chronically ill; training health care workers to provide more user-friendly services for OVC and caregivers; supporting community care initiatives; and supporting formation of peer groups.

• Child Protection Services: TASO will provide access to child protection services to benefit 8,000 OVC as and when deemed necessary. Child protection services will comprise of raising awareness on legal issues affecting OVC and their caregivers and legal redress; awareness-raising on fostering, adoption

and guardianship arrangements; awareness-raising on role of Child and Family Protection Units at police stations; awareness-raising on Vital Registration and Information Systems (Birth & Death registration); awareness-raising on domestic violence, child abuse, child neglect and child labor; and awareness-raising regarding on reduction of stigma and discrimination towards OVC.

Through the above approach, TASO plans to ensure that at least 3,000 OVC access at least three forms of OVC services excluding psychosocial services. Given additional resources, TASO can ensure that at least 5,000 OVC access at least three forms of OVC services excluding psychosocial support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	582,800	

Narrative:

The identification of infants born to HIV-infected women is a necessary step in infant diagnosis. TASO shall continue to use the national ART and PMTCT diagnostic protocols by screening children using Dried Blood Spots (DBS) where HIV is suspected, starting as early as six weeks after birth. DBS will be obtained by finger or heel prick and transported to Regional Referral Laboratories for Virologic Polymerase Chain Reaction (PCR) test. Children under 18 months will be closely monitored. Children under 18 months who are known or suspected to have been exposed to HIV will be closely monitored and early timely interventions including ART instituted to reduce early morbidity and mortality. Children of any age confirmed HIV positive will be counseled and linked to care, treatment and support. All infants once confirmed HIV positive shall be started on HAART (Irrespective of CD4/CD4% status).The decision as to when to start HAART in children more than 12 months shall be guided by immunologic and clinical staging of thee children..Regimens shall be based on the National ART and care guidelines for infants and children (MoH, Second Edition, July 2008).Most of the ARVs available for adults can also be used in children, though not all formulations are suitable for children. History of PMTCT shall be considered in selection of 1st line regimens. Use of Paediatric Fixed Dose Combinations (FDCs) shall be considered. Modification of treatment regimens will be considered for tuberculosis co-infection as there is potential for multiple drug interactions. (Rifampicin plus NNRTIs/PIs). Counselling for ART is crucial ion children. Basic monitoring of children on ARVs shall consist of: clinical examination and WHO staging; immunologic CD4 %/CD4 counts; viral loads will be reserved for complicated management decisions following case conferences and training of TASO staff in Paediatric HIV care, treatment and support will be undertaken. Growth and development monitoring will be done using revised WHO growth charts for early identification of growth faltering and institution of corrective measures including nutritional supplements to promote growth and development. Weighing scales, Stadiometers and tape measures shall be procured. Infant feeding within the context of HIV shall be done according to National guidelines. Optimal feeding to minimize MTCT, prevent malnutrition and promote growth and development shall be

practiced. Cotrimoxazole prophylaxis shall be instituted for all HIV exposed and infected children starting at 6 weeks of age and continued until HIV is excluded. For HIV-exposed children of any age that are still breastfeeding, CTX will be continued until HIV is excluded i.e. 12 weeks after complete cessation of breastfeeding. Paediatric-specific adherence issues e.g. availability and palatability of drug formulations, relationship of drug administration to food intake in young infants and dependence on caretakers for administration of drugs shall be considered. Adherence shall be monitored through pharmacy refill records, pill counts and home visits for spot checks. Opportunistic Infections Prevention and Care. Provision of opportunistic infections prevention and care will be based on recommendations contained in the National Guidelines for CTX preventive therapy. All HIV infected children, regardless of CD4%/CD4 count shall receive CTX preventive therapy. All TASO HIV exposed and infected children shall be linked to appropriate specialized health facilities and community care e.g. Immunization clinics. Comprehensive Paediatric HIV care, treatment and support shall be provided according to the Ten-point package of the African Network for the care of children affected by HIV/AIDS (ANNECA) and adapted by the government of Uganda. This includes: confirming HIV infection status as early as possible; monitoring the Childs' growth and development; immunizations according to National guidelines; prophylaxis against OIs particularly Pneumocystis Carina Pneumonia (PCP); treatment of acute infections and other HIV-related conditions; counselling on infant feeding, good personal and food hygiene; conducting disease staging; ART for the infected child if needed; provide psychosocial support for the infected child, mother/caretaker & family and referral to higher levels of specialized care when necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	197,319	

Narrative:

TASO AB interventions will aim at influencing key HIV drivers through: minimizing risky individual behavior such as premarital sex, early sex debut, casual sex, multiple sexual partners and extramarital sex; highlighting risk linked to economic factors such as OVC and child-headed households; highlighting risk linked to socio-cultural factors resulting in human rights abuses; addressing risks linked to gender factors such as sexual violence; addressing risks linked to geographic locations such as post-conflict settings; and addressing risks linked to lack of food and nutrition security.

Abstinence interventions will target youths and/or young people in and out of school. The interventions will empower male and female youth in targeted communities with life skills to prevent HIV infection through abstaining from sex. Service providers dealing with youth will be empowered with appropriate communication skills and facilities to support abstinence issues among youth. TASO will develop and implement effective IEC interventions for addressing abstinence issues among the youth. Be Faithful interventions will target people engaging in marital sex and/or sex in stable ongoing relationships such as

married couples and cohabiting couples (these will mostly comprise of adult community members). The interventions will empower adult male and female community members to prevent HIV infection by practicing mutual faithfulness in their sexual relationships. Service providers dealing with adults will be empowered with appropriate communication skills and facilities to support this target group. TASO will develop and implement effective IEC interventions for addressing "be faithful" issues among sexually active adult community members.

Sexual Prevention (AB) activities during FY2010 will include: building capacity of local communities and indigenous organizations in AB; supporting AB partnerships, networks and linkages; conducting AB outreach activities in communities; providing financial and technical support to identified local AB partners; training, facilitating and supervising AB service providers and community volunteers; conducting group and/or individual counseling sessions at facilities and/or community venues; conducting health talks on AB issues; mobilizing and empowering community structures such as cultural, social, economic and political entities to promote/advocate for AB. These interventions have been selected because they align the TASO AB approach to the National HIV/AIDS Strategic Plan (NSP) 2007/08-2011/12. The interventions also respond to the gaps in the national HIV response as identified by the UHSBS and other key studies. The interventions are also backed with evidence of their effectiveness. The geographic coverage will include the catchment area served by the 11 TASO Centres located in Entebbe, Gulu, Jinja, Masaka, Masindi, Mbale, Mbarara, Mulago, Rukungiri, Soroti and Tororo (each Centre serves the host district and 3 to 4 neighboring districts). The coverage will also include the areas served by 11 indigenous organizations that will be identified by TASO through competitive local RFAs in 2009/2010. The TASO-supported AB activities will have partnership and referral linkages to other services/platforms within TASO and other health service delivery partners in the targeted communities. AB activities will also promote other HIV Prevention approaches, HIV Care/Support and HIV Treatment services by TASO and other partners.

Mechanisms to promote quality assurance will include: ensuring adherence to national and international quality standards and policies; conducting regular refresher training for service providers; rigorous support supervision of service providers; support supervision training; technical support visits to teams and partner sites; conducting QA meetings by service delivery teams; generating regular client satisfaction feedback; and availing standardized QA materials. Evaluation and monitoring of AB activities will be guided by the TASO Performance Monitoring Plan (PMP) which is based on the rich TASO M&E experience and the lessons and good practices gained from a quarter a century of the national HIV response. The TASO PMP is also aligned to the Performance Measurement and Management Plan for the NSP 2007/8-2011/12 and the PEPFAR Results Frameworks. The PMP will guide assessment of progress for all AB activities. The PMP will outline the AB activities, baseline values and targets, performance indicators, sources of data, methods of data collection, frequency of data collection and

responsible persons. The PMP will enable availability of accurate and timely AB data for tracking progress; and availability of reliable and timely information to support decision making.
experience and the lessons and good practices gained from a quarter a century of the national HIV response. The TASO PMP is also aligned to the Performance Measurement and Management Plan for the NSP 2007/8-2011/12 and the PEPFAR Results Frameworks. The PMP will guide assessment of progress for all AB activities. The PMP will outline the AB activities, baseline values and targets, performance indicators, sources of data, methods of data collection, frequency of data collection and responsible persons. The PMP will enable availability of accurate and timely AB data for tracking progress; and availability of reliable and timely information to support decision making.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	434,681	

Narrative:

TASO Sexual Prevention (Other) interventions will aim at influencing key HIV drivers through: minimizing risky individual behavior such as premarital sex, early sex debut, casual sex, multiple sexual partners and extramarital sex; highlighting risk linked to economic factors such as OVC and child-headed households; highlighting risk linked to socio-cultural factors resulting in human rights abuses; addressing risks linked to gender factors such as sexual violence; addressing risks linked to geographic locations such as post-conflict settings; and addressing risks linked to lack of food and nutrition security.

Sexual Prevention (Other) interventions will target the groups at higher risk, as per the NSP, including people living with HIV and sexually active people (especially those using condoms inconsistently, having multiple sexual partners and those engaging in other forms of risky sex). The interventions will challenge and empower male and female members of targeted communities to prevent HIV infection/transmission through other means beyond AB. Service providers dealing with these target groups will be empowered with appropriate communication skills and facilities to support HIV prevention through other approaches beyond AB.

Other Prevention activities during FY2010 will include: building capacity of local communities and indigenous organizations in Other Prevention; supporting Other Prevention partnerships, networks and linkages; conducting Other Prevention outreach activities in communities; providing financial and technical support to identified local partners to implement Other Prevention services; training, facilitating and supervising service providers and community volunteers to give Other Prevention services; and developing effective IEC interventions for addressing HIV prevention using approaches beyond AB. These interventions have been selected because they align the TASO Sexual Prevention (Other) approach to the National HIV/AIDS Strategic Plan (NSP) 2007/08-2011/12. The interventions also

respond to the gaps in the national HIV response as identified by the UHSBS and other key studies. The interventions are also backed with evidence of their effectiveness. The geographic coverage will include the catchment area served by the 11 TASO Centres located in Entebbe, Gulu, Jinja, Masaka, Masindi, Mbale, Mbarara, Mulago, Rukungiri, Soroti and Tororo (each Centre serves the host district and 3 to 4 neighboring districts). The coverage will also include the areas served by 11 indigenous organizations that will be identified by TASO through competitive local RFAs in 2009/2010. The TASO-supported Sexual Prevention (Other) activities will have partnership and referral linkages to other services/platforms within TASO and other health service delivery partners in the targeted communities. Sexual Prevention (Other) activities will also promote AB prevention approaches, HIV Care/Support and HIV Treatment services by TASO and other partners.

Mechanisms to promote quality assurance will include: ensuring adherence to national and international quality standards and policies; conducting regular refresher training for service providers; rigorous support supervision of service providers; support supervision training; technical support visits to teams and partner sites; conducting QA meetings by service delivery teams; generating regular client satisfaction feedback; and availing standardized QA materials. Evaluation and monitoring of Sexual Prevention (Other) activities will be guided by the TASO Performance Monitoring Plan (PMP) which is based on the rich TASO M&E experience and the lessons and good practices gained from a quarter a century of the national HIV response. The TASO PMP is also aligned to the Performance Measurement and Management Plan for the NSP 2007/8-2011/12 and the PEPFAR Results Frameworks. The PMP will guide assessment of progress for all Sexual Prevention (Other) activities. The PMP will outline the Sexual Prevention (Other) activities, baseline values and targets, performance indicators, sources of data, methods of data collection, frequency of data collection and responsible persons. The PMP will enable availability of accurate and timely Sexual Prevention (Other) data for tracking progress; and availability of reliable and timely information to support decision making.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	100,000	

Narrative:

During FY 2010, TASO will enhance laboratory infrastructure at TASO Centres in the districts of Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Tororo and Wakiso. This will focus on consolidating automation of laboratory processes; enhancing Quality Assurance (QA) of laboratory services; capacity building for laboratory personnel; ensuring reliable supply of laboratory reagents and consumables; reviewing laboratory guidelines and standard operating procedures; and improving the laboratory information management information system (LIMBS). Through this TASO will improve the quality of complementary medical services, as well as contribute to systems strengthening for public

health facilities and districts where TASO Centres are located. During the period, TASO will conduct 42,000 diagnostic laboratory tests for the targeted and/or eligible clients through the supported laboratories annually. These tests will comprise of 20,000 HIV antibody tests, 12,000 TB tests (sputum smears) and 10,000 syphilis diagnostic tests. TASO will partner with MOH to refresh Master Trainers for each of the 11 TASO Centres. The Master Trainers will in turn train the staff of their respective TASO Centre and partner organizations. TASO will procure the necessary equipment for Health Care Waste Management including colour coded waste bins, sharps disposal containers, protective clothing and wear. TASO will also work in partnership with public health and municipal authorities to ensure proper disposal of Health Care Waste.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9340	**Mechanism Name: TB/HIV Integration Activity**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: The International Union Against Tuberculosis and Lung Disease	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Uganda mission of USAID obligated funding to the TB Control Assistance Program (TBCAP) to support the Ministry of Health (MOH) and districts in Uganda to deliver integrated services for Tuberculosis (TB) and HIV and to strengthen Community Based Directly Observed Therapy-Short course (CB-DOTS). The International Union against Tuberculosis and Lung Disease (The Union) is the coordinating partner for TBCAP in Uganda. The goal of the program is to decrease the burden of TB among people living with HIV/AIDS (PLWHs) and the burden of HIV among notified TB patients. The strategic approach for implementation has been to focus efforts on increasing HIV/AIDS Counseling and

Testing (HCT) uptake amongst TB clients as an entry point into HIV care, intensify TB case finding in HIV care settings and consolidate CB-DOTS. TBCAP operates within the existing MOH and district health systems and supports the implementation of national policies and guidelines on TB/HIV. TBCAP is currently supporting over seven PEPFAR TB/HIV as well as USAID TB Implementing partners to improve implementation and scale up of TB/HIV interventions. Additional partners will be supported in year three. TBCAP works closely with the Uganda offices of the World Health Organization (WHO), the U.S. Centers for Disease Control and Prevention (CDC), and other Uganda Stop TB Partnership (USTP) partners to support the MOH to improve guidance to districts and partners on the implementation of TB/HIV activities. The strategy TBCAP has employed is to build partnerships at all levels and improve existing TB and HIV services.

Selected intervention areas:

The main intervention areas for the project are:

1. Continue to support CB - DOTS and TB/HIV collaborative activities in twelve (12) districts.

2.Provide technical assistance (TA) to USG PEPFAR TB/HIV as well as USAID TB Implementing partners in order to scale up TB/HIV collaborative activities and strengthen CB-DOTS in the PEPFAR supported districts.

3.Provide support to the NTLP to strengthen coordination of the Multi Drug Resistance (MDR) TB response at the national level and implement some MDR activities.

Expected project outputs:

Output 1: Improved quality of CB-DOTS and TB/HIV collaborative activities in the twelve (12) TBCAP districts.

Output 2: TA to PEPFAR TB/HIV as well as USAID TB Implementing partners to scale up TB/HIV collaborative activities and strengthen/ consolidate CB-DOTS to PLWH

Output 3: NTLP supported to strengthen the coordination of the MDR response at national level and implement some MDR activities.

Project technical approach:

Given the resources currently available to TBCAP, supporting existing PEPFAR partners with TA to be able to scale up TB and TB/HIV collaborative activities was identified as the best approach to scale up these services. Although it was envisaged that the USAID mission would identify another partner to support direct implementation of TB and TB/HIV collaborative activities in the twelve (12) districts, this has not been realized. Therefore, TBCAP will continue to build on existing achievements in the twelve (12) districts so as to consolidate and sustain good performance in the area of CB-DOTS and TB/HIV collaboration until that time when another partner will be identified to support direct implementation of activities in those districts.

The strategies used in the 12 districts which have provided good results will be promoted in the other districts supported by PEPFAR partners. TBCAP will continue to support the NTLP with a focus on strengthening the coordination of the MDR response at the central unit in addition TBCAP will support

another NGO to follow up TB patients in one other division of Kampala district. Contribution to strengthening of the health systems at national and district level remains core in all TBCAP supported interventions.

The twelve districts that TBCAP will continue to support are:

Central: Kampala, Mukono, Kayunga, Mpigi

Eastern: Soroti, Bukedea, Mbale, Manafwa

Western: Kiboga, Hoima, Masindi, Bulisa

The expected outputs shall be achieved by supporting the following activities:

Output 1: Improved quality of CB-DOTS and TB/HIV collaboration in the 12 TBCAP districts

In order to consolidate CB-DOTS and TB/HIV collaboration in the 12 TBCAP districts, TBCAP will continue its support in the following areas:

1.1 Support the districts' coordination mechanisms for TB/HIV

Support quarterly TB/HIV coordination meetings for the District Health Team and all partners within the districts;

Support the district health team to monitor activities of partners (USG and non-USG) within the district and overall performance indicators.

1.2 Support districts to improve the quality of CB-DOTS

Support supervision activities for CBDOTS including laboratories;

Support Village Health Teams (VHTs), PLWHA networks and CBOs to identify and refer TB suspects and to support adherence to treatment (includes Kawempe Home Care and Mengo homecare)

Support improvement of the drug logistics management system in the 12 districts.

Support maintenance of microscopes in 12 districts.

Support dissemination of laboratory Standard Operating Procedures (SOPs) in 12 districts.

Build capacity for hospitals and HC IVs in 12 districts to reconstitute laboratory reagents.

Support production of TB sign posts for health facilities in three (3) TBCAP supported districts (these signs will help to identify health facilities that provide TB services in these three remaining TBCAP supported districts).

1.3 Increase access of HIV diagnosis and care for TB patients and TB diagnosis and care for PLWH

Support implementation of ACSM activities;

Bridge the gap for HIV test kits and Cotrimoxazole in the 12 districts;

Support the use of the ICF tool (endorsed by the NCC) at HIV care settings and general OPDs among health facilities in TBCAP supported districts.

Support the districts to strengthen the referral system to ensure that TB suspects identified within HIV care settings receive prompt diagnosis and treatment for TB, and HIV patients identified within TB clinics receive ART as soon as recommended; Support Human Resource capacity development issues especially follow-up and on-job support including Nurses and Midwifery schools;

Follow up support supervision for health workers trained on CBDOTS, TB/HIV, Microscopy and Nurse

tutors from Kampala area, Lira and Jinja
Support the NTLP to develop a human resources development (HRD) plan
Assessment of the Knowledge and Practice of graduating nursing students in supported Nurses training institutions.
Support M&E activities for TB/HIV, including dissemination of revised NACP recording and reporting tools.
Support supervision activities in the districts including Laboratory Focal Persons
Print and disseminate TB and revised NACP Registers
Facilitate data collection from facilities on a quarterly basis
Conduct data quality assessment exercises
Hold regional performance review meetings to monitor performance
1.4 Support TB-IC activities
Support sharing of best practices and learning from one another in infection control among districts based on updated TB Infection Control guidelines.
Support administrative TB-IC activities at facility level
Support MOH to produce IEC materials on TB-IC, and support partners to reproduce and disseminate
Output 2: Technical assistance to PEPFAR TB/HIV and USAID TB Implementing partners to scale up TB/HIV collaborative activities and strengthen/consolidate CB DOTS
TBCAP will provide TA to PEPFAR partners and District Management Teams to improve implementation of CB-DOTS and TB/HIV collaborative activities and will regularly monitor activities and performance advising on remedial actions in ensuring improvement in performance. TBCAP will specifically:
Support production of a quarterly newsletter to provide updates to partners on TB/HIV issues
Support coordination of partners implementing TB & TB/HIV programs with District Management Team
Support sensitization of all stakeholders on the revised TB guidelines and support them to disseminate the guidelines in the districts
Provide follow up support to partners to ensure that trainings on CB-DOTS TB/HIV collaboration and TB-IC are carried out in PEPFAR supported districts
Support the Health Care Improvement project to incorporate ISTC with in the quality improvement program for HIV and ART scale up
Support TOT for new partners on TB/HIV and TB-IC
Regularly monitor activities of partners in TB/HIV, IC and CB-DOTS in the districts in relation to strengthened M&E systems and tools
Link partners to national bodies for coordination of TB and TB/HIV activities (Uganda Stop TB partnership and the NCC) and national and regional supervisory bodies, to improve coordination and support supervision in partner sites/districts
Output 3: NTLP supported to strengthen the coordination of the MDR response at national level and to implement some MDR activities.

The MDR survey is ongoing, and data will soon be available on patient numbers. Provision has been made under the APA4 work plan to support the NTLP in MDR activities, and a strategic review of the situation will be conducted with these funds. An external consultant will support the national program in the drafting of guidelines for MDR which will form the basis for the future direction in this area. To support the national program to move ahead in this area, TBCAP will specifically support:
A full time Medical Officer to support coordination of all MDR activities
Printing and dissemination of MDR guidelines
Development of M&E tools for MDR
Training of teams of health workers at 5 regional referral hospitals.
Support supervision activities to MDR treatment centres including culture and DST laboratories.
Attribution
The Project will provide TA and financial support to consolidate CB-DOTS and TB/HIV collaborative activities in the 12 TBCAP districts. Additionally, the project will provide TA to PEPFAR partners to improve CB-DOTS and TB/HIV collaboration in the districts they support. Improvement in case detection and treatment success rates in the 12 TBCAP districts and other PEPFAR supported districts will contribute to improvement in the national TB indicators. By sustaining access to HIV diagnosis and care for TB patients in the project districts and supporting PEPFAR partners to do the same in other districts, the project will contribute to an increase in the proportion of TB patients tested for HIV, the proportion started on cotrimoxazole and the proportion of eligible TB/HIV patients started on ART. Likewise, promoting active TB screening among PLWH attending health care facilities will contribute to an increase in TB case finding in addition to improving TB diagnosis and care among PLWH. Through ongoing support to community based interventions, TBCAP will support and promote the involvement of communities in TB and TB/HIV care. Support to laboratory strengthening will contribute to health system strengthening. The Program will continue to collaborate with WHO and CDC on technical issues. The success of the NTLP in increasing its performance indicators can only be partially attributed to TBCAP as much of the commitment and funding for important activities will come from other USG partners and Global Fund.

Next steps and relation with other interventions:
The Union, as the coordinating partner, expects that long term sustainability of the TBCAP activities will be ensured by building the organizational capacity and TB/HIV expertise within PEPFAR partners, and all administrative levels of NTLP and NACP, by facilitating regular coordinating meetings between MoH NTLP and NACP and all stakeholders. The program will continue to build relationships between partners at the district level and facilitate all stakeholders to effectively plan and implement collaborative TB/HIV activities after the end of the project. This project will build new and reinforce existing structures, as well as develop and implement tools, for improved TB/HIV collaboration. The Union anticipates that after three years of program implementation, sufficient skills and knowledge will have been transferred from the

project team to local partners for the NTLP and NACP to assume responsibility for TB/HIV collaborative activities. TBCAP has worked with the NTLP, NACP, DHT and partners, most especially USG partners, and ensured that TB and TB/HIV collaborative activities were included in their work plans and strategic plans. These work plans or strategic plans can be presented to other donors, including the Global Fund fight HIV/AIDS, TB and Malaria, for mobilization of resources. The primary challenge to the continuation of TB/HIV collaboration after the project will depend on the ability of the MOH to mobilize resources to fund necessary core activities for TB/HIV and CB-DOTS. Until the Government of Uganda can independently fund these activities, donor support will be needed to continue the implementation of TB/HIV and CB-DOTS activities.

Sustainability of interventions will continue to be considered with every activity in TBCAP, including: Having established The Union-Uganda office within the NTLP, TBCAP staff has been able to give daily technical assistance and support to the NTLP. This professional partnership will continue to build the technical and management capacity of the NTLP to draft realistic long-term strategic plans, implement effective annual work plans, develop comprehensive budgets and absorb funding more efficiently;

1. The program will continue to strengthen the ability of NACP, NTLP and partners to monitor and evaluate TB and TB/HIV in Uganda by the ongoing improvement of the recording and reporting system, and the inclusion of joint supervision as part of their regular program activities;

2. The trainings supported by the program include a TOT component so that the lessons delivered in the training can then be transferred by trained health care workers to colleagues in the workplace;

3. A conscientious effort is being made to foster Ugandan and MOH ownership of all the tools and policies developed with the support of this program;

4. Throughout the implementation of the program, but with particular emphasis on PLWH in Year 3, the TBCAP will work closely with the NCC, NACP and NTLP to disseminate and encourage adoption and scaling up of best practices to other districts.

The program will continue to work closely with USG partners to ensure that the best practices identified through the project are adopted and diffused to health centers and services supported by the USG partners. It is assumed that the long-term costs of TB/HIV and CB-DOTS activities will be supported through current and future GF rounds and ultimately by the Government of Uganda when donor funds are no longer available.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9347	**Mechanism Name: SPEAR**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: World Vision for Khaulhelo Area Development Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,503,302	
Funding Source	**Funding Amount**
GHCS (State)	1,503,302

Sub Partner Name(s)

Research Triangle International		

Overview Narrative

SPEAR ACTIVITY NARRATIVE – FY 2010

World Vision is a Christian humanitarian organization dedicated to working with children, families and their communities worldwide to reach their full potential by tackling the causes of poverty and injustice.

World Vision supports communities to improve their lives through integrated programs including HIV/AIDS prevention and care for the affected populations. World Vision is the lead implementing agency for the USAID-funded five year program for Supporting Public sector workplaces to Expand Action and Responses Against HIV/AIDS (SPEAR). This is a five-year USAID/PEPFAR funded initiative for supporting the Ministry of Internal Affairs (MoIA), Ministry of Local Government (MoLG) and Ministry of Education and Sports (MoES) to enhance HIV/AIDS prevention in their respective workplaces through expanded access and utilization of quality HIV/AIDS prevention, treatment and care services. World Vision is the prime implementing agency of SPEAR project and works in collaboration with Research Triangle Institute (RTI). The goal of the SPEAR Project is to enhance HIV/AIDS prevention among adults through expanded access and utilzation of HIV/AIDS prevention, treatment and care services for selected public sector workers in Uganda that shall be attained by achieving three key results and eight intermediate results as summarized below.

R 1 Support public sectors to develop policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees
IR 1.1 Enhance capacity of public sector workplaces to adopt/adapt policies and practices that improve employees' access to high quality HIV-related services
IR 1.2 Target workplaces and partner service-providers equipped with HIV-related technical and institutional development skills to develop and implement sustainable strategic plans and operational activities
IR 1.3 Effective stigma and discrimination reduction programs developed and implemented in target public sector workplaces
R 2 Increased access to and utilization of quality HIV prevention, care and treatment services by target public sector workers, with a focus on identifying HIV-positive individuals and facilitating access to networked care and treatment services
IR 2.1 Increased personal perception of risk of HIV infection/transmission and utilization of prevention services through aggressive targeted behavior change programs
IR 2.2 Increased access to and utilization of HCT services by targeted public sector workers and their families
IR 2.3 Improved access to and utilization of palliative care, treatment services, and psychosocial support services for HIV-positive public sector workers and their families
R 3 Improved access and use of wrap-around services by target public sector workers living with HIV/AIDS and their families through effective partnerships with other USG and non-USG supported programs
IR 3.1 Improved public sector workers' awareness of the value and sources of wrap-around services available and from public, private, faith-based and non-governmental organizations

IR 3.2 Increased # of target public sector workers and their families accessing wrap-around services through effective referrals and linkages

In FY 2010, SPEAR will implement a number of activities designed around a needs-driven, transformational development approach that provides a solid foundation for achieving the project's objectives and results listed above. To ensure sustainability of its interventions, SPEAR will strategically mobilize political and popular support to benefit workplaces through coalition building, engagement and networking with governments, universities, donors, USG-funded NGOs/local NGOs, CBOs and key stakeholders. Investments will also be made in institutional capacity strengthening, policy and advocacy as a means of engendering a cultural shift at all levels on the importance of protecting the lives of public sector employee and the urgent need for creative and appropriate HIV/AIDS workplace interventions utilizing readily available resources. In addition, project interventions will be based upon participatory and inclusive decision-making, with a focus on engaging the public sector and targeted workplaces/workforces in decision-making at all levels of the project's implementation, monitoring and evaluation.

Cross-Cutting Budget Attribution(s)

Education	50,000
Gender: Reducing Violence and Coercion	200,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9347**
Mechanism Name:	**SPEAR**
Prime Partner Name:	**World Vision for Khaulhelo Area Development Program**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	353,302	

Narrative:

Activity Narrative: Adult Care and Support FY 2010

In FY 2010, SPEAR project activities, under this budget code, will contribute towards improving access to and utilization of a range of quality HIV-related care and support services (excluding TB) as well as wrap-around services for HIV-positive public sector workers and their families. Improved access and utilization of care, treatment and support services for HIV-positive public sector workers has direct and positive implications for addressing the impacts of HIV/AIDS in the workplace. Increased access to care and treatment enhances stigma reduction, disclosure and positive prevention lifestyles which contribute to reduction in worker absenteeism, staff turnover and improvements in staff morale and productivity. Activities described here are thus designed to tap into and build upon services being provided by existing family, community, FBO, private and public health and social support systems to increase care, treatment and support to public sector workers living with HIV/AIDS. All care and support activities will target both male and female employees aged 18 and above within the workplace setting and employee community (e.g barracks setting) of the targeted Ministries. SPEAR project activities provide a combination of care and support services - some directly through training and others through referral mechanisms that will contribute towards improving access to and utilization of a range of HIV-related care, treatment and support services as well as wrap around services for HIV-positive public sector workers and their families (adolescents, adults, women etc).

In FY2010, 1,000 eligible adult public sector workers and their family members including their children will be provided with a range of services that include psychosocial support, management and treatment of opportunistic infections, routine Septrin prophylaxis and ART. SPEAR will create awareness among public sector employees of the targeted line ministries, i.e. MoES, MoIA & MoLG on available care and treatment services within their communities and encourage them to seek, participate in and benefit from these programs. After the provision of HCT services, beneficial referral strategies will be implemented and SPEAR will ensure that persons identified to be HIV positive have access to appropriate medical, treatment, and psychosocial support services through effective linkages and referral systems. In addition, SPEAR will identify service providers who are accessible and acceptable by the employees and referrals will be made to these medical service providers to address their HIV care needs. Special referral will be provided to couples identified to be positive, pregnant women, and people susceptible to TB. Follow-up efforts after referral will be done to facilitate initial contact with care and support service providers to verify completed referrals. In addition SPEAR will provide septrin prophylaxis and hygiene kits directly to organized PHA groups and the facilities they frequented use. Uganda Prisons Service and the Ministry of Education and Sports already have a network of PHAs in their sectors and the formation of associations of public sector employees living with HIV/AIDS in other sectors will be encouraged and supported. To ensure continuity of services for the targeted 1000 PHAs, SPEAR will also establish formal collaboration with local and national HIV/AIDS service providers; negotiate mechanisms through which beneficiaries can be linked or referred to their programs. The project will commit to identifying and referring public sector employees that need care and treatment while seeking partner organizations' provision of these

services.

To strengthen institutional capacity for sustainability, SPEAR will support the respective ACP units of the target ministries to carry out training of 200 lay volunteers in palliative care to supplement the efforts of health workers providing ART for HIV positive workers and their families in their clinics and facilities in accordance with Ministry of Health standards. Examples of lay palliative care volunteers to be trained include associate counselors, home-based caregivers, ART adherence monitors and adherence counselors. The associate counselors will disseminate information about HIV/AIDS care, support services, and be available for psychosocial support and counseling colleagues in the workplace.

To enhance quality care services for HIV positive workers and their families, in addition to the training of the 200 lay volunteers, SPEAR will also train 200 health care providers in basic ART skills according to MoH protocols and guidelines. Training will emphasize ART clinical skills including HIV diagnosis, disease staging, ART eligibility assessment, treatment adherence monitoring and counseling in addition to prevention and treatment of opportunistic infections (OIs). These health care workers will be selected from the target workplace-based facilities and will include school nurses and health workers in police, prisons and local government health facilities. This activity will be limited to facilities where no other USG partner has already undertaken training or is planning to do so in the target year. To strengthen the delivery of treatment services, health care providers will also be trained in the skills needed to ensure continuity of service provision from testing to care and treatment for HIV positive workers and their families and to recognize the need for referral to clinics and community-based health delivery systems. To reduce costs, SPEAR will seek partnerships with other programs/organizations such as MJAP, PIDC, JCRC, Hospice Uganda, TASO, IRCU, AIDSRelief, and Mildmay to incorporate target health workers in their training programs and provide ongoing mentoring.

The effects of HIV/AIDS transcend the medical challenges of infected individuals to include broad socio-economic impacts on families, communities, and high-prevalence geographic regions. Therefore SPEAR will also enhance access to information on available Wrap-Around services to target HIV positive public sector employees beyond the project's core services of HIV prevention, care, treatment and support targeted at the primary causes of HIV-related illness and death. Improved access to wrap-around services by target public sector workers living with HIV/AIDS will be achieved through effective partnerships and collaboration with ongoing USG funded programs and capacity strengthening of national and district PHA networks for sustainability. To meet the demand for wrap-around services by target PHA and their families, SPEAR will strengthen relationships already established in FY 2009 with CSOs, FBOs and government departments/agencies so as to enroll more PHA in their programs. SPEAR will also establish linkages with various private, public and FBO treatment centers supported by the USG and other donor agencies to provide the 5,000 PHA with a basic health care service package that

includes: Insecticide Treated Nets, Nutrition packages including nutrition education and literacy, fortified food supplements, family planning as well as safe water, hygiene and improved sanitation. To make it easy for PHA to identify where to access services, SPEAR will map service providers offering a range of wrap around services and make information/resource lists available to employees as part of the regular information component of the workplace program.

To sustain the provision of wrap-around services, 500 HIV positive public sector employees selected from existing and new workplace-based PHA groups and networks will also be trained in skills that will enable them develop wrap-around services themselves. To maintain quality assurance in the care component, effective monitoring and follow-up, to track the level of care and support will be done using appropriate methods and tools including special studies, record reviews and program reports. Identified PHAs will be enrolled by SPEAR and provided with referral forms to the organizations or health facilities that provide the needed services. SPEAR will then liaise with these organizations or health facilities for proper tracking of complete referrals and the type of services they received. To ensure quality of the data collected, quarterly verifications of the complete referrals will be done by the M&E team. In addition, quarterly follow-ups of the clients retained on the program will be done to ensure efficiency of the program and thus reduce on the drop out rate. Assessments will be done to establish reasons for drop outs and incomplete referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	150,000	

Narrative:

Activity Narrative for Counseling and Testing: FY 2010

In FY 2010, SPEAR project activities under the Testing and Counseling area will be geared towards increasing access to and utilization ofHIV Counseling and testing (HCT) services by 60,000 MoLG, MoES and MoIA public sector workers and their families. SPEAR will focus on increasing demand and utilization of quallity HCT services for public sector employees and their families not only for enhancing HIV/AIDS prevention, but also as a foundation for care, treatment and support services. The HCT target population includes health workers, occupational migrant workers and the uniformed services, such as teachers, police, immigration officers and private security guards. Promotional HCT activities under this budget code will target both male and female employees aged 18 and above within the workplaces of the targeted Ministries. Even though activities will be workplace-based, target employees' families (including spouses and partners) will also be targeted in the context of their communities. Specific activities will include promotion of HCT services to increase individual and social perceptions of the costs and benefits associated with the service and adoption of the health behavior. The campaigns will involve a mix of

strategies to address the negative perceptions, reduce the barriers and encourage uptake of HCT among target workers. Development/adaptation of expertly designed IEC materials to support targeted HCT promotional messages will also be accomplished through collaboration and partnership with HCT service providers and other HIV/AIDS educational opportunities by both the project team and other partners. To increase and sustain uptake of HCT services, SPEAR will continue to support the respective AIDS Control Programs units of the ministries and trained Behaviour Change Agents (BCAs) to promote HCT services within their Units with a view of increasing individual and social perceptions of the costs and benefits associated with the service and adoption of the health behavior. Associations of people living with HIV/AIDS (PHAs) will also be mobilized and facilitated to promote HCT by disseminating key messages on the benefits and the importance of early testing and the importance of engaging with support mechanisms like post-test clubs etc. To ensure accurate and consistent messaging, standard HCT promotional guides and protocols developed by the MoH and other International standards will be followed. In addition, SPEAR BCAs will also be trained in peer counseling on HCT to facilitate the development and nurturing of an HIV/AIDS peer counseling program in all targeted workplaces for reaching out to peers with HCT messages and counseling services in a bid to increase HCT uptake.

To increase HCT access and availability, SPEAR will partner with and support 50 workplace-based HCT outlets (20 in Uganda Prisons Service, 14 in Uganda Police Service and 16 in Education sector) in addition to Local Government facilities including district hospitals and Health Center IVs to provide effective outreach and group-friendly HCT services for public sector employees and their families. SPEAR support to the selected 50 HCT outlets and facilities will include service delivery materials/supplies and also offer training to improve the capacity for delivering HCT services that benefit public sector employees. Specific training support from SPEAR will target health workers (not previously trained) from these selected health units in Uganda Prison Service, Uganda Police Force and the Minsitry of Education on the use of HCT protocols and new approaches to HCT including routine counseling testing (RCT), provider initiated testing and counseling (PITC), Couples counseling and testing, home-based counseling. For maximum coverage, SPEAR will target hard-to-reach workplaces in rural under-served remote areas through a mix of innovative approaches that include mobile counseling and testing camps, work place (e.g office, barracks setting, etc) HCT family days and home based HCT. SPEAR's focus on workplaces outside urban settings (e.g immigration and boader post securty employees) is to help meet the unmet demand for HCT among underserved rural and peripheral public employees. In all these activities, SPEAR will encourage and facilitate pre-marital and couples HCT and mutual disclosure among public sector workers and all efforts will be made to bring HCT services as close as possible to the workplace communities. In FY 2010, a the number of Public Sector Workers (PSW) and their family targeted for counseling, testing and receiving results is 60,000 using a mix of strategies outlined above.

To ensure quality assurance, HCT training of health workers will be based on the approved national HCT

algorithm, and trained staff will be coached on a routine basis by Sector HCT coordinators with support from SPEAR HCT Technical Specialists. Regular support supervision will be conducted to the HCT providers by the district HCT Coordinators to ensure proper adherence to the National HCT Algorithm, and conformity to the standard operating procedures for HCT services. As part of HCT quality assurance, quality control re-testing samples will be done every quarter to ensure provision of reliable, accurate and dependable HIV test results. In addition, regular training of the HCT team in data collection, use and reporting will be done to achieve data quality control. In addition, SPEAR will carry out limited operations research activities to assess the effectiveness of HCT and enhance the quality of evidenced-based service delivery. Special follow on initiatives will be put in place to provide on going support to both the HIV- and HIV+ employees and family members.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	400,000	

Narrative:

The goal of SPEAR's AB activities is to contribute to the development of healthy and transformed youth who are empowered to practice positive social norms, particularly abstinence and mutual faithfulness in monogamous relationships, within a supportive family and community environment. The overall strategic approach is the promotion and re-enforcement of abstinence and faithfulness behaviors among young people who may be encountered in the targeted communities within which SPEAR workplaces: MoIA, MoLG and MoES in all the 84 districts of Uganda. Behaviors that will be supported and encouraged include:

• Abstinence for youth aged 18 and below particularly teacher trainees and recruits in Police and Prisons
• Secondary abstinence for sexually active youth
• Mutual faithfulness in marriage for married youth and adult Public sector workers
• Open communication between youth about sexuality using a life skills and value-based approaches
• Open communication between youth, public sector workers and their partners about sexuality
• Parent – youth communication around abstinence and faithfulness

Key Activities

SPEAR will adopt and modify where necessary the World Vision/John Hopkins tried-and tested Abstinence Risk avoidance and Knowledge (ARK) model in the delivery and achievement of its AB Targets. Key activities will include the following:

Group Dialogue: Monthly community group dialogues and conversations designed around the community melting pot" meeting approach that brings together parents and youth to discuss matters of abstinence and mutual faithfulness will be conducted. The goal of these discussions is to break down communication barriers around sexuality and model communication around sensitive topics such as abstinence, life skills

decision making, faithfulness, and youth sexuality. The group dialogue will be designed to foster youth empowerment and enhance communication on sexuality between adults and youth. They will also be structured in accordance with PEPFAR minimum size limits to ensure that they provide opportunities for reflection on HIV risk and vulnerability factors and community/group actions to address them. The parent-child communication approach that has been used by WV in other countries will inform the facilitation and delivery of these 'Melting Pot' discussions that will serve as a forum to foster dialogue and mutual understanding

Training: SPEAR will train 1000 AB agents as youth mentors and coaches Peer Educators to conduct training for youth and adult populations (religious leaders, teachers, service providers, etc). To support the implementation of AB messages, Trainees will form action groups and conduct outreach in their communities, using materials, tools, discussion guides and job aids developed around AB and risk avoidance to facilitate discussion and dialogue among their peers.
Interactive IEC: SPEAR will engage the target youth and PSWs and their partners and their families' audiences through the development and dissemination of age-appropriate and linguistically-appropriate brochures, leaflets, flyers, and posters. In collaboration with target partners, a total of 50,000 IEC materials that support youth to develop and gain, skills in abstinence will be produced in FY 2010. SPEAR will work with existing community structures – including faith-based organizations, CBOs, schools, formal and informal workplaces, as well as informal social organizations – to ensure that appropriate AB messages are widely disseminated through these mechanisms to facilitate the translation of awareness and knowledge on abstinence and risk avoidance into healthy behaviors that foster mutual faithfulness and practices that reduce HIV vulnerability. Message content for IEC materials will draw on successful national programs to reinforce and sustain the acquisition of risk-free practices and behaviors. Issues of stigma and discrimination will also be addressed to contribute to longer-term behavior change and prevention.
Community radio: Short radio spots and longer interactive discussions will also be developed and broadcasted on community radio stations. These interactive discussions engage experts to speak on AB key messages, and take questions from youth via a call-in format. Specifically AB messages will seek to increase community perception of the benefits of safer behaviors compared to the costs of risky behavior. In addition, messages will re-enforce mutual faithfulness and target the reduction of behaviors that increase risk for HIV transmission such as un unprotected casual, transactional sex, sex with an HIV-positive partner or whose status is unknown, concurrent multiple sexual partners and serial monogamy. To complement radio programming, listener groups will be established in project sites to stimulate discussions among different age groups on abstinence and mutual faithfulness.
ARK Toolkit: World Vision has already developed an AB toolkit which features an array of materials that can be used with both adults and youth to promote and support abstinence and mutual faithfulness. To provide guidance for the adoption and maintenance of Value-Based Life Planning Skills among youth,

SPEAR will procure and adapt this toolkit to help youth to abstain or be faithful.
Partnerships: SPEAR will partner and establish linkages with current Ugandan Government and other US Government supported AB activities and initiatives implemented through UAC, the Unity Project, Straight Talk Foundation and the YEAH Project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	600,000	

Narrative:

SPEAR Prevention activities will be conducted in the workplaces, affiliated private sector workplaces and workstations of three Government of Uganda Ministries: Local Government, Education and Sports, Internal Affairs and their semi-autonomous dependent departments. The target population includes health workers, occupational migrant workers and the uniformed services, such as teachers, police, immigration officers and private security guards. Prevention services under this budget code will target both male and female employees aged 18 and above within the workplaces of the targeted Ministries. Even though activities will be workplace-based, targeted employees' families (including spouses and partners) will also be targeted in the context of their communities. Life skills prevention education will be provided for target family members under the age of 18 and out of school who will be encountered in these programs. Risk factors of the target population includes multiple partners, discordance, lack of condom use, transactional sex, alcohol and drug use that are further accentuated by stigma, denial and discrimination and inadequate and inequitable access to HIV-related services. Sexual and other behavioral risk prevention activities will be geared towards increasing personal perception of risk of HIV transmission and utilization of prevention services through aggressive targeted behavior change communication (BCC) programs to enable beneficiaries to assess their risk for HIV infection, promote behaviors to reduce their risk and acquire skills to enable them to walk away from risky behaviors. BCC initiatives will also focus on Information, Education and Communication (IEC) that encourages employees (and their partners) to learn about STI, avoid transmission and access medical services for diagnosis and treatment as well as dealing with HIV-related stigma and discrimination. SPEAR will also ensure information on correct condom use and sources where condoms can be accessed and made available to all employees and spouses. SPEAR will train 2500 public sector workers and family members as Behavior Change Agents (BCA) to conduct 4000 small group risk reduction education sessions targeting 100,000 adult workers and their family members aged 18 and above.

To promote quality assurance, SPEAR will adapt existing training manuals, develop/adapt IEC materials and communication guidelines in collaboration with partners. All activities will be delivered by well-trained staff in conformity with national and PEPFAR standards. Monthly BCA reports submitted to district BCA coordinators will be reviewed and consolidated by SPEAR staff in addition to quarterly supportive

supervision and progress reviews at all levels of implementation. Promotional activities/IEC on behavior change is integrated with advocacy for workplace policies and plans that assure availability, integration and utilization of sustainable HIV/AIDS prevention, care and treatment services including HCT and PMTCT. Capacity building for workplace HIV/AIDS programming: Capacity building is essential for enhancing sustainability of HIV/AIDS interventions in the workplace. SPEAR project will support the target public sectors to have policies, plans and activities that assure availability, integration and utilization of sustainable HIV/AIDS prevention, care and treatment services for their employees. SPEAR will build the capacity of the three target line ministries to address workplace HIV-related stigma and discrimination by supporting human resource departments and PHA support groups to organize creative events (such as debates, radio seminars, video shows, concerts, testimonies, etc) and anti-stigma and discrimination (S&D) campaigns to highlight dangers of S&D and raise awareness in the respective workplaces and communities. About 750 individuals will be trained as S & D champions and 800 as community mobilizers for prevention.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9483	**Mechanism Name: Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Infectious Disease Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,375,748	
Funding Source	**Funding Amount**
GHCS (State)	2,375,748

Sub Partner Name(s)

Buliisa District	Hoima District Health Office	HOSPICE AFRICA, Uganda
Kibaale District	Kiboga District Local Government	Masindi District Health Services
Strengthening HIV Counselor Training in Uganda	The AIDS Support Organization	

Overview Narrative

The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Acting Principal of the College of Health Sciences. IDI is a leading institution in HIV/AIDS training, research, care and treatment in collaboration with local, regional and international partners.

In August 2008, IDI received a five-year PEPFAR cooperative agreement through CDC entitled: Building Capacity for Scaling up HIV/AIDS Services in rural underserved and high prevalence districts in the Republic of Uganda. The objectives of the five-year project were to support target districts to: (1) establish and manage routine confidential HIV counseling and testing services for all patients; (2) provide comprehensive clinical care for persons with HIV, including staff, through provision of basic palliative care services and ART to eligible clients; and (3) support the capacity of the target health facilities to provide comprehensive HIV/AIDS care services through appropriate training, networking, information exchange and planning

In FY 09, the project was initiated in the two districts of Kibaale and Kiboga as a partnership with the two district local governments, two sub partners: The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) and other key HIV/AIDS stakeholders including, Baylor Uganda (pediatric care and treatment), PACE (basic care package supply and training), and PREFA and EGPAF (PMTCT services).

Based on a baseline assessment of the HIV/AIDS care services in the two districts, the FY 09 objectives were further refined to include supporting the districts of Kibaale and Kiboga to: (1) increase access to care and treatment services for HIV/AIDS, STD, OIs; through strengthening existing service providers and introducing new services; (2) increase TB screening and TB/HIV integrated treatment to TBHIV co-infected individuals; and (3) scale up HIV counseling and testing services through the expansion of routine counseling and testing (RCT) in health facilities and in the communities using the HCT approach.

Achievements in FY 09 included: baseline assessment of HIV/AIDS services in the two districts, that informed the operational plan; project start up activities, including signing of Memoranda of Understanding (MoUs) and setting up project offices; trainings for 100 AIDS Care Volunteer (ACV) and over 150 health

facility staff: and support for the initiation and/or strengthening of service provision at 10 health facilities in the two districts (including 2 hospitals , 5 Health Center IVs and 3 Health Center IIIs).

In FY 10, the project will expand to 11 additional sites in Kibaale and Kiboga districts (10 HCIIIs and one HC II). In addition, the project will expand to three additional districts: Hoima, Masindi and Bullisa, based on the PEPFAR Uganda call for the rationalization and provision of HIV/AIDS comprehensive services. In the new districts, IDI will provide sub-grants to the districts through MOUs, for the provision of comprehensive HIV/AIDS services based on identified needs and HIV/AIDS work plans. IDI and consortium partners will support recipient districts to plan, implement and evaluate comprehensive HIV/AIDS services. Emphasis will be placed on partnerships, grant management, project planning and management, monitoring and evaluation, procurement and logistics as well as the other technical aspects required to successfully achieve a comprehensive HIV/AIDS program.

Targets:
Targets for FY 2010 in 5 districts are as follows
• TB/HIV: 400 HIV+ clients initiated on TB treatment.
• Laboratory Infrastructure: Improving and establishing laboratory capacity in 36 health facilities in 5 districts.
• Counseling & Testing: 150,000 clients in 5 districts.
• Sexual Prevention: The project will target Most at risk populations (MARPS) such as adolescents, school children, discordant couples, commercial motorcycle riders, truck drivers and their sexual partners.
• Care & support: Provision of care and support to 16,659 clients (11,709 old and 4950 new).
• Treatment: 4,998 clients on ART (old and new).
• ARV drugs: Provision of buffer stocks to support the increased demand for care and treatment as well as to support continued counseling and testing in HCT outreach activities.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Water	40,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9483**		
Mechanism Name:	**Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV**		
Prime Partner Name:	**Infectious Disease Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	577,065	

Narrative:

In FY 2010, IDI will support the district in conjunction with its partners in providing adult care and support services at the 21 health facilities in Kibaale and Kiboga districts (2 hospitals 5 HCIVs 10 HCIIIs and 1 HCII) and the 15 facilities in the three new districts. In addition to the facility based services, the project will support the implementation of community based services to ensure a holistic family based approach for service provision

All the active adult clients (16,659; 11,709 old and 4,950 new) will receive a comprehensive package of high quality care and support services comprising : counseling for clients and family members; screening and treating opportunistic infections; screening and treating sexually transmitted infections (STIs); providing vital information on cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT; enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing condoms to sexually active clients.

Prevention with positives interventions (PWP) will be supported in the target facilities and communities. HIV-infected individuals and couples will be supported to prevent HIV transmission to sexual partners and children. Individual, couple, family and community based activities will be promoted to ensure access to family planning, PMTCT and reproductive health services.Post test and discordant couple clubs will be strengthened and supported to ensure sustainability of prevention activities in communities.
In partnership with the district health teams, PACE (Program for Accessible Health, Communication and Education) and TASO basic care kits will be provided to eligible clients. Pediatric and adolescent care will be provided in partnership with our Baylor College.

The project will implement an intensive strategy to quickly boost the number of people being tested and counseled and entering into care for those testing HIV+. The project's roll out to date in the ten health facilities has shown that the health care system situation is much more complex than anticipated and requires additional resources and strategies to achieve the projected results. Critical service delivery

gaps including human resource; training; equipment and supplies; infrastructure; and information systems will be addressed as appropriate, based on the needs assessment.

The districts of Buliisa, Masindi and Hoima in Western Uganda lie in the Albertine Rift Valley Region. These districts have a combined population of over 800,000 (UPHC 2002), and HIV prevalence of 6.9% among the 15-49 years age group (UHSBS 2005). This region is predominantly rural with hard to reach areas and limited access to health care services. The region also suffers a severe shortage of comprehensive HIV/AIDS services with only limited presence of PEPFAR support.

In FY 2010, Infectious Diseases Institute (IDI) will expand its geographical coverage of PITC, Basic Care, and ART to this region in a bid to rationalize comprehensive HIV/AIDS service delivery among USG implementing partners, as well as provide services to underserved communities. A rapid pre-implementation assessment by IDI however revealed formidable challenges, including few and far apart health facilities with poor infrastructure, severe human resource shortages, limited and/or no functional laboratories and lack of transport, among others. All this occurs in a backdrop of remote, hard to reach communities with MARPS (fisher folks) along Lake Albert landing sites.

Objectives:

• To provide PITC services to communities in Buliisa, Masindi, and Hoima

• To identify HIV infected individuals and initiate early prevention, care, and treatment services

• To build capacity of health facilities in the region to provide quality HIV/AIDS services

This funding will be used to support IDI with high impact start-up activities with the potential of improving quality and utilization of HIV/AIDS services in the region. Specifically, the following activities will be done:

• Refurbishing laboratory, counseling, and care facilities in 3 health units that are most in need. These are Buliisa HCIV in Buliisa District, Kigorobya HCIV in Hoima District, and Bwijanga HCIV in Masindi District

• Procurement of basic laboratory equipment for diagnosis of TB and OIs in the refurbished labs, and one CD4 count machine for Masindi Hospital

• Procurement of one vehicle to facilitate coordination, supervision, and transportation of supplies and samples across the region

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	600,000	

Narrative:

In FY 2010, IDI will support the district in conjunction with its partners in providing adult care and treatment services at the 21 health facilities in Kibaale and Kiboga districts (2 hospitals 5 HCIVs 10 HCIIIs and 1 HCII) and the 15 facilities in the three new districts. In addition to the facility based services, the project will support the implementation of community based services to ensure a holistic family based approach for service provision

All the active adult clients (16,659; 11,709 old and 4,950 new) will receive a comprehensive package of high quality care and treatment services comprising : counseling for clients and family members; provision of antiretroviral therapy (ART); screening and treating opportunistic infections; screening and treating sexually transmitted infections (STIs); providing vital information on cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT; enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing condoms to sexually active clients. This activity will support ART for 3,000 adults.

In partnership with PACE (Program for Accessible Health, Communication and Education) and TASO, IDI will ensure that a basic care kits are provided to eligible clients. Pediatric and adolescent care will be provided in partnership with our Baylor College.

The project will implement an intensive strategy to quickly boost the number of people being tested and counseled and entering into care for those testing HIV+. The project's roll out to date in the ten health facilities has shown that the health care system situation is much more complex than anticipated and requires additional resources and strategies to achieve the projected results. Critical service delivery gaps including human resource; training; equipment and supplies; infrastructure; and information systems will be addressed as appropriate, based on the needs assessment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	480,000	

Narrative:

In FY 09 IDI supported HIV Counseling and testing (HCT) provision in Kibaale and Kiboga districts through community and facility based approaches.

In order to access hard to reach communities, the project supported health units conduct HCT outreaches. A total of 152 communities were reached with 24,865 people counseled and tested (including 850 positive). Fishing communities along Lake Albert were targeted through a camping strategy focusing on eight landing sites.

At the facilities, provision of VCT was on-going and in addition 93 health workers in the two districts were trained by SCOT to provide Provider Initiated Counseling and Testing (PICT). Community mobilization for HCT services was conducted through the district leadership and 100 AIDS Community Volunteers (ACVs), trained by TASO.

In FY 2010, IDI and its partners will support counseling and testing in the two project Districts of Kiboga

and Kibaale and in the three new districts of Hoima, Masindi and Bullisa through multiple HCT approaches and sites to reach a target of 150,000 individuals. HIV prevention will be enhances through targeting of couples and mothers eligible for PMTCT services.

In collaboration with MOH, National Medical Stores (NMS) and Supply Chain Management Systems (SCMS) IDI will strengthen logistics management to minimize stock-outs of HIV test kits and related supplies.

Regular support supervision and refresher training will be provided to service providers to ensure quality service provision. Technical support will also be provided to improve collection, analysis, distribution and use of data on HCT so as to inform and improve program activities.

Post test support will be provided through the strengthening of existing support groups and/or creation of new groups at facility and community levels. External quality assurance for HIV tests will be done through the district laboratory network.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	60,000	

Narrative:

In FY 2010, working with Baylor College, IDI will support the districts to provide pediatric HIV care and treatment services at the 21 health facilities in Kibaale and Kiboga districts (2 hospitals 5 HCIVs 10 HCIIIs and 1 HCII) and the 15 facilities in the three new districts. In addition to the facility based services, the project will support the implementation of community based services to ensure a holistic family based approach for service provision. This activity targets 4,165 children with HIV care services.

Child clients will be facilitated to access a comprehensive package of high quality pediatric care and treatment services as advocated by the African Network for the Care of Children affected by AIDS (ANNECA). Pediatric care and treatment services to be offered include; early confirmation of HIV infection status; growth and development monitoring; immunizations according to the recommended national schedule; prophylaxis against opportunistic infections especially Pneumocystis Pneumonia; treatment of acute infections and other HIV-related conditions; counseling caretakers on optimal infant feeding, personal and food hygiene, disease staging; ART where indicated, psychosocial support for the infected child, caregiver & family; and referral of the infected child for specialized care if necessary; and community-based support programs.

Pediatric care and treatment program area is related to the program areas of PMTCT, adult care and

treatment, TB/HIV, psychosocial support, Counseling & Testing, ARV Drugs and laboratory infrastructure and will be delivered as part of an integrated service.

The partners will use a continuous quality improvement approach to enhance data management, as well as conduct quality assurance support visits and clinical mentoring. Staff from the district health teams, IDI and Baylor will conduct regular quarterly mentoring, support and supervisory visits to health facilities, outreaches and community drug distribution points to support basic primary care services for HIV exposed and infected children, OI management, TB/HIV integration and PMTCT. Support supervision will entail assessment of clinic infrastructure, training needs, staffing and other HR issues, logistics, transportation, children/client satisfaction, liaison with families and communities. Continuing Medical Education will be ensured through clinical case reviews, assessment of guideline use and ART regimen decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	230,000	

Narrative:

In FY 2010, working with Baylor College, IDI will support the districts to provide pediatric HIV care and treatment services at the 21 health facilities in Kibaale and Kiboga districts (2 hospitals 5 HCIVs 10 HCIIIs and 1 HCII) and the 15 facilities in the three new districts. In addition to the facility based services, the project will support the implementation of community based services to ensure a holistic family based approach for service provision. This activity targets 4,165 children with comprehensive care services,of whom 371 will be supported for ART.

Child clients will be facilitated to access a comprehensive package of high quality pediatric care and treatment services as advocated by the African Network for the Care of Children affected by AIDS (ANNECA). Pediatric care and treatment services to be offered include; early confirmation of HIV infection status; growth and development monitoring; immunizations according to the recommended national schedule; prophylaxis against opportunistic infections especially Pneumocystis Pneumonia; treatment of acute infections and other HIV-related conditions; counseling caretakers on optimal infant feeding, personal and food hygiene, disease staging; ART where indicated, psychosocial support for the infected child, caregiver & family; and referral of the infected child for specialized care if necessary; and community-based support programs.

Pediatric care and treatment program area is related to the program areas of PMTCT, adult care and treatment, TB/HIV, psychosocial support, Counseling & Testing, ARV Drugs and laboratory infrastructure and will be delivered as part of an integrated service.

The partners will use a continuous quality improvement approach to enhance data management, as well as conduct quality assurance support visits and clinical mentoring. Staff from the district health teams, IDI and Baylor will conduct regular quarterly mentoring, support and supervisory visits to health facilities, outreaches and community drug distribution points to support basic primary care services for HIV exposed and infected children, OI management, TB/HIV integration and PMTCT. Support supervision will entail assessment of clinic infrastructure, training needs, staffing and other HR issues, logistics, transportation, children/client satisfaction, liaison with families and communities. Continuing Medical Education will be ensured through clinical case reviews, assessment of guideline use and ART regimen decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	300,000	

Narrative:

In FY 10, PMTCT services will be supported as part of the comprehensive HIV/AIDS service provision in five districts in Western Uganda (Kibaale, Kiboga Masindi, Hoima and Buliisa). IDI will utilize a district wide approach employing facility and community based approaches, where the District Health Officers (DHOs) will develop PMTCT plans as a component of the overall district HIV/AIDS plans. Joint MOH/IDI technical teams will assist DHOs in prioritizing their PMTCT activities according to district coverage and uptake needs. Based on these plans, IDI will award conditional grants to support the five districts through the local government enabling the project to offer PMTCT services from the hospital level up to Health Center-IIIs.

The objectives of the PMTCT service will be to: 1) provide high quality PMTCT services (comprehensive family-based HIV and reproductive health services especially family planning); 2) increase community and family involvement in PMTCT program around the selected health facilities; 3) promote the 4-pillar approach to PMTCT programming and contribute to the quality of PMTCT services. This activity proposes to reach 7,879 HIV-infected mothers with PMTCT services.

The PMTCT package will include antenatal/HIV/AIDS education, HIV/AIDS Counselling and testing (HCT); to enhance coping and avoidance of re-infection or getting infected for women that test negative. Mobilization and education for PMTCT will be carried out in the communities using drama groups radio talk shows , film shows and home visits by HCT counsellors and AIDS Community Volunteers (ACV's). Male involvement will be encouraged through drama, with targeted messages that encourage male partners to accompany their wives for antenatal care and HCT. All female and male PHAs of reproductive age will regularly be educated and counselled about family planning and PMTCT. Follow up of pregnant

women is critical and will be done by the trained ACVs. This will support follow up of new born babies to ensure early infant diagnosis. The national PMTCT policy and draft HBC guidelines provided by MoH will be followed.

At health facility level, the project will support training of service providers in comprehensive HIV/AIDS care services including provision of PMTCT; provision of prophylactic treatment and on-going counseling; infrastructure improvement to provide more space for counseling and testing; support recruitment of human resource and nutritional supplements for malnourished children and mothers. Additionally the project will train ACV's in PMTCT basics to help with community sensitization and mobilization for HIV care and support services; make referrals for PMTCT services; conduct home visits for HIV+ mothers and their babies and establishing and managing family support groups.

At community level the project will support community sensitization and mobilization to create demand for PMTCT services, enhance family and male involvement and enhance referrals and support. Multiple community education approaches will be utilized including community meetings, IEC materials, radio talk shows and spot messages.
Community based HIV counseling and testing will be conducted to identify eligible mothers and families. Appropriate referral networks will be established through the use of ACVs to link community services to facilities and vice versa. Effective coordination of community activities will be assured through feedback meetings with the ACV's and HCT counselors as well as members of the community supported with regular quarterly supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	128,683	

Narrative:

In FY 2010, IDI and its partners will support host districts to strengthen TB/HIV integration activities across 21 health facilities in Kibaale and Kiboga districts. In the new districts of Hoima, Masindi and Bullisa a similar approach will be taken, targeting 15 health facilities. The objectives of the support will be to support recipient districts 1) improve TB screening for HIV-positive individuals; 2) provide HIV testing to all TB patients and 3) improve care and treatment for TB/HIV co-infected individuals.

The project will support a combination of facility and community based approaches to strengthen TB/HIV services. The project will support the screening of 16,500 HIV+ patients for TB (cumulative) and provide TB/HIV integrated care to 400 TB-HIV co-infected individuals. To ensure sustainability of services, IDI and its partners will support the improvement of existing structures and systems within the health facilities based on the results of a needs assessment that is complete for the two existing districts and will be

conducted for the three new districts.

TB Screening and diagnosis
All identified HIV-infected individuals will be screened for TB. In cases where HIV –infected individuals are identified at HCT outreaches, TB screening will be conducted and appropriate referrals will be made to the eight health facilities Kiboga and Kibaale that have TB diagnostic capacity. For communities where these facilities are distant, the project will support the establishment of sputum referral mechanisms to ensure timely TB diagnosis and follow-up of clients.

The program will provide support for a communications campaign aimed at increasing awareness about knowledge of HIV status, TB symptoms, TB-DOTS and ART literacy in target health facilities and the surrounding communities.

On-going technical support will be provided to all the laboratories capable of TB sputum examination including introducing florescence microscopy diagnostic techniques in district hospitals.

TB Treatment
The project will support the districts and the facilities to improve the services provided at TB clinics and institute SOPs to enhance quality service provision, to ensure optimal client retention and treatment completion. District Health Offices will be supported to ensure a constant supply of TB drugs, septrin and ARVs to TB/HIV co-infected patients.

CB-DOTS workers will be trained to collect follow-up sputum samples during a patient's treatment course (i.e. at 2, 5, and 8 months of treatment), as part of scheduled follow-up.

Health facility staff will be supported in data management and analysis to enable them to better monitor adherence to relevant treatment regimes and to track progress in the performance of their activities. Support supervision and on-job training will be provided by district teams, supported by IDI and consortium partners.
HIV testing for TB patients
All identified TB patients will be offered HIV testing and if HIV-infected will be accelerated into a care and treatment programme.

TB infection control
The project will support the health facilities to implement client triage to identify and prioritize those with TB-related symptoms for prompt service. All HIV/AIDS clients will be screened for TB, provided with a continuous supply of TB drugs while on treatment, have a separate room for those suspected of TB. The

project will support the remodeling as appropriate, to ensure adequate ventilation.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9541	**Mechanism Name: Strengthening the Tuberculosis and HIV/AIDS Response in the South Western Region of Uganda (STAR-SW)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Strengthening the Tuberculosis and HIV/AIDS Responses in South-Western Uganda (STAR-SW) is a new activity that will provide comprehensive facility and community-based HIV/AIDS and Tuberculosis (TB) services in 9 underserved and high prevalence districts in the South-western region. The goal of this program is to increase access to, coverage of and utilization of quality comprehensive TB and HIV/AIDS prevention, care and treatment services. This new program will integrate activities of the Western/South-western District-based HIV/TB program (RFA No. 69-08-09) and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Call to Action project. Program objectives are to: 1) Strengthen decentralized HIV/TB service delivery system, with emphasis on health center IVs, IIIs and community outreaches; 2) Improve quality and efficiency of HIV/TB services within health facilities and community service organizations/groups; 3) Strengthen networks and referrals systems to improve access to, coverage of and utilization of HIV/TB services; and 4) Intensify demand generation activities for HIV/TB prevention, care and treatment service.

The STAR-SW project will provide a comprehensive service package of HIV counseling and testing (HCT), Prevention of Mother to Child transmission (PMTCT), HIV/AIDS chronic care services, HIV/TB collaborative services, community based directly observed TB treatment-short coarse (CB-DOTS), and antiretroviral treatment (ART) for both ARV-naïve people living with HIV/AIDS (PLWHAs) and PLWHAs currently receiving ART through the USAID/TREAT program. This new activity will provide direct technical support to local governments and will use performance-based financing through local competition to civil society organizations in Ntungamo, Kiruhura, Kisoro, Rukungiri, Bushenyi, Kanungu, Isingiro, Ibanda, and Kabale districts. Demonstration of a strong political will and commitment for sustainable TB and HIV programming by local governments will be one of the key priorities for selection. This program will foster the development of strong partnerships with other district-based TB and HIV/AIDS programs in each of the regions in order to improve coordination, expand the referral network, and ensure more efficient use of resources.

Target beneficiaries for this activity are TB patients, pregnant women, HIV exposed children, People Living with HIV/AIDS and their families and communities. At the end of five years, the STAR-SW program has five key results areas: 1) Increased uptake of comprehensive HIV/TB services within supported districts; 2) Decentralized service delivery systems strengthened for improved uptake of quality HIV/TB services; 2 (a) Lot Quality Assurance Sampling Survey is institutionalized at the district level; 3) Quality HIV/TB services delivered in all supported health facilities and community organizations/activities; 4) Networks, linkages, and referral systems established or strengthened within and between health facilities and communities to improve access to and uptake of comprehensive HIV/TB services; and 5) Increased demand for comprehensive HIV/AIDS/TB prevention, care and treatment services.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9541**

Mechanism Name:	Strengthening the Tuberculosis and HIV/AIDS Response in the South Western Region of Uganda (STAR-SW)		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

Despite significant achievements in the reduction of the HIV prevalence in Uganda, it still poses a challenge to the health system in Uganda due to the high incident rate of over 132,000 new infections every year; high population growth rate of 3.2%, overwhelming the already stretched health system. As HIV related deaths reduce, the numbers requiring HIV/AIDS care and support services has increased and access to care and treatment by poor and hard-to-reach people particularly in the rural areas still remains a challenge. The national response has largely focused on scaling up of access to services rather than on strong initiatives to increase utilization and quality of those services.

The STAR-SW program will be implemented within the existing decentralized health systems providing HIV/AIDS care and support services in all health centre IVs and below in the 9 districts in the South western region of Uganda i.e. Kabale, Kisoro, Kiruhura, Isingiro, Ibanda, Bushenyi, Ntungamo, Rukungiri, and Kanungu. Integrated HIV/AIDS care and support services will be implemented at both facility and community levels. Clinical care interventions will include diagnosis and treatment of opportunistic infection, medical prophylaxis using Cotrimoxazole for OIs and Fluconazole for 20 prevention of Cryptococcal meningitis will be provided as part of routine care. Pain and symptom management integrated in to supported health facilities including HC3's. Other services include psychosocial support, spiritual support, bereavement counseling and end-of-life care. The program will strengthen the provision of laboratory tests for diagnosis of HIV and other opportunistic infections; including TB. Target beneficiaries for this program are adolescents, adults, women, MARPs, People Living with HIV/AIDS, their families and communities.

This activity will support best practices and proven interventions and approaches that would improve access to the continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities. Quality assurance/ Quality improvement in care and support services is a fundamental in addressing client retention. HIV care and support services will be provided according to national and international standards, guidelines and protocols. The program will establish facility-base quality improvement teams. Program monitoring will occur through Lot quality Assurance surveys, integrated support and supervision to strengthen data collection, utilization and reporting.

Establishment of networks, linkages, and referral systems for effective referral strengthened within and between health facilities and communities is a key deliverable for this program in order to improve access to and uptake of comprehensive HIV/TB services. The program will utilize GIS mapping of public and private service providers, community-based organizations providing both HIV/AIDS and other established partnerships and coordination structures with existing organizations/groups/activities supporting prevention, care and treatment services. Capacity building of village health teams will strengthen the continuum of care and support at community level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

Anti-retroviral therapy is one of the key interventions that this new activity will provide as part of the comprehensive HIV/AIDS and TB services. The STAR-SW program will contribute to the national efforts of increasing universal access to ART using standardized ART regimens according to national ART policy guidelines. The national ART guidelines require that ART service delivery be part of a holistic program that integrates all elements of a continuum from HIV prevention to HIV testing, treatment, care and support including integration of HIV/TB services. By the end of September 2008, 79 of the 80 districts in Uganda had at least one accredited ART service delivery outlet with wide variation in ART service coverage ranging from 3% at Health Centre IIIs to 100% at hospital level (MOH, 2008). Only 43% adults and children in need of ART were actively on treatment. With the maturity of the national ART program since 2004, the need for monitoring risk factors of HIV drug resistance (HIV-DR) is increased.

The program will increase access and availability of antiretroviral therapy to adult populations in need. Public health facilities in the region will be supported to attain accreditation for ART and those already accredited will be supported to maintain the standards of offering quality ART services. Adult PHLWAs will be screened for ART eligibility using WHO Staging, CD4+ counts. PLWHAs currently accessing treatment from the TREAT supported health centre IVs in the target districts will be transitioned to this program. The program will establish and/or strengthen adherence to ART at both facility and community level through adherence counseling, community follow-up, and active management of side effects in order to reduce drug resistance. Public health laboratories will be strengthened to conduct clinical monitoring tests for ART toxicity e.g. Full blood counts, renal and liver function tests according to national guidelines. Samples for viral load will be collected and transferred to regional labs at least once a year to monitor response to treatment and ART drug resistance.

Systems will be strengthened at the decentralized level to facilitate improved delivery and uptake of ART services i.e. health management information systems (HMIS), supply chain management, strategic

information, and laboratories. The program will strengthen the capacity of human resources to provide ART service through in-service training, mentoring, and continuing medical education. Monitoring and evaluation will involve integrated support and supervision, and data quality assessments. Lot Quality Assurance Surveys will be used to track and evaluate clinical outcomes, improve monitoring and evaluation and ultimately to improve planning and evidence-based decision making at both facility and district level. Integrated support supervision is conducted within each health sub district and ART sites will track the MoH quality improvement indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The STAR-SW program will strengthen access to HIV counseling and testing to promote early knowledge of HIV status, enhance positive behavior change through HIV prevention counseling for both the HIV-negatives and positives and support effective referral of HIV positive clients to HIV treatment and care services. HCT services will be provided at all health units up to health centre II as well as community level through outreaches, HCT camps, and HCT moonlighting. HCT services will be provided at all health units from hospital level up to health centre II. The program will engage in the implementation of the National HCT campaigns in the targeted districts.

Provider – initiated HIV counseling and testing will be provided to all patients as part of routine health care services within public and private health units in the target districts. Specific prevention counseling will be offered based on the HIV status and risk assessment.

Target beneficiaries are individuals most at risk populations, pregnant women as an initial step to PMTCT access, HIV exposed children, TB patients, discordant couples, presence of clinical signs and symptoms which indicate increased risk of HIV infection i.e. STDs, opportunistic infections, and during occupational and non-occupational exposure and prophylaxis.

The program will provide in-service training of health workers to strengthen skills for HCT. REDACTED. The program will update and/or develop QA/QI protocols that will be distributed to the service providers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

The STAR-SW program will scale up and strengthen pediatric care and support services at health centre IV level and below. HIV exposed children identified through the PMTCT program will be linked to care

and support services. The comprehensive pediatric care and support service package that will be supported by this new activity entails scaling up early infant HIV diagnosis with DNA/PCR starting at 6 weeks of age, Cotrimoxazole prophylaxis, treatment of opportunistic infections, immunization, deworming, treatment of all HIV infected infants regardless of CD4+ count, screening older children for ART eligibility according to national policy guidelines, pediatric HIV counseling, growth and development monitoring, pain and symptom management, nutritional assessment, nutrition counseling and promotion of infant and young child feeding according to national and WHO guidelines. Target beneficiaries are HIV-exposed, infected or affected children, their guardians/parents, families and communities. Pediatric care and support services will be provided as an integral component of routine Pediatric in- and out patient services, MCHN, and community outreach activities. Capacity of providing pediatric care and support services will be strengthened through in-service didactic training of health workers, mentoring, continuing medical education and regular support and supervision. The program will establish networks and referral systems within and between facilities and communities in order to strengthen follow-up, retention in care and adherence to treatment. The program will strengthen linkages to other wrap around services like access to ITNs, hygiene and sanitation programs, food security and other OVC support services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

HIV infected children follow a more aggressive course of illness, and approximately 66% die before the age of 3 years (UNAIDS, 2006). The majority of these deaths could be avoided through early diagnosis and timely provision of effective care, support and treatment. The STAR-SW program will contribute to the national universal access target for Pediatric treatment to provide either antiretroviral treatment or Cotrimoxazole, or both, to 80 per cent of children in need by 2010. Key interventions for pediatric treatment will be scaling up Early infant diagnosis using DNA/PCR tests at the regional referral hospitals, strengthen linkage of HIV exposed infants identified through the PMTCT program to care and treatment, and follow-up for ART adherence. The program will support the increased access and uptake of Pediatric ART according to national guideline increasing it from the current 40%. Infant and young child feeding services will entail counseling on appropriate feeding practices according to national policy guidelines, maternal nutrition counseling, nutrition assessments, and referral of malnourished children to the therapeutic and supplemental feeding programs. Pediatric ART services will be provided as an integral component of routine pediatric care, nutrition and MCH. The program will further support the supply chain management, and monitoring of pediatric ART outcomes in the target districts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	HVSI	Redacted	Redacted

Narrative:

In order to promote evidence-based planning, this activity will support the Government of Uganda to institutionalize the carrying out of the Lots Quality Assurance Sampling (LQAS) and ensure that the data generated is used. The activity will also support the key national HIV/AIDS data use (including reporting) processes and activities taking place at the district in order to build sustainability. These activities will be implemented in nine districts in the South western region of the country, namely: Bushenyi, Kabale, Kisoro, Kiruhura, Kanungu, Ibanda, Isingiro, Ntungamo, and Rukungiri. Evidence-based planning and decision making will be achieved through regular measurement of program performances and progress at the districts and lower levels. Regular and timely feedback to the supported local governments, non-governmental organizations ad civil service organizations will be provided through systems strengthening of district level monitoring and reporting systems including HMIS and PMMP. While the LQAS results will be used to inform district level work planning in order to identify intervention areas and sub-counties on which to focus in the future, this USG investment goes beyond this and achives two other objectives. One, the support is also intended to build the capacity of the central level GOU to design, plan, manage, coordinate, and institutionalize the carrying out of the LQAS. The other objective of this USG support is to ensure that these district-based programs support the existing national data collection, collation, use, and reporting systems at the district and lower levels for purposes of building sustainability i.e. strengthening the local government's capacity to coordinate the collation, management, and use of multi-sectoral data for monitoring performance of service delivery as well as for the overall district planning. Coordination at the district also includes ensuring that the the existing supply of, and demand for, ICT (information, communication, and technology) resources (that includes human) are optimised.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

Health Systems Strengthening barriers include inability to pay for services, long distances to access services at facilities, inappropriately skilled staff, poorly motivated staff, shortages and inadequate distribution of appropriately qualified staff, inadequate technical guidance, program management, and supervision, inadequate drugs and medical supplies, lack of equipment and infrastructure, weak drug policies and drug supply system. Other gaps entail reliance on aid agency funding, which reduces flexibility and ownership, corruption.

Key HSS interventions for this new program include supporting institutional capacity building at district level in supply chain or procurement systems, strategic information, human resources for health, service delivery, leadership and governance, and financing.

This activity will enhance the delivery of effective, safe, and quality TB and HIV/AIDS services to the TB patients, PLWHAs, their families and communities. The program will support the dissemination of national policy and implementation guidelines to the direct service providers and establish facility based quality improvement programs to monitor health outcomes of the beneficiaries. The program will create institutional networks and improved referral systems at facility and community level to ensure continuum of care.

The program will provide technical assistance for timely, cost-effective procurement and distribution of medical commodities, drugs and equipment within the decentralized systems in nine districts in the south western region of Uganda i.e. Kabale, Bushenyi, Kisoro, Kiruhura, Kanungu, Rukungiri, Ibanda, and Isingiro.

The program will build the capacity for effective data collection, analysis and timely reporting to the district and national level. The program will update/utilize existing national data collection tools and reporting systems in order to ensure harmony and ownership of the data by the local governments. In order to increase demand for services, the program will provide performance based grants to civil society organizations and build their capacity to engage in advocacy and policy dialogue for HIV/AIDS and TB services.

This program will increase access to TB and HIV/AIDS by providing outreach services at community level and follow-up care. The program will provide continuing medical education to develop planning and management skills in both the public and private sectors. Performance review forums will be conducted regularly. The program will work with District Management Committees to ensure effective recruitment, retention, leadership and motivation of service providers. In order to improve efficiencies in service delivery and reduce work load, task-shifting and supportive supervision will be supported with the leadership of the District health offices.

Strengthening national and regional health systems calls for well coordinated partnerships between government, NGOs, donors and other sector stakeholders such as the private sector. This program endeavors to strengthen collaboration and networking with other key stakeholders at the district level in leveraging HSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted

Narrative:

The STAR South Western project will scale up Medical Male circumscison though training of health workers at 26 health units i.e eight hospitals and 18 health centre IVs. The Project will design and implement a communication strategy that will be used to change negative attitudes on Medical Male circumcision. A network of CBOs, LNGOs, FBOs and other community resource persons will be used to promote positive messages about medical male circumcision (MMC) that is done in health facilities with trained staff using sterile conditions, and to promote it as one of the ways recommended by leaders and the government for HIV prevention. Traditional chiefs and traditional circumcisers will be trained as MMC promoters and counselors in order to support Medical Male Circumcision. Faith-based organizations will be targeted to ensure that the bias against circumcision is minimized and that it is promoted by certain religious denominations

MMC will be addressed by equipping health units with the necessary equipment for MMC, and training of at least two MMC practitioners from among the health workers at each of the Health IVs and all Hospitals. All HCIVs have mini-operating theaters, and all hospitals have full operating theaters that will be upgraded and equipped accordingly to handle MMC.

In order to promote quality assurance, a series of trainings in support supervision for MMC will be held for the clinical officers. The project will adapt training tools from other USG partners e.g.Walter Reed project to ensure that a critical mass of MMC trained staff are present in the 9 districts based at Health Centre IVs and Hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Sexual transmission is the largest mode of HIV transmission accounting for over three-fourths of all new infections (marital sex 42%, commercial sex work 21%, and casual sex 14%). The HIV epidemic has shifted to the older age groups, for which there has been little prevention programming in recent years. Risky sexual behavior is on the rise, including an increase in casual sex, sex with multiple partners, and a decrease in condom use; yet most people who engage in risky behaviors, such as having multiple concurrent sexual partners, do not perceive themselves to be at high risk of HIV infection. Only 21% of female and 23% of male respondents to the UHSBS (2006) believe it very likely that they will contract HIV.

The STAR South Western program will contribute to the National Strategic Plan (NSP) (2007-2012) focus intervention of making HIV prevention the cornerstone of HIV/AIDS programming. The project will implement comprehensive prevention approaches that are aligned to specific groups, behaviors, and

underlying factors in the target population and will support prevention strategies that address social and gender norms that underlie risky sexual behavior. Target beneficiaries are adults, youths, and most-at-risk populations. The STAR SW project will provide financial and/or technical support to increase comprehensive knowledge and risk perception of HIV/AIDS through advocacy interventions that promote positive behavior change for risk reduction and risk avoidance among populations at high risk of HIV infection, and promotion of protective social norms for both women and girls.

The project will strengthen behavior change approaches among youth, including educational counseling and communication efforts, and will utilize lessons learnt and best practices of other prevention interventions. Self-perception of risk among youth and within the general population and correct, consistent condom use will be promoted among sexually active populations. The program will strengthen linkages with other USG-funded social marketing programs to ensure distribution and availability of condoms. Prevention efforts will consolidate youth programming through abstinence programs among young people 10-14 years old, a combination of school-based and out-of-school programs, media, and community approaches. The program will improve programming and linkages across prevention for youth and OVC prevention needs and services addressing prevention with young positives.

Prevention counseling and messages targeting discordant couples and concurrent sexual relations will emphasize faithfulness as well as correct and consistent condom use within discordant relationships. Couples will be encouraged to receive HIV counseling and testing and disclosing their Sero-status to their sexual partners.

The project will provide prevention programming for targeted high risk, vulnerable and mobile populations, as they remain sources of new infections e.g. commercial sex workers, internally displaced persons (IDPs), truck drivers and fishermen. They are more prone to have many sexual partners, to use condoms inconsistently, and consequently increase the risk of acquiring and/or transmitting HIV to several partners, including their cohabiting spouses.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

The STAR South Western program will focus its HIV prevention efforts through targeted interventions focused on most-at-risk populations (MARPs); one of the notable drivers of the HIV epidemic in the region. The MARPs include: migrant workers, distance truck drivers, 'boda boda' cyclists, transactional sex workers, bar and lodge attendants, fisher folk and persons in multiple or concurrent sex partnerships. Program focus will be in underserved and/or hard-to-reach areas.

An estimated 12,000 MARPs will be reached with individual and/or small group level HIV preventive interventions mainly through peer-to-peer interactions and community outreach programs. The program will train and utilize VHT or other peers to deliver other HIV prevention messages and distribute condoms.

This new activity will provide training on OP activities focusing on condom education and distribution at health units providing comprehensive HIV and TB services in order to increase access to prevention education to all clients. Condom distribution will further be strengthened though partner CSOs who will focus on community distribution points.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

The STAR South western project will support the national efforts to improve access to PMTCT services through support to nine districts in the South Western region of Uganda including Kabale, Bushenyi, Rukungiri, Ntungamo Isingiro, Kanungu, Ibanda, Kisoro and Kiruhura. Whereas these districts are estimated to have more than 77,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners providing HIV/AIDS care and treatment services. The STAR- SW project will contribute to the national PMTCT strategy (2006 – 2010 to roll out the revised PMTCT policy guidelines, support the holistic implementation of the four-year pronged PMTCT strategy (primary prevention, family planning, provision of ARV prophylaxis, care and support). In order to achieve the policy implementation goals, the district based program will focus on the following areas:

1. Increasing program coverage for PMTCT: Focus will be placed on strengthening PMTCT service delivery in health units previously supported by the EGPAF program i.e. from hospital up to Health Center III level. PMTCT outreach services will be extended to H/C II or lower level health facilities that do not have the capacity to offer maternity services. the project will strengthen PMTCT quality improvement interventions at health facilities in order to increase PMTCT uptake. Linkages between the community and the health facility will be enhanced through peer educators selected from HIV positive parents (mothers and their male partners) identified during PMTCT, trained, and assigned roles alongside professional health workers at the care and treatment sites.

2. Increase the uptake of combination ARV regimen for the maternal/infant pair. Capacity to offer the more efficacious regimen will be developed through increased training and the streamlining of logistics management at both national, district and health facility level. Logistical support for the procurement and distribution of ARVs, drugs for opportunistic infections and HIV test kits will be major activity. All of eligible HIV positive pregnant women (CD4+ > 350/ml) will be started on HAART and pregnant women

(CD4+ <350) will receive Combined ARV regimens according to national guidelines.
3. Continuum of care and treatment of the HIV positive mothers and their families: The provision of treatment, care and support services to eligible individuals has been shown to improve the uptake of all other PMTCT services. Focus will be directed at strengthening the enrollment of identified HIV-exposed and infected infants into continuum of treatment and care programs through the scale up early infant diagnosis of HIV and follow-ups. This project will further support HIV infected families to adopt safe infant feeding practices in relation to the revised infant feeding materials. Malnourished HIV positive pregnant women and their infants will be linked to the therapeutic or supplemental feeding program implemented by NuLife.
4. Capacity building and mentoring: The program will reinforce the skills of health workers in the MCH/HIV/AIDS/ART clinics by the provision of mentoring programs (from the Regional Referral hospitals) and Continuing Medical Education (CME) in order to improve program uptake. Approximately, 150 service providers (such as counselors, mid wives, laboratory staff and data/records management assistants) will be trained. Individuals trained from the community will focus on encouraging community discussions in areas such as gender power relations aimed at reducing gender-based violence, increasing male involvement and facilitating couple dialogue. Support and supervision will be directed at enhancing the quality of PMTCT service delivery and the development of linkages between PMTCT and other HIV/AIDS care services, including care and treatment, and supporting the full integration of PMTCT programs into district and MOH work plans.
5. In collaboration with other stakeholders, the STAR South western project will review, print, distribute and disseminate new/updated information, education and communication (IEC) materials (including job aides) that will focus on increasing uptake of PMTCT services and create positive behaviors such as supportive male involvement, appropriate/alternative infant feeding practices, spouse disclosure, partners support, living positively and IPT uptake.
6. Integration of family planning services into HIV/AIDS/MCH/Treatment services.
7. Through community mobilization, support will be provided to psychosocial support (PSS) groups for HIV+ mothers and their spouses as coping mechanism on top of accessing the care services. The PSS groups will be supported to leverage other wrap around services such as mosquito nets from the President's Malaria Initiative (PMI), nutrition support from World Food funded programs, etc
8. This activity will also support integrated support supervision conducted quarterly within each health sub district; establish and/or maintain facility based quality improvement teams; introduction of continuous ART quality improvement tools in coordination with HCI or HIVQUAL; support accreditation of new ART sites, mapping community resources; and create community and facility networks.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

Laboratory systems strengthening for TB and HIV/AIDS services are a key component of the STAR-SW activity. The program will focus on public health unit laboratories at health centre IV and III where the majority of the target population for this program can easily access health services. The program will establish linkages/coordination structures and referral systems with National Public Health Laboratory and other laboratories at district and regional referral hospital for external quality assurance, and handling of tests that are not offered in the lower health units i.e. biochemistry tests, CD4+ tests, DNA/PCR, Serum Crag, etc.

Key program interventions will be the improvement of laboratory infrastructure for improved ventilation, waste management, and water supply in order to ensure safety. Laboratories will be renovated to conform with national standards and guidelines for space and safety. The program will support laboratories at each level of health care to provide the recommended tests for that level according to the national MOH guidelines. These include complete blood counts, Hemoglobin tests, malaria tests, TB diagnosis, and HIV diagnosis at District hospitals, health centre IVs, and health centre IIIs. In addition, the program will support provision of liver function tests, renal function test, pregnancy tests and serum glucose tests at the districts hospitals. Blood samples for CD4+ testing will be transported to regional referral hospital laboratories. During program year II, districts hospitals that are not co-located with Regional Referral hospitals will be supported to provide CD4+ machines on a case by case basis.

This new activity will strengthen the capacity of laboratory personnel to conduct quality laboratory tests as recommended by the national laboratory policy guidelines. They will receive pre-service training, in-service training, mentoring from teams from the Regional referral hospitals or National Public health laboratory, and on-going coaching to ensure adherence to laboratory standard operating procedures.

The program will strengthen the laboratory logistics management systems to ensure an effective supply chain management system for supplies. A system for equipment maintenance and servicing will be established utilizing MOH Regional/Central maintenance units. The program will establish a system of quality assurance for laboratory tests including internal quality control, external quality assurance and quality improvement. Regular support and supervision will be done to monitor efficiency and effectiveness of laboratory services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

The program will enhance collaboration between tuberculosis and HIV/AIDS services in the provision of a continuum of quality care in the target districts for people with, or at risk of, tuberculosis and people living

with HIV/AIDS. The program will contribute to the national TB and HIV/AIDS response through implementation of collaborative TB/HIV strategic interventions that include1) active participation in the Stop TB Partnership in collaboration with the National TB and Leprosy program and AIDS Control Program; 2) decrease the burden of tuberculosis in people living with HIV/AIDS; and (3) to decrease the burden of HIV in tuberculosis patients.

At the national, district and sub-county level, the STAR-SW program will be a key stakeholder in the national coordination committee of the Stop TB partnership. The program will establish and/or strengthen surveillance systems for HIV prevalence among TB patients through utilization of data from the routine HIV testing and counseling of tuberculosis patients, carry out joint TB/HIV planning, conduct monitoring and evaluation of TB/HIV collaborative activities according to national guidelines.

The second TB/HIV collaborative strategy is to decrease the burden of tuberculosis in people living with HIV/AIDS through: 1) intensified tuberculosis case-finding where TB patients or suspects will receive HIV counseling and testing at facility and community level; 2) strengthen Isoniazid preventive therapy according to national guidelines; 3) and establish tuberculosis infection control in health care and congregate settings. Intensified case finding comprises screening for symptoms and signs of TB in PLWHAs, diagnosis and prompt TB treatment in PLWHAs co-infected with TB, and their household contacts. The program will strengthen access and availability of TB services for populations at high risk for HIV and those in congregate settings (e.g. prisons, workers' hostels, police and military barracks) with the goal of improving their quality of life. The program will use administrative, environmental and personal protection measures to for infection control for health care workers, prison staff, police and their clients, and any other persons living in the congregate settings. Administrative measures will include early recognition, diagnosis and treatment of tuberculosis suspects, particularly those with pulmonary tuberculosis, and separation of pulmonary tuberculosis suspects from others, until a diagnosis is confirmed or excluded. Environmental protection will include maximizing natural ventilation. Personal protection will include protection of the PLWHAs from possible exposure to tuberculosis. Each supported health unit will have a tuberculosis infection control plan, which includes administrative, environmental and personal protection measures to reduce transmission of tuberculosis in health care and congregate settings.

The program will decrease the burden of HIV in tuberculosis patients through provision of HIV testing and counseling to all TB patient and their families, provision of comprehensive HIV prevention services, Cotrimoxazole prophylaxis to > 80% of TB patients, linkage of HIV co-infected TB patients to care and support services and screening them for ART eligibility using WHO staging and CD4+ counts. Eligible TB patients will be started on HAART according to national guidelines.

Quality of TB/HIV collaborative services will be enhanced through capacity building of service providers at facility and community level including training, and mentoring. Community based DOTS will be implemented in order to improve adherence to therapy and improve treatment success. The program will enhance the health care system to in order to increase access to TB/HIV laboratory diagnosis, logistics management and referral systems. The program will utilize the existing national M&E tools, IEC materials and reporting systems at district level to implement TB/HIV collaborative activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9542	**Mechanism Name: Health Communication Partnership (HCP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Center for Communication Programs	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,738,157	
Funding Source	**Funding Amount**
GHCS (State)	2,738,157

Sub Partner Name(s)

AIDS Information Center	Communication for Development Foundation Uganda	Makerere University School of Public Health
Media for Development International	Regional Center for Quality Health Care	

Overview Narrative

HCP provides technical assistance, implements communication strategies and approaches, and supports capacity building for USAID and PEPFAR partners to achieve three intermediate results:

1. Improved ability and motivation to use services and practices that enhance health
2. Supportive social environments fostered to enable positive health behavior

3. Strengthened capacity for sustained health communication.

HCP provides HIV/AIDS communication support to services in all parts of Uganda in the following programmatic areas, and for the following populations:

• HIV/AIDS prevention among young people 15 – 24 years old nationally through the multi-channel Young Empowered and Healthy (Y.E.A.H.) initiative and associated telephone hotline;
• AIDS treatment uptake and adherence among PLHA, including young people, and children in geographic areas served by PEPFAR treatment and HCT partners;
• Prevention of HIV transmission among HIV-positive young people and married adults who know their HIV status;
• Couple HIV counseling and testing, risk reduction counseling, and referral for treatment and care services in 8 districts served by PEPFAR-support HCT services;
• Medical male circumcision (MMC) education, counseling, and advice for men who are not circumcised, health workers, leaders, and media representatives in 6 districts that have MMC services;
• Medical male circumcision education, counseling, advice, and referrals for young men who are not circumcised, leaders, parents, and health workers in 4 districts of Bugisu, and Kasese where traditional circumcision takes place.

In an effort to strengthen health systems, HCP works closely with the Ministry of Health to strengthen the Village Health Team (VHTs) system for provision of information, referrals, and some limited services at village level; to train health workers in the provision of pediatric ART services; to develop job aides and training materials for HIV/AIDS service providers and community outreach volunteers; and to disseminate policies, strategies and guidelines throughout the health system. HCP also assists the MOH and partners to innovate training approaches for health workers and VHTs that do not interrupt services or require costly residential workshops.

HCP, through its support to Y.E.A.H. for the True Manhood campaign, focuses on the cross cutting issue of gender. Through interpersonal communication supported by media messaging, True Manhood is designed to challenge young men to question gender norms that promote multiple sexual partners and alcohol abuse, inequitable attitudes toward women, violence against women, and transactional sex.

Other key issues tackled by HCP include family planning and TB. HCP integrates all health topics in the MOH minimum health care package through its distance learning programme for VHTs. In addition, HCP supports a hotline that provides counseling and referrals not only for HIV/AIDS, alcohol abuse, gender based violence, and male circumcision, but also for family planning and TB.

HCP works in partnership with Ugandan organizations to build capacity for sustained HIV/AIDS communication beyond the end of the project. It supports Y.E.A.H. to leverage funding for its activities through non-USG sources, including commercial sponsorships of the radio drama and comic book series "Rock Point 256", with the aim to achieve 100% sponsorship by the end of FY2010. HCP also works through partnerships with networks of Ugandan organizations funded through PEPFAR and non-USG donors to implement communication activities at community level, using tools, approaches, and materials prepared with HCP assistance. In many cases, partners fund production and reproduction of communication materials as well as training for community outreach workers. In these ways, HCP is able to expand geographic coverage at minimal cost. HCP relies entirely on government and private sector service providers to offer HIV/AIDS services, including counseling and communication. For example, HCP will partner with RCQHC to train public and private sector service providers in pediatric ART counseling and service provision working with the government and PEPFAR partner training systems.

HCP will continue to monitor its activities through activity reports from partners, collection of service delivery data, observation of community outreach activities, and small-scale evaluations of selected communication interventions. Also during FY2010, HCP will evaluate the effectiveness of various communication efforts through an analysis of the findings from a mid-term evaluation survey that will take place at the end of FY2009, and is comparable to the FY2007 baseline survey.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	100,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9542**
Mechanism Name:	**Health Communication Partnership (HCP)**
Prime Partner Name:	**Johns Hopkins University Center for Communication Programs**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	486,570	

Narrative:

Since FY2007, HCP has worked with a variety of ART providers and PHA groups to roll out two communication campaigns on ART literary, and paediatric ART. These partners include: JCRC, PIDC, the Mildmay Center, Reach Out Mbuya, Young Positives, The Uganda Network of Young Positives, EGPAF, HIPS Project, NUMAT, and NACWOLA. During FY2009, HCP plans to expand this network to include new treatment providers, to critically assess progress under the ART communication strategy developed in 2006, and to identify communication needs for future focus. Based on this assessment, and a review of literature concerning AIDS treatment and adherence, HCP plans to assist this network to design an updated HIV/AIDS treatment communication strategy; and to implement it. It is anticipated that this strategy will include client counseling and education approaches, provider job aides and training to support provision of comprehensive information for ART and PMTCT clients at clinic and community levels. The strategy will include approaches for providing essential information for PHA, counselors, health workers, and community volunteers about treatment, prevention of transmission and re-infection, prevention and treatment of opportunistic infections including TB, family planning, nutrition, and stigma reduction. Messages and materials will be developed based on a review of relevant research and feedback from existing community volunteers and clinical providers, and with input from technical experts. The aim will be to support clinical providers and community volunteers/VHTs to provide services and information tailored to the needs of particular clients, with an aim of empowering PHA and ART clients to take responsibility for maintaining their own health and well being. HCP will assist with the training for trainers, will facilitate and coordinate the development of common messages and educational materials, and will develop and disseminate media materials that model and build the expectation for comprehensive treatment, prevention, care, and support services among PHAs and their families. These activities will be closely linked to the "Go together, Know together" couple counseling and testing campaign activities and services, to ensure concurrent positive and discordant couples are referred on for treatment services.

Near the end of FY2009, HCP will conduct a survey to assess the effects of its communication efforts since the initial survey in FY2007. The survey will provide information about the effectiveness of ART communication activities, messaging and materials. HCP also plans to evaluate adherence counseling tools to determine their effectiveness in improving client counseling and compliance.

In FY2010, HCP will assist the network of ART providers to critically assess the communication needs of PHA, ART clients, and the public, and to adjust the ART communication strategy accordingly, based on data from the HCP survey conducted in FY2009. HCP will then assist the partners to design and roll out updated communication concerning treatment. It is anticipated that this roll out will include client adherence counseling job aides and client education materials for ART clients, as well as targeted communication concerning treatment for PHAs. The focus will be on increasing uptake of services

among eligible PHA, and preventing the most common adherence issues as revealed through the literature review and assessment of adherence aides.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	385,000	

Narrative:

During FY2008, HCP in partnership with the National HIV Counseling and Testing (HCT) Coordinating Committee (CT17) designed and launched a communication campaign promoting counseling, testing and disclosure of HIV status among cohabiting partners in seven regions of Uganda where AIC has services: central, north central, northwestern, eastern, southwestern, West Nile, and northeastern. The campaign encourages and motivates couples to assess their risks of HIV, test, and share their status with each other, and directs them to all health facilities in their areas offering couple HCT. Although AIC is the lead implementing agency, this initiative is a coordinated effort with participation of various partners at various levels of implementation. HCP's role during FY 2008 & 2009 was to design the "Go together, Know together" communication strategy, map locations of HCT services in the 7 regions, develop/adapt campaign media and materials, develop community mobilization tools for couple testing days, assist with the development of a national couple HIV counseling and testing training manual for health workers, develop a campaign monitoring and evaluation system, and determine baseline indicators. AIC is primarily responsible for assisting the MOH to train national trainers in the updated training materials, organize couple counseling and testing weeks in 7 districts, and report on HIV counseling and testing clinical data. HCP also designed and produced a radio distance learning programme for Village Health Teams (VHT), which includes sessions on HIV counseling and testing and couple counseling and testing specifically. HCP also provided training for AIC staff in strategic communication and media relations. During FY2009, the media and mobilization campaign rolls out in all districts in the 7 regions, utilizing a mixture of communication approaches to attract couples for HCT, and to promote disclosure of HIV status among cohabiting partners, including mass media, client education and information, and community outreach. The educational campaign culminates in couple counseling and testing weeks in eight districts where AIC has services, during which HCT services are available free of charge to couples. AIC and the MOH ensure that needles and other biological wastes are disposed of according to infection prevention guidelines and protocols.

Late during FY2009, HCP will expand the "Go together, Know together" campaign to specifically target couples in high risk communities. Counseling and testing weeks will be expanded to 21 more districts, and the campaign will target most at risk populations, identify people who are HIV-positive, and enroll them in PLHA services, and promote HIV transmission prevention behavior among HIV-negative concordant and discordant couples. Specifically, communication will be tailored to high risk populations

such as refugees, fishermen, transient laborers, members of uniformed services, and their spouses. HCP plans to work with PEPFAR-funded partners (eg. STAR Projects, HIPS and ROADS) as well as non-USG partners working in these high risk communities such as IOM and Uganda Cares. Through this national communication campaign, HCP plans to reach a minimum of 10 million adults throughout Uganda through the mass media, and a minimum of 1,000 men and women per district with interpersonal communication about HCT, resulting in an estimated 18 couples counseled per day in 290 health facilities over a 6 month period. Assuming that each facility offers couple counseling and testing services 2 days per week, the campaign will result in 250,560 couples counseled and tested between 1 October 2009 and 30 September 2010. AIC is responsible for reporting on numbers of couples counseled and tested.

In late FY2009, HCP plans to conduct a survey to evaluate the effects of its interventions, including the "Go together, Know together" campaign, to inform the design of HCT communication for FY2010 and beyond.

During FY2010, HCP will work with the CT17 to review and revise the "Go together, Know together" campaign strategy, communication tools and approaches in light of HCP evaluation survey and campaign monitoring data. Campaign materials and tools will be revised, translated to additional languages, and reproduced for use in 25 new districts in addition to the 29 reached during FY2009. The updated "Go together, Know together" campaign will then be rolled out to all 54 districts. HCP will provide communication materials and training for trainers of community mobilizers, and will orient partners to this new phase of the campaign, as well as disseminate media materials. Partners will be responsible for ensuring the availability of testing commodities, for training counselors in couple HIV counseling and testing using the national curriculum, and for supportive supervision of services. HCP intends to partner with MOH, MJAB, AIC, Uganda Cares, the STAR Projects, ROADS, HIPS, NUMAT, and any other HCT service providers interested in coming on board in the 54 districts.

Assuming an average of 10 HCT sites in each district, and 3 trained counselors in each site capable of counseling 6 couples per day, the campaign will result in 9,760 couples counseled and tested per day in the 54 districts. If we assume that couple counseling and testing services are offered on average twice each week for a period of 6 months, this will result in 466,560 couples counseled and testing as a result of the campaign in the 54 districts.

HCP will train an estimated 2 trainers each from among 8 partner organizations working in the 54 districts in community mobilization for couple HCT; these 16 trainers will, in turn, train and supervise 20 community resource persons/village health teams (VHT) per district (for a total of 1,080 community mobilizers trained) to mobilize couples for HCT in the communities served by couple HCT services.

HCP will work with the CT17 and partners to design supportive supervision guidelines and tools, and a monitoring and evaluation system to track community mobilization activities.

The "Go together, Know together" campaign includes tools, job aides and client materials for post-test counseling and referral for services. The couple counseling and testing training curriculum includes instructions on post-test counseling and referrals. In addition, HCP will work with CT17 and its partners to map HIV prevention, treatment and support services in all the 54 districts, and will provide referral directories for use by counselors. In addition, HCP will conduct in-service training for telephone hotline counselors at the HCP- supported national hotline to provide information and referrals for couple counseling and testing, as well as post-test follow up and risk reduction counseling.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	516,587	

Narrative:

Since November, 2007, HCP has been assisting the Ministry of Health and MOH Male Circumcision Task Force to provide accurate and easy-to-digest information about medical male circumcision (MMC) for HIV prevention. The purpose of this effort was to correct misinformation about MMC and HIV prevention, to inform policymakers and health workers about MMC and HIV, and to influence policy concerning the provision of MMC services. HCP, in partnership with Makerere University School of Public Health, conducted a literature review and quantitative research on male circumcision knowledge, attitudes, practices, and programmatic interventions in Uganda and elsewhere in the region, assisted the MC Task Force to develop a MMC communication strategy; produced and distributed informational materials about MMC and HIV to policy makers and health workers; conducted media relations training for MMC providers and experts, and briefings for representatives of both print and electronic media and parliamentarians; organized public debates and radio and television call-in talk shows about MMC and HIV prevention; and worked with Signal FM in Bagisu region to educate community members, leaders and traditional circumcisers about safe circumcision practices during the traditional circumcision season in 2007. HCP oriented District Health Educators from 82 districts and incorporated accurate information about MMC and HIV prevention into training materials for Village Health Teams (VHTs) and other community volunteers; incorporated sessions on MMC and HIV for broadcast during a distance learning radio series for VHTs; and trained telephone hotline counselors to provide information about medical male circumcision and prevention of HIV acquisition. Also in FY2008, HCP conducted a mapping of MMC services throughout the country through a telephone survey. While the quality of MMC services is not known in the facilities, the mapping exercise does allow MOH to know where services are currently available and their approximate case load.

HCP works in partnership with the Makerere University School of Public Health (SPH), strengthening its capacity to key research findings concerning MC and HIV into advocacy and communication materials, and supporting the development of a MMC policy and strategy for service delivery/scale up appropriate to Uganda's health and socio-political setting. During FY2009, HCP and SPH plan to work with religious, cultural and community leaders as well as health workers in seven districts where traditional male circumcision is done—Mbale, Bududa, Manafwa, Sironko, Kapchorwa, Kasese and Bundibudyo. In partnership with the Association Surgeons of Uganda (ASOU), HCP will implement a combined effort to improve the quality of existing medical male circumcision services through training in the provision of MMC as well as counseling, coupled with a concerted communication and advocacy campaign aimed at convincing young men to get circumcised at MMC facilities, rather than through traditional circumcisers, and to understand the relationship between MMC and HIV prevention.

Specifically, HCP, SPH and ASOU will work with the MOH to develop a training curriculum on MMC counseling and client education for health workers, and will train 10 national trainers. These trainers will in turn train 70 health workers from a total of 25 health centers in the 7 targeted districts; 25 of the trainees will also receive training by ASOU to strengthen their skills in MMC. HCP/SPH will select health facilities in the 7 districts that already provide MMC, and together with ASOU, will conduct site assessments to determine quality improvement gaps in MMC services, and develop plans to address them.

HCP and SPH will work with local CSO partners, including Signal FM, TASO, AIC, and others, as well as the HIPS Project, to mobilize men for the strengthened MMC services. HCP will develop a community mobilization training curriculum that includes MMC, HIV/AIDS prevention, including multiple concurrent partners, condom use, and sexual violence. A total of 50 mobilizers/Village Health Teams (VHT) will be trained to talk with parents of young men and the young men who are ready to be circumcised about the dangers of traditional circumcision, the relationship between MC and HIV, and to promote MMC services. Each mobilizer will be expected to reach 3 people each week for a period 7 months, for a total of 4,200 young men and parents reached. These interpersonal discussions will be reinforced through radio programmes and discussions with cultural, religious, and other community leaders, extolling the dangers of traditional circumcision and the safety of MMC.

In addition, HCP will support the 10 national trainers to train health workers in hospitals and HCIV in Kampala that already offer MMC services, TASO and AIC clinics to educate clients and correctly answer their questions concerning MMC and prevention of HIV acquisition, as well as male norms and behaviors that increase risk of HIV transmission, including multiple sexual partners, and sexual violence. Training for health workers in MMC will also be integrated with health worker training being conducted by other PEPFAR and USAID-supported projects (eg. family planning/reproductive health, malaria, HIV/AIDS, or

TB/HIV).

It is anticipated that by FY2010, Uganda will have a national policy on MMC, and the roll-out of MMC services will be underway by the MOH. HCP will assist the MOH and its partners to get the word out about MMC and HIV, and direct clients to MMC services nationally, with an emphasis on the 7 districts from FY2009 plus 8 additional districts. This will be done through a combination of targeted community mobilization and media programming, supported with in-facility client education and counseling. HCP will focus on improving the availability of client counseling and information about MMC/HIV at an additional 40 health facilities in 8 districts, by training 100 health workers. HCP will also train 100 VHTs/community mobilizers in communities surrounding the 40 health facilities. These mobilizers in addition to the 50 mobilizers trained in FY2009 will be expected to reach 3 people per week over a 12 month period, resulting in 21,800 people reached with information about MMC and HIV prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	800,000	

Narrative:

HCP has been working in Uganda since July, 2004, assisting the Uganda AIDS Commission to establish a national multi-channel communication initiative for young people 15 – 24 years old called Young Empowered and Healthy (Y.E.A.H.). Y.E.A.H. is managed by a partnership of Ugandan organizations led by Communication for Development Foundation Uganda (CDFU), and has launched three consecutive multi-channel communication campaigns for young people—one discouraging transactional and cross-generational sex, one called the Be a Man campaign that promoted more gender equitable attitudes and behaviour among men, and most recently the True Manhood campaign which equates masculinity with attitudes and practices that prevent HIV. All campaigns promote HIV/AIDS prevention through abstinence, partner reduction, faithfulness, and HIV counseling and testing.

In FY 2005, Y.E.A.H. launched a weekly half-hour radio serial drama called "Rock Point 256", which won an international award for excellence in HIV/AIDS communication in 2007, and has an estimated listenership of 59% among young 15 – 24 year olds, according to a survey conducted in 14 districts by HCP in 2008. Y.E.A.H. is a national campaign, implemented in six major languages: Luganda, Runyoro/Rutoro, Runyankole/Rukiga, Luo, Ateso, and English. During FY 2008, Y.E.A.H reached more than 2 million young people through mass media and 50,000 through community outreach promoting gender equitable relationships, faithfulness and partner reduction, open and non-violent communication between intimate partners, couple counseling and testing for HIV.

Near the end of FY 2008, HCP assisted Y.E.A.H. to launch the True Manhood campaign, which focuses

on alcohol, violence against women, multiple concurrent partners, and transactional sex. True Manhood is a phased campaign, and Y.E.A.H. launched the first phase umbrella campaign in June, 2009. The second and third phases on alcohol and violence against women are planned for FY2009. This includes a continuation of Rock Point 256 radio serial drama and comic books in four languages, radio spots, print materials, as well as community outreach activities. The emphasis will be on social and individual change to create an environment where multiple sexual partners and transactional sex are no longer associated with manhood; where young people, especially men, recognize the association between alcohol, violence, concurrent partners and HIV; and where community resource persons such as the police and peer educators are trained to assist young people resist alcohol abuse and violence against women, adopt abstinence, faithfulness or condom use as HIV prevention strategies; and avoid stigmatizing and discriminatory practices and language toward people with HIV and AIDS.

HCP will also work with the media and influential leaders at both national and community level to ensure that they recognize concurrent partners, violence against women, alcohol abuse, and HIV/AIDS related stigma as underlying factors to HIV infection and speak out against these practices. Additionally, HCP will work with the media to encourage portrayals of the underlying causes of HIV (violence against women, alcohol abuse, multiple sexual partners, transactional sex, and HIV/AIDS related stigma) in a more serious and constructive manner. All media will continue to refer young men and women to a hotline that was established during FY 2008 for personalized information and counseling.

During FY2009, HCP will also assist YEAH to continue training facilitators among men's groups and youth groups at community level, and vocational training institutions, universities to facilitate interactive discussions using materials and tools produced by Y.E.A.H.. HCP will assist Y.E.A.H. to adapt successful tools and approaches produced by various partner organizations and train facilitators to use them during community outreach work. Community-based interpersonal approaches will be designed to raise consciousness and stimulate changes in the ways men and women relate to one another—specifically, encouraging more responsible drinking behavior, non-violent resolution of differences, mutual respect and equity in relationships, faithfulness and partner reduction. Campaign media and interpersonal approaches will be designed to reinforce one another, leading to informal dialogue about these issues among young people and their influencers, and changes in individual and collective practices. Y.E.A.H. will orient the peer educators and community resource persons it has already trained in the use of community outreach tools on alcohol, violence against women, sexual networks, and multiple concurrent partners. In addition, Y.E.A.H. has developed a flipchart for use by community leaders and police Community Liaison Officers, and will orient 44 to use this tool to discussion alcohol abuse and violence against women in small groups. These peer educators and community resource persons will each counsel and facilitate discussions 1 – 2 times per month over a 3 month period for groups of approximately 23 young people, resulting in a total of 44,298 young men and women reached

through community outreach with alcohol and HIV prevention information.

HCP is also assisting Y.E.A.H. to mobilize resources to ensure sustainability of its activities after HCP ends in 2012. During FY2009, Y.E.A.H. plans to leverage private commercial sponsorship for Rock Point 256 comic books and radio programmes; institutional support through private foundation funding; and applying for bilateral or multi-lateral donor funds to support future campaign activities.
In July, 2010, HCP will assist Y.E.A.H. to evaluate the reach and impact of its communication through a second household survey in the same 14 districts as were surveyed in FY 2007.

In FY2010, HCP and Y.E.A.H. will launch a third campaign under the True Manhood umbrella focusing on transactional sex and multiple concurrent partners. The campaign, which will run for six months, will use a mix of community outreach and individual communication reinforced with mass media and print. Assuming Y.E.A.H. has secured sponsorship for "Rock Point 256", the drama will be designed to carry storylines about transactional sex, sexual networks and the increased risk of HIV, masculinity and gender equitable attitudes and practices. The campaign will rely heavily on HIV/AIDS prevention partners for community outreach activities, and will direct young men and women to the telephone hotline for individualized counseling and information about HIV/AIDS, transactional sex, multiple concurrent partnerships, sexual networks, alcohol, violence against women, and other risky practices.

At community level, Y.E.A.H. will train existing peer educators and community resource persons in five regions (Busoga, Northern, Southwestern, Central, and Kampala) to conduct small group interactive sessions of not more than 25 people to discuss transactional sex, multiple sexual partnerships, sexual networks, male gender norms, and to give young men and women an opportunity to practice life skills necessary to reject the practice. A total of 89 peer educators at tertiary institutions, community and youth groups, will each conduct 1 or 2 sessions each month for a total of 2 months, reaching a total of 20,424 young men and women with HIV prevention messages promoting abstinence or faithfulness.

Y.E.A.H. has designed checklists and guidelines for supportive supervision of peer educators, which its staff and partners use when observing and supervising community outreach activities. Y.E.A.H. trainers and outreach supervisors will visit the five regional lead organizations quarterly to co-facilitate supportive supervision visits to outreach volunteers/peer educators, observe the quality of interactions, and provide feedback. In addition, all peer educators will be trained to use standard tools when conducting outreach activities.

Y.E.A.H. works in partnership with organizations that provide HIV/AIDS services, or prevention guidance, including the AIDS Information Center, Straight Talk Foundation, Save the Children, and Student Partnerships Worldwide, Reproductive Health Uganda, among others. Through these partners, young

people get direct referrals to services.

Each peer educators is required to submit monitoring forms to the regional lead organization in his/her locality. Each month, the regional lead organizations summarize and submit returns to Y.E.A.H. headquarters in Kampala. Y.E.A.H. maintains a database to compile all the monitoring data for community outreach activities. In addition, Y.E.A.H. supports a team of radio monitors who listen to the weekly radio broadcasts and report to Y.E.A.H. when broadcasts are missing or cut short so Y.E.A.H. can contact the radio stations. Y.E.A.H. also receives many letters from young people who listen to its radio programmes or participate in its activities. Y.E.A.H. maintains a tracking system for these letters, and once a year conducts an analysis of letter content. The results are shared with the radio drama script writers and Y.E.A.H. program officers to improve future programming. Once every 2 years, HCP assists Y.E.A.H. to conduct a household survey in 14 districts to assess the reach and effects of its programming. The first such survey took place in July, 2008, and will be repeated in July, 2010.

A comparison of the data will help to identify program strengths and areas for improvement , and will contribute to the body of knowledge concerning the effectiveness of prevention efforts.
During FY2010, HCP will continue to assist Y.E.A.H. to secure funding for other sources, and to build its capacity to design and implement communication activities independently. HCP will decrease its level of technical assistance during the year to give Y.E.A.H. a chance to work more independently. HCP will assist Y.E.A.H. to write and submit at least 3 proposals for external funding, and to market its services and products to commercial and non-USG partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	550,000	

Narrative:

In FY2008, HCP worked with Y.E.A.H., the Uganda Network of Young Positives, Joint Clinical Research Center (JCRC) and Paediatric Infectious Disease Center (PIDC) to reach out to HIV-positive adolescents between 15 and 24 years of age, including those on ART, with two purposes:

1) to encourage them to disclose their HIV status to their sexual partners, and to use condoms to prevent transmission and re-infection; and
2) to promote adherence to their ARVs.

HCP and Y.E.A.H. prepared two entertaining and educating tools for use with groups of young positives: the "Make a New Start" board game with HIV/AIDS facts and information, and the Jessica and Mike comic book and audio story about a discordant young couple and how they have dealt with it. Y.E.A.H.

trained peer educators from JCRC and the Uganda Network of Young Positives in 5 districts to facilitate small group sessions, during which young positives participated in the exercises, discussed issues having to do with disclosure of status, stigma, adherence, condom use, and prevention of HIV infection. In FY2009, YEAH plans to extend this activity to 13,440 additional young positives in 8 additional districts.

During FY2010, Y.E.A.H. will turn its attention from positive prevention to the prevention of sexual transmission among young people living in communities at high risk of HIV/AIDS, including communities on transport corridors, fishing communities, and areas around police and UPDF barracks. Y.E.A.H. will train 24 peer educators to conduct interactive sessions with young men and women to discuss transactional sex, multiple concurrent partnerships, sexual networks, condom use, and HIV/AIDS prevention, using tools and materials produced by Y.E.A.H. Each peer educator will conduct 1 – 2 sessions per month over a period of 2 months; each session will reach approximately 23 young people, leading to a total of 2,967 young men and women reached. Peer educators will be trained to use standardized interactive tools, and will conduct condom demonstrations during the sessions. When possible, peer educators will collaborate with a condom social marketing group or health workers from local health facilities to provide condoms for the participants.

Please see the description of the Y.E.A.H. supportive supervision, monitoring and evaluation systems described in the AB narrative for HCP. The same system will be used with these peer educators.Community level activities will be reinforced through radio and print media, and through larger community events featuring characters from the popular radio drama "Rock Point 256".

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9879	**Mechanism Name: Eastern Region - HIV/AIDS & TB Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,390,046

Funding Source	Funding Amount
GHCS (State)	5,390,046

Sub Partner Name(s)

Inter-Religious Council of Uganda	Joint Clinical Research Center, Uganda	Liverpool Associates in Tropical Health
National Association of Communities of Women Living with HIV/AIDS		

Overview Narrative

USAID awarded a cooperative agreement (No. 617-A-00-09-00006-00) to Management Sciences for Health (MSH) to implement the Strengthening TB and HIV/AIDS Responses-Eastern District (STAR-E) project with the goal of increasing access to, coverage of and utilization of quality comprehensive Tuberculosis (TB) and HIV/AIDS prevention, care and treatment services in 8 districts in the Eastern Region of Uganda namely: Budaka, Bududa, Busia, Butaleja, Bukwo, Kapchorwa, Pallisa, and Sironko. The prevalence rate of HIV in Eastern Uganda is 5.3% with an estimate of 42,264 HIV positive people in the area. However, the USG supported service coverage in the region is limited: ART – 38%, PMTCT-16%, CT – 4.4%, OVC – 10.5%, PC –44%, AB – 50% and OP – 6%. When the region was analyzed in greater detail, it was found that 8 districts in eastern Uganda were underserved in the context of HIV/TB response.

The mission of the STAR-E project is to empower the communities in eastern Uganda to effectively respond to the challenges of fighting the HIV/AIDS and TB epidemic by focusing their efforts on key relevant interventions for (i) preventing the spread of HIV and TB, (ii) treating, caring and supporting those infected and affected by AIDS/TB and (iii) mitigating the health and social impacts of HIV and TB.

The project has five result areas, namely: 1) Increased uptake of comprehensive HIV/TB services within supported districts; 2) Decentralized service delivery systems strengthened for improved uptake of quality HIV/TB services; 2(a). Lot Quality Assurance Sampling (LQAS) is institutionalized at the national level to support and coordinate district level implementation; 3) Quality HIV/TB services are delivered in all supported health facilities and community organizations/activities; 4) Networks, linkages, and referral systems established or strengthened within and between health facilities and communities to improve access to and uptake of comprehensive HIV/TB services; and 5) Increased demand for comprehensive HIV/AIDS/TB prevention, care and treatment services.

The project will be implemented through two components, namely: the comprehensive HIV/AIDS/TB component and the LQAS component. While the first component will address technical assistance to direct service delivery through health facilities and to the communities, the second will focus on establishing the necessary conditions for institutionalizing LQAS within the country (national and district levels) so that the health sector may improve on its monitoring and evaluation systems accordingly.

Strategic approaches for the attainment of project deliverables will be through 3 main technical approaches: 1) health systems strengthening, 2) building technical capacity of the health services, and 3) strengthening community-based services through performanc-based grants.
Health systems strengthening will support the District Health Management teams and the health facilities to plan, implement and monitor health services more effectively. The project will provide District Support Teams staffed by 3 people—a District Support Officer, a Clinical Mentor and a Community Mobilizer, who will work with the DHMTs and facility staff to increase access to and improve the quality of comprehensive HIV/AIDS & TB services. This component will also have quality assurance, logistics and laboratory strengthening components.

Technical strengthening will occur through a team of expert advisors in ART, TB, PMTCT, HCT, pediatric HIV/AIDS and BCC/prevention. These components will strengthen implementation of national plans, policies and guidelines in the health facilities, and provide intensive technical training to existing and new health service providers.

Performance based grants will provide resources to a network of CBOs/FBOs/LNGOs to provide case managers in each health facility to provide support to all HIV+ clients and strengthen the referral system; home based care where needed; outreach for HCT in the community to strengthen access to care; and community mobilization to support all comprehensive HIV/AIDS/TB services and decrease stigma and discrimination. This network of CSOs will provide a "safety net" of community services to ensure that all HIV+s are indentified, receive the needed services either in a health facility or in the home, and improve adherence to treatment and reduce the lost-to-follow up rate.

Project results at the end of five years are: 1) Increased uptake of comprehensive HIV/TB services within supported districts; 2) Decentralized service delivery systems strengthened for improved uptake of quality HIV/TB services; 2(a). Lot Quality Assurance Sampling (LQAS) is institutionalized at the national level to support and coordinate district level implementation; 3) Quality HIV/TB services are delivered in all supported health facilities and community organizations/activities; 4) Networks, linkages, and referral systems established or strengthened within and between health facilities and communities to improve access to and uptake of comprehensive HIV/TB services; and 5) Increased demand for comprehensive

HIV/AIDS/TB prevention, care and treatment services.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Human Resources for Health	550,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9879**		
Mechanism Name:	**Eastern Region - HIV/AIDS & TB Program**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	544,000	

Narrative:

Palliative Care: care and support

The goal for palliative care and support is to improve the quality of life of people with HIV through relief from pain improvement in other symptoms, such as fatigue, nausea, loss of appetite, shortness of breath and stress. Patients will be empowered to better understand their condition so that they can participate in making choices for care, improve their ability to tolerate medical treatments, and carry on with everyday life independently as much as possible.

The package for palliative care will include:

• Co-trimoxazole prophylaxis
• TB treatment (discussed under separate TB strategy)
• Treatment for opportunistic infections (OIs)
• Home Based Care (HBC) for the bed ridden and those with disabilities
• Symptom and pain management
• Terminal care for those with life threatening conditions
• Distribution of home care kits through CBOs and NGOs supported by our performance based grants

To achieve the above STAR E project will employ a combination of strategies:

• Creation of fully functional service delivery points (FFSDP): This standards based management approach to quality improvement in the health facilities will enable each unit to identify bottlenecks to quality of care, including palliative care. Each health facility will have a quality improvement plan to improve these bottle necks and a phased approach to implementing these plans. This technical approach will create an environment that is client friendly and supports the provision of quality palliative care at all health facilities by incorporating standards for palliation into the FFSDP and evaluating progress towards achieving these standards at regular intervals. The first step is to introduce the principle of FFSDP in a few units, through TOT of STAR-E staff conducted by STRIDES, a sister project in Uganda that is also using the FFSDP.

• PHA involvement at every stage of implementation of palliative care interventions improves the services provided, such as senior PHAs trained as case managers, and through organized groups such as posttest clubs. STAR-E partner NACWOLA will take the lead in helping to organize groups of PHAs at every health center who can support the clients needing palliative care both in the health center and in the home. Case managers working in the health facility will coordinate a personalized palliative care plan and ensure that all needed services are received by the client in both locations.

• Mentoring of clinical services and case managers by District based STAR-E Clinical Mentors . The Clinical Mentors and project District Support Officers will work with the DHOs to develop and implement a plan for supportive supervision and mentoring visits monthly to each health facility providing ART and comprehensive HIV/TB services. These visits will ensure state of the art and adherence to national standards in palliative care services provision. The FFSDP and supervisory tools adopted from the NACP will be used by the mentors and supervisors to ensure consistency in approaches and service provision.

• Leadership and management training to ensure support for quality services. This will target district leaders, health units' management committees, and in-charges to ensure that everything that is needed to provide quality palliative care is in place. There shall be cascade training for the direct services providers. MSH staff from the Leadership and Management Sustainability (LMS) will assist us by doing TOT in the Leadership Development Program .

• Family based /home based care approaches will be provided through performance based grants to FBOs, CBOs, LGNOs and other support groups to provide palliative care services in the home, with support of the Village Health Teams and other community volunteers. These grants will allow us to scale up HCT, HBC, Nutrition, client welfare and support services to ensure equity and expansion of services.

• Linking patients and their support groups to specialized agencies that can improve livelihoods, food security and social protection through a collaborative partnerships with other programs and projects

• Co-trimoxazole prophylaxis will reduce the incidence of Malaria, PCP, and other opportunistic

infections. All health units will be supported by STAR-E to access free co-trimoxazole from the National Medical Stores, since the national program provides free co-trimoxazole for HIV and AIDS clients. Additional Cotri-moxazole will be mobilized through Districts, by the District support officers, interacting and encouraging the Sub-Districts to allocate a reasonable amount of funds for Co-trimoxazole under the PHC funds. The logistics advisor will help the Districts to forecast and plan for use of the credit line from the Ministry of Health so that there is a constant flow of Cotri-moxazole to the Districts. Cases managers will check on the adherence patterns and refer to the clinician's in-case there are problems of adherence or the client cannot tolerate Co-tri. All clients who test HIV positive will be put on Cotri-moxazole, as a well as all HIV exposed children. When the status of the child is deemed HIV negative they will be removed from Co-tri.

• Terminal care: For patients with terminal illness, a nurse, clinician or midwife from each of the 38 ART health facilities will be trained on terminal care in partnerships with Mildmay, JCRC and Hospice. The units where there is a trained terminal care service provider will work with the logistics officer to forecast and quantify the supplies and medications needed for pain management including codeine, morphine derivatives, naso-gastric tubes, gloves, and other supplies. The training will emphasize how to use and account for pain medications. Pain management and other symptom management will be carried out in these units for admitted patients or in a home based care setting through home visits provide by the community network of local organizations. The health facility will supply the client the pain medications to take home and administration of the medications will be supported by trained home based care personnel. Terminal care also encompasses spiritual care needs for the family, and this shall be extended through the FBO partners at the grass roots. A family based approach will be used to ensure that terminal care is provided not only by the visiting health professional, but also by the network of volunteers, and with full involvement of the family members. Family members will trained by NACHWOLA on writing of Wills, and their implementation, writing of memory books and access to legal aid support. Due to the outreach of HCT, an effort to diagnosis HIV early, and the expansion of ART to clients in need, we feel that the patients who will require terminal care will reduce in numbers as the project matures and as the capacity of the Districts to manage HIV/AIDS /TB clients improves.

The entry point to palliative care will be case managers, who are senior PHAs recruited through NACWOLA and other CBOs, to be placed at each of the 38 ART health units this year. The case managers will ensure that each patient has a personalized care plan, and has the responsibility to follow-up on that plan to ensure that all needed services at both the health facility and the home are received. STAR-E project will use a network of VHTs, COPRS, treatment buddies and case managers to reach every client who needs palliative care. To ensure continuous support to this network, the performance based grants will be used, so that the CBOs, LNGOs and other community groups identify, supervise, recruit, and supply the requirements for home base care. Home based care kits will help patients and their immediate care takers to have access to pain killers, such as paracetamol, antiseptics, cotton,

gauze and soap .Through the PBGs, the support groups will procure and distribute home care kits that will contain water guard for water purification, a vessel for keeping clean water and insecticide treated mosquito nets.

The project will implement a training program for the grantees, to have case managers and representatives from CBOs trained as trainers to train the primary care takers on adherence support and home based care. Home based care will include tips on good nutrition, and recognition of side effects from the drugs or from opportunistic infections such as nausea, loss of appetite, diarrhea, and vomiting. STAR-E will strengthen the referral system composed of case managers, health units, primary care takers and patients. Through this referral system it will be possible to refer clients for serious side effects to a unit where there shall be a trained health worker who can handle such conditions, or refer to a clinician in case of more severe side effects.
The supervision and support to home based care will be done by a collaborative network of case managers, CBO trainers and district HIV focal persons. These will monitor the activities under home based care to ensure consistency of approaches, quality and equitable service delivery at community level. Reports generated from these networks will be shared during District project review meetings, and consolidated into one report to be submitted to STARE BCC advisor, FBO Advisor, Gender Advisor and finally the Director Technical programs. Continuous quality improvement activities be take place during the monthly supervision visits to health facilities and the communities based on the project reviews.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,646,933	

Narrative:

ART coverage in the region is estimated to be 25% of the national targets. In PY2, the STAR-E target is to enroll 3112 HIV positive people on ART in addition to the 443 clients recruited in FY09 . We shall reach 960 clients with palliative care services. In order to do this we shall support 5 District hospitals, 11 HCIVs that currently provide ART. Once these 16 facilities become fully functional ART centers, we will expand ART services to an additional a 22 HCIIIs to provide ART.
The ART care, treatment and support package will include: Confirming HIV status through HCT; determining the client's disease status by using WHO clinical staging for adults and monitoring CD4, CD8 and CD3 cells ; and HB ,CBC and blood chemistry at baseline and at six monthly intervals. A system for collecting and transportin CD4 tests samples to the JCRC reference laboratory and getting results back will be established. Enrollment in HAART will be guided by the 2008 National ART and care guidelines for adults and children of the MOH .All children below 12 years who test HIV positive will be prepared and initiated on HAART as soon as possible according to the guidelines discussed above. Inclusion criteria for enrollment on HAART is to be used to ensure adherence, follow up and readiness for HAART.

For palliative care, all adults who test HIV positive in health units and through outreaches will be started on co-trimoxazole prophylaxis at the participating units; all HIV exposed children will be started on co-trimoxazole prophylaxis till proved HIV negative. In addition, all HIV positive clients will receive treatment for any opportunistic infections, as they arise, and all will be screened for TB clinically. If the client has a cough, TB sputum microscopy will be done. All those with suspected or confirmed TB will be managed as per CBDOTS guidelines of the National TB Leprosy program under the MOH (see TB discussion below).

Training activities:
A critical mass of health workers and case managers will be trained on comprehensive HIV/AIDS/TB case management, at the initial 16 health facilities that provide ART through refresher courses. The full ART training package offered by JCRC will be provided during the rest of PY2 to staff in 22 new facilities selected in conjunction with the DHOs to become ART centers. These will all be HC IIIs, and careful consideration to staffing patterns and population density will be made in the rollout plan. Shortages in human resources for health will be addressed through task shifting, clinical mentoring and supportive supervision. The training modules will be from MOH and JCRC will provide the training. Baylor Uganda can support paediatric training.
The STAR-E project will hire and recruit 4 clinical mentors, who shall be trained as mentors by JCRC. JCRC has developed a mentor's manual that support experience ART providers to acquire clinical mentorship skills. The clinical mentor will conduct on job mentoring, coaching and support to all health workers and case managers to ensure quality and equity in clinical care of HIV/AIDS /TB in the health facilities. Each clinical mentor will cover two districts. Clinical mentors will be absorbed into the District establishment after 3 years. (see discussion of clinical mentors under Result 3)
MSH will hire 4 District Support officers to work with the DHTs, to ensure that the different arms of local Government, work together to ensure coordination and mobilization of inputs for quality comprehensive HIV/AIDS/TB care from the project or through local resources. The logistics Advisor will build capacity and support districts and health units to ensure proper commodity management for inputs for care, treatment and support. Procurement of commodities will follow USAID guidelines and will be done through SURE, SCMS and JMS to ensure a continuous supply of ARVs and other needed medications with zero stock outs as the objective. Leadership courses will be run for individual health units to create a client friendly environment at health units and to motivate the political arm of government to allocate more resources for HIV/AIDS/TB case management. A standards-based management performance quality improvement approach will be used to create fully functional service delivery points to ensure quality care, treatment and support services
Tracking and evaluating clinical outcomes:
The aim of ART is to lower the viral load to undetectable levels (50-400 copies/ml3), restore the function of the immune system, improve quality of life and physical function of the body , reduce HIV related

morbidity and mortality, and promote growth and neurological development in children. The following mechanisms will help in tracking clinical outcomes:

Client will visit clinicians on a monthly basis and as needed by any change in health status. Lab investigations will be done (hematology, blood chemistry : complete blood count including HB, liver and kidney function tests, serum glucose for those on protease inhibitors, and every 6 month CD4 levels). When necessary, a viral load will be done for suspected treatment failure (10% of clients). Each client will have a case notes file, to record and register history, physical and clinical findings from the client and to document the personalized care plan and progress made, or problems with, the care plan. The case notes file will be kept secure. The clinicians and relevant project staff will use the case notes to determine clinical state and well being of clients based on weighted and scored variables. There shall be pre-HAART and HAART registers to record and track all prescriptions and a BMI recorded for all adult clients. Weight for age (<36 months olds) and developmental mile stones will be recorded for all children. A performance scale (WHO clinical staging) and monitoring of side effects from the medications will be done at the health facilities by case managers with support from the health service providers. Clinical mentors will support this process on a monthly basis. Cohort analysis for clients on HAART will be done by the ART team to determine and document mortality rate, transfer in , transfer out and lost to follow up. All the information on client status and outcome will be entered into the records and clients data bases, and the data shall be analyzed at each facility to measure overall treatment outcome

There will be case managers in each health unit, who are senior PHAs, one per health unit who will be selected by the community, and seconded to the project by a CBO or NACWOLA. The Case managers are to be trained to guide clients and offer support at the health facility to individual clients. Members of VHTs will be identified and trained on psychosocial support to counsel and support clients after treatment in the health center. The VHTs and treatment buddies will meet with clients in the home to determine how they are using the drugs and will refer back to case managers problematic cases, who in turn will screen and refer to a clinician or relevant health worker. Each client will have a treatment buddy selected by the client, preferably a spouse, and for children, the parent or care giver. The treatment buddy will support clients to take medications as recommended. The treatment buddies will be trained and supported by the case managers and clinicians.

When clients come back for refill they will be asked to bring the containers of the drugs, and a pill count will show whether the client is adhering or not. However, the VHTs will also do home visits to reinforce adherence. Each client will have an adherence calendar and carry away prescription card to assist taking medications as prescribed on a daily basis and to promote adherence. The card will also have return dates for re-visits to the health center. The adherence calendar will be in local language and for those who cannot read, the graphical lay out will support clients to take medications appropriately. Clients with problems of adherence will be given more counseling and guidance by case managers and clinicians, with more frequent follow-up in the home. Clients who live in hard to reach areas will get refills through ART outreaches to be conducted by staff from an accredited site on a regular basis.

Outcomes of these adherence activities:
Our targets for this objective are: 80% of clients achieve adherence rate of 95% to care plan, loss to follow up <10%, reduced need for treatment switch, majority of clients still responding to first line HAART for the period under review, well being of clients (immunological, physical, social) inproved, overall mortality to be below 10% cut off point for 12-24 months ART cohorts and low levels of treatment failure .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	300,000	

Narrative:

We are targeting to reach 60,500 with HCT in PY2, both adults and children. Although 5.3 % of sexually active people 15-49 years are estimated to be living with HIV, only 11 % of men and 13% of women actually know their status, based on data from the 2004-05 National Sero- Behavior prevalence survey. STAR-E will have a BCC advisor on board in PY2, who will spear head the development of a communication strategy (see Result 5). Part of the communication strategy will focus on increasing demand for and uptake of HCT. Community mobilisation for HCT will use inter-personal communication, mass media, theatre for development and group counseling, working with religious and community leaders to provide support to these efforts. This will be done at busy trading centers, at health facilities, tertiary institutions, busy trading centers, drinking joints, special events such as World AIDS day, TB day, Child Health days and political rallies and other cerebrations. MOUs will be developed with the DHOs to provide financial support to mobile HCT teams who can travel to these events and locations on specific days to accomplish this HCT outreach. Communities will be informed about the dangers of HIV, benefits of knowing HIV status and location of available service points. To support social mobilization we will train male peer educators and motivators, religious leaders and case managers in social mobilization for HCT. We will integrate HCT in all service points within all 97 Health facilities by training and equipping all health workers to conduct provider initiated counseling and testing (PICT) at all service points. Testing kits will be available at all service points in every health facility. Testing will take place at Health centers and in outreaches. Outreaches will be negotiated with communities and could be at schools, trading centre, open markets, or other convenient locality. Hard to reach areas and most at risk people (MARPs) will be given priority.
Trained laboratory staff are limited in the districts' health facilities; however, as part of PICT, all health workers will be trained on rapid testing protocols .The few available lab personnel will provide confirmatory testing and will be trained to offer supportive supervision to other staff doing PICT through spot checks and on-the-job training for staff involved in testing. Ten percent of blood samples will sent to JCRC to check on validity of HIV test results as part of the external quality assurance (EQA) program. Any deficiencies will be followed up to insure the quality of testing results. Determine will be used as a screening test, Stat pack will confirm the positive test result, and Uni-gold will be used as a tie breaker.

Dried blood Spots kits will be used to collect blood for children below 12 months born to HIV+ mothers and samples will be sent to JCRC/Mbale for DNA/PCR. At 12 months a rapid test can be used to screen children, those who test positive will need a DNA/PCR confirmatory test as soon as possible.
Each client will have an HCT card capturing demographic and tracking information about the client along with test results. Each client will have a specific code on the HCT card to allow tracking individual clients. The case manager will use this card to track all positives to support active referral to needed treatment services and reduce the lost-to-follow-up rate (LTFUR). Data from the HCT cards will be aggregated and entered into the project data base . This data will be analyzed on quarterly basis and shared with MOH, USAID, MEEPP , Districts, MSH and communities to analyze trends and document successful methods for increasing uptake of HCT over time.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	136,000	

Narrative:

Early identification and diagnosis
PICT is the entry point to care. We will use all departments in all health facilities that offer maternal and child health services to test as many children as possible through in-patient pediatric wards, out-patient clinics, immunization clinics, nutrition clinics, TB clinics, PMTCT programs, post-natal clinics, and family planning clinics. Blood drawn will be sent to JCRC/Mbale regional laboratory for DNA PCR. For every child that tests positive, a family centered approach will be used to identify and diagnose more children within the family. Other family members who test HIV positive through other service outlets can be used to identify more children with HIV. Identification will also be done by inquiring about the status of the mother and/or through systems that document the mother's status on the child's health care card. HIV+ children tend to get sick more frequently, thus PICT through all pediatric services in the health facility should capture more HIV+ children who can participate into early treatment services.

Mobilization and sensitization campaigns of the communities will be integrated with HCT so as to offer the services to those in the hard to reach areas and those who do not come to hospitals for the various reasons Babies born to HIV positive mothers will be followed up on in the communities to ensure that they are tested for HIV infection, referred for DBS, and those that are found positive are initiated into care. The community will be empowered to be able to identify and refer children with signs and symptoms of HIV infection.

Pediatric Care and Treatment
The capacity of health care workers will be built through training in comprehensive pediatric HIV care and treatment, pediatric counseling, and DBS sample collection. The STAR-E project will provide monthly

supervision and support to improve the quality of pediatric services offered at the health facilities. Pediatric HIV/AIDS standards will be incorporated into the Fully Functional Service Delivery Point quality improvement tool we will ensure uninterrupted supply of pediatric formulas of ARVs through collaboration with Baylor and the Clinton HIV/AIDS Foundation program, who have agreed to continue to provide these formulas to STAR-E supported facilities. All HIV exposed children will receive cotrimoxazole prophylaxis, until proved HIV negative. Ongoing counseling will be emphasized to ensure that clients adhere to co-trimoxazole & ART, and also to encourage the children/caretakers to keep appointments.

To reduce malnutrition and mortality among children, we shall partner with the NuLife program to have ready-to-eat nutritious foods. Networks and linkages with organizations in the community will also be established to improve on the nutrition of children so as to provide food supplements to even those that are not malnourished.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	411,733	

Narrative:

Introduction

Research has shown that if HIV+ children are not started on treatment early, 50% will die by their second birthday. It is therefore important that all HIV+ children are identified and initiated into care early. This strategic plan therefore seeks to achieve that objective.

Early identification and diagnosis

PICT is the entry point to care. We will use all departments in all health facilities that offer maternal and child health services to test as many children as possible through in-patient pediatric wards, out patient's clinics, immunization clinics, nutrition clinics, TB clinics, PMTCT programs and post natal clinics, and family planning clinics. For children exposed to HIV+ mothers below 12 months , facilities will have good stock of DBS kits; blood drawn will be sent to JCRC/Mbale regional laboratory for DNA PCR (see Strengthening Laboratories, Result 2 below). The children above 12 months will be screened for HIV using rapid tests to be available at all service points in a health facility. Those testing positive will receive DBS PCR tesing up to 18 months. Health units will be facilitated to transport these samples to the JCRC/Mbale reference laboratory and collect results. For every child that tests positive, a family centered approach will also be used to identify and diagnose more children within the family. Other family members who test HIV positive through other service outlets be used to identify more children with HIV. Identification will also be done by inquiring about the status of the mother and/or through systems that document the mother's status on the child's health care card. HIV+ children tend to get sick more frequently, thus PICT through all paediatric services in the health facility should capture more HIV+

children who can feed into early treatment services.

Mobilization and sensitization campaigns of the communities will be integrated with HCT so as to offer the services to those in the hard to reach areas and those who do not come to hospitals for the various reasons (see HCT strategy above and communication strategy in Result 5). Babies born to HIV positive mothers will be followed up in the communities to ensure that they are tested for HIV infection, referred for DBS, and the positive ones initiated into care. Through our community network, with the support of the case managers, the community will be empowered to be able to identify and refer children with signs and symptoms of HIV infection. We will also work with community based organizations offering services to children to ensure that the children in their care are tested for HIV infection.

Pediatric Care and Treatment
Capacity of health care workers will be built through training in comprehensive Pediatric HIV care and treatment, pediatric counseling, and DBS sample collection in collaboration with JCRC. STAR-E clinical mentors will be trained by JCRC in pediatric HIV case management. Through these mentors, monthly supervision and support as need arises will be done in order to improve the quality of pediatric services offered at the health facilities. Pediatric HIV/AIDS standards will be incorporated into the Fully Functional Service Delivery Point quality improvement tool that will be used by clinical mentors (see discussion on clinical mentors and FFSDP in Result 3). We will ensure uninterrupted supply of pediatric formulations of ARVS through collaboration with Baylor and the Clinton HIV/AIDS Foundation program, who have agreed to continue to provide these formulations to STAR-E supported facilities. All HIV exposed children will receive co-trimoxazole prophylaxis, till proved HIV negative. Through case managers and clinicians, on-going counseling will be emphasized to ensure that clients adhere to co-trimoxazole & ART, and also to encourage the children/caretakers to keep appointments.
Health units will be improved to be child friendly by painting sections of the health units in colors, cartoons and pictures on the wall, and stocked with play materials and toys. Where possible, the children will be provided with a drink and snack as they wait to see a clinician. To reduce malnutrition and mortality among children, we shall partner with NuLife program to have ready to eat nutritious feeds, such as PlumpyNut. We will also develop networks and linkages with organizations in the community that work to improve on the nutrition of children so as to provide food supplements to even those that are not malnourished.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	400,000	

Narrative:

Strategies for improving Strategic Information system of STAR-E project

STAR-E aims at improving the health systems of the supported districts. To achieve this STAR- E will support the implementation of robust Strategic Information (SI) activities in the supported districts. This support will cut across the Health Management Information System (HMIS), Monitoring and Evaluation (M&E), Survey and Surveillances and Coordination of SI activities.

HMIS: This is one of the challenging areas in health service deliveries as evidenced by inconsistencies in reporting. STAR-E will therefore support the districts and CBOs to strengthen their HMIS in order to produce timely and accurate data needed for project monitoring and decision making at the various levels. To strengthen the HMIS in the district, the project will develop a comprehensive capacity building strategy that will involve training of personnel, support supervision, provision of supplies and equipment for data management. The specific activities to implement under HMIS strengthening will include the following:

1. Train facility based staff in HMIS according to the national guideline.
2. Train CBOs' personnel in data collection and management with major focus on the STAR-E data requirements.
3. Support the provision (re-print and distribute) of HMIS tools to the supported districts.
4. Develop, print and distribute community based data collection tools which are missing in supported districts.
5. Support 8 districts and 11 HC IVs to acquire computers in order to improve on their HMIS.
6. Develop a comprehensive database at STAR-E to capture both facility and community based data.
7. Support districts to carry out quarterly data quality assessment with the view of addressing any inconsistencies when it is still early.

It is expected that, with the implementation of the above activities, districts will be in position to improve on their HMIS and hence strengthen the system at project and national levels.

Monitoring & Evaluation: The M&E function of the health sector has been weak at both district and national level. This has been partly due to inadequate resources and capacity to execute the M&E tasks. STAR-E plans to strengthen the M&E functions of the districts by building the capacities of the DHMT in M&E skills and provision of logistical support to the districts. This will be done by implementing the following activities:

1. Train DHMT in M&E of HIV/AIDS/ TB programs which will strengthen their capacity to monitor these activities in the future.
2. Train sub-granted CBOs in M&E of HIV/AIDS/TB programs. This will strengthen the M&E capacity at the community level where community based activities are implemented.
3. Support districts to carry out joint and integrated periodic support supervisions in their catchment areas.
4. Support 2 project performance review meetings per district. This will help districts to assess their

performance and re-strategies to achieve better results.
5. Hold one annual regional forum for information sharing/ feed-back mechanisms about program project performance. This activity will bring all the 8 districts together and help them to review how the project has performed in the region. The deliverables of this activity will inform the districts about where to draw much attention in the subsequent financial year.
6. Develop a documentary system for success stories. This will be one way of how the project impacts will be will captured and it will be a basis for advocating for additional resources depending on the successes registered. Documented best practices will be replicated to other districts.
7. Advocate for information use during planning and decision making processes. STAR-E will continue to encourage districts to use their data to improve their planning and decision making processes. Information will used in forecasting for logistics, commodities and supplies, prioritization of needs and strategic planning.
With the above activities in place the M&E function will be strengthened in districts and this will have positive impact on the national M&E system.

Surveys and surveillances: Successful program planning depends on the facts collected routinely or periodically about the interventions being implemented. STAR-E will promote collection of data outside the routine mechanism by supporting periodical surveys and surveillances to inform program managers and policy makers. This will be achieved by implementing the following activities:
1. Institutionalize LQAS in districts. The project will support 4 districts to apply LQAS in program monitoring. This will help them to know the extent to which they are meeting the targets.
2. Carry out operations research to indentify program challenges and avenues for performance improvement. The findings of the research will provide a platform for policy making, reviews and program planning.
3. Carry out an annual impact assessment. In the first year the focus will be on the community based interventions. The assessment will look at BCC, KAP, and other socio- economic aspects in the communities with a major focus on the PHA families.
To ensure sustainability and ownership of the program, local capacity will built in relevant fields and the district and the sub-granted CBOs will be involved in these activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	147,030	

Narrative:

This result focuses on health system strengthening in the districts, especially at the facility and community level. Client satisfaction and confidence in the services provided is a key factor in promoting the uptake of comprehensive HIV/TB services. This result addresses the system weaknesses that

adversely affect client satisfaction—poor infrastructure, weak and absent human resources, lack of medications and commodities, lack of evidence-based practices due to lack of information, weak leadership and management of staff at all levels, poorly functioning laboratories, and a weak community support network.

Objective 1: To strengthen infrastructure at the facility level

Decaying and poorly functional infrastructure at health facilities is an obvious marker for poor quality care. Upgrading infrastructure thus becomes a top priority to improve quality services and client satisfaction at health facilities. For this reason, infrastructure standards are one of the critical standards in the FFSDP quality improvement tool (see discussion under result 3). The baseline facility survey will provide a database on infrastructure needs, eg, building, grounds, furniture, equipment, lab function, etc. This data will help produce an infrastructure improvement plan for each district. REDACTED. Thus, the intial implementation efforts of this improvement plan in each district will focus on the "low lying fruit", the visible and the bottlenecks to improved quality, eg, painting and fixing up the facility to make it "child friendly", clean up of grounds and simple landscaping, essential equipment such as hemoglobinometers, capillary test tubes, or a functional microscope. STAR-E does not have the resources to complete all the improvements needed, but this infrastructure improvement plan will provide a blueprint for all partners so that the DHMT can maximize the resource input from a variety of sources.

Objective 2: To strengthen human resources

Most districts have a 50% vacancy rate and task shifting is the norm, eg, a physician may start the ART services, then leave and a nurse picks up that set of services and continues on input from a variety of sources. While we cannot address all the reasons that staff turnover is so high, especially the economic reasons for why people leave, MSH has developed an approach for improving recruitment and retention using non-monetary incentives developed through our Leadership and Management Sustainability project. We propose some STTA from the LMS human resources staff to help us prepare a master human resource strengthening plan and to train staff in the Work Climate Assessment Tool (WCAT), a tool that can be used by staff in each health facility to develop ways to improve their work climate and, thus, retention. We will also develop a training plan based on the needs assessment and the work plans of the districts, and support implementation of this plan through our district training advisor and technical staff. Result 1 outlines an ambitious training program to upgrade technical skills in key HIV/TB areas. Improved training frequently provides an improved sense of competence and self worth, which can lead to improved retention, especially amongst female nurses which tend to stay longer in a posting. Other activities suggested during our work planning activities with district staff include facilitation of the district recruitment and hiring, since funds don't exist to place newspaper ads or interview potential staff, and

facilitation of visits from NACP and NTLP staff to share best practices in Uganda with the local staff in the districts, thus providing a morale boost and incentives for continued productivity.

Objective 3: To strengthen commodities management

Stock outs of medications and commodities, such as test kits and laboratory reagents, are very disappointing to clients and frustrating to staff. Stock outs of ARVs and anti-TB drugs are very dangerous, since they lead to the development of resistance and increased mortality despite treatment. Currently, enough ARV, OI, anti-TB medications and test kits exist in the country to support all project needs. The problem is that they are not flowing very well from the National Medical Stores (NMS) out to the peripheral health service units. The Joint Medical Stores (JMS) has been selected as an intermediary to fill all orders, distribute and store medicines and commodities. By the start of PY 2, an MOU should have been negotiated with SCMS and JMS to support STAR-E, so the delivery to service delivery points should improve. However, much work remains to be done at the individual facility level to ensure proper storage and record keeping systems are functional, and to support ordering re-stocks in enough time to prevent stock-outs. STAR-E has a logistic advisor who will work closely with our sister projects—SURE and SCMS—to develop training and supervision processes to improve local commodities management. Logistics standards will be incorporated into the FFSDP quality improvement tool, and the clinical mentors will use these standards when the visit clinical facilities to ensure zero stock outs of ARVs, OIs, and anti-TB meds, as well as test kits, our gold standard for systems improvement. It may take some time to reach zero stock outs in each facility, but it could happen by the end of PY2.

Objective 4: To strengthen district HMIS

Training and mentoring district health staff and health facility management teams in the use of "data-for-decision making" is one of our key project strategies for ensuring that management decisions are based on the best available evidence. However, data collection, flow and analysis is very weak in the districts, and strengthening the HMIS is one of our highest priorities. In order to achieve this, we will focus on very specific activities, such as printing and providing all HMIS forms and registers to the health facilities and DHOs, as well as develop more creative approaches for sharing and analyzing data using cell phone. We will need to develop a community-based information system that captures all community services, adapting one of several that currently exist to the needs of the STAR-E project. And we will need to train and then mentor staff at all levels on the HMIS standards, protocols and forms, how to ensure adequate data flow, and how to analyze the data at each level and use it to make decisions. At the DHMT, a portion of each monthly meeting will be set aside to analyze the HMIS data and the minutes will document what decisions were made based on that data, a good outcome measure of an improved HMIS.

Objective 5: To strengthen leadership and management

Many DHOs, DHMT staff and the in-charge of health facilities have been promoted to positions of senior management responsibility based on years of experience within the health system and not related to any formal preparation in leadership and management. The MSH Leadership Development Program (LDP) has been developed through the LMS project to address this issue, a series of short workshops for key management staff in the districts so they do not have to leave their home base location. The LDP has also been developed into an e-platform and can be provided virtually in district HQs towns that have access to internet, thus decreasing the time away from the work location. Based on the MSH manual, Managers Who Lead, the LDP/VLDP can significantly improve the management capacities of senior staff, leading to improved decision making and more efficient and effective use of the scarce resources available. This, in turn, should lead to improved quality of all health services and increased uptake of comprehensive HIV/AIDS and TB services. Several other activities will support this L&M training, including holding quarterly regional and monthly district coordination meetings where L&M tools are used, inter-district visits to learn best practices from each other, and facilitation of transport for DHMTs for joint supervision and monitoring visits.

Objective 6: To expand access to community services through performance based grants

Result 1 focused on the role of the case managers and their linkages to the communities through PBGs to local organizations. This objective focuses on the "nuts and bolts" of the PBG process, from development of the initial scopes of work to include a wide range of community based services, in addition to the case managers; development of the RFA itself; workshops for local CBOs, FBOs, NGOs on how to prepare a proposal in response to an RFA; then the selection and award process. Development of performance indicators is a key step in awarding and signing a PBG, since progress towards achieving those indicators allows us to monitor grant performance. We anticipate that a minimum of 1 RFA will be issued for the Eastern region (although it could be more than 1), with multiple awards made by March/April. Consistent with our management capacity building approach, we will work closely with the DHMTs in every step of the process so they learn by doing and can then replicate the process in future years. At some point, the districts may receive increased funds from a new USAID project, and this valuable experience will help the district level staff manage increased resources more effectively.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	50,000	

Narrative:

Medical Male Circumcision

According to the 2004/05 HIV/AIDS Sero- behavioral prevalence survey, 55% of men 15-49 years in Eastern Uganda have undergone circumcision, either due to traditional /cultural or religious requirements. However Male circumcision is much more common among Muslim men with over 97% of them having been circumcised by age 15 years. Studies have indicated that Medical Male circumcision is protective against HIV infection, because the removal of the fore skin, where the HIV susceptible Langerhan cells are located, reduces the risk of contracting HIV by almost a half.

In Eastern Uganda most of those who are circumcised do so in a traditional cultural setting. This may pose a risk for acquiring HIV if the knife used is used on more than one person before being sterilized. Therefore cultural circumcision rites pose a risk for HIV transmission. Traditional cultural circumcision is unhygienic and is associated with bleeding, sepsis and complications. On the other hand, men who have been circumcised in health units are regarded as cowards, often regarded as social outcasts, and are sometimes barred from performing other cultural rituals.

This project will design and implement a communication strategy that will be used to change negative attitudes on Medical Male circumcision .A network of CBOs, LNGOs, FBOs and other community resource persons will be used to promote positive messages about medical male circumcision (MMC) that is done in health facilities with trained staff using sterile conditions , and to promote it as one way of the ways recommended by leaders and the government for HIV prevention. Traditional chiefs and traditional circumcisers will be trained as MMC promoters and counselors, to win them over, in order to support Medical Male Circumcision. Faith based organizations will be targeted to ensure that we minimize the bias against circumcision that is promoted by certain religious denominations

Strategically, women will need to be involved in the campaigns, because traditional cirucmisicion is often associated with selection of fiancés and future brides. When women recognize MMC , it will encourage more young men to utilize MMC. Through RFAs and award of PBGs, more CBOs and LGNOs will take the campaign for MMC forward, since we will include promotion of MMC as a performance standard.

MMC will be made addressed by equipping health units with the necessary equipment for MMC, and training of at least two MMC practitioners from among the health workers at each of the Health IVs and all Hospitals this year (16). All HCIVs have mini operating theaters, and all hospitals have full operating theaters that will be upgraded and equipped accordingly to handle MMC.

Our target is to reach 10% of eligible youths and men in the 8 Districts this year with MMC.
In order to promote quality assurance, a series of trainings in support supervision for MMC will be held for

the clinical officers by the Clinical mentors and District support officers. We shall adapt training tools from the Walter Reed project in Kayunga to ensure that a critical mass of MMC trained staff are present in the 8 districts based at Health centre IVs and Hospitals. We shall use the LQAS methodology to evaluate uptake of MMC and its impact on communities. More solid operations research will done in partnership with the Walter Reed project and Makerere Institute of Public Health to gauge changes in HIV incidence among the circumcised and uncircumcised men in subsequent years of the project, thus measuring the impact of the MMC interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	238,888	

Narrative:

Although the prevalence rate of HIV/AIDS in the project region is at 5.3%, lower than the national prevalence of 6.4%, the incidence of HIV is feared to be on the rise. Sexual transmission is the major mode of transmission, with the highest new infections rates rising among married couples. Lack of access to HIV/TB-related information and, stigma, discrimination, gender based violence and complacency all play a role in this situation.

Under the STAR-E project, HIV/AIDS prevention mechanisms will be put in place to target the youth (unmarried boys and girls of 15-24 years), married couples (15-49 years), Most at Risk Populations (commercial sex workers, truckers, fisher-folks, incarcerated populations, uniformed Service Groups, Street children) and sexually active adult men and women.

Prevention mechanisms targeting the youth and sexually active adult women and men will involve the use of AB components. The AB strategy is deemed practicable for all age groups, and all people from different walks of life. However individuals need access to correct and appropriate information to Abstain or to be faithful to single sexual partners. This will range from messages targeting individuals to those targeting groups and communities, such as schools, hotspots, drinking joints, internally displaced people's camps and busy centers. Messages will reinforce empowerment of individuals to practice their chosen method of HIV prevention.

The STAR-E project will use the existing wealth of information, including the 2004/5 sero-behavioural survey, and also conduct rapid assessments using participatory methods to identify Knowledge, Attitude, Behavior and Practice gaps to help in the drafting of a communication strategy to guide the roll out and implementation of the AB interventions in the eight Districts. An inventory of existing Information Education Communication (IEC) materials will be conducted, and appropriate materials will be translated into the 3 dominant languages spoken and/or understood in the Eastern region, namely Luganda,

Kiswahili and Lugisu. This will help to ensure that the existing materials produced by different partners will be effectively utilized and STAR-E will not need to create new IEC materials.

Appropriate Abstinence (A) messages will be designed for both in and out of school youths (male and female between 18-24 years). The communication strategy will spell out the messages, methods of dissemination, target audiences and the monitoring and evaluation mechanisms. However it is envisaged that mass media will be exploited in relaying these messages. Local radio stations will be used to run appropriate radio slots at an agreed interval for a period of three months per slot. These messages will be redesigned, modified and /or changed based on a continuous feed back from the target audiences. Radio talk shows on Abstinence and Be Faithful will not only help in reaching the hard to reach, but will also have a multiplier effect on neighboring districts where the project is not operational. These talk shows are ideal dissemination mechanisms for those who can not read or write.

Similarly, print media on AB will be used so that the same messages are captured and distributed through leaflets, brochures, pamphlets and posters, to be widely distributed to health units, schools, shops, families and beyond. Print media messages will reinforce the messages provide through radio and through inter-personal communication. Specifically the youth with will be targeted at schools, institutions and organizations that have many youths. In schools, talking compounds will be supported and designed together with school authorities and with full participation of the school children. At strategic points, sign posts and billboards carrying AB messages will be erected to catch a wider audience and to direct the people at service outlets.

Male and female Peer educators will be trained so that they can in turn educate others on how to prevent HIV through Abstinence and Be Faithful messages. Once trained, they will be equipped with necessary job aides for consistency of messages. Youth in schools will be facilitated to form clubs to help in one to one communication (IPC), role-plays, music, dance and drama to pass on messages for abstinence and faithfulness. Teachers will be trained as Senior Health educators, to be able to handle class rooms, on sensitive matters of sex, sexuality and HIV and AIDS.

Religious and other community leaders (like youth leaders) will be encouraged to use religious events to spread the messages and to visit schools and other tertiary institutions, as well as organized youth groups, to share information and encourage abstinence. Youth functions such as youth camps, and football matches will be used as a mobilization strategy in order to reach the youth with messages of abstinence, and provide counseling and testing services to those that might be interested. It is hoped that by September 2010, 10,000 boys and girls in and out of school will have been reached through the above means.

'Being Faithful'

'Be faithful' messages will target the married (being faithful to an uninfected sexual partner, or partners in the case of Muslim men or people in concurrent sexual relationships). Religious leaders will preach the "Be faithful messages" during prayers and other social gatherings as well as during marriage counseling. Community and other leaders of influential character will be used to encourage mutual faithfulness among married couples as well as among discordant couples. Discordant couples who have successfully implemented the 'B' will be encouraged to share their testimonies which will be documented and used as testimonials.

People Living with HIV/AIDS will also be used to give testimonies to the population. Women and men who have AIDS will be facilitated to give these testimonies at HCT outreaches, or during their own social mobilization sessions. In liaison with the clergy and other community and political leaders in the district, PHAs will be encouraged to give these testimonies in churches and during social gatherings, e.g. Funerals, feasts, celebrations and World AIDS day.

Billboards denouncing violence and Trans-generational sex will be designed, translated in the local languages and erected in strategic places. This will give a wider coverage of the population. Other hard to reach areas will also have these billboards and posters erected with appropriate messages.

By September 2010, over 40, 000 clients will have accessed AB messages through the mass media as well as through community case managers, community leaders, religious leaders, and the Village Health Teams (VHTs).

To reach a wider audience with AB messages, RFAs will be issued and performance based grants awarded to enable Community based Organizations (CBOs), Local NGOs and other organized groups to carry forward the prevention campaign using the AB messages. Case managers, VHTs, CBOs, FBOs will form collaborative networks around health units to be trained on reinforcing the AB messages. STAR-E will use LQAS to evaluate the outcome of the AB campaigns and modify the campaign and strategy accordingly to respond to individual community needs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	316,666	

Narrative:

Correct and Consistent Condom use campaign

Appropriate and accurate information about condoms will be provided to the target populations. This information will include both the health benefits and the failure rates of condoms in HIV/AIDS prevention. Condom promotional activities will pass consistent messages that condoms are an alternative prevention technology for people who are un able to abstain, the discordant, the MARPs, but caution that failure rate range from 5-10%. Condom messages will emphasize that the most effective prevention methods are Abstinence, and having sex with HIV negative person in a mutually faithful relationship, thus re-enforcing the AB approaches. Correct and consistent use of condoms can prevent STDs, unwanted pregnancies and is as pleasurable as unprotected sex between two consenting HIV negative partners.

Young adult men and women who are sexually active and those who engage in concurrent sexual relationships will be targeted with appropriate C messages. Discordant couples and couples where are both HIV positive will be encouraged to consistently use condoms to avoid cross infections and re-infection respectively. Condoms will be distributed to these categories of people through outlets that are accessible for respective groups, including health facilities and social marketing outlets. They will also be included in home care kits and in prevention for positives approaches.

Working with the community leaders and community case managers, we shall organize deliberate HCT outreaches to busy centers, hot spots, and drinking joints and these shall be avenues to make condoms available to the sexually active members of the population, as well to Most at Risk Populations (MARPs) such as commercial sex workers, long distance truck drivers and fisher-folks. Condom distribution will be done in collaboration with bars, hotels, and lodges. Condoms will also be made available at places like offices of the cross border points and health facilities.

A workshop will be held for community leaders eg traditional, youth and religious leaders, family protection officers from the police and prisons, and the district gender officers and law enforcement officers to sensitize them on gender inequalities, gender violence, stigma and discrimination that hinder the uptake of HCT and other HIV/AIDS-related services, and consequently expose women and men to infection by HIV/AIDS. This same workshop will address issues like widow inheritance and polygamy that expose people to HIV infection. This community sensitization will increase demand for HIV-related services and therefore the general public will be well-equipped to prevent infection.

In order to promote quality assurance, a series of trainings in support supervision will be held for the service providers including CBOs, FBOs and NGOs to train more people on condom use .This will be done through Performance Based Grants (PBGs) to increase knowledge and access to condoms. Community Case Managers and health workers will be given appropriate trainings to help in support supervision to help the project identify gaps, and plan how to deal with them. Standardized supervision materials will be designed and distributed accordingly, for consistency.

In collaboration with the Monitoring and Evaluation department, LQAS will be used in all the eight project districts to determine the degree of impact, and to guide planning for future interventions for the C strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	765,000	

Narrative:

Currently, PMTCT uptake is only 16% in the 8 Districts (i.e., only 16% of pregnant women receive any PMTCT services). Challenges to be addressed include low FP uptake (43%), low health facility-based deliveries (34%), gaps in human resources providing health services, heavy work loads for existing staff, poor staff attitude, poor referral systems, and limited awareness in the community on the mechanisms of MTCT of HIV. Our target population is all women of child bearing age, with a focus on most at risk women for testing and referral for PMTCT services: all pregnant women and their spouses (especially pregnant women living with HIV), non-pregnant women living with HIV, and children born to HIV positive women. The four pronged PMTCT approach will be used to reach the target groups: primary prevention of HIV among the uninfected; promotion of family planning services for prevention of unintended pregnancies, especially among those with HIV; reduction of vertical transmission to children among HIV infected pregnant women; increase access to care, treatment and support to HIV positive mothers, their infants and families; and outreach HCT to all women in the community. In order to increase PMTCT coverage, women will be encouraged to use ANC services, deliver at health units, and come back for post-natal services. Women who test positive for HIV will be referred to the case managers at each units, who will coordinate all service delivery and ensure that the women and their children receive a full evaluation of HIV status and have a personalized care plan.

The key to increasing uptake of PMTCT services will be community outreach of HCT services to the populations at risk described above. By involving more women and their partners in testing at community testing sites, the STAR-E program will increase the number of HIV+ women who will receive comprehensive services in the health facilities. Routine opt-out HIV counseling and testing services will be provided during ANC, maternity, post-natal and Well child clinics in the health units. HIV negative women and their spouses will be supported to remain HIV free. Building on efforts already started in the region through PREFA, we will continue training current and new ANC providers on modified obstetric care, counseling and provision of more efficative ARV prophylactic regimens and HAART for eligible HIV positive pregnant women according to national and WHO policy guidelines. Single dose NVP will be given to women found to be HIV+ at labor and delivery but did not receive pre-natal HIV counseling and testing and ARV prohylaxis. Counseling on safe infant feeding practices and support to exclusive breast

feeding for the first four months of life will be provided. In the post-natal period, women and children enrolled for PMTCT will continue to be followed up to ensure they adhere to PMTCT protocols through the case manager and the community based network of service providers, such as VHTs, male motivators and grantee CSOs. We will also integrate PMTCT services into RH/FP services for these families with promotion of the use of condoms, and creating links to food security and income generation support agencies.
At district level, PMTCT activities will focus on coordination of all partner activities, transition of PREFA-supported services to STAR-E, improved infrastructure, supplies, and supervision of implementing facilities (see Result 2 below). Health facilities will be supported by clinical mentors to develop the capacity for integrated PMTCT services, protocols and job aids will be posted, and the FFSDP will include all standards related to PMTCT in the quality improvement efforts (see discussion in Result 3). Through our community mobilization and communication strategy, awareness, mobilization and support for PMTCT will be carried out in all districts (see Result 5).

These strategies will allow the project to reach the PMTCT targets by September 2010:
At least 40 health facilities provide PMTCT comprehensive services, 400 health workers trained to provide PMTC services, 150 HIV-positive women access food supplementation through PBGs and 431-positive pregnant women on ARV prophylaxis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	153,333	

Narrative:

Background
There are 5 district hospitals, 11 HC IVs and 86 HC IIIs in the 8 project target districts. It is envisaged that the entire laboratories in these 102 health facilities shall be upgraded over the next 5 years. Improvement of the laboratory infrastructure will be made in a systematic and phased minor. That is, initially focusing on the 5 district hospitals and 11 HC IVs, and moving on to the HC IIIs based on the results of the baseline survey.

MSH has hired Laboratory and Quality Assurance Advisors (2) who will provide technical inputs including training of the laboratory staff as well as providing oversight towards quality improvement of laboratory infrastructures and functions.

Activities planned for PYII (i.e. October 1, 2009 – September 30, 2010)
Conducting refresher training for laboratory staff from all the hospitals and HC IVs and some HC IIIs in HIV/TB services; ensuring regular supply of reagents and test kits; implementing laboratory infrastructure

improvement plan in priority hospitals and HCs; facilitating community outreach testing for HIV/ TB; strengthening specimen collection from health facilities and communities with transport to the district hospital or JCRC reference laboratory in Mbale.

Sustainability plan
MSH/STAR-E will advocate for ownership and maintenance of the infrastructures and equipment it will put in place by the district local government (DLG). At the end of the project period, DLG should take over full management. Any training provided to health workers is an investment for the district.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	280,463	

Narrative:

The main objective is to increase case detection to at least 70% and treatment success rates to at least 85% in all the STAR-E districts.
Strategy: Implementation shall follow the National TB/HIV collaborative policy:
The project will establish mechanisms for sharing information and collaboration through support to all the 8 districts and the TB/HIV focal persons at the district. Joint TB/HIV planning, advocacy, communication and social mobilization will be supported and regular meetings held in each district to facilitate this process.
In order to decrease the burden of Tuberculosis in people living with HIV/AIDS, STAR E will train health service providers to use clinical screening for TB for all HIV+ clients, and those with a cough will undergo sputum microscopy. For sputum negatives with clinically suspect TB, and for extra-pulmonary TB, the project will use PBGs to CBOs for transport to Mbale Hospital for additional diagnostic tests, such as X-rays. All active TB cases will receive proper treatment through community based DOTS (CBDOTS), and the project will ensure TB infection control and airborne precautions in health care and congregate settings

In order to decrease the burden of HIV in tuberculosis patients, STAR-E shall distribute tools, offer training and clinical mentoring, and provide necessary inputs for rapid testing for HIV to ensure all TB patients are screened for HIV.
Achieving of the targets for case detection and treatment success will be best achieved through increasing the index of suspicion of all health care providers, especially those that provide HIV/AIDS services, and implementation of the CB-DOTS strategy. This will involve training staff on TB/HIV and CB-DOTS in all the facilities providing TB services. Once a client is diagnosed with TB in the facility, and does not need in-patient treatment, the health service providers will work through the case managers to contact both the District TB focal point and the sub-county health worker of the new case of active TB.

The client will receive a 2 week supply of anti-tuberculosis medications, and the sub-county health worker follow up in the community to organize home-based DOTS. The sub-county health worker will then re-visit the patient every two weeks to resupply the medications and work with the family to ensure adherence with the DOTS plan. The case manager will also coordinate with the CBO grantee in the home village and the VHTs to ensure additional visits by home-based care personnel, who will monitor side effects, adherence to therapy, and refer any significant changes in clinical status back to the health facility. The District TB/Leprosy Supervisor and the Health Sub-district TB focal person will be facilitated to carry out their supervisory and monitoring functions. The districts will be supported to have a fully functional supply chain system so that there are no drug stock outs. Innovative ways of improving diagnosis of extra pulmonary TB and Childhood TB shall be done, including X-rays as needed with support of the community network.

The project will support districts to improve access to and performance of TB laboratories in order to ensure the provision of reliable diagnostic services for TB control. JCRC will do the external quality control (see laboratory work plan in Result 2 below). Clinicians and laboratory staff will be trained or given refresher courses in TB/HIV co- management. All the partners working in TB control activities will be invited to attend monthly district review meetings. Quarterly regional partner's coordination meetings will be held.

The NTLP reporting tools will be adopted by the project, and STAR-E will print and distribute the necessary updated registers, the different reporting, referral, and patient cards, and intensified TB case finding forms as needed. The DTLS and HSD TB focal persons, and the records assistants, will be supported to carry out the M&E functions and report accordingly. STAR E will regularly review and report high-quality data using the national TB and HIV M&E framework and tools to track progress toward stated objectives/targets

Support will be given in building the capacity of the local CBO's. STAR-E will work with the community own resource persons (CORPS), in particular the case managers, in community mobilization, advocacy and communication and treatment supporters in improvement of treatment success rates. By supporting the improvement of the existing district and community structures, sustainability will have been built.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10003	**Mechanism Name: HIVQUAL**

Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The HIVQUAL Program in Uganda is implemented under the leadership of the Ministry of Health [MoH], in close collaboration with CDC Uganda and the New York AIDS Institute for program management and technical support.

The Comprehensive goals and objectives are:

Goal: Improve the care and treatment of individuals with HIV/AIDS by building capacity and capabilities for quality management activities at the national, regional, district and facility level

Objectives 1: Provide Technical Assistance in the development of a national quality management program.

The development of a national framework for quality will help systematize activities across the entire health system infrastructure. The program will provide technical assistance in the development of a national quality management plan and a strategic plan which will guide the activities and the integration of quality improvement into the existing national health system infrastructure. To accomplish this the program will continue to work closely with senior MOH leadership to assure the quality program reflects the vision of the MOH. Strategies for implementation will be developed and implemented, with communication of plans to all levels of the health system. A Quality Steering Committee, begun in 2008 will continue to provide oversight of these activities and will help to provide harmonization of multiple QI programs currently supporting the country. This group meets monthly and technical assistance will be provided as needed. A key stakeholders meeting to guide the process and provide regular input and

analysis will meet at least annually. This group will review existing indicators to refine the quality improvement package and make recommendations for national priorities.

An annual national assessment will be performed to assess the nation's progress in developing a sustainable quality management infrastructure. Technical Assistance will be targeted to specific components needing improvement. System indicators will be developed based on the results of the assessment.

Objective 2: Promote sustainable quality improvement activities in 120 health facilities across all regions in the country.

A total of 450 health workers will be trained in quality improvement strategies and quality management planning during biannual regional learning networks and onsite coaching and mentoring. Participating facilities will report on QI activities at their facilities to promote peer learning and to identify themes and trends across facilities in a particular region and across the country. The regional groups will also promote the quick spread of best practices. Benchmarking data reports will be provided to allow sites to compare themselves to others in their region.

Coaching and mentoring activities will be provided by the central team and through district health supervisors during their regular supervision visits. 60 District health officials across 32 districts have been trained to date with an additional 60 individuals targeted for training in 2010. These individuals will fully understand QI methodology and will be provided specific coaching tools to help facilitate their activities.

Collaborate with implementing partners to identify technical assistance needed to support QI activities in facilities they support. Regular meetings will be held with implementing partner leadership to identify technical assistance needs. Implementing partners will be included in key stakeholders meeting to provide input on indicators and in regional learning networks to share best practices. This will help to leverage resources across programs and to reduce redundancy in QI efforts. Partners will are also invited to attend monthly Quality Steering Committee.

Objective 3: Develop and implement performance measurements to assess the quality of care provided at 120 health care facilities

Indicators will continue to be utilized during biannual data collection periods. Indicators will include Adult, Pediatric and in FY 2010, PMTCT. Key stakeholders will provide feedback on an annual basis to assure indicators are aligned with national priorities and national treatment guidelines.

Bi-annual national reports will be compiled and generated. Reports will be stratified by region and by district. Reports will be reviewed by the Quality steering Committee and the key stakeholders group to help set national priorities and benchmarking reports will provided to attendees of regional groups.

Geographic coverage

All regions within the country have some HIVQUAL participating facilities. Additional targeted sites will include those facilities with no current support for QI activities from HIVQUAL or other implementing partners, in particular HCI.

Health System Strengthening

The program is supporting the development of a national quality plan and a strategic plan to help integrate QI into the national health system structure. A framework for the national plan is expected to be completed during FY 2010.

Cost Efficiency Strategies

Cost savings will be accomplished through systematic training of local MOH officials at the district level. Once trained, these individuals will provide local coaching and mentoring, whereby the central team will be able to reduce significant travel costs.

Collaboration with other implementing partners to assure that national coverage is met without duplication of partner activities. HIVQUAL and HCI have already assured that only program is functioning in each site.

Monitoring and Evaluation

Performance Measure results, national and organizational assessments and number of Health care workers trained will be used to monitor and evaluate the program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10086	**Mechanism Name: Refugee HIV/AIDS services in Kyaka II Settlement**
Funding Agency: U.S. Department of State/Bureau of Population, Refugees, and Migration	Procurement Type: Cooperative Agreement
Prime Partner Name: International Medical Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 283,345	
Funding Source	**Funding Amount**
GHCS (State)	283,345

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IMC has been implementing a project to scale up HIV/AIDS in Kyaka II Refugee Settlement since August 2007. GTZ and IMC with support from PEPFAR have been able to expand HIV/AIDS related services reaching out to both the refugees and the host populations. Networking with Wekomire Health Centre IV has increased with regard to sharing both technical and physical resources. Clinical officers from the Health Center come to the ART clinic to review cases and also help in prescribing doses to the clients. IMC continues to use the CD-4 equipments in Mubende hospital to follow up on the clients. GTZ, in partnership with UNHCR, continues to be the leading partner in the provision of health services at the Bujubuli Health Centre III and Mukondo Health Centre II. Current staffing is 17 including one doctor, 3 clinical officers, 2 Laboratory technicians, 2 Midwives, 1 Comprehensive Nurse, 2 Enrolled Nurses, 1

Psychiatric nurse, and 4 nursing aides. IMC provides support to the Health Center by having on it's staffing rolls, two nurses, one midwife and another counselor. These support the provision of health care especially to patients referred from the ART clinic to enable GTZ staff concentrate on general patients. Current average monthly outpatient attendance is 3,000. The major disease cases seen and treated include malaria, respiratory track infections, diarrhea, and intestinal worms. Monthly antenatal attendance is approximately 350. Kyaka –II Settlement is located on the western side of Kyenjojo district and is about 215 kilometers from Kampala (197 kilometers on the Kampala –Kyenjojo highway and 18 kilometers from the diversion on a dirt road). The refugee population is accommodated in 23 villages which are divided into 9 zones. The average distance from the zone to the base camp (Bujubuli) is 9.3 kilometers (the farthest village is 18 kilometers from the base camp while the closest is 2 km; 6 zones are located more than 10 kilometers distance). By January 2009, according to Office of Prime Minister (OPM), Kyaka-II settlement has a refugee population of 14,893 and a host population of 14, 783 (total population 29,676). The majority of the refugee population originate from the Democratic Republic of Congo and Rwanda. However the government of Uganda in association with the UNHCR has begun voluntary repatriation of the Rwandese considering that the conditions in Rwanda has improved. Some of the refugees from Rwanda have, however, expressed unwillingness to go back Kyaka II has a young population with the majority of residents within the age range of 0 – 17 years. The population has remained reasonably constant. There have been new relocated refugees from Kyaka I as well as repatriation of the Rwandese which is ongoing. While the HIV/AIDS response has been scaled up in Kyaka II a lot more needs to be done to ensure delivery of comprehensive services. There are some gaps in service provision which have been identified in the course of implementation of the current project. The proposed project will involve the refugee community in Kyaka-II settlement at all stages of the implementation. Involvement of the refugees as community volunteers and community groups will further strengthen the community's sense of ownership of the project. The project will facilitate the communities in acquiring the skills to protect and prevent against HIV infection and also provide care for the infected cases.

The project will compliment the HIV/AIDS prevention and treatment initiatives of Ministry of Health. The project will compliment the efforts of the SGBV initiatives of IMC in the same project area and with the active participation of the community and key stake holders; the project is expected to achieve the goal of reducing the incidence and prevalence of HIV/AIDS in the project area. The HIV/AIDS task force with representation of refugees will continue to play a key role in monitoring progress and assessing impact of the project.

Cross-Cutting Budget Attribution(s)

Education	14,039

Food and Nutrition: Policy, Tools, and Service Delivery	15,000
Human Resources for Health	31,861

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10086		
Mechanism Name:	Refugee HIV/AIDS services in Kyaka II Settlement		
Prime Partner Name:	International Medical Corps		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	52,191	

Narrative:

The project continues to provide educational and nutritional support to 770 registered OVCs but this support is still inadequate, with only one uniform per OVC provided to all school-going OVCs and seedlings and tools provided to the OVC's families. The program still does not cover other aspects of the OVC program such as legal, care and support and palliative care to those who test positive. This is because of the lack of pediatric care at the Bujubuli Health facility. IMC will continue to seek ways that these groups of OVC can receive the full complement of OVC care. . The HIV/AIDS Counselor will continue to handle the emotional needs for the OVC while those with severe psychological problems will be referred to the Psychiatric nurse resident in Kyaka II. IMC will continue to strengthen OVC program using a family centered approach where OVCs are targeted within their families to ensure adequate monitoring, support and, ownership of program. To address the psychosocial needs of these OVC and their families/caregivers, a refresher training will be conducted for 10 volunteers trained in child counseling during FY09 and IMC provide ongoing supportive supervision to these individuals. The Counselor will be responsible for providing psychosocial care directly to those OVC with particular needs when referred by the 10 trained counselors. Existing child rights committees at zonal level will be trained to integrate OVC care in their child rights education programs in the communities as well as monitor the conditions of OVC in their zones.

IMC will also continue to provide scholastic materials to 518 OVC in school. However the materials will be distributed at household level to reduce stigma associated with distribution in schools. This will be

complemented by an awareness-raising campaign coordinated by the Community Educators aimed at changing the attitudes of families/care givers to promote children's right to education, particularly those younger girls currently undertaking traditional 'female roles' in the household.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	47,408	

Narrative:

The HIV Counseling and Testing (HCT) program has grown tremendously; the current project has been able to reach out to 3,422 new individuals with HCT services so far. The outreach program has however been constrained by inadequate transport (vehicle) facilities. Secondly, the project has two counselors who are normally overwhelmed by the turn of people demanding for HCT. Disclosure of test results to sexual partners for the few who test presents a key challenge to addressing partner sero-discordance. Existing Post test clubs have been supported to raise awareness on the benefits of HCT and this has contributed to the increased demand for HCT however these clubs need to be further supported to effectively to promote positive living and reduce stigma.The services at this center will continue to be operated.. Health staff will continue to receive refresher trainings on HIV counseling as well as ethical issues associated with RTC and routine counseling and testing (RCT). Selected individuals will be trained as Counseling Assistants to support the HVCT unit to better the counselor-client ratio and improve the quality of HVCT provided, especially at outreach sites where many people turn up demanding for counseling and testing services. HIV test kits and related materials will be obtained from the health sub-district but IMC and GTZ will procure some to prevent stock outs. In addition to promoting the available services, periodic community awareness campaigns especially around key international events like World AIDS Day –December 1st, will address issues related to disclosure of status to partners and families and the need for couple counseling and testing. Couple counseling will be promoted through training of Counselors in couple counseling and also tokens in the form of T-shirts, fast services, refreshments etc. will be provided to couples that turn up for HVCT. Community Educators will emphasize the importance of testing for children at risk of infection as part of this campaign. Children about 12 years can access VCT at the different outlets or outreaches.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	29,949	

Narrative:

IMC had been providing HIV awareness campaigns in Kyaka II, expanding the programs to cover all the zones in the settlement. Knowledge of the basic HIV facts increased, covering over 90% of the refugee population. However, comprehensive HIV knowledge is still a challenge across all age groups. In addition, there is need to focus on social change to create environments that support positive behavior

change among young people and adults since increased knowledge does not entirely translate into safe behaviors and practices. To implement this objective, IMC will continue raising awareness on AB as well as focus on translating existing HIV Knowledge into the desired behavioral change using the health belief model within the context of HIV/AIDS targeting segments of the community as well as in and out of school youth. The model involves providing comprehensive HIV knowledge, assessing risk for HIV and consequences and identifying alternatives to risky behavior and drawing action plans to reach desired behavior. Life skills training for the youth (in and out of school) is also a key component of this model. The model will be tailored to promote abstinence and marital fidelity. IMC will continue to promote the use of the PIASCY (Presidential Initiative For AIDS Strategy on Communication to youth) in order to provide comprehensive HIV/AIDS knowledge for the youth especially those in schools. In each school, life skills clubs were implemented. . In addition, door to door visits will be conducted by community educators targeting families to improve communication between parents and children hence motivating positive and responsible behaviors. Behavioral change campaigns will be conducted around World AIDS Day, Day of the African Child and World refugee day. These campaigns will also provide avenues to provide public information about HCT, OVC care and ART. HIV counseling and testing will be conducted at the celebration sites. IMC will support establishment of another group of PHA building on the experiences and activities of the one formed last year and train them to carry out HIV/AIDS awareness. IMC will also continue to work with faith based institutions to create awareness on abstinence and promote marital fidelity. The existing GBV program implemented by IMC will provide an opportunity to promote girl child education and also create awareness on gender and gender based violence to facilitate the creation of more stable homes. The community centers will be furnished with games to reduce idleness of the out of school youth. IMC will recruit and train 20 new community educators to work among the refugee and host populations. HIV/AIDS talks will be organized in schools, using guest speakers from the church, other health centers, district and, NGO staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	24,506	

Narrative:

From 2007-2009, the project focused on raising awareness on the benefits of condoms and making them available in the community via the establishment of condom dispensers installed at or near the bars. Notwithstanding the increased knowledge levels among communities about condoms as a key HIV prevention strategy, a continued robust condom promotion campaign will be vital to promote correct and consistent condom use especially among the high risk groups. Operational research to assess condom use needs to be undertaken to inform further interventions in this area. IMC will continue with condom promotion, integration of RH and STI management, prevention with positives activities and, promotion of HCT as a prevention strategy. IMC will launch a rigorous condom promotion campaign in addition to

ongoing door to door sensitization by community educators. The condom outlets will support additional condom outlets from the existing number. IMC and GTZ will continue to monitor the use of these outlets and will increase the number based on the demand by the community. STI prevention and treatment will be strengthened through outreach testing, community sensitization, training of community workers, training of health staff in syndromic management of OIs, IEC materials and provision of a broad spectrum of antibiotics. Adolescent friendly reproductive services will be instituted at one health center through the training of health staff, providing related supplies and materials, school talks and providing straight talk newspapers. Another group of PHAs will be formed and trained on positive living and prevention of STIs including prevention of re-infection building on the activities of the group formed last year. They will also be encouraged and supported to carry out HIV/AIDS awareness including condom use. During public information campaigns, HCT will be promoted as a prevention strategy. During HCT and condom awareness, communities will be informed about discordance and the need for discordant couples to use condoms consistently. Awareness on male circumcision within the context of HIV will be done through door to door sensitization by community educators, IEC materials and routine health education. Those in need of circumcision services will be referred to Kyegegwa HC III. The existing Gender Based Violence Program will implement interventions aimed at changing unequal decision making powers at household level and other gender norms. This will provide an opportunity to discuss issues around negotiation for safer sex among couples. Alcoholism is a major impediment to practicing safer sex and accelerates sexual coercion. The project will therefore raise awareness about the linkage between alcohol, HIV and GBV in the communities through drama, community meetings and impromptu discussions conducted by educators. IMC will also work with the OPM and the refugee welfare leaders to enact and enforce by-laws regulating drinking hours and operations of bars in order to reduce alcohol consumption.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	60,000	

Narrative:

Continued sensitization will remain instrumental in increasing the number of women attending antenatal care services and accessing PMTCT services. Over the past years, there has been an improvement in the number of pregnant women who were tested under PMTCT setting. In the last year, 1639 were tested and out of that number 46 were positive. These mothers were enrolled in the program to receive support and care from other mothers and also to receive counseling on how to protect their unborn children from being infected. The mothers were also encouraged to attend PMTCT meetings with their partners who provided support for them and encouraged them to attend. Increased uptake of PMTCT services is highly linked to the husband's participation, and while this has improved more outreach needs to be done to change both expecting mothers and husbands attitudes. Some mothers who enroll in the PMTCT program dropped out before their delivery dates due to the distances they have to travel to reach the

Health Centers. To be able to support mothers in this category a Home based PMTCT program was tried and started implementation during the latter part of the year. IMC will monitor the success of this program in countering the absence of mothers to deliver at the health facility. IMC expanded PMTCT services to one other health center II in Mukondo as well as improved the quality of PMTCT services outlined below. Incentives like t-shirts and mosquito nets will be used to motivate couples who attend antenatal care services as part of the process of increasing men's enrolment into the PMTCT program. In addition, a special antenatal clinic day will be set aside to attend to couples. Specific services provided to HIV positive expectant mothers will include HIV specific infant feeding education, provision of micro nutrient supplements like iron, OI management, nutrition counseling, education on good hygiene practices, personal and home care. Reproductive health services such as treatment of sexually transmitted disease, family planning / child spacing, intermittent preventive treatment of malaria, and postnatal care will be integrated into PMTCT programs through education and provision of services. HIV positive mothers will also be provided with preventive ARVs (basic regimen, combined regimen or HAART using MOH PMTCT guidelines). In addition IMC will support HIV positive mothers by taking their blood samples to the JCRC in Fort Portal where CD4 counts can be conducted. Follow up care and support for mother and baby will be done after delivery in order to increase uptake of PMTCT services.

IMC will conduct a rigorous PMTCT campaign using film vans, IEC materials and door to door sensitization. The PMTCT awareness campaign will highlight the benefits of PMTCT services to girls, pregnant women, their partners, parents and communities as well as the need for male partners to provide appropriate support. IMC and GTZ will conduct refresher trainings for existing Traditional Birth Attendants (TBAs) on PMCT to provide PMCT awareness and also to ensure that they refer HIV positive mothers to the health centers for delivery.

IMC will continue to run the home-based PMTCT program to follow up on expectant mothers not accessing ANC services and PMTCT clients who drop out. IMC will continue to monitor the success of this program in educating mothers of the need to attend to delivery at the health centres instead of delivering at home.

While a fully fledged pediatric care program is yet to be established at the Health Center, an early infant diagnosis (EID) and limited pediatric care program was established to cater for HIV positive babies. This program will continue to be operated, with support from Health personnel from Kyegegwa Health Center. HIV positive babies will be enrolled in the ART program. HIV specific infant feeding counseling to HIV+ mothers will continue after delivery and during further postnatal visits, soon after delivery and at 5 to six months when babies are expected to be weaned. IMC will continue to promote exclusive breastfeeding since it is the most viable option in this context. Awareness on early cessation of breast feeding and

rapid weaning will be done during the home visits. IMC will continue to approach UNICEF and other partners for the supply of RUTF to children who become malnourished after the cessation of breastfeeding by their mothers. IMC will also contact other partner such as NULIFE to ensure that the children are enrolled in the nutrition program which provides food to people living with HIV. The families of HIV positive mothers will be supported to strengthen or set up income generating activities for purposes of raising money to manage complementary feeding.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	69,291	

Narrative:

IMC/GTZ will continue to implement TB/HIV interventions at the Mukondo HCII which had an effect of increasing the service outlets for clients To ensure a continuing high standard of care, IMC will undertake continous refresher training to 10 health professionals to provide clinical prophylaxis, TB diagnosis, treatment protocol and elements of Community based Directly Observed Treatment Short-course (TB-DOTS). Training will be conducted by TB staff from the district that have substantial knowledge on national TB and ACP programs. IMC will identify and train 18 community health workers as TB/HIV focal persons on CB-DOTS using national TB/HIV collaborative guidelines and provide them with relevant materials and logistical support to improve drug adherence and defaulter tracing. Communities will be sensitised about respiratory tract infections in general & T.B in particular – issues related to indoor smoke pollution, over-crowding, and the risks of drinking partially boiled milk during community gatherings. A TB campaign will be conducted on World Tuberculosis Day (March 24) which will help to improve case finding, reduce stigma and defaulter rates as well as promote preventive and care aspects of tuberculosis. TB reagents and prevention therapy will continue to be accessed at Kyegegwa Health Sub district.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10280	**Mechanism Name: Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Integrated Community Based Initiatives	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,062,231	
Funding Source	**Funding Amount**
GHCS (State)	1,062,231

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO),founded in 1994, registered with the National NGO Board in 1996 and incorporated in 2004. ICOBI is operating in both South Western (15 districts) and central districts (6 districts) of the Republic of Uganda. Its head quarters are located at Plot 37 Lumumba Avenue, Kampala with field offices in districts and a regional office located in Kabwohe-Itendero Town Council-Bushenyi District.

In July 2008, Integrated Community Based Initiatives (ICOBI) received funding from CDC/PEPFAR to implement a Full Access Home Based HIV Counseling and Testing (HBHCT) and provision of basic care project in six central districts of the Republic of Uganda in five years (1st July 2008- 30th June 2013). The project integrates four components namely HCT, Basic care, sexual prevention (AB and other prevention options) and TB/HIV. HBHCT project goal is to provide 100% Full access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities from Mubende and Mityana districts to other two districts of Nakasongola and Luwero. During the period from April-June 2009, HBHCT project implementation focused on HCT in homes, HIV/AIDS prevention activities, by collaborating with district health systems and other service providers, Care and support of identified HIV infected clients and we reached 18,817 Households, 36,653 clients were counselled and tested for HIV and given results at home, 12,000 individuals were counselled and tested as couples; overall identified 1,816 individuals were HIV infected and all were referred for care and 631 reached the health units and were assessed and initiated on Cotrimoxazole prophylaxis. 1,349 individuals were reached with Abstinence only message in schools and 10,472 individuals with AB messages both in schools (private) and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Specific objectives and activities for COP 2010.

• To achieve 100% awareness on HCT among community members living in 6 districts of Mubende, Mityana, Luwero, Nakaseke, Nakasongola, Wakiso and beyond by the end of September 30th 2010.

o To offer HBHCT to 150,000 people above 14 years of age (adults and children with potential risk of HIV) in 6 districts by the end of September 30th 2010.

o To reach 75,000 people with AB messages and other prevention strategies in Mubende, Mityana, Luwero, Nakaseke, Nakasongola and Wakiso by the end of September 30th 2010.

To provide basic health care, ongoing support and Counseling to 6,000 HIV+ clients by the end of September 30th 2010.

o To obtain simple data on utility of HBHCT in various service outlets (sub counties

o To document and disseminate good practices

Activities

Community mobilization and education

o District, sub county, parish and village sensitization meetings

o Radio talk shows

• HBHCT in six district of Mubende, Mityana, Luwero, Nakaseke, Nakasongola and Wakiso districts

o Training for supervisors (ICOBI and district), field teams in HBHCT

o Collection of DBS from adults, children and infants for quality control and assurance of field test processes and for PCR to enhance EID and paediatric care

o Identification and training of RPMs as Counseling aides

• Intensify HIV prevention messages through radio, community outreaches, meetings and home visits

o Peer educator training among MARPS from each parish.

o Orientation of Model couples for Mubende and Mityana

o VHTs orientation in HBHCT so as to enhance prevention and care at community level.

o Holding FGDs, Film shows, sports, drama, PTCs meetings to communicate and reach people with prevention messages

• To reach HIV positive clients with basic care and psychosocial support

o Distribution of starter kits by Basic Care Officers and Health Workers

o Demonstration of proper usage of basic care commodities by health workers and RPMs

o Follow up home visits by RPMs, Counselors, Field Teams and VHTs

o Formation of post test clubs, PTC meetings

• Integration HBHCT into prevention, care and HIV/ TB prevention activities.

o Awareness on TB prevention at village level and testing TB clients for HIV in homes by VHTs and health Workers

o Referral of HIV+ with chronic cough for TB screening at health units

o DOTs support by VHTs and RPMs

• To strengthen linkages and collaboration with the Districts health system through

o Purchase and distribution of Cotrimoxazole supplements and monthly stipend to health units.
o Training for health workers in basic health care package
o Orientation for Village health teams.
o Training of health workers in Comprehensive HIV/AIDS management(Care and treatment)
• Carry out support supervision and monitoring of project activities through
o Field supervision visits,
o Support interpretation of data and use for program improvement
o Monthly review meetings for RPMs
o Quarterly review meetings for supervisors and field teams
o Review meetings (DHT, ICOBI, and CDC).
o Sharing reports with stakeholders

Cross-Cutting Budget Attribution(s)

Water	40,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10280**		
Mechanism Name:	**Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts**		
Prime Partner Name:	**Integrated Community Based Initiatives**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	240,000	
Narrative:			
Introduction In July 2008, Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from CDC/PEPFAR to implement a Full Access Home Based HIV Counseling and Testing(HBHCT) and provision of basic care project in six central districts of the Republic of Uganda in			

five years(1st July 2008- 30th June 2013). HBHCT project provides 100% Full access Home Based HIV Counseling and testing services to all adults(>14 years) and at risk children residing in the six districts of Mubende, Mityana, Luwero, Nakaseke, Nakasongola and Wakiso. Currently it has scaled up project activities from Mubende and Mityana districts to other two districts of Nakasongola and Luwero.

In addition the project provides preventive basic care and support to all identified HIV infected individuals and their families through an established referral process to health units (both public and private), support organisations like TASO and post test clubs in communities. The clients are visited in homes by basic care officers, health workers, counselors and volunteers called resident parish mobilizers (RPMs). During the period from April-June 2009, we visited 18,817 Households, 36,653 individuals were counselled and tested for HIV and given results at home, 12,000 individuals counselled and tested as couples; overall identified 1,816 individuals were HIV infected and all were referred for care and 631 reached the health units and were assessed and initiated on Cotrimoxazole prophylaxis. 1,349 individuals with Abstinence only message in schools and 10,472 individuals with AB messages both in schools (private) and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Types of HIV care and support services: HIV infection prevalence in the districts of Mubende and Mityana is on average about 5-6%. We shall scale HBHCT implementation to all the six districts during FY2010. We will identify about 7,500 HIV infected people while implementing HBHCT in 46 service outlets. ICOBI through collaboration with the district health systems and other service providers will provide preventive basic care and support to all identified HIV infected individuals and their families. HIV care and support services include; Procurement and distribution of starter kits(each containing safe water vessel,ITNs,Condoms,water guard solution to treat water, information in local languages to support use by the client),supply of Cotrimoxazole tablets to health units, initiation, formation and support of existing Post test clubs/PTCs, home visits and follow up of PLHIV and support of a network of volunteers like peer educators, model couples,RPMs,CDOs in care.

Working closely with the RPMs, VHTs and health units (levels 2, 3, 4 and hospitals) the project basic care officers deliver Basic Care Kits to the infected individuals at parish level through Post Test Clubs and health units. So far PACE has provided about 300 basic care kits that have been distributed to HIV infected clients in homes and are being used by families. The PLHIV families have been supported by RPMs and members of post test clubs through demonstrations on the use of commodities and actual hanging of mosquito nets in orphan PLHIV homes and elderly care givers

Cotrimoxazole supplementation to the health units: ICOBI supplements the health units with Cotrimoxazole tablets (CTX) to ensure CTX is available at health units for all the referred by the HBHCT

teams from homes. Since March 2009; 300 x 1,000 CTX tablets have been supplied to 25 health units in Mubende district and Mityana. All the HIV infected clients (HIV+/PLHIV) identified will be referred by the HIV Counseling and Testing teams with referral chits/letters to health centres and hospitals to be assessed for eligibility and initiation of Cotrimoxazole prophylaxis,TB screening and treatment of OIs within each of the project districts. We intend to work and supplement about 120 units with CTX in FY 2010. Similarly referred clients to health units will be referred to other support groups and individuals like PLHIV support net work agents (SNA) that exist in some of the project districts for additional psychosocial support by health workers and vice versa.

Strengthening health the health system

The DHOs office and DHT, health units used as referral points will be supported with a monthly stipend to support them as they provide care to referred clients at health units as well as making follow up visits in homes to provide home based care and supportive counseling. In order to ensure success, RPMs and all health workers in the project districts will be trained in the provision of the basic care package (130 HWs from Mubende and Mityana were trained) using a curriculum developed by CDC/MOH and more will be trained from other project districts, 65 health workers that include doctors and clinical officers will be trained in comprehensive HIV/AIDs management and treatment. The above trainings will ensure availability of staff in health units to receive and provide basic care to the referred clients In order to ensure that the HIV+ receive basic health care, priority is given to collaboration and strengthening of the Mubende,Mityana,Nakasongola, Wakiso, Luwero and Nakaseke districts health systems. The health system in the six districts will be supported and strengthened to be able to receive and care for HIV-infected people. Specifically health units will be supplied with Cotrimoxazole and provided with the necessary infrastructure (e.g. renovations and remodeling of health units so as to create space for the increased numbers of clients visiting health units as a result of referrals by the project implementation in the districts.

Follow ups/Home visits: Collaborating with the health staffs, RPMs , basic care officers, HIV positive peers and model discordant couples the project conducts home visits to positive individuals, discordant couples, PMTCT mothers and bedridden clients for continued psychosocial and supportive counseling especially among the discordant couples. During the visits the following issues domestic violence, divorce and neglect as a result of positive results or discordance are attended to. Sometimes the issues are referred to the CDOs mandated with family and children issues and have been oriented on project activities and their roles. Additionally a range of health issues are discussed ranging from components of basic care, nutrition, family planning, PMTCT, early infant diagnosis, hygiene and making appropriate referrals depending on clients' preference.

Initiation, Formation and Expanding of existing of Post Test Clubs: As an effort to improve the quality of life of PLHIV identified by the project, efforts will be put in mobilizing them to join existing PTCs or form new ones at parish levels so as to promote disclosure among those testing as individuals to their families, to enhance health seeking behaviours, psychosocial support and ongoing peer counseling and support.

When field teams test an individual positive s/he is counselled about the importance of disclosure to the family members, RPMs and to staffs at health units of referral. The same is done during the data dissemination meetings every after completion of a village/ cell. 30 new PTCs will be formed at parish levels where they do not exist. As positive individuals disclose to RPMs and the health units staff they are counselled on the importance of formation and joining post test and at times they are referred to existing PTCs. During PTCs meetings there is more information dissemination, education on HIV/AIDs, psychosocial support and member discuss life challenges and get solutions to them from their peers. PTCs are problem solving strategies to the subscribing members because it is in such meetings when they get life skills, livelihood skills and entrepreneurship skills from the already trained peers by the project or other organization working in the project areas like Mild may International, PREFA, NOPHOFANO, NIFEAD and others. All PTCs will be supported by CDOs in respective sub counties to register as and be recognized as CBOs or support groups which will be linked to other services in the districts in future. So far 10 PTCs have been formed with an enrolment of HIV positive members 230 tested by the program.

In addition, PLHIV clients will be given additional psychosocial support by health workers, basic care assistants, and counselor supervisors during follow up visits and ongoing counseling and support will be given by RPMs to those who will have disclosed to them.

Home based care is provided during follow up visits of infected clients by health workers, basic care officers and resident parish Mobilisers (RPMs).

Coverage in the geographical area: HIV care and support services are currently provided in Mityana and Mubende and will be scaled to include all six central district of; Luwero, Nakasongola, Nakaseke and Wakiso and basic care services target all adults and children identified HIV positive during HBHCT in homes by field CT teams. We shall provide basic care to about 3,000 PLHIV and this will contribute to country and PEPFAR targets for care in FY 2010.

Client retention and referrals: HIV positive individuals from homes are referred to health units for treatment and care, however after medical assessment and treatment at the health units, health workers may refer to community support groups (PTC) at parish levels for continued psycho social and sustained follow up support by peers, health workers, RPMs, basic care officers, counselors and community educators, peer counseling, on CTX adherence, income generating activities, training in legal and clients rights plus positive living. Specifically follow up and support of clients in homes will be intensified by health workers and basic care assistants as well as RPMs to ensure retention.

Linkages between program sites with other HIV care, treatment and prevention sites within jurisdiction and linkages and /or referrals between programs sites and non-HIV specific sites(at minimum food support,IGA,RH/FP and PLHIV support groups): The project refers positive individuals from homes to health units for CTX prophylaxis, TB screening and diagnosis, pre-ART assessment (CD4 counts) to accredited centers in districts where blood can be drawn for CD4 counts, initiation on ART and treatment of OIs. The project also refers to other centers like Mild may in Mityana/Mityana hospital and JCRC for

specialized HIV pediatric care .The project networks with other organization and faith based institutions for spiritual needs of clients, OVC support (Kiyinda diocese) in Mityana , Minnesota International for Family Planning needs and OVC support, ACTION AID in providing legal support in issues of in heritance in Mubende district, NOPHOFANO in income generating activities in Mityana and government programs such as NAADS and SACCOs in agriculture and microfinance services to individuals living with HIV/AIDS. The above is coupled with establishment and strengthening of community support groups (PTCs) for clients' psycho social support at parish levels in all the six districts. We hope to reach out to other service providers in communities and district as project implementation evolves.

Methods of program monitoring and evaluations, monitoring the quality of care and support services: The project utilizes CTX registers and cards, TB registers, pre ART registers and ART registers at the health units to access the number of successful referrals and services given to these clients. Successful referrals and services received from health units are monitored at referral points mostly Health centers 2, 3, 4 levels by health workers and basic care assistants who also do follow up through home visits and are supported by RPMs. Also monitored are the clients mobilized to join the existing support groups or new ones formed in the communities/ parish levels for purposes of psychosocial support and ongoing peer counseling by members.

The above is coupled with support supervision from the district health offices in the various districts and the health sub districts to lower health units plus field visits to homes of beneficiaries by CDC technical team and other stakeholders. Follow up visits by implementers like BCOs, RPMs and health workers.

The project also uses daily activity reports, weekly reports, monthly reports, quarterly, bi annual and annual reports coupled with monthly review meetings with RPMs, quarterly review meetings with health staffs, review meetings with field staffs and weekly supervisors meeting at the district level to assess the progress of the project towards realization of objectives and goal. There are no planned evaluations or studies for the adult care and treatment component of the project.

Funding under budget code HBHC(adult care and support): The funds under this activity will be used for procurement of commodities like basic care kits to ensure availability of preventive basic care package all the time to PLHIV clients, Cotrimoxazole, training of health workers in caring for the HIV positive and for supporting the districts' healthy system in handling and tracking the HIV+ referred, follow up and home visits to the clients started/ enrolled in chronic care, supporting establishment and meetings of post test clubs in parishes, re-training of basic care officers, community educators, RPMs and VHTs in basic care provision, follow up clients in homes by health workers, staff salaries, stipend to health units , community development officers etc.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	533,041	

Narrative:

Introduction : In July 2008, Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from CDC/PEPFAR to implement a Full Access Home Based HIV Counseling and Testing(HBHCT) and provision of basic care project in six central districts of the Republic of Uganda in five years(1st July 2008- 30th June 2013). The project integrates four components namely HCT, Basic care, sexual prevention (AB and other prevention options) and TB/HIV. HBHCT project provides 100% Full access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities from Mubende and Mityana districts to other two districts of Nakasongola and Luwero.

During the period from April-June 2009, HBHCT project implementation focused on HCT in homes, HIV/AIDS prevention activities, by collaborating with district health systems and other service providers, Care and support of identified HIV infected clients and we reached 18,817 Households, 36,653 counselled and tested for HIV and given results at home, 12,000 individuals counselled and tested as couples; overall identified 1,816 individuals were HIV infected and all were referred for care and 631 reached the health units and were assessed and initiated on Cotrimoxazole prophylaxis. 1,349 individuals with Abstinence only message in schools and 10,472 individuals with AB messages both in schools (private) and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Location and Coverage: During the period 1st October 2009- 30th September 2010; Home Based HIV Counseling and Testing project (HBHCT) implementation will be in the districts of Mubende, Mityana, Luwero and Nakaseke, Nakasongola and Wakiso. HBHCT (provider initiated) will be offered to the following principal target populations: adults above 14 years of age and all children at risk of HIV infection [e.g. mother HIV+ or mother suspected to have died of AIDS related illness]) in the six districts.

The six districts have 75 sub counties; Mubende (15), Mityana (9), Luwero (13) and Nakaseke (9), Nakasongola (9) and Wakiso (20). The project service outlet will be a sub county. HBHCT will be implemented in about 46 service outlets/sub counties. We will offer HBHCT to 150,000 individuals adults (>14 years) and children at risk of HIV infection (e.g. mother HIV positive) at home and provide them with same day HIV test results at home. 20,000 couples (40,000 individuals) will be among those offered HBHCT. 7,500 HIV infected individuals will be identified. In the covered areas proportion of eligible people for HCT who will have accessed and known their HIV status will increase from as low as 20% to above 80%.

Promotional activities to react the target population: The promotional activities include meetings with the District Health Management teams (DHMT) for each of the districts. We hold sensitization meetings/workshops in a decentralised manner from district, Sub County, parish and communities and villages. All the meetings involve stakeholders from local, political, civic/religious, cultural leaders, health

workers, community workers and organisations implementing HIV/AIDS interventions. Communities are involved in selecting parish representatives called resident parish mobilisers (RPMs) who continuously hold community meetings for the purposes of creating awareness and sustain community mobilisation and they are supported by an extensive community mobilisation, sensitization and education efforts through a weekly radio talk shows, radio spots, health talks by DHOs, announcements of field team visits to communities aired on local FM stations in the program districts. Other informal activities like music, dance and drama shows, games and sports competitions will continue to be used to promote program activities. The RPM is supported by Village health teams (VHT) in some districts where the structure is established. The program activities are further promoted in the households and communities as RPMs map households including listing of the household residents in each of the villages and later compiling a parish register to be referred to and used by CT teams during HBHCT implementation. Once HBHCT has started in the communities' beneficiaries of the service in homes promote the activities through testimonies and eventually this translates to increase up take of HCT and other care services in homes, special events, like youth camps are also used to give prevention messages. Across the six program districts a project launch was held in April 2009 as an important promotional activity for the program in the beneficiary districts.

Activities for support supervision, quality assurance, M+E: The CT teams responsible for HCT in homes are supported through field visits by counselor supervisors, laboratory supervisors, data officers and occasionally by the monitoring and evaluation officer at least twice a month for each team. The teams are also supported by community educators, basic care officers and health workers from sub county level health units. All the staff especially supervisors had an integrated training in HBHCT. The RPMs are supported by community educators, basic care officers and health workers who from time to time attend to their activities as they map out households and carry community education activities in villages including follow up of clients in homes. The community educators ensure that the mapping has been completed in each village before the teams are deployed to carry out HBHCT in homes. On the converse the RPMs, VHTs, local councils and residents support the CT teams as they lead them from door-door while implementing HBHCT in homes.

The laboratory supervisors support CT teams to observe standard operating procedures (SOPS) as they do HIV testing in homes as well as ensuring proper waste management. The laboratory supervisors also ensure that quality dried blood spots(DBS) are collected and labelled from the 20th HIV negative clients in the negative series by each team and all HIV positive clients and later shipped for re testing at UVRI/HRL/CDC Entebbe.

Similarly the counselor supervisors use the quality assurance guide/ check list so as to support CT teams and counselors self assessment of HBHCT sessions guide is also used to ensure the quality of counseling in homes. Client satisfaction assessments are done by supervisors, as well as assessing the competence and confidence of the field CT teams in addressing issues and concerns that arise during the counselling session and dialogue. Proficiency assessments using a guide/check list about the quality

of HIV testing by the field CT teams are done during joint supportive supervision with the district laboratory supervisors. Furthermore, through collaboration health workers have started supporting the CT teams in homes as part of supportive supervision of health activities in their areas of jurisdiction.
The data officers, M+E officer supports the CT teams in data collection of all variables on the HCT card and eventually submitted for data entry, processing, analysis, reporting and dissemination of lessons learnt as well as decision making to improve program implementation.
The project monitoring plan has set targets that are periodically monitored against actual achievements on a monthly, quarterly, semi-annual and annually basis. The program activities will be monitored with stakeholders during review meeting at community, service outlet level (quarterly) ,districts by DHMTs as well as reporting on National indicators to Ministry of Health through the district health services departments and PEPFAR indicators through semi-annual and annual reporting/MEEPP. The district level output indicators monitored in this project are also in line with the national performance measurement and management plan and this is aggregated data from all service outlets in each of the project districts and is reported to the respective district health officers on a monthly basis. The DHOs eventually report through the HMIS to MOH.
HBHCT is a provider initiated intervention in homes. However, individual, Couple, group, peer counseling in HIV discordance relationship, children and crisis counseling happen in homes. 46 outreach teams (each consisting of a counselor and laboratory assistant) trained in HBHCT implementation by TASO/SCOT and are currently implementing HBHCT in homes in two districts of Mubende (15 service outlets/sub counties) and Mityana (9 service outlets/sub counties), during the period 1st October 2009-30th September 2010; HBHCT implementation will be scaled to 46 service outlets in the six district. The teams move systematically from door-door guided by RPM, VHTs or other volunteers. CT teams educate household members present about HIV/AIDS. Consenting eligible household members will be tested for HIV results given after post test counseling. HIV infected clients will all be referred to health units offering basic care services that include Cotrimoxazole prophylaxis, TB screening, pre-ART assessment.
HIV testing algorithm used: All CT teams do pre-test HIV Counseling for the eligible clients identified after health education and listing of household members, consenting individuals and couples are tested for HIV using the National approved testing algorithm, serial that include determine for screening, stat pak for confirmation and unigold as a tie breaker. Same day HIV test results are given to individuals and couples after post-test counseling. While CT teams are in homes individual specific data is collected on a standardised HCT Card approved by Ministry of Health (MOH).
Assessment of the performance in ensuring effective referrals and linkages to care, treatment, and prevention services: About 7,500 HIV infected clients will be identified by the project and all will be referred to health units mostly for Cotrimoxazole prophylaxis, TB screening/examination of those with a chronic cough to enhance TB case finding and treatment of opportunistic infections. Successful referrals are monitored at referral points mostly at health centres 2, 3, 4 levels by health workers and basic care assistants who also do follow up through home visits and are supported by resident parish mobilisers.

The HIV infected are supported by CT teams and basic care officers who help them to disclose and this improves on their health seeking behaviours, clients will be mobilised/referred to existing support groups or new ones will be formed at parish levels for purposes of psychosocial support as well as positive prevention interventions like peer counseling by members. The members joining post test groups, adhering to Cotrimoxazole and treatment of opportunistic infections will be monitored at both the referral points; health units and in their respective communities or homes during follow up visits.
The funding under this budget code will go specifically to support the procurement of HIV test kits, related consumables and materials, payment of staff salaries, providing logistics for home-based counseling and testing, re-training of staff 46 counselors and 46 laboratory assistants, 4 counselor and 4 laboratory supervisors, 4 community educators, 4 basic care assistants and 1 M+E officer and 4 data clerks in HIV counseling and testing and provision of basic care including data collection and management. 350 RPMs will also receive re-orientation and training using a tailored curriculum as assistant counselors. About 200 health workers will also be oriented on HBHCT and basic care provision for the HIV infected and 600 village health teams/local councils will be oriented on HBHCT, supporting health units and for community education and mobilization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	60,000	

Narrative:

Introduction:
In July 2008, Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from CDC/PEPFAR to implement a Full Access Home Based HIV Counseling and Testing(HBHCT) and provision of basic care project in six central districts of the Republic of Uganda in five years(1st July 2008- 30th June 2013). The project integrates four components namely HCT, Basic care, sexual prevention (AB) and other prevention options) and TB/HIV. HBHCT project provides 100% Full access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities from Mubende and Mityana districts to other two districts of Nakasongola and Luwero.
During the period from April-June 2009, HBHCT project implementation focused on HCT in homes, HIV/AIDS prevention activities, by collaborating with district health systems and other service providers, Care and support of identified HIV infected clients and we reached 18,817 Households, 36,653 counselled and tested for HIV and given results at home, 12,000 individuals counselled and tested as couples; overall identified 1,816 individuals were HIV infected and all were referred for care and 631 reached the health units and were assessed and initiated on Cotrimoxazole prophylaxis. 1,349 individuals with Abstinence only message in schools and 10,472 individuals with AB messages both in schools (private) and communities through outreaches by community educators, 57 condom outlets

established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Mechanism target population and contribution to scaling up pediatric participation in treatment programs, including pediatric targets:
During HBHCT activities in the homes, pregnant mothers are offered HBHCT and identified HIV infected mothers are referred to health center 3, 4 and hospitals for preventive services provided by PMTCT programs by respective district health systems and other providers. HIV positive children above 18 months are referred to JCRC where there is free HIV/AIDS pediatric care. The prevalence of HIV infection in the Central region/districts of Mubende and Mityana is about 5-6%. During the period between 1st October 2009- 30th September 2010, we hope to counsel and test about 150,000(adults and children), We estimate about 15,000 shall be children below 14 years who will have been tested by the project and 5% of these about 750 HIV infected children with will be identified during HBHCT in the six districts by the counseling and testing teams. We shall also identify about 100 HIV infected pregnant and breast feeding mothers who will be referred and about 200 infants and children born to HIV infected mothers (HIV exposed children) of six weeks to 18 months will also be identified during HBHCT in the six districts. The HIV counseling and Testing teams ,basic care teams collect blood samples from the children (6 months -> 2 years)and submit them to DHOs to be shipped to centers carrying out HIV DNA PCR virologic tests like JCRC to confirm HIV infectivity (enhance early infant diagnosis). All HIV exposed children <2 years (parents and care givers) are referred to health units for immunization updates as well as growth development, nutrition counseling, promotion and monitoring. The children > 2years to 14 years born to HIV infected mothers or any other potential risk of HIV infection identified are offered HIV counseling and tested (consent from guardian or parent) using the serial(three tier) test algorithm. All identified HIV exposed infants(< 18 months) during HBHCT in homes will have an EID dried blood spot sample taken, prepared and submitted to district health officers to be submitted to the Joint Clinical Research centre(JCRC) as a district batch. However we have had recently challenges of having no feed back to what came out of the tests for the samples submitted to the district. All the 46 teams and health workers trained in basic care have had training in EID sample collection by JCRC.
ICOBI counseling and testing teams will refer all children infected with HIV using referral forms to health units(hospitals and health center 4) and service providers offering pediatric HIV care and treatment and the referral centers for pediatric care and treatment. Pediatric care and treatment is offered at ART accredited centres that include hospitals and health center 4s in the districts. Notable is JCRC sites that continue to offer these services free. In the six districts the services are offered at about 10 centers (both public and private).other samples are collected from health units by midwives and nurses for those who deliver in health units and the samples are submitted as a district batch. PMTCT activities in the districts

of Mubende and Mityana are supported by PREFA. The process is supported by basic care officers (BCO) with collaboration of health workers when results come back and a dialogue is held depending on result outcome plus risk reduction plans in cases of breast feeding mothers. There is continued follow up in homes by the BCO teams for more psychosocial support to the parents and treatment adherence for those positive children.

Activities that provide drugs, food and other commodities for pediatric clients: The project uses the networking and referral mechanism to ensure a holistic approach to the HIV pediatric care. Here the project refers to known pediatric centers like JCRC and Mild may for medical, food and other commodities in pediatric care in all the two districts. Through post test club meetings, home visits by the basic care team, and Peer educators; nutrition in HIV infection is emphasized and parents/ care takers of this children are linked to existing programs like NAADS programs and the USAID LEAD project and other food relief agencies to be able to able to produce enough and quality foods using affordable technologies and usual local food stuff to prepare nutritious recipes for the pediatric HIV infected children for sustainability purposes. The pediatric age group is also provided with basic care commodities in the starter kit as well as initiation and maintenance on Cotrimoxazole prophylaxis.

Activities for supervision, improved quality of care and strengthening of health services: Routine supervision from the district teams and health sub districts is done to health centers doing pediatric care centers where we refer the children. The above is coupled with the routine procedures in maternal and child health/pediatric clinics i.e. temperature taking and weighing to assess weight gain and if not to find out the cause and possible solutions and this is done together with the children guidelines. The above is coupled with routine support visits to children's family home by the basic care team, health staffs RPMs and Peer Educators. During review meetings there is experience sharing and adaptation of acceptable good practices to improve the quality of care to pediatrics.

In order to ensure success in pediatric care, health workers (doctors, midwives, nurses, health educators etc) at health center 4 and hospital level and all HBHCT counselors and laboratory assistants will be trained in pediatric HIV care and treatment, pediatric HIV counseling and psychosocial support, infant feeding counseling for the HIV positive children, nutritional counseling and feeding options for the children to caregivers and orientation of all RPMS on infant feeding for the HIV positive children.

Furthermore to ensure that the HIV+ children receive pediatric care and treatment; priority is given to collaboration with other institutions offering pediatric care like JCRC that can provide services related to ART eligibility assessment free, PREFA which is offering PMTCT preventive services in the districts, OVC programs and strengthening of the Mubende, Mityana, Luwero, Nakasongola, Wakiso and Nakaseke districts health systems at hospital level and health center levels. The health system hospitals and health center 4 levels will be strengthened to be able to receive and care for HIV-infected children. Specifically health units will be supplied with Cotrimoxazole syrup and tablet forms appropriate for the HIV infected children and provided with the necessary infrastructure (e.g. renovations and remodeling of health units so as to create space for the increase in numbers of clients visiting hospitals and sub district

hospitals that are approved to offer pediatric care and treatment (ART),within in the districts and logistics (stipend for staff) to handle the HV+ infected children as well as carrying out home visits to families of HIV infected children to provide psychosocial support to both the children ,mothers/,caregivers and family. The health system hospitals and health center 4 levels will be strengthened to be able to receive and care for HIV-infected children. Specifically health units will be supplied with Cotrimoxazole syrup and tablet forms appropriate for the HIV infected children and provided with the necessary infrastructure (e.g. renovations and remodeling of health units so as to create space for the increase in numbers of clients visiting hospitals and sub district hospitals that are approved to offer pediatric care and treatment (ART),within in the districts and logistics (stipend for staff) to handle the HV+ infected children as well as carrying out home visits to families of HIV infected children to provide psychosocial support to both the children ,mothers/,caregivers and family.

Activities promoting integration of routine pediatric care, nutrition services and maternal health services: During HBHCT activities, both positive and negative pregnant mothers are referred for antenatal services to the health units. At the health units' tetanus immunization, intermitted preservative treatment of malaria to pregnant mothers in the second and third trimester, family planning, screening and treatment of STDs, breast feeding and alternative options to PMTCT mothers, nutrition for pregnant mothers, child nutrition activities and referral for TB screening, iron supplementation, weighing and general examination of mothers plus the routine immunization, deworming and weighing of children to access their growth and development is done. Vitamin A supplementation and provision of mosquito nets to infants and their mothers is also done. The above is supplemented by home visits specifically to PMTCT mothers and their babies to give more support and exploring different options depending on client's requirement. It's during such visits that DBS for early infant diagnosis is done by the basic care team or midwives if it was not at the health units. The pediatric activities need to be integrated e.g. for example during immunization days mothers can access HCT for themselves and their infants and health workers can take of DBS for the HIV exposed infants as well.

In addition, all the identified HIV positives (HIV infected children inclusive) will receive basic care commodities from health centers (4, 3, & 2) and will be initiated on Cotrimoxazole prophylaxis. Homes and families of HIV infected will have follow up visits by the community volunteers called Resident parish Mobilisers (RPMs) to provide supportive counseling, demonstration on use of preventive basic care commodities.

Activities to strengthen laboratory support and diagnostics for pediatric clients: Health units especially health center 111s with no functional laboratories shall be equipped with Binocular Microscopes and calorimeters to start TB screening and other OIs diagnosis for quality management of pediatric clients and to access hemoglobin levels so as to enhance care for children and subsequent referrals for further management. .

The funds under this activity will be used for procurement of commodities, community mobilization and sensitization of parental groups, training of health workers ,HBHCT counselors and laboratory

assistants, community volunteers in pediatric counseling, home care for the HIV positive children and for supporting the districts' healthy system in handling and tracking the HIV+ children referred for care

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	

Narrative:

Introduction: In July 2008, Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from PEPFAR through CDC/ to implement a Provision Full Access Home Based HIV Counseling and Testing(HBHCT) and basic care project in six central districts of the Republic of Uganda for five years(1st July 2008- 30th June 2013). HBHCT project provides 100% Full Access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities to other two districts of Nakasongola and Luwero in addition to Mubende and Mityana districts. In addition the project provides preventive basic care and support to all identified HIV infected individuals and their families. During implementation of HBHCT in homes prevention strategies are discussed with a focus on communicating appropriate information to individuals, couples and children. Sexual prevention (AB) and other prevention (OP) options components of the project will aim to reach about 75,000 adults and youth through various strategies. During the period from April-June 2009, we reached 1,349 individuals with Abstinence message in schools and 10,472 individuals with AB messages both in schools and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Populations that will be targeted: Females and Males in the age groups of 10-14 years, 15-24 years and above 25 years in about 300 parishes in the districts of Mubende, Mityana, Luwero, Nakasongola and Nakaseke will be reached. The population in the age group 15-24 year some of them are married/sexually active, adults(mostly 25 years and above of age are in marriage (couples), single(out of school or in school), and those in long sexual relationships/partnerships who do not know their HIV status, discordant couples all targeted with sexual prevention(AB) interventions

Description of interventions specific for each target population:

• 10-14 years age group (Male and Female): This age group faces biological changes in their bodies and predisposes the group to risky behaviors that include pre-marital sex (casual sex) including cross-generational sex with sugar daddies/mummies, boda-boda cyclists in exchange for petty things like a ride to school, pocket money cell phones/airtime and the desire to look like other peers from well to do families and sex as a result of drug abuse. The above something for something "love" behaviors put this age group at risk of acquiring the STIs and HIV infection. This age group is found both in school and out

of school. This group will be targeted with Abstinence messages only and skills development. In schools we shall only target private schools (secondary) in each of the sub counties in project districts. Out of schools children will mobilized by peers collaborating with RPMs using the Home Based HIV Counseling Testing parish registers (census). We shall hold sessions for out of schools in small groups of 10 people in about 500 villages thus reaching more than 5,000 persons in the age category.

• Out of school youth(10-24 years, Male and Female):

Out of school youth will be reached through community meetings by organizing youth friendly activities where they can convene, enjoy and participate in dialogue sessions with their peers trained in HIV prevention. The activities will involve sports(football and net ball competitions with a related theme either A only or AB focus, film shows/video shows on abstinence, debates on abstinence using trigger videos and testimonies, focused group discussions on abstinence, drama/dance competitions on the role of abstinence in HIV prevention among the age categories at parish levels. We shall reach about 5,000 people with AB messages in the communities.

• In school youth(14-24 years, Male and Female) : The above categories constitute the young people (mostly in schools) and are more vulnerable to acquiring STI/HIV infection as they usually succumb to various challenges related to sexuality. This age category will be reached during the school calendar and we shall target 74 private schools (secondary) of age group 14-24 years old. The strategy here is to hold interclass debates on the roles of abstinence and being faithful(AB) in HIV prevention, identification of peers and training peers, inter-house(club) debates, competitions in music dance and drama (scripts on HIV prevention from MOH resource Center),film shows(10 per district at selected schools), netball(30)and football(30) competitions as well as students radio modulated programs on abstinence and Be faithful. We shall reach 5,000 school going children in private secondary schools in the six project districts.

Providing life skills building and development among these age groups gives them resilience amidst sexual desire, peer pressure, temptations from sugar daddies and mummies so as to focus on their pre determined objectives of completing studies and getting married at the right age. Such life skill helps in HIV sexual prevention in this age category.

Secondly when peers are identified and trained among them in communication of abstinence messages, it has a multiplier effect in that they go on telling the same to other peers thus causing behavior change among the age group. Thirdly peers understand and listen more from their peers as compared when they will be communicated to by other people of different age groups like adults. Activities like films, music, sports that have high appeal among the age group help this age category to perceive and internalize better the advantages of abstinence and the disadvantages of early sexual intercourse, share life experiences thus delaying their indulgence in sexual activities sustains increased age of sexual debut and eventually reducing on the risk of STIs/ HIV transmission

• 25 years of age and above (adults): Both females and males in this category will be reached through

community outreaches. Mainly this will be by holding formal and informal community meeting e.g. during gatherings like parties, church services, women groups/ councils and other associations in the communities. Activities like video shows, sports, music dance and drama will be used to mobilize people and in small group's discussion will be held and focused messages communicated. The strategy will facilitate us to reach about 10, 000 with AB messages. In addition using model couples(50) to be identified one per sub county, trained in Be faithful and Couple counseling and trained in model couple counseling will hold couple sessions or family dialogue sessions (4 sessions per month) to promote HCT for couples and sustain B message communication in the program areas through reaching 5,000 individuals among couples. Model couples training (Manuals for training model couple counselors will be used) in peer education and communication will sustain AB messages in the general population.

• Drivers for the epidemic targeted:
The above interventions will address factors related to drivers of the epidemic among the targeted population age groups in different settings mentioned above. These include; Individual behaviors contributing to increased risk of sexual transmission (early age at sexual debut, casual sex, and poor health seeking behaviors for STIs among young people etc), knowledge about their HIV status, STI/HIV and where to seek services like HBHCT, poverty (predisposes to transactional sex), Gender issues related to sexual violence, rape, inability to negotiate for safer sex, lack of skills to use protective options during sex, coerced sex etc. locations e.g. in urban, peri -urban ,rural areas, in school/institutions that increases their vulnerability to acquiring STIs/HIV infection including early pregnancies.
• Geographical and population coverage:
All targeted age groups of both females and males of age categories 10-14 years, 15-24 years and above 25 years will be reached with AB messages in about 300 parishes in the districts of Mubende, Mityana, Luwero, Nakasongola, Wakiso and Nakaseke(6 districts). In school (74 private schools[2 schools per sub county]) and 300 parishes (community outreaches) using debates, FGDs, film shows, music, sports, dance and drama we shall reach 10,000 and out of school in parishes about 30,000 and using model couples we shall reach 5,000. In total we shall reach 45,000 individuals with AB messages during COP 2010.
• Mechanisms to promote Quality Assurance: During implementation of HIV prevention activities the project we use the ABC guide lines by Ministry of Health to ensure quality of messages communicated thus leading to quality results and communicating relevant information to the targeted age groups. The messages will be communicated in small groups. Standardized materials for HIV prevention relevant to age categories will be used (IEC materials production, material interpretation, training and dissemination plus support supervision) will be done in conjunction with reputable organizations in communication strategies under the guidance of MOH. The sessions will be supported by health workers and district health educators, community educators/trainers and community development officers in respective sub counties and districts. We shall ensure there is no double counting, through data quality checks and

validation using our community/parish registers for HBHCT as our reference to ensure right age category is focused on.

• Linkages to other services:
We build net works with other service providers to efficiently reach the target audiences. There are various CBOs with funding from CSF fund (PEPFAR) who are carrying out various prevention interventions in the program districts at parish and sub counties e. g NFED is working with youth and communities in Bulera and Busimbi sub counties in Mityana and these areas are not sub counties of our prevention interventions during COP 2010. Similarly for other districts we shall avoid overlap of our interventions as we use scarce resources. However, we integrate HIV prevention messages during household education and risk reduction session to clients in homes during HBHCT by CT teams and RPMs during mobilization of communities although our primary intentions in homes are to do HCT. Other linkages are with Government health units for STI management, PNFPs for HCT for the youth, OVC support organizations, Government programs e.g. NAADS, UPE, USE and SACCOs, religious denomination to sustain the AB interventions among their folks, businesses like hotels and bars are being used as condom distribution outlets, community support groups (PTCs) for continuing psycho social support, preventive counseling and improved health seeking behaviors among PLHIV, care, treatment and support centers.

• Monitoring and Evaluation plan: Project progress and evaluation will be monitored through daily activity reports, weekly reports, monthly reports, and monthly and quarterly review meetings with RPMs, health educators, health workers, school administrators, community leaders, beneficiaries' youth, couples and adults, CBOs implementing HIV prevention interventions, semi-annual and annual reports to District officials, standardized indicators according to national performance and monitoring plan as well as CDC/PEPFAR indicators will be reported on to MOH and through MEEPP to PEPFAR. There is no evaluation studies planned under this project.

The funds under this budget code will be spent on paying staff salaries, community mobilization and Education (IEC), supporting radio program, development and adaptation of IEC/BCC materials, identification and training of model couples and peer educators, facilitating community educators, basic care officers, resident parish mobilizers,health workers, peer educators among the youth, counseling and testing teams to carry out family dialogue and community educations sessions to emphasize AB messages among targeted age categories of people.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	

Narrative:

Introduction

In July 2008, Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from PEPFAR through CDC/ to implement a Provision Full Access Home Based HIV Counseling and Testing(HBHCT) and basic care project in six central districts of the Republic of Uganda for five years(1st July 2008- 30th June 2013). HBHCT project provides 100% Full Access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities to other two districts of Nakasongola and Luwero in addition to Mubende and Mityana districts. In addition the project provides preventive basic care and support to all identified HIV infected individuals and their families. During implementation of HBHCT in homes prevention strategies are discussed with a focus on communicating appropriate information to individuals, couples and children. Sexual prevention(AB) and other prevention(OP) options components of the project will aim to reach about 75,000 adults and youth through various strategies. During the period from April-June 2009, we reached 1,349 individuals with Abstinence message in schools and 10,472 individuals with AB messages both in schools and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Target population

We shall target the following population groups with people of 15 and above years that will include both male and female. The groups to be targeted will include adults in marriage (couples) who do not know their HIV status, discordant couples, those in long term sexual relationships and high risk populations that will include uniformed men and women, like fishing communities(men and women), alcohol brewers and sellers, tea plantation workers, mine workers, market vendors, long distance truck drivers, construction(road) workers, boda- boda riders, gold miners in Mubende district, commercial sex workers in urban centers, Bar maids and hotel waiters, fish mongers and residents on Islands in Lake Wamala in Mityana and Lake Kyoga shores in Nakasongola districts and 7,500 PLHIV(individuals and HIV+ mothers) to be identified during HBHCT. More population groups will be identified in due course.

In addition people tested as HIV negative will be supported to remain HIV negative by encouraging adoption of appropriate prevention behaviors; this will be through outreaches to communities where meetings will be held. The mobilization for the meetings will be by RPMs.

Basis for selection, strategies and activities

We have selected the mentioned categories of population groups basing the drivers to be addressed in the national response to the HIV epidemic and on the results from our HBHCT implementation in Mubende and Mityana districts. For example HIV prevalence is 10.2% among the market vendors.

Specifically for other Prevention and condom distribution we shall use various strategies that will include

• Film shows that will be followed by health talks and behavioural change communication of preventive

messages mainly to target out of school youth between 15-24 years of age and general population through outreaches and film staging.

• Music dance and drama; community groups like PTCs will be identified and scripts with specific prevention messages (already developed) will be in cooperated in relevant plays and songs to target audiences and will be performed at parish and sub county levels to sustain preventive messages and information dissemination among the population. Similar messages targeting the general population (those tested for HIV and those not) throughout the project implementation through a weekly radio talk show program.

• Sports that will include netball and football competitions will be organized to bring the youth and general population at half time there will be health talks by health educators and community educators to people especially the youth present.

• Market booth strategy at bi-monthly and monthly market venues to reach to market vendors with BCC messages including distribution and social marketing of HIV prevention options like condoms.

• Other population groups to be reached will include military populations and their families of Kabamba, Bombo and Nakasongola Barracks of about 20,000 men and women in Mubende, Luwero and Nakasongola districts respectively despite constraints to accessing their families in barracks environment, there has been sustained demand from the military populations to access project services like HCT, preventive basic care package, TB awareness and other available HIV prevention options.. Additionally the civilian populations use the military health establishment for their health service needs, others have had a great interaction with the project implementers like basic care assistants, community educators and field teams as well as interfacing with their post test clubs and drama groups that we are using in prevention activities and some of them have been enrolled as peers responsible for distributing condoms.

• Aside from the uniformed personnel, motorcycle (boda-boda) cyclists, long distance drivers, commercial sex workers in urban centers, widows and divorcees will be targeted and reached by identification and training of peer educators in HIV/AIDS prevention and care.

Peer identification, enrollment, orientation & training

There are many at risk population groups and most of them hard to reach, our plan is to map the groups using RPMs and village health teams. High risk groups and their strategic sites where they congregate for leisure and targeted employment will be mapped. In order to effectively reach out to the target group, peer educators will be identified and enrolled from each of the category of the target population in the 46 sub counties. The enrolment of the peer educators will be a participatory process, different categories of the groups will meet and select their colleagues who will undergo training in peer education and will be responsible to carry a one- -one peer education and support to their groups. They will encourage their peers through focus group discussions to mobilize and participate in home based HIV counseling and

testing during outreach visits by the counseling and testing teams in the target area/homes. Peers will be trained using a curriculum for peer educators by MOH. We will identify, enroll and train 300 adults and youth as peer–educators and 50 model couples (1 per each sub county). We hope the 300 peer educators should be able to identify and induct others based at village level that will be able to interact on one to one in one year at about 10 individuals@ per month thus reaching about 30,000 individuals with abstinence and be faithful messages and behavioral change information.

Prevention with positives among HIV infected individuals and discordant couples
As part of positive prevention intervention and ongoing supportive counseling we will mainly target HIV infected individuals (7,500 HIV+ to be identified annually) e.g. couples with discordant results will be supported through prevention with positives activities to reduce transmission and other negative consequences such as marital separation and breakdown, domestic violence and neglect that may put the negative partners and others at risk of acquiring HIV infection. Peers among discordant couples who may be model couples will be identified and trained using model couple training manuals available and developed by USAID complemented with training materials for peer educators among positives (prevention with positives materials) from TASO/SCOT. About 50 discordant couples will be identified, recruited and trained as peer educators, condom distributors as well as reaching the couples with AB messages and behavior changes interventions. We shall identify discordant model couples and encourage establishment of discordant couple clubs that will be used in behavior change communications specifically the use of condoms in discordant relationships. There will be one discordant club per Sub County that will responsible in mobilizing and sensitizing communities about HBHCT, discordance and condom use.
Similarly other high risk population groups that will be identified will be reached through identification and training of their peer educators among themselves. The peers through a one to one be able to discuss behavioral change interventions and options as well as life skills building among peers.
Disclosure
Tested individuals in the homes especially those diagnosed positives are encouraged to disclose to their immediate family members ,RPMs and to the health staffs at referral health units for treatment of OIs , care and support especially behavior change as regards to use of condoms. When individuals disclose to RPMs they are encouraged to join post test clubs at parish levels where issues of stigma and discrimination are addressed by the peers. We hope about 6,000 HIV+ individuals will have disclosed to at least a family member and are able to seek for basic care services.
Condom Distribution
The mobilization will be through the trained peer educators (model couples, expert clients among PLWHA, others depending on risk groups) who will assist in condom use promotion, education, demonstration, condom distribution and also in identifying community condom outlets. This will involve initially encouraging identified HIV infected clients to join existing post test clubs or form new post test

clubs or expand the existing post test clubs in each parish.
The PLHIV clients who will get the starter kits(contain packets of condoms as one of the commodities) already will have received and had demonstration on condom use by the health worker, basic care assistants, members of post test clubs and will be from time to time be supported by the Resident Parish Mobilisers (RPMs). This will provide an opportunity of using the RPMs or PTCs in parishes as supply points. Similarly other peers from any risk group will be given responsibility of supplying the condoms to their peers. At minimum we hope to open and establish condom supply points in each of the 500 parishes in the project six districts however during the period 2009-2010 we hope to establish about 300 condom distribution points.
.Geographical /population coverage
During COP 2010 we will reach 7,500 HIV infected individuals, about 500 discordant couples (HIV negative individuals among the discordant couples), 30,000 individuals among the high risk groups, and establishment of 300 condom distribution outlets (300 parishes in about 46 sub counties) in six districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso.
Quality assurance
During the implementation, the project will make use of standard national guidelines from the ACP/MOH and other reputable organizations in other preventions. Specifically the project will utilize ABC strategy and PMTCT guidelines by MOH during its implementation. During training of peer educators we shall use trainers from PACE, PREFA, TASO SCOT and MOH. Supportive supervision will routinely be performed by community educators, health workers, health educators and other trainers from NGOs and CBOs working with the beneficiary communities.
Linkages to other services
We build net works with other service providers throughout the project life. PMTCT interventions in districts; for example during HBHCT, pregnant mothers and those breast feeding mothers identified infected with HIV are counseled about PMTCT interventions and are referred to the nearest PMTCT sites of their choice. Early Infant Diagnosis to babies born to PMTCT mothers is done in conjunction with midwives in collaboration with health units' staff and basic care officers of the project. The DBS from this babies are collected and submitted to districts which latter submits to JCRC for a PCR DNA analysis. When the results come at times we delivered them to clients homes where other dialogues are held depending on the results out comes. Some other organizations already have peer educators working in the area OP and we have worked with them during their community outreaches as facilitators and similarly we shall tap their experiences as we implement. We are utilizing the project resources to be able to distribute condoms in hard to reach communities where other implementers have constraints in transport.
We closely collaborate with Government health units to provide condoms for distribution by the HBHCT teams at the moment, FBOs/PNFPs, OVC support organizations, Government programs e.g. NAADS, USE and SACCOs, community support groups (PTCs) ,network support agents(NSA) who link the PLHIV

with health units.

The funds for this activity will be spent mainly on paying staff salaries, allowances for peer educators, model couples, setting up of condom distribution outlets in locations of populations at risk e.g. urban centers like bars, disco halls, hotels etc, training of community condom distributors among the high risk population groups (300 peer educators) in communicating and demonstrating how to use condoms effectively to avoid HIV sexual transmission, distribution of condoms at community level and social marketing of condoms by peer educators in market places so as to reach to the vendors in market places by using the market booth strategy at monthly or bi monthly markets venues, hold peer modulated radio programs(20) and debates addressing factors that lead to high risk behaviors among young people and hold meetings for discordant couples and post test clubs to promote condom education(discuss health seeking behaviors) and distribution among faithful but discordant couples and high risk individuals, procurement, development and distribution of IEC/BCC materials. Health units in the implementation of this strategy. In an effort to implement this activity, RPMs whom the positives disclose to, will joins hands in implementations of this activity to deliver and demonstrate effective condom use to positives and discordants.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	79,190	

Narrative:

Introduction:
In July 2008 Integrated Community Based Initiatives (ICOBI) an Indigenous Organization received funding from CDC/PEPFAR to implement a Full Access Home Based HIV Counseling and Testing(HBHCT) and provision of basic care project in six central districts of the Republic of Uganda in five years(1st July 2008- 30th June 2013). The project integrates four components namely HCT, Basic care, sexual prevention (AB and other prevention options) and TB/HIV. HBHCT project provides 100% Full access Home Based HIV Counseling and testing services to all adults and at risk children residing in the six districts. Currently it has scaled up project activities from Mubende and Mityana districts to other two districts of Nakasongola and Luwero.
During the period from April-June 2009, HBHCT project implementation focused on HCT in homes, HIV/AIDS prevention activities, by collaborating with district health systems and other service providers, Care and support of identified HIV infected clients and we reached 18,817 Households, 36,653 counselled and tested for HIV and given results at home, 12,000 individuals counselled and tested as couples; overall identified 1,816 individuals were HIV infected and all were referred for care and 631 reached the health units and were assessed and initiated on Cotrimoxazole prophylaxis. 1,349 individuals with Abstinence only message in schools and 10,472 individuals with AB messages both in

schools (private) and communities through outreaches by community educators, 57 condom outlets established in parishes by the counseling and testing teams and 22,780 pieces of condoms were distributed. The project intervention activities to be implemented with funds provided under this budget code will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda.

Alignment of partner activities with country policy: is the partner able to show that activities are aligned with host country national policies and strategic plans for TB and HIV:
ICOBI will provide preventive basic care and support to all HIV infected individuals and their families ultimately this includes care for clients co infected with HIV/TB. The prevalence of HIV infection in the central region/districts of Mubende and Mityana is about 5-6%. During the period between 1st October 2009- 30th September 2010, we hope to identify 7,500 HIV infected people. All the HIV+ will be assessed and initiated on Cotrimoxazole prophylaxis, and will receive safe water vessels, water guard, and mosquito nets from public health units or delivered by ICOBI basic care officers and RPMs during their home visits. We will procure these commodities put them to referral centers/health units and the health workers will provide the HIV infected clients with basic care kits and Cotrimoxazole prophylaxis. With the clients referred from homes to the health units to receive basic care package commodities provides an important and unique linkage to offer TB screening and examination for the HIV infected clients during those visits to health units. Even at home level our CT teams are in position to use the MOH TB case finding tool to identify those who had had a cough >2 weeks and other signs that may point to TB infectivity. Similarly those living/in contacts with known pulmonary TB cases are referred to health units for TB screening and further examination (clinical assessment).
TB activities are organized under the district TB and Leprosy supervisor assisted by the health assistants based at sub counties who link up to the communities and clients with the support of volunteers under the CB DOTs to the health units mostly health center 3 level.. The sub county health assistants, health workers, RPMs, Village health teams and Peer Educators, the basic care team does the follow up at homes to counsel on drug adherence and to ensure the implementation of CBDOTs at the community level and to do community sensitization meetings on TB transmission, treatment and prevention strategies in place.
Coordination across partners: Does the partner activities ensure added value relative to other related partner activities that target similar technical and geographical areas
The project uses a networking and referral mechanism to ensure a holistic approach to HIV/TB care. During the HBHCT in homes individual HIV+ clients are referred for TB screening and other assessments at health centers. Other needs ranging from OVCs support, IGAs, spiritual support and psycho social support or micro finance services and an appropriate referral is made. All TB activities in the district are coordinated under the TB/L supervisor. We have ensured coordination of the activities initially through

training of health workers in basic care and TB/HIV was facilitated by TB/L supervisors. We have ensured that all health assistants are involved in all community activities by sharing information of suspected referred clients to health units and those who could be getting treatment from other units beyond the district to be included in the TB registers at sub county levels. HBHCT activities in homes and referral of HIV Infected initially with a chronic cough will enhance TB case detection rate in the district. With continued follow up of HIV positives by RPMs, Basic care officers and PTCs members will contribute to adherence and completion of TB drugs/treatment. This in long run will have an added value in prevention and control of TB in the general population.

Human resource capacity and sustainability: How does the partner activity ensure that there are sufficient trained personnel to carry out proposed activities and sustain the program over time?

Training health staffs and RPMS, Field Teams in Basic care delivery

In conjunction with district health department, PACE, ICOBI more than 120 health workers were trained in Mubende and Mityana in basic care and TB/HIV infection and control was integrated in this training and more health workers will start training in comprehensive HIV/AIDS management and the training content has TB. All the field teams of counselors and laboratory assistants, supervisors, basic care officers, community educators and RPMs have had an orientation on TB/HIV co-infection. All have been creating awareness on TB/HIV infection explaining the relationship and the referral system related to the disease and where to seek TB screening and examination. In addition the field staffs, RPMs, Peer educators and health workers in basic care delivery components of Basic care because of their continued presence in the communities have an added advantage of engaging the community residents to actively participate in TB/HIV prevention and increase their knowledge on the relationship between TB and HIV which will in a long run increase utilization of TB/HIV services as well as increase in referrals of patients for TB and HIV.

Training HIV/AIDS Comprehensive Management: Health workers (80) specifically registered nurses; clinical officers, registered midwives and medical officers from health centre 111 to Hospital are trained in comprehensive management of HIV/AIDS which includes adults and paediatrics care. This improves staffing levels at health units and the quality of care, thus ensuring sustainability of project activities.

Training health workers and lab assistants in sputum examination so as to enhance TB screening and confirmation

For increased detection of TB and early initiation of smear positive cases on treatment, laboratory personnel above shall be trained in quality TB screening and detection with support from the Ministry of Health and the various district health teams in the six districts.

Equipping of health units with Microscopes and reagents

Health units especially health centres 111s with no functional laboratories in sub counties with very high HIV prevalence shall be equipped to start TB screening and other OIs diagnosis to improve TB case detection and management among HIV infected clients.

Monitoring and evaluation: Does the partner regularly review and report high quality data using the

national TB and HIV M&E framework and tools to track progress towards stated objectives/targets? To what degree is the partner prepared to report on the revised TB/HIV indicators?
The project implements TB/HIV activities in collaboration with health units. We only monitor referrals for TB screening who reach the health units and we tend to reach and support those who have not gone to referral points to encourage them to respond to the referral. We review with respective health units on a quarterly basis all the results for the program in each of the districts. All the services offered to the clients and other related information is integrated in HMIS of districts/MOH. The contribution of this program is its unique presence in homes and influencing to be taken at that level thus influencing the health seeking behaviours that translates in increased utilisation of TB and HIV services starting from referring all HIV positives with a cough> 2 weeks to health units for TB screening and any other care that is appropriate for PLHIV. There are so many registers capturing similar data at health units these include and PMTCT, TB, pre ART, ART and HCT registers plus clients profiles from the MOH in data capture, analysis and evaluation to discern successful referrals for HIV infected individuals screened and diagnosed for TB, started on treatment, but the program network of the human resource it avails at community level uniquely contributes to the success of TB/HIV interventions and the CB-DOTS strategy in homes and communities. The above will be coupled with support supervision from the district health teams and health sub district, together with the project coordinator and the basic care team. This will be supplemented by review meetings with the stake holders and activity reports.
Accomplishments: what were the key accomplishments and lessons learnt since last year's COP and how do proposed activities take this into considerations
The project has tested about 37,000 individuals during the quarter April to June 2009. About 1,800 HIV among them 40 were referred for TB screening; in Mityana alone where only 8 clients had initial symptomatic TB screening in homes and referred only 4 reported to the Hospital and confirmed with TB infection the client is benefiting from the program presence at home. Some TB clients confuse assume that the two diseases and others believe it is witch craft and may not seek treatment unless they are meant to understand TB/HIV co-infection and this can be advanced with people that live in those communities like PTCs members, local leaders, VHTs, RPMs and field teams. Most of the health units at level 3 hardly to any laboratory tests save for inadequate staffing levels. 500 were initiated on Cotrimoxazole.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10281	**Mechanism Name: Teachnical Assistance for data use/M&E systems strengthening for**

	Implementing Partners
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of California, San Francisco School of Nursing	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,401,139	
Funding Source	**Funding Amount**
GHCS (State)	1,401,139

Sub Partner Name(s)

Makerere University School of Public Health	Uganda Ministry of Health	

Overview Narrative

UCSF Organizational Overview:

UCSF Global Health Sciences (GHS) program is uniquely positioned to provide the technical assistance (TA), support, and guidance for the proposed project. GHS has a long history and successful track record of providing training, mentoring and support in all aspects HIV/AIDS M&E, surveillance, strategic information and planning, data use, education, and training. GHS's Prevention and Public Health Group (formerly the Institute for Global Health) includes over 70 affiliated faculty and senior staff members who carry out a variety of interdisciplinary research and training activities directed at diseases of public health significance in the resource-constrained world. GHS is recognized internationally for its faculty's expertise in the field of evidence-based guideline and program development and policy; it houses the Cochrane Collaboration's HIV/AIDS Group. Building on its many years of experience in the field, GHS recognizes that, when it comes to putting new knowledge and skills into practice, on-site mentoring is one of the most effective and flexible approaches to training. This is because on-site mentoring promotes an atmosphere of trust and respect between mentors and mentees, it gives mentors a chance to better appreciate the systemic context in which mentees operate, and it allows mentees to establish a long-term relationship with their mentors that in turn gives them a channel to address their specific needs and to ask for advice and help beyond the formal mentoring period.

GHS has core expertise in providing training, TA, mentoring, and capacity building to in-country partners for their M&E needs - such as improving the collection, management, and use of HIV prevention, care, and treatment program data, including PEPFAR indicators and surveillance data - and in improving data use at the regional, provincial and national level. This includes organization and presentation of data and data analysis across time to examine trends. GHS also has considerable experience in providing guidance and services to develop, implement, and test evaluation information systems, including the effective use of data and strategic information (SI) for program planning and improvement. Specifically, we have assisted sites to develop data collection strategies and have trained staff to clean study data, ensuring high quality datasets through local or remote database infrastructure. We have helped sites generate reports and translate results into SI. We have helped program staff use data from key indicators that are collected routinely for program evaluation and improvement; assessed program needs for capacity in M&E; and established flexible solutions for collecting, managing, analyzing, and providing information to country programs. GHS has experience in implementing the Global Fund's M&E Strengthening Tool and in conducting assessments of M&E capacity and systems at all levels: programmatic, sub-national, and national.

Goal: To empower CDC IPs with knowledge, skills and systems to efficiently manage, use, harmonize and disseminate M&E data both internally and externally and to build national capacity to train and mentor IPs for M&E.

Objectives:
1. To assess the general capacity for IP data management among CDC IPs (year 1)
2. To improve capacity among 36 selected CDC-IPs to collect, manage, analyze, interpret, use and report program data by the end of the project period
3. To develop an M&E training & mentoring program adapted to IP needs
4. To improve harmonization, accuracy, and timeliness of indicator reporting for selected IPs by end of each training cycle
5. To improve capacity of IPs to conduct outcome evaluations by the end of project period
6. To assist CDC Uganda and selected IPs to conduct evaluations of HIV care & treatment programs

Geographic Coverage and Target Populations:
-National coverage
-Target population are the implementing partners and all those to whom they provide services

UCSF will work with MUSPH and MOH to create a network of M&E experts. This network of experts will constitute the seed of a Centre of Excellence in M&E that will be organized and coordinated by the MUSPH team of M&E officers with continuous support from UCSF and will constitute the main exit

strategy of this project. This will include establishing satellite training sites to cover the four major regions of the country. UCSF will contribute directly to this Centre through the training of M&E specialists, trainers, and mentors as mentioned above, and will provide additional support in the form of personnel, equipment, and other supplies necessary to establish functional M&E systems within IPs in Uganda. In this way, when fully functional by the end of the project period, the MUSPH Centre of Excellence will have the capacity to provide on-going support to the IPs mentored by this project, to train and mentor additional PEPFAR and non-PEPFAR IPs, and to help establish the MUSPH-planned academic track in M&E within the MPH program at MUSPH.

Monitoring and Evaluation Plan

UCSF will be responsible for organizing the monitoring and evaluation of the activities proposed in this application. A framework summarizing the detailed M&E plan and related indicators has been created. The monitoring and evaluation plan for the proposed activities will track the processes, outcomes and impacts of interventions on the beneficiaries and will be integrated in the program of activities in each annual cycle. The results monitoring will attempt to examine the causal linkages between the inputs, outputs and the results. Tracking will be conducted through several different methods. First, evaluations of workshops and training sessions will be conducted using an on-line system for assessing knowledge gained, participant satisfaction, and participant activities post-training. Second, meta-evaluations will be conducted to assess the success of the outcome evaluations that selected IPs will be doing throughout the project period. This will include an assessment of the protocol-writing process and non-research determination application process. Third, assessments of indicators being collected, data quality, reporting and analysis of programmatic data will be conducted with each participating IP. Reports and data use within IPs will be compared post-training to pre-training. Finally, post-intervention reviews will be conducted with each IP to ensure that harmonization of indicators across partners has been successful. The results of our project evaluation will establish whether the overall M&E capacity building strategies implemented both at the IP level and at the national level are successful in raising the level of expertise in M&E for each IP and in increasing the numbers of M&E mentors and experts in Uganda.

The evaluation of the proposed activities will include tracking the utilization of inputs (resources) in the production of outputs including processes/activities. The main tools of analysis will be the annual budget and work plans, and periodic progress report. Tracking will be done though administrative data recording, both narrative and financial progress reporting, spot checks/follow-up and financial audits. The outcome of implementation monitoring will determine efficiency in the utilization of resources and whether the set targets were met.

Results will be disseminated to IPs and key partners at the end of each cycle and at the end of the project nationally. The final evaluation will be distributed to all stakeholders.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	350,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10281**		
Mechanism Name:	**Teachnical Assistance for data use/M&E systems strengthening for Implementing Partners**		
Prime Partner Name:	**University of California, San Francisco School of Nursing**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	120,000	

Narrative:

The UCSF-MUSPH team will evaluate the M&E capacity and needs of all CDC Care and Treatment IPs, including MOH, and will train and mentor every year a selected number of IPs with different areas of programmatic focus to implement a comprehensive project tailored to the specific needs of each IP. This will be accomplished through a combination of formal short-course training and on-site mentoring that will aim to ensure that beneficiaries not only acquire M&E knowledge but fully understand how to apply this knowledge to their programs and develop mentoring skills of their own in the process. This will equip a cadre of staff with knowledge and skills that will enable them to address identified M&E gaps, to ensure timely and accurate M&E reporting, and to develop and implement program-specific outcome evaluations and related protocols in compliance with ethical standards and protection of human subjects.

UCSF will assist selected care and treatment IPs to conduct evaluations of their care and treatment programs, with the goal of performing at least one ART outcomes project per year of the overall project. Clinical outcomes will include mortality, ART initiation, average CD4 counts, drug regimens in use, loss to follow up.

UCSF will be assessing systems in place in care and treatment clinics for tracking adherence and loss to

follow-up.

Over the course of the 5-year project UCSF plans to assess the monitoring systems in place at all CDC-supported care and treatment clinics in Uganda. We will not be providing treatment or clinical services, but rather will be conducting assessments, trainings, and making recommendations for improvements to existing systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	1,090,000	

Narrative:

Key Strategies of the SI Component of the Project:

1. To work in close consultation with key stakeholders in planning and implementing the different phases of the M&E capacity building project. In order to ensure that efforts are complementary, coordinated, and supportive of the national HMIS, the project will establish strong partnerships with key players during the planning and implementation phase of the project, including MEEPP, the PEPFAR SI TWG, UAC, CDC-Uganda Informatics and Program Units, the HMIS TWG, and the MOH M&E Section. The project will also support one or more staff positions within NACP to help coordinate the national M&E harmonization effort, to provide increased capacity and expertise within MOH, and to be involved with the IP training and mentoring program.

2. To assist, train, and mentor IPs in improving all aspects of their M&E capacity and systems in partnership with MUSPH. The UCSF-MUSPH team will evaluate the M&E capacity and needs of all CDC IPs, including MOH, and will train and mentor every year a selected number of IPs with different areas of programmatic focus to implement a comprehensive project tailored to the specific needs of each IP. This will be done through a combination of formal short-course training and on-site mentoring that will aim to ensure that beneficiaries not only acquire M&E knowledge but fully understand how to apply this knowledge to their programs and develop mentoring skills of their own in the process. This will equip a cadre of staff with knowledge and skills that will enable them to address identified M&E gaps, to ensure timely and accurate M&E reporting, and to develop and implement program-specific outcome evaluations and related protocols in compliance with ethical standards and protection of human subjects. By combining UCSF's international M&E experience and training skills with MUSPH's role and expertise in HIV/AIDS research, education, and capacity building in Uganda, we will maximize the chances of success of this project and the potential for its continued growth beyond UCSF assistance.

3. In an effort to provide support to national capacity building relating to collection, management,

analysis and use of data, UCSF will work with collaborating institutions to build a Centre of Excellence in M&E at MUSPH. This Centre of Excellence will provide training and academic leadership in M&E and will further support and strengthen the M&E capacity of USG IPs, the Uganda MOH, as well as of other governmental organizations and NGOs in Uganda. By building a cadre of staff and professionals with the academic depth and capacity to provide training and mentorship in all aspects of M&E at the governmental and IP levels, the project will contribute to MUSPH's plans to develop a comprehensive curriculum on M&E with both formal degree-granting and short-course offerings for NGOs and professionals in Uganda. This strategy will promote the development of capacity for robust and sustainable M&E in Uganda in the long term.

Training

The MOH, UCSF-MUSPH Team and CDC-Uganda will come together to develop three levels of M&E and Mentoring courses for PEPFAR IPs. These courses will aim to provide participants with a practical understanding of M&E and mentoring concepts and methods, and how to integrate them into program planning, implementation, and management. Emphasis will be placed on imparting knowledge and skills that will allow participants to use M&E to generate meaningful program data for supporting decision making within the context of Uganda's national HIV/AIDS strategy. The novel use of mentoring using an M & E project tailored to the particular needs of each IP in addition to exercises, small group work, large group discussions, and facilitator-led presentations, will enable participants to gain hands-on experience in M&E that will be applicable in their own work. The course's exercises will reinforce concepts covered within a course module. Small group work and large group discussions will provide participants with opportunities to share their various perspectives on the concepts covered and clarify their level of understanding. This training and mentorship will build the selected IPs' capacity in M&E data management, analysis, and reporting and help IPs define a harmonized set of indicators relevant to their areas of focus (prevention, care & treatment, HCT, PMTCT, OVCs, etc.) with guidance and support from the SI TWG and under the coordination of the NACP Harmonization Coordinator.

Trainings: Monitoring, Evaluation and Mentoring -I

Description

The Monitoring and Evaluation (M&E) Team of MOH, UCSF-GHS, MUSPH and CDC-Uganda have come together to develop 3 levels of Monitoring, Evaluation and Mentoring. This first course is designed to provide participants with a practical understanding of M&E concepts, methods and how to integrate them into program planning, implementation, and management. The course emphasizes the development of useful knowledge and skills that will allow participants to use M&E to generate meaningful program data for supporting decision making within the context of a country's national HIV/AIDS strategy.

The novel use of mentoring an individual project in addition to exercises, small group work, large group discussions, and facilitator-led presentations, will enable participants to gain hands-on experience in M&E, which can be applied in their own work. The course's exercises introduce content or reinforce concepts covered within a course module. Small group work and large group discussions provide participants with opportunities to share their various perspectives on the concepts covered and clarify their level of understanding. Participants are given tools for planning program-specific M&E and assessing M&E readiness, which can provide a starting point for developing M&E action plans.

Trainings: Monitoring, Evaluation and Mentoring -II

Description
The second course is designed to provide participants with a deeper understanding of data quality and how to assess it, how to get there, and innovative ways of finding data sources and data use. The course builds on to what was covered in M&E&M-I but goes in more depth. The course emphasizes the development of relevant knowledge and skills that will allow participants to use M&E to generate meaningful program data for supporting decision making within the context of a country's national HIV/AIDS strategy.

The novel use of mentoring as well as individual projects, exercises, small group work, large group discussions, and facilitator-led presentations, will enable participants to gain hands-on experience in M&E, which can be applied in their own work. The course's exercises introduce content or reinforce concepts covered within a course module. Small group work and large group discussions provide participants with opportunities to share their various perspectives on the concepts covered and clarify their level of understanding. Participants are given tools for planning program-specific M&E and assessing M&E readiness, which can provide a starting point for developing M&E action plans and their individual M&E projects.

Training: Monitoring, Evaluation and Mentoring - III:

Description
The third course is designed to provide participants with a deeper understanding evaluation theory, and designing and implementing evaluation studies. This course will cover cost effectiveness, impact evaluations, data triangulation, and advances in the field of evaluation studies.

Implementation of Activities:

Building and sustaining the M&E capacity of PEPFAR IPs will be the core focus of this project. To achieve this in a relevant and efficient manner, UCSF will listen to and work with key M&E stakeholders in Uganda, support the creation of a new M&E Harmonization Coordinator position at NACP, and team up with MUSPH. The main operational strategy will be to review the M&E capacity of successive groups of IPs with diverse programmatic specificities, geographical locations and capacities, and to support them to address their needs and harmonize their indicators in a way that integrates training with day-to-day responsibilities. We will implement this strategy by working with a limited number of IPs every year, including centrally located IPs with relatively developed M&E capacity as well as more peripheral IPs working in underserved rural areas with limited M&E capacity. We will conduct in-depth reviews of their M&E capacity and systems, and addressing their needs through a combination of instruction and hands-on design and implementation of a comprehensive M&E or outcome evaluation project related to their existing programs. This exercise will also serve as a platform to generate or improve electronic M&E data capture and reporting systems for each main programmatic area. After completing their project, the focal M&E persons from each IP will be involved in supporting (on a part-time basis) a new group of IPs selected in subsequent years as a way of honing their training and mentoring skills.

This project will be implemented in close consultation with CDC, MOH, UAC and the TWGs on SI and Care and Treatment. In addition, UCSF will team up with MUSPH to combine their technical and programmatic strengths. The operational team will be comprised of a UCSF in-country project coordinator and three M&E trainers/mentors that will be identified and/or hired through MUSPH in year 1 and subsequently trained by UCSF, using a curriculum customized to their experience and needs. The team will work in close collaboration with CDC-Uganda and the MOH NACP Harmonization Coordinator to identify IPs and their training and mentoring needs. The in-country team will have continuous technical support from UCSF experts in M&E, information technology (IT), surveillance, HMIS, and data analysis.

A general assessment of CDC IPs' M&E capacity will be done by the UCSF-MUSPH team in collaboration with CDC, MOH, and MEEPP to inform the adaptation of training and mentoring curricula in M&E at three different levels. Six IPs with national coverage and various programmatic specificities will then be selected in year 1 with input from MOH and CDC and will be asked to designate an M&E focal person (FP) and a back-up to work closely with the UCSF-MUSPH team and identify their own M&E gaps and needs (in staffing, data collection, management, analysis, and reporting). The UCSF-MUSPH team will train the IP focal persons using the relevant M&E curricula and will mentor them to evaluate in-depth their own organization's capacity for data collection, management, analysis and reporting.

The results of this evaluation will be used to design an on-the-job, hands-on comprehensive M&E project (for all IPs) and an outcome evaluation (for one of the six IPs) focusing on the specific gaps and priorities

of each IP. This project will be planned over a 12-month period during which the IP focal persons will be regularly trained, supported and mentored by the UCSF-MUSPH team. The MOH, UCSF-MUSPH Team and CDC-Uganda will come together to develop three levels of M&E and Mentoring courses for PEPFAR IPs. These courses will aim to provide participants with a practical understanding of M&E and mentoring concepts and methods, and how to integrate them into program planning, implementation, and management. Emphasis will be placed on imparting knowledge and skills that will allow participants to use M&E to generate meaningful program data for supporting decision making within the context of Uganda's national HIV/AIDS strategy. The novel use of mentoring using an M&E project tailored to the particular needs of each IP in addition to exercises, small group work, large group discussions, and facilitator-led presentations, will enable participants to gain hands-on experience in M&E that will be applicable in their own work. The course's exercises will reinforce concepts covered within a course module. Small group work and large group discussions will provide participants with opportunities to share their various perspectives on the concepts covered and clarify their level of understanding. This training and mentorship will build the selected IPs' capacity in M&E data management, analysis, and reporting and help IPs define a harmonized set of indicators relevant to their areas of focus (prevention, care & treatment, HCT, PMTCT, OVCs, etc.) with guidance and support from the SI TWG and under the coordination of the NACP Harmonization Coordinator.

The proposed activities will support the broader technical program areas for monitoring, evaluation and for information systems. The proposed assessment and subsequent improvement of M&E capacity of staff, the assessment of information systems in use for monitoring service uptake, process and clinical outcomes, and the harmonization of indicators will cut across all HIV program areas and include information systems in use for all types of service delivery. Implementing partners working in each of the program areas will be included in M&E and systems improvement activities for year 1, as will MOH staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	191,139	

Narrative:

This activity will address gaps in systems in place for monitoring and evaluation of activities supported by implementing partners working in Uganda across all HIV service areas.

UCSF in partnership with CDC, MUSPH and MOH, will conduct assessments of current systems in place, make recommendations for improvements, and provide technical assistance in implementing these improvements. The overall goal is to harmonize indicators across implementing partners and in line with those set out in the national level M&E plan.

The plans to strengthen strategic information systems across all HIV services areas and implementing partners by definition links functional areas and will have intentional spillover, especially as regards training Ugandan nationals both at MOH and MUSPH as M&E experts and mentors who will work closely with IPs as they improve their own M&E systems in use in their service areas.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10326	**Mechanism Name: Strengthening Uganda"s Systems for Treating AIDS Nationally (SUSTAIN)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Joint Clinical Research Center, Uganda	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Joint Clinical Research Centre (JCRC) pioneered the use of antiretroviral therapy in Sub Saharan Africa as early as 1992 when it conducted the first ARV therapy trial in Africa aimed at determining the safe and effective use of Zidovudine, a new drug by then. By 2003, JCRC was the biggest provider of ART in Uganda with close to 10,000 patients enrolled on ART. JCRC has managed to reach a number of remote and hard to reach areas with high HIV prevalence. ART sites have been established in IDP camps in Gulu and Pader districts; the marginalized communities of Batwa in Bwindi, the fishing community in Sesse islands and hard to reach areas like Kaabong and Moyo district hospitals.The Program for Timetable for Regional Expansion of Anti-retroviral therapy (TREAT) is a Seven Year Program implemented through a co-operative agreement between USAID/Uganda and the JCRC, which ends on September 30, 2010. The TREAT program works closely with the MOH and HIV/AIDS partners to increase access and build capacity for ART in 46 satellite clinics and 25 outreaches. 5 TREAT sites have been transitioned to the

new district based HIV/TB programs in STAR -East, and STAR- East Central (Kapchorwa, Kamuli and Iganga district hospital). Apac and Patongo HCIII in Pader were transitioned to NUMAT Project. JCRC established Six Regional Centres of Excellence (RCEs) to ensure, to ensure access to quality ART and comprehensive laboratory services. RCEs include; Kakira, Mbale, Gulu, Fort Portal, Mbarara and Kabale, and a mini RCE in Mubende.
The TREAT program has successfully expanded access to ART, increasing the number of people supported on ART from under 10,000 in 2003 to over 32,189 currently accessing ART. With support from Clinton Foundation Initiative,JCRC will enroll new OVCs on ART. JCRC will not enroll new adults on ART but will refer them to other partners and MOH facilities that have capacity to enroll new clients.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11429	**Mechanism Name: CDC GHAI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: USG Core
Prime Partner Name: HHS/Centers for Disease Control & Prevention	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 780,000

Funding Source	Funding Amount
GHCS (State)	780,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The US Centers for Disease Control and Prevention [CDC] in Uganda will implement the following activities:

Program and incidence based surveillance: The goals of this activity are to pilot and expand a new way of ante-natal clinic based surveillance by tapping into the PMTCT program. It aims at making use of both reported, aggregated, clinic based PMTCT data (HIV prevalence) as well as using remnant HIV-positive bloods from PMTCT clinics for HIV incidence surveillance. This activity will commence in the capital at select PMTCT clinics before expanding up-country with the aim of covering all current ANC sentinel surveillance sites. At select sites routine electronic data capture systems will be established, and hence better inform both the PMTCT and the HIV surveillance system. This activity's cost efficiency is largely a function of the cost of lab consumables for HIV incidence testing. Data will be used to inform about Uganda's HIV epidemic as well as the PMTCT program.

ACASI: Following deliberations and discussions with interested parties and stakeholders the goals and objectives have broadened to address the following: Demonstrate the feasibility of audio-computer-based self interviewing (ACASI) in household-based survey settings, the feasibility of eliciting information on socially sensitive behaviors (through ACASI), the addition of measuring chronic disease related markers (partially through ACASI), and exploring the potential of a district based continuous surveillance system that informs both the district and national level. The elicited information has great potential to contribute to health systems strengthening through planned co-ownership of this activity. The coverage is aimed at just 1 or 2 districts to demonstrate feasibility and advocate for a future standing national system. It also has a clear potential to inform the Government about chronic diseases that affect both HIV infected and uninfected citizens. Cost efficiency will mainly be a function as to what degree such a surveillance system can replace very expensive ad-hoc population-based surveys (DHS, AIS, SPA, others); other cost efficiency measures may be realized through utilizing district based infrastructure and staff. A protocol that is now part of a larger AIDS Indicator Protocol (nested sub-study) may be revised and re-submitted for review as a stand-alone protocol and will include measures to inform about the costs of such a surveillance system.

Last 1000 infections (protocol title: VCT based surveillance of HIV acquisition): This enterprise aims at establishing a dual use activity: To improve the routine voluntary and counseling (VCT) process and to inform about Uganda's HIV epidemic. The objectives are to establish an audio-computer-based self interviewing (ACASI) mechanism that largely replaces the face-to-face interviews with clients, to process the ACASI data in real time and thus make it available for the post-test counseling process. Additional HIV incidence testing on HIV-infected clients' remnant blood will enable us to evaluate factors associated with HIV acquisition which in turn should further improve the counseling process. This activity is currently limited to Kampala and the surrounding Wakiso District; the target population comprises routine VCT clients. The introduction of this relatively novel information technology has the potential of being expanded to other routine health services within the same provider, potentially lessening the work load of staff. An approved protocol will evaluate the ACASI data and regular feedback with the counselors will inform about the utility of this novel form of client interviewing.

MARPS study: Also dubbed "Crane Survey", its goal is to establish a standing and flexible bio-behavioral surveillance system that is capable to repeat survey established HIV high risk groups as well as conduct ad-hoc surveys among groups suspected to be of high risk for HIV or groups that stakeholders in Uganda expressed a need to learn more about. Its other goal is to introduce and promote the novel use of information technology, including ACASI, fingerprint scanning and the use of other electronic media to interact with survey participants. Its objectives are to measure HIV prevalence, STI prevalences, as well as demographic and behavioral risk factors in defined most-at-risk populations. Its geographic coverage currently is limited to greater Kampala; a protocol amendment under review proposes to repeat select surveys up-country. The Crane Survey's procedures contribute to health system strengthening through pre- and on the job training in counseling persons on high risk behaviors, and expanding the capacity of the MOH's STD laboratory to perform non-routine tests for select sexually transmitted infections. As this surveillance activity will become a standing system, it is expected to also become more cost-effective as start-up costs would no longer be required.

Appropriate Technologies: The CDC Informatics Unit (IU) in Uganda provides technical assistance for the development and implementation of strategic information systems to PEPFAR funded partners. Our emphasis on these electronic systems is to align the systems to the existing national Health Sector Strategic Plan as we develop appropriate EMR.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	337,500

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11429**		
Mechanism Name:	**CDC GHAI**		
Prime Partner Name:	**HHS/Centers for Disease Control & Prevention**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	780,000	

Narrative:

VCT-based surveillance of HIV acquisition: (aka "Last 1000 Infections"): This activity aims at demonstrating and using VCT as a surveillance data source: With the use of audio-computer assisted self interviewing (ACASI) technology, VCT clients will undergo a more detailed routine client interview. In addition VCT clients who test HIV-positive will have their left-over blood sample undergo additional testing to identify whether they were recently infected or are long-term infected. Both ACASI and lab data will then be used to describe HIV acquisition, transmission, and at risk behaviors. ACASI data will be made available to counselors to improve on the counseling process as well. The protocol is approved and preparations are in place to start this project in the coming months. A delay occurred as the initially chosen VCT provider could not provide an adequate physical environment on its premises and a new VCT provider had to be found. Currently we are making final preparations on the data instruments and overall design. We anticipate a start within FY2010, depending on the time it takes to identify for the right funding mechanism – currently the main reason why this project has not yet started at time of writing. Training for 3-4 staff will include protocol adherence and project-specific data management. We anticipate that the implementation of the ACASI technology will have a show-casing effect for many visitors from other organizations and promote the spread of this technology that is still new for Uganda. The introduction of IT use for routine HIV-related services also has the potential to expand to other areas such as using IT to deliver routine (standardized) information to clients or to replace paper-based data collection at health facilities.

"Evaluating use of ACASI": This was supposed to be a nested sub-study within the planned UAMIS (Uganda AIDS/Malaria Indicator Survey). The intent was to pilot the feasibility and utility of using audio-computer assisted self interviewing (ACASI) technology within a household, population-based survey. However, after postponing UAMIS twice since 2008, this survey was meanwhile cancelled and is

expected to be replaced with an AIDS Indicator Survey (AIS) only. Investigators may propose to extract the sub-study from the original UAMIS protocol and submit an independent protocol to the local and CDC IRB. Investigators also propose to make better use of the monies and – in addition to the original objective - widen the scope of the substudy to 1) evaluate the feasibility of asking highly sensitive behavioral questions in a household setting and 2) to add chronic disease biomarkers. Thus the overall goal is now to demonstrate the feasibility of a different type pop-based survey that makes better use of IT in data collection, uses a refined data instrument and informs the Ministry and stakeholders on the distribution of chronic disease in the country. The sample size will be small (500-1000) as this is a demonstration project only, the survey participants' data are not intended to be nationally representative. We plan to implement this project in FY 2010, during or after the main survey has been completed. Training will include biological measurements, IT-related data management and protocol adherence. Investigators expect that local stakeholder in this activity, especially the Ministry of Health, will recognize the potential of this novel interview technology and gradually apply it in other data collection activities as well. The added biomarkers related mostly to non-infectious, chronic disease will demonstrate the added value that HIV-focused surveys can provide to other pressing health information needs.

Program & Incidence-based HIV surveillance: Preparations are ongoing with the MoH to pilot and later expand HIV incidence surveillance in a PMTCT setting with the ultimate goal of replacing conventional ANC based HIV surveillance that conduct unlinked anonymous HIV testing on left-over blood without consent. Training for 4-6 staff will encompass protocol adherence and possibly IT-related data management. The protocol is meanwhile approved; identifying the right funding mechanism led to further delays in this activity which is now expected start its field activities in FY2010. Once shown to be feasible and successful, this pilot is expected to expand, be incorporated into the MoH's routine HIV surveillance system and discontinue conventional ANC surveillance.

MARPS study: This is an ongoing surveillance activity (dubbed "Crane Survey"). The survey's 1st phase was successfully completed in 2009 (sampling female sex workers and their male partners, men having sex with men, university students, and motorcycle taxi drivers). Current activities include data cleaning and analysis as well as preparing for the next phase that will survey school students, drug users and high risk heterosexuals. Field activities are currently paused due to ongoing IRB review of the protocol amendment, unexpected cost increases, and the necessity of finding a new survey office in downtown Kampala. This 2nd phase of field activities will commence in the 1st half of 2009. We anticipate training for approximately 15 staff on protocol adherence, IT training (ACASI), possible also on VCT. This collaborative activity between CDC, MOH, and Makerere University (School of Public Health, SPH) mostly involves SPH staff, thereby greatly expanding SPH's technical capacity and skills.

Appropriate Technologies: The CDC Informatics Unit (IU) in Uganda provides technical assistance for the

development and implementation of strategic information systems to PEPFAR funded partners. We have identified within IU the need to further strengthen the usage of appropriate technologies at the national, district and health facility levels. Our emphasis on these electronic systems is to align the systems to the existing national Health Sector Strategic Plan as we develop appropriate EMR. In FY 2010, the Informatics Unit, through contracts where necessary, will evaluate the performance of manual and electronic systems, develop new and upgrade electronic systems using appropriate technologies, train 30 key personnel in Strategic Information and install and support electronic systems at different administrative levels in support to the GOU through 21 implementing partners.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11479	**Mechanism Name: State Department**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: USG Core
Prime Partner Name: U.S. Department of State/Bureau of Population, Refugees, and Migration (State/PRM)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 401,000	
Funding Source	**Funding Amount**
GHCS (State)	401,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The focus of the PEPFAR Small Grants Program of the Department of State – The Community Grants Program to Combat HIV/AIDS is to provide care and support to Orphans and Vulnerable Children and Adult Care and Treatment. The most fundamental way to meet the needs of vulnerable children is to keep their parents alive and prevent them from becoming orphans. The Community Grants Program also provides care and support for people living with HIV/AIDS, enabling parents to resume their role as

caretakers and thus allowing children to reclaim their childhood. The Community Grants Program recognizes the critical contribution played by grassroots organizations in providing care and support to these target populations, often in deeply rural underserved areas. Many of these organizations do not qualify for the million-dollar grants awarded by USAID and CDC and are unable to access the services provided by USG Implementing Partners. Grants are awarded for a one-year period to organizations working in direct service delivery in one of the nine priority intervention areas that have been identified as being essential to the well being of OVC, namely socio-economic security, food security and nutrition, care and support, mitigation of the impact of conflict, education, psychosocial support, health, child protection and legal support. Comprehensive care supporting as many of these core areas is the preferred approach.

In FY2009, we are funding 11 OVC projects. They are animal husbandry projects that will serve as both income-generating activities for OVC as well as a source of nutrition; boreholes that will provide clean, safe drinking water for OVC; vocational training for OVC with an emphasis on employment following their graduation; REDACTED; Mobile Outreach Clinic that will provide basic healthcare services to OVC and the individuals and caregivers that care for them; funding for Ntungamo Fruit Dryers Association who is working in partnership with Fruits of the Nile to strengthen the income-generation activities for OVC caregivers involved in fruit-drying initiatives; an Arts Education project that provides food security, health and educational, psychosocial support; and a school economic, business and social education program to inspire self-employment through individual income-generating activities. This is achieved through the creation of after-school clubs of 50 students each. The students are encouraged to be entrepreneurial focused, innovative and financially literate. Additionally funding will be provided to support a Saturday school community outreach program at Bukaleba Development, a 2500 acre development/working farm that will provide hands on training in agriculture, and goat and piggery rearing.

In FY2010 the Community Grants Program will continue to provide direct support to OVC throughout Uganda by providing funding for OVC in the core program areas. The Community Grants Program will place an emphasis on socio-economic security for OVC households by supporting and linking the caregivers of OVC to successful income-generating activities. Once an OVC household has socio-economic security, it will be able to provide for the OVC in other core areas, namely education, health and food security. We will also place an emphasis on education and advise our partners to adopt the block grants model. We will encourage Peace Corps Volunteers to apply for grants on behalf of the grass roots organizations they are working with. These volunteers act as an invaluable link between the Small Grants Office and the rural, underserved communities in Uganda.

In FY2009 we are funding 7 Adult Care and Treatment Projects. These include safe water interventions by building a water tank and 150 Biosand Water Filters and latrines for PHAs in 12 communities and their children's schools; REDACTED; a vehicle for support of services to 13 rural health clinics; an innovative technology outreach of mobile messaging to support prevention services and counseling and testing; funding for facility and home based care activities that provide treatment of opportunistic infections and

psychological and social support of PHAs and their families.
In FY2010, Adult Care and Treatment will provide care and support to 1000 PHAs and their family members through the provision of clinical, psychological, social, spiritual and prevention services in underserved areas of Uganda.
In FY2009, sub-partner International Medical Corps (IMC) will continue their HIV/AIDS and gender-based violence awareness activities which will be integrated into substance abuse education campaigns, drama and other community outreach programs in Kitgum and Pader. Trained village health teams will continue to provide comprehensive HIV/AIDS knowledge and carry out STI and GBV Prevention activities. Condom promotion campaigns and agriculture/livelihood activities will also be continued.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	90,000
Food and Nutrition: Commodities	20,000
Gender: Reducing Violence and Coercion	80,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11479**
Mechanism Name:	**State Department**
Prime Partner Name:	**U.S. Department of State/Bureau of Population, Refugees, and Migration (State/PRM)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	175,000	

Narrative:

The Community Grants Program to Combat HIV/AIDS receives funding for 2 PEPFAR Program Areas, namely Orphans and Vulnerable Children and Adult Care and Treatment. Grants are awarded for a one-year period. Adult Care and Treatment supports programs offering care and support from the moment of diagnosis forward for the PHA and their family members in an effort to optimize their health status and help them remain productive. This population is served through programs in both the clinical setting and

community based health care throughout Uganda in rural and urban sites. Besides physical support such as medications and health services, the target population of adults/adolescents can receive psychological and social support through counseling, post-test clubs, de-stigmatization campaigns, and prevention for positives education. The Community Grants Program developed its own reporting forms which are collected from grantees semi-annually, aggregated, and entered into the MEEPP system for the PEPFAR Semi-Annual and Annual Report. Additionally Small Grants Coordinators monitor projects through site visits to the projects.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	226,000	

Narrative:

Through primary support or leveraged support, the Community Grants Program will strive to provide comprehensive care to 500 OVC throughout Uganda.
Community Grants is well placed to link community-based partners to donor-funded initiatives to build long-term sustainability. One such partnership helped two small, often forgotten fishing villages on the shores of Lake Victoria access free health services from a healthcare partner and mosquito nets from the U.S. President's Malaria Initiative. (PMI) Additionally linkages have been made with the Director of Hope Ward, International Hospital Kampala, who admitted one of our OVC beneficiaries who was in critical condition; as well as the AIDS Support Organization (TASO). Community Grants and Peace Corps succeeded in negotiating the opening of a TASO Outreach Center in Iganga District. Eliminating the transportation barrier, this satellite branch is providing comprehensive care and treatment services to PHAs in Iganga District.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11480	**Mechanism Name: Peace Corps**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Peace Corps Uganda has been involved with PEPFAR activities since the beginning in FY04. Over the past years, Peace Corps Uganda has patterned with a number of smaller community groups, CBOs, FBOs, Government supported facilities and NGOs both local and international through Volunteer placements to increase accessibility to and utilization of prevention, care and treatment promotion services. The overall goal of the Peace Corps HIV/AIDS program is to increase access to quality comprehensive HIV/AIDS prevention care and support services through strengthening organizational service delivery systems to ensure efficiency and sustainable support. Peace Corps Uganda HIV/AIDS program ensures that Volunteer placements occur in under served areas with visible critical service gaps to ensure a meaningful coverage of in areas of need.

•Peace Corps contribution in the fight against HIV in Uganda arguments the support from other USG agencies to the GOU through patterning with both USG/PEPFAR funded and non USG supported service providers to ensure that there is a coordinated approach and technical coordination in the HIV responses. Peace Corps Uganda's contribution to the fight against HIV/AIDS in Uganda mainly focuses on building and strengthening the capacity of individuals/groups-PLWHA, OVC, families, communities and other civil society groups to design appropriate and sustainable interventions to prevent further spread and mitigate the impact of the epidemic at the different levels.

•The Peace Corps Uganda program covers almost all the regions in Uganda except the North Eastern part of the country which is still considered unsafe for Volunteer placement due to social problems. However, Peace Corps will in future consider placements in districts around this region once the GOU disarmament program in the area succeeds in stabilizing the region. Data from the 2004-2005 Uganda National HIV Sero-behavioral Survey indicates that the HIV prevalence in Northern Uganda stands at 8% a figure which is above the national average. Although HIV/AIDS services are in existence in the region, there is still a gap in strengthening local support through involving communities in designing appropriate home grown solutions. As a way of responding to these findings, Peace Corps Uganda in FY09 reintroduced Volunteer placements in the region with an aim of supporting local, national and international efforts to accelerate and support the rehabilitation program being coordinated by GOU and other development partners. The assignment of more Peace Corps Volunteers will expand the role of families, communities, and local groups in designing relevant care and support interventions and strengthen existing initiatives. Currently PCU have two Peace Corps Response Volunteers working with Local NGO's to support the resettlement initiatives under the Northern Uganda rehabilitation program. In

FY09/10, plans are underway to scale up Volunteer presence in the region by placing more two year and short term Volunteers in other neighboring districts of Lira, Apac, Pader, Kitgum and West Nile districts. These Volunteers will be attached to local and international NGO's including USG supported ones and GOU institutions to support the Northern Uganda recovery program. Districts covered by the program include Wakiso, Mpigi, Rakai, Masaka, Masindi, Luwero, Nakaseke, Mbarara, Kisoro, Kabale, Rukungiri, Mbale, Pallisa, Hoima, Kabarole, Kibaale, Iganga, Kamuli, Tororo, Budaka, Gulu, Kitgum, Pader, Namutumba, Sembabule, Soroti, Ntungamo, Kyenjojo, Kamwenge, Ibanda and Lyantonde. Volunteer assignments in these districts include education assignments with GOU education institutions and community health and economic development placements with civil society organizations and government units.

•Cross Cutting Areas
• Education - the Peace Corps Uganda education program supports the GOU education goals through placement of Volunteers with government teacher training institutions and individual schools. Volunteers support, train and mentor teachers to improve classroom delivery and school management and administration as a way of promoting efficient, effective and sustainable systems. The Primary Teacher Training project benefits from the EP by supporting the Ministry of Education and Sports efforts to effectively train teachers to deliver HIV/AIDS information in age appropriate ways. The Ministry of Education's flagship initiative for HIV prevention, PIASCY, which is currently focused on primary schools, is in the process of expanding into the first two years of secondary schools, with further plans to target out-of-school youth.
• Increasing women's access to income and productive resources - all Volunteers are trained in promoting improved access to resources and income for women through such activities as Village Savings and Loans (VSLAs) and income-generating activities. Many Volunteers, whether serving under the health, economic development, or education sectors carry out such activities as primary or secondary projects.

Peace Corps Global introduced an electronic/web based monitoring and evaluation tool (Volunteer Activity Database) to capture all Volunteer field activities. This is the tool that enables Peace program to capture all Volunteer HIV/AIDS activities including people served, trained, networks and partnerships created and success stories. All the relevant PEPFAR program reporting indicators according to NGI are uploaded in the system to ensure a better alignment of Peace Corps Volunteer activities with national and PEPFAR reporting standards. Volunteers report their data on a quarterly basis and the program staff monitors Volunteer activities through site visits

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12476	**Mechanism Name: Securing Ugandans" Right to Essential Medicines (SURE)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,284,696	
Funding Source	**Funding Amount**
GHCS (State)	3,284,696

Sub Partner Name(s)

Euro Health Group	Fuel PHD	Makerere University/IDI

Overview Narrative

The mandate of the Securing Uganda's Right to Essential Medicines (SURE) project is to ensure that the population of Uganda has access to adequate quantities of good quality essential medicines and health supplies (EMHS) by strengthening the national essential medicines and health commodities supply system. The SURE team of Management Sciences for Health (MSH), Euro Health Group (EHG), Fuel Group/Pharmaceutical Healthcare Distributors (PHD), and Makerere University has designed a technical

approach to transform Uganda's pharmaceutical supply system by clarifying and harmonizing pharmaceutical policy, finance and regulatory frameworks, strengthening financial and performance management at all levels, and strengthening the capacity of National Medical Stores (NMS) to serve as the hub of a newly effective and revitalized supply chain for EMHS. SURE will also develop a strategy for selecting the best alternative options in case policy reform fails to produce an environment conducive to long-term success, particularly in the case of NMS.

The SURE project will expand upon the progress made over the past five years by working with all key stakeholders to build capacity from the top of the health system to the bottom, integrate the government's vertical program supply systems from side to side, and establish a logistics management information system (LMIS) that provides full transparency at all system levels. To tackle the policy, finance, supply chain, and capacity building issues key to achieving project goals and objectives, the SURE team will use a combination of technical approaches and tools, all grounded in decades of experience, to strengthen pharmaceutical management, supply chain/logistics, and financial systems in Uganda. By the project's end, SURE will leave a functional supply chain system at central and district levels with the necessary tools, approaches, skills and coordinating mechanisms that will allow the GOU to maintain and expand on these investments.

During the planning and development process in Year 1, SURE will ensure that existing services and programs, such as logistics data reporting for HIV/AIDS commodities, will be maintained so that there are no disruptions to supply.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12476**		
Mechanism Name:	**Securing Ugandans'' Right to Essential Medicines (SURE)**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Other	OHSS	3,284,696	

Narrative:

In Year 1, SURE will work with all key stakeholders to develop a master supply chain management implementation plan. The consultative process includes an initial Policy Options Analysis (POA) to identify specific reforms needed in policies affecting the supply chain (e.g. financing and cash flow, product selection, procurement, distribution, HR, three-year rolling procurement plan), define the specific changes needed to remove roadblocks, determine the feasibility of proposed changes, and obtain necessary commitments for change. The POA combines political mapping, indicator-based measurement of system performance and analysis of operating costs and efficiency of the supply chain. The outcome of the process will be stakeholder consensus and memoranda of understanding with key GoU agencies and donor partners that clearly define each relevant agency's role, responsibilities, milestones and timelines which correspond with the master implementation plan.

Also in Year 1, SURE will design and pilot an integrated supply chain and logistics management information system in selected districts. The integrated supply chain model will feature cost-effective innovative solutions to minimize stock-outs and leakage, information on district-level baseline indicators to track performance, and stronger linkages between the central level, the district, health sub-districts, and facilities. SURE will support NMS to improve procurement practices, central warehousing, transport and distribution. In year 1, GOU/MOH stakeholders will be trained on quantification procedures and NMS and MOH managers at central level will receive training on financial management and leadership and management. For capacity building, a key focus will be on developing standard operating procedures for supply chain functions, including financial management and procurement. In Year 2, SURE will develop and implement appropriate curricula for pre- and in-service training in priority areas such as procurement, procurement management, warehouse management, distribution/transport management at the NMS, financial management skills, use of management information systems, quantification skills at the national and district levels, and organizational management and strategic planning for senior managers in the MoH and NMS.

All MOH health services, including malaria and FP/RH services, will benefit from SURE's supply chain system strengthening activities by increasing the availability and accessibility of essential medicines and health supplies to clients of government and non-governmental health facilities. The MOH and World Bank have proposed that funds from the WB health sector loan (scheduled to be available next year) be used to roll-out SURE's district-level interventions in districts not included in the program.
.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12477	**Mechanism Name: Comprehensive Training**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this TBD mechanism is to support the Government of Uganda to meet the increasing need for HIV/AIDS service delivery training including pre-service and in-service training, by strengthening national systems for training to plan, coordinate, implement, supervise and perform quality assurance with regard to HIV/AIDS training. Activities will be coordinated with principal non-HIV/AIDS stakeholders for an integrated approach, and training could also be expanded to cover other priority public health concerns as appropriate. This implementing mechanism is aimed at the Laboratory Infrastructure and Other Health Systems Strengthening technical areas.

The overall aims of this program are to:
1) strengthen national systems for planning, coordination, standardization, certification, accreditation and supervision of both pre- and in-service HIV/AIDS training through the line ministries of Health (MoH), Education and Sports (MoES), Gender, Labor and Social Development (MoGLSD) and relevant professional bodies
2) support pre-service training institutions for health workers, teachers and other relevant professionals to integrate standardized HIV/AIDS training into their curricula and conduct this training
3) support Medical Laboratory Training Schools to meet MoH and MoES national standards, and

4) support HIV/AIDS service delivery training institutions and other relevant institutions to integrate standardized in-service HIV/AIDS training into their programs and conduct this training.

Coverage of this program will be national. The program's Monitoring and Evaluation system will include a Performance Monitoring Plan with key activities and indicators. REDACTED.

REDACTED.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12477**		
Mechanism Name:	**Comprehensive Training**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted

Narrative:

Uganda lacks effective, comprehensive Human Resources for Health training, curriculum, accreditation, certification and monitoring system. This program will focus on HRH strengthening to improve HIV and other health-related service delivery across technical areas. Through this program, support will be provided to the MOH, other ministries and stakeholders as appropriate to strengthen their institutional capacity to comprehensively assess and document HIV/AIDS training needs, set the minimum standards for training, develop work plans, accredit training providers, and coordinate and supervise implementation of this training program. Planning and coordination of HIV/AIDS training will be supported in line with the national Human Resources for Health (HRH) plan and policies. Standardization of curricula, certification of trainees and accreditation of training providers will be primarily supported by working with relevant ministries but in coordination with relevant professional bodies. In addition, the program will support pre service and in service training using a variety of approaches including; training of trainers, procurement

of learning materials, equipment and supplies, exposure visits, clinical attachment and other forms of institutional support necessary to uplift the standards of training and practice.

Scholarships may be given to staff in public, private and NGO sectors to support in-service and pre service trainings accros technical areas if these trainings are consistent with the national training plan. While allocating training scholarships, priority will be given to public health sector workers in rural districts and community based organizations that are less likely to access direct support from PEPFAR and or other donors. Provision of scholarships will come with requirements and mechanisms that support retention of trained persons in service as appropriate. Other incentives that improve and encourage the execution of skills acquired may also be included in the scholarship package. A system for monitoring and reporting on training and retention of these staff over time will be put in place in coordination with the national Human Resources Information System. These undertakings will be developed in close coordination with the appropriate district service committees or the appropriate agencies that employ the beneficiaries.

Sub grants will be used for lead HIV/AIDS training providers based on their mandate, expertise and collaborative advantage. Through this coordination process, district and lower level health facilities, private sector organizations and PHA networks will be supported to identify their HIV/AIDS training needs, and request and access ('pull' system) these trainings from accredited training providers. Capacity building in the form of skills and organizational development will be provided to accredited training organizations to implement standardized training programs, with the goal of these programs becoming fully established, and incorporated in their training calendar.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12478	**Mechanism Name: Leadership, Management and Sustainability/LMS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

Over the past two decades, there has been a rapid growth in the civil society sector, with many organizations coming up to complement public sector efforts in responding to the HIV/AIDS epidemic. The public sector has also expanded rapidly through decentralized health service delivery and the emergence of new districts as government attempts to bring services closer to where they are needed. These developments have increased the demand for leaders throughout the country. However, development in leadership and management skills has lagged behind and this to a large measure accounts for the escalation of cases of mismanagement, lack of creativity and initiatives, lack of clarity of vision, and an overall environment of uncertainty within both public and private organizations. Leadership development opportunities are lacking in both pre and in-service settings. Training institutions in Uganda produce graduates with academic credentials but with no leadership skills to that are ideally required to influence change, creatively re-engineer work processes, build teams and to proactively perceive, plan for and mitigate imminent challenges. It is these same graduates that are later appointed to assume leadership roles without any orientation to this important skill. It is imperative that good leaders are made if the country is to maintain its grip on the epidemic in the current context where innovation is necessary, resources are dwindling and new challenges unfolding.

This new activity aims to build technical and leadership competence for health and HIV/AIDS service delivery in Uganda. It is a follow-on to the ending Chemonics capacity building program that targeted key indigenous Uganda HIV/AIDS service organizations. The new activity will take a two pronged approach. It will have a pre-service training component targeting individuals graduating from universities in the disciplines of medicine, pharmacy, nursing and social sciences. These individuals will be exposed to short-term didactic training in HIV/AIDS service delivery, management and planning, after which they will be placed as interns into the major HIV/AIDS service organizations. The aim is to offer opportunities for them to practice what they have acquired in theory to produce all-round professionals. The second component will include leadership training targeting those graduating from internship, chief executives and senior of the major PEPFAR programs, directors and managers of health services at district and sub-district level, as well as central government leaders in ministries of health and local government that oversee services at district level.

The overall goal of this new Leadership and Management Program is to develop opportunities for developing and/or strengthening a leadership and management program that is housed and managed locally and will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12478**		
Mechanism Name:	**Leadership, Management and Sustainability/LMS**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by manpower constraints, both in technical and leadership dimensions. HIV/AIDS presents unique challenges given the rising number of individuals in need of care, the rapidly evolving approaches as new empirical evidence emerges and the tapering resources from global programs. The HIV/AIDS epidemic is itself dynamic, and continues to unfold in new and more complex ways. Therefore, availability of well trained and skilled personnel in technical and leadership positions is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges. These challenges also signal the need for the public sector to step up its role in the national response.

Since 2005, USAID/Uganda has been working to build HIV/AIDS competence in targeted Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH Resource Center which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services in the country. The new program will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

The new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of HIV/AIDS services. First it will have an internship component that targets fresh graduates from major universities in the disciplines of medicine, nursing, social work and pharmacy. These individuals will be exposed to intensive didactic training in state of the art HIV/AIDS care and support skills after which they will be seconded to major HIV/AIDS care programs where they will engage in apprenticeship training under the mentorship of host institutions. Some of the key areas of training will include clinical management of HIV/AIDS based on newly emerging knowledge, counseling and psychological care, diagnosis and management of pain and symptoms, home based care, preventive care, establishment of HIV/AIDS services in contexts where they don't exist, monitoring, evaluation and reporting of HIV/AIDS results, as well as end of life care. Particular attention will be given to management of effective HIV/AIDS services in resource constrained public sector settings. As they train, they will also be filling critical manpower gaps at these facilities.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable, accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link clients to wrap around services such as food, education, microfinance and micro-credit support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of health and HIV/AIDS disease epidemics; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in HIV/AIDS care and support. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by manpower constraints, both in technical and leadership dimensions. HIV/AIDS presents unique challenges given the rising number of individuals in need of care, the rapidly evolving approaches as new empirical evidence emerges and the tapering resources from global programs. The HIV/AIDS epidemic is itself dynamic, and continues to unfold in new and more complex ways. Therefore, availability of well trained and skilled personnel in technical and leadership positions is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges. These challenges also signal the need for the public sector to step up its role in the national response.

Since 2005, USAID/Uganda has been working to build HIV/AIDS competence in targeted Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH RC which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services in the country. The new program will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

In order to build competence for OVC care, the new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of OVC services. First it will have an internship component that targets fresh graduates from major universities in the disciplines

of social work, sociology and education. These individuals will be exposed to intensive didactic training in state of the art OVC care skills after which they will be seconded to major OVC programs where they will engage in apprenticeship training under the supervision and guidance of host institutions. Those to be enrolled into the program will have to demonstrate a strong passion for OVC programming and care as a major entry pre-requisite. Some of the key areas of training will include counseling and psychological care for orphans, particularly diagnosis and management of stress and other psychosomatic dysfunction, home and community based OVC care, establishment of HIV/AIDS and OVC services in contexts where they don't exist, monitoring, evaluation, reporting and quality control for OVC services, networking and coordination, and overall programming of OVC services. Particular attention will be given to management of effective OVC services in resource constrained public sector settings. As they train, they will also be filling critical manpower gaps at the host institutions.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable, accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link clients to wrap around services such as food, education, microfinance and micro-credit support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of OVC services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of HIV/AIDS; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding

from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in OVC care. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by manpower constraints, both in technical and leadership dimensions. HIV/AIDS presents unique challenges given the rising number of individuals in need of care, the rapidly evolving approaches as new empirical evidence emerges and the tapering resources from global programs. The HIV/AIDS epidemic is itself dynamic, and continues to unfold in new and more complex ways. Therefore, availability of well trained and skilled personnel in technical and leadership positions is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges. These challenges also signal the need for the public sector to step up its role in the national response.

Since 2005, USAID/Uganda has been working to build HIV/AIDS competence in targeted Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH RC which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services in the country. The new program will continue to focus on consolidation of service delivery systems, capacity

building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

The new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of HIV/AIDS services. First it will have an internship component that targets fresh graduates from major universities in the disciplines of medicine, nursing, social work and pharmacy. These individuals will be exposed to intensive didactic training in state of the art HIV/AIDS treatment skills after which they will be seconded to major care and treatment programs where they will engage in apprenticeship training under the host institutions. The training will focus mainly on management of HIV/AIDS based on newly emerging knowledge and treatment regimes, diagnostic competence especially analysis and interpretation of laboratory findings, disease monitoring and management of drug resistance, treatment literacy, ART counseling and psychological care, diagnosis and management of pain and symptoms, preventive care, establishment of HIV/AIDS services in contexts where they don't exist, monitoring, evaluation and reporting of HIV/AIDS results and outcomes. Particular attention will be given to management of effective HIV/AIDS treatment services in resource constrained public sector settings. As they train, they will also be filling critical manpower gaps at the host facilities.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable, accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link clients to wrap around services such as food, education, microfinance and micro-credit support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as

mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of health and HIV/AIDS disease epidemics; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in HIV/AIDS treatment. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by manpower constraints, both in technical and leadership dimensions. HIV/AIDS presents unique challenges given the rising number of individuals in need of care, the rapidly evolving approaches as new empirical evidence emerges and the tapering resources from global programs. The HIV/AIDS epidemic is itself dynamic, and continues to unfold in new and more complex ways. Therefore, availability of well trained and skilled personnel in technical and leadership positions is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges. These challenges also signal the need for the public sector to step up its role in the national response.

In Uganda, pediatric HIV/AIDS care and support is one of the areas that are inadequately addressed especially due to lack of technical skills. With an estimated 200,000 children living with HIV in Uganda and another 25,000 getting infected annually, it is imperative that the country rises up to this challenge. Indeed expanding access to pediatric and adolescent HIV and AIDS care is outlined as a critical priority in the National Strategic Plan. This will necessitate building the competence of existing health workers and more importantly integrate pediatric care and support in pre-service training for health workers.

Since 2005, USAID/Uganda has been working to build HIV/AIDS competence in targeted Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH Resource Center which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services in the country. The new program will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

The new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of HIV/AIDS services. First it will have an internship component that targets fresh graduates from major universities in the disciplines of medicine, nursing, social work and pharmacy. These individuals will be exposed to intensive didactic training in state of the art pediatric HIV/AIDS care and support skills after which they will be seconded to major HIV/AIDS care programs where they will engage in apprenticeship training under the mentorship of host institutions. The HIV/AIDS care and support needs of the majority of children in Uganda are psychosocial, deriving from the communication gaps between these children and their caretakers in regard to their HIV status. Children have had to endure situations uncertainty, where they grow questioning how and why they got infected and what this means for their future. These challenges become more real in adolescence where children expect to begin discovering themselves, exploring their sexuality and engaging in relationships.

To address these challenges, the follow on program will emphasize building skills in pediatric counseling among health and social workers to be able to engage children and their caregivers in ongoing discussion of HIV and AIDS, and the implications of HIV infection for their future. The training will also focus on building skills in identification and management of stress disorders, general child health and nutrition, current practices in pediatric HIV/AIDS care and support, as well as networking and co-management of clients to ensure access to comprehensive services. The trainees will also be assisted to acquire skills in adolescent reproductive health, integration of child HIV/AIDS services in contexts where they don't exist, monitoring, evaluation and reporting of pediatric HIV/AIDS care and support results and outcomes. Particular attention will be given to management of effective pediatric HIV/AIDS care services in resource constrained public sector settings. As they train, they will also be filling critical manpower gaps at the host institutions.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable, accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link children to wrap around services such as food, education, and apprenticeship support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of health and HIV/AIDS disease epidemics; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive

wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in pediatric HIV/AIDS care and support. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by manpower constraints, both in technical and leadership dimensions. HIV/AIDS presents unique challenges given the rising number of individuals in need of care, the rapidly evolving approaches as new empirical evidence emerges and the tapering resources from global programs. The HIV/AIDS epidemic is itself dynamic, and continues to unfold in new and more complex ways. Therefore, availability of well trained and skilled personnel in technical and leadership positions is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges. These challenges also signal the need for the public sector to step up its role in the national response.

In Uganda, pediatric HIV/AIDS treatment is one of the areas that are inadequately addressed especially due to lack of technical skills among providers, the comparatively longer provider time required and the stigma on the side of parents and caregivers. Currently 11,000 children are accessing treatment, representing only 22% of all those in need. With an estimated 200,000 children living with HIV in Uganda and another 25,000 getting infected annually, it is imperative that the country rises up to this challenge. Indeed expanding access to pediatric and adolescent HIV and AIDS care is outlined as a critical priority in the National Strategic Plan. This will necessitate building the competence of existing health workers and more importantly integrate pediatric treatment in pre-service training for health workers.

Since 2005, USAID/Uganda has been working to build HIV/AIDS competence in targeted Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH Resource Center which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate

and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services in the country. The new program will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

The new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of HIV/AIDS services. First it will have an internship component that targets fresh graduates from major universities in the disciplines of medicine, nursing, social work and pharmacy. These individuals will be exposed to intensive didactic training in state of the art pediatric HIV/AIDS treatment skills after which they will be seconded to major HIV/AIDS care programs where they will engage in apprenticeship training under the mentorship of host institutions. Pediatric treatment is both a clinical and psychosocial domain, and therefore, the training will focus on building skills in counseling and child communication among providers, identification and management of stress disorders, clinical management of HIV/AIDS symptoms and disease among children, general child health and nutrition, current practices in pediatric HIV/AIDS treatment, analysis and interpretation of laboratory results, as well as networking and co-management of clients to ensure access to comprehensive services. The trainees will also be assisted to acquire skills in adolescent reproductive health, integration of child HIV/AIDS services in contexts where they don't exist, monitoring, evaluation and reporting of pediatric HIV/AIDS treatment results and outcomes. Particular attention will be given to management of effective pediatric HIV/AIDS treatment services in resource constrained public sector settings. As they train, they will also be filling critical manpower gaps at the host institutions.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable,

accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link children to wrap around services such as food, education, and apprenticeship support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of health and HIV/AIDS disease epidemics; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in pediatric HIV/AIDS treatment. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

USAID/Uganda has had a history of supporting innovation in Uganda's HIV/AIDS response. The early efforts gave rise to some of the major national HIV/AIDS service organizations, including TASO, JCRC, AIC, as well as the evolution of faith-based initiatives like CHUSA and IMAU. Since 2005, USAID/Uganda has been working to further build HIV/AIDS competence in some of the Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in

Uganda, as well as UAC and MOH Resource Center which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

This activity is a follow-on activity to the capacity building activities previously under the ACE project. The activity will involve internships (including placement under CDC fellows program) and organizational capacity building for M&E. It will also include customized training in 'communicating data to policy-makers' for middle and senior GOU managers. The final scope including specific activities will be identified through consultations with stakeholders. Through this activity, about 5 key senior officers (a total of 35) each from the Ministries of Health, Gender, ICT, Planning, and Education, UAC, and UBOS will be trained on how to 'communicate critical data to policy-makers for action'. In addition, this activity will provide a general purpose course to introduce HIV/AIDS M&E concepts and principles to a select number (at least 50 per year) of health workers newly graduating from training institutions. The objective is to expose the graduates to practical experience on how to monitor and evaluate HIV/AIDS programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

HIV/AIDS and overall health service delivery in Uganda continues to be daunted by weak systems

manifesting through manpower constraints, leadership challenges, weak or non-existent procurement systems and lack of supportive policies and guidelines. Consequently providers have had to endure difficult working conditions, characterized by erratic supplies, frequent stock out of commodities, high staff turn over, lack of leadership and common purpose, as well as uneven service standards and practices due to lack of uniform policies and guidelines. Where policies exist, they are rarely updated and hence cannot offer meaningful guidance to enable services remain responsive to the current needs of the target population. In this context, a strong and dynamic policy and systems environment is of critical importance and indeed a defining factor to the country's ability to cope with the highly dynamic health and HIV/AIDS challenges.

Over the past ten years, USAID/Uganda has been working to build and strengthen systems for HIV/AIDS services. Initial interventions focused on strengthening capacity and systems for procurement and distribution of drugs and medical supplies in the country. Since 2005, USAID has been providing technical assistance to Uganda AIDS Commission (UAC) and the Ministry of Health Resource Center to improve coordination of the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The assistance has to some extent enabled these organizations to collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will, among other tasks, continue to strengthen systems for improved HIV/AIDS service delivery at national, district and sub-district levels. The major thrust of the new activity will be in improving leadership by building competences that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, growing customer needs and the changing nature of the epidemic. Therefore, the program will strive to train both the existing and new emerging leaders and also to establish leadership practices and ethos that enhance accountability, shared vision, empowerment, trust and customer focus at all levels of HIV/AIDS service delivery. The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming.

In order to consolidate the skills and practices imparted, the new program will establish a mentoring and coaching program through which trained beneficiaries will be linked to highly experienced and seasoned leaders for on-going guidance and monitoring. The program will be targeted at the Chief Executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for developing and/or strengthening a leadership and management program that is housed and managed locally and will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in leadership and management skills that support them to build confidence and zeal to propel their organizations through the highly turbulent and dynamic organizational environment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Uganda has recently concluded modes of transmission study which indicates, among other things, that there have been shifts in the risk factors and drivers of the epidemic. The key risk factors now include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviors due to antiretroviral treatment (ART). More importantly, the study also indicated that the country is facing serious challenges in programming HIV prevention interventions, pointing out that most data generated over the years have not been utilized in designing new prevention interventions that respond to the changes in the epidemic. Uganda's continued success in its HIV/AIDS response strongly hinges on its ability to initiate prevention programs that are aligned with the current context and also to re-discover the major drivers of its success of the early and mid 1990s. Re-focusing HIV prevention is more critical now as resources for treatment from global programs begin to level off. Rejuvenation of the national HIV prevention program requires new thinking, which in turn necessitates new professionals who will perceive and confront the epidemic in its current form and context and not be swayed by the mental models of the past.

USAID/Uganda has had a history of supporting innovation in Uganda's HIV/AIDS response. The early efforts gave rise to some of the major national HIV/AIDS service organizations, including TASO, JCRC, AIC, as well as the evolution of faith-based initiatives like CHUSA and IMAU. Since 2005, USAID/Uganda has been working to further build HIV/AIDS competence in some of the Ugandan private and public institutions providing HIV services throughout the country. These included JCRC, HAU, IRCU and

UWESO that played pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, as well as UAC and MOH Resource Center which coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The technical assistance was in five thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. This assistance has enabled the organizations to accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation and have developed and adopted necessary management tools such as manuals, strategies and organizational structures to improve existing practices and create long-term ownership in organizational success. This support ends in November 2009.

Building on the success of this program, the USG is proposing a follow-on activity that will continue to focus on consolidation of service delivery systems, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained HIV/AIDS service providers and managers. Currently technical and professional educational training in Uganda contains very little, if any practical skills training; therefore recent academic graduates enter the labor market ill prepared to take on their assigned jobs. These graduates also have comparatively low leadership and business skills and any mentorship or advice they might get on the job is minimal.

The new program will use a two pronged approach in building a sustainable technical workforce for planning, management, and implementation of HIV/AIDS services. First it will have an internship component that targets fresh graduates from major universities in the disciplines of medicine, nursing, social work and pharmacy. These individuals will be exposed to intensive didactic training in state of the art HIV/AIDS prevention programming after which they will be seconded to major HIV/AIDS programs where they will engage in apprenticeship training under the mentorship of host institutions. Training in HIV prevention will mainly focus on qualitative inquiry, where trainees will be required to gather national HIV transmission data, develop trends on the causes, key drivers, affected populations and propose interventions with maximum potential to effectively address the identified transmission factors. They will also be required to undertake extensive desk investigations to establish and recommend best practices from other high prevalence countries that offer promising insights for addressing HIV transmission in Uganda. They will also be trained in approaches to establishing HIV/AIDS services in contexts where they don't exist, especially in resource constrained public sector settings. Trainees will also be exposed to monitoring, evaluation and reporting of HIV/AIDS prevention results and outcomes. As they train, they will also be expected to actively engage in HIV prevention programming both within the host institutions

and also where necessary with other national level stakeholders.

The second component of the program will focus on building leadership competences to create cadres of people skills that adequately match the current realities in the HIV/AIDS environment that is characterized by competition for resources, diminishing funding, rapidly changing approaches, and the changing nature of the epidemic. This requires leaders who are visionary, highly dependable, accountable, politically savvy, with intellectual breadth and able to take risks and inspire innovation.

The training will also incorporate issues of gender and stigma/discrimination to strengthen client organizations' ability to identify opportunities for more appropriate/sensitive programming and also to link clients to wrap around services such as food, education, microfinance and micro-credit support programs.

The new program will seek to address these needs through training and establishment of a mentoring and coaching program. It will be targeted at students graduating from the internship program (described above), chief executives and senior managers of key PEPFAR supported HIV/AIDS programs as well as mangers of health and HIV/AIDS services at national, district, and sub-district level, both in the private and public sectors.

The overall goal of this new Leadership and Management Program is to develop opportunities for students from different educational backgrounds to receive first hand, practical experience needed to respond to the multifaceted challenges of health and HIV/AIDS disease epidemics; and develop and/or strengthen a leadership and management program to be housed and managed locally that will meet the needs of a variety of managers, including but not limited to public sector staff (central and district); senior staff of key PEPFAR programs (priority on Ugandans); National NGOs, and other civil society organizations. The outcomes of the program are anticipated to manifest through improved technical competences of local Ugandan professionals, improved leadership and management of Health and HIV/AIDS services and organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

Using FY2010 resources, it is anticipated that a total of 50 professionals will be trained in HIV/AIDS prevention. They will also be trained in leadership skills that prepare them to take on leadership challenges within both the private and public sector.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12479	**Mechanism Name: Comprehensive Community Based HIV/AIDS Prevention Care & support**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Reproductive Health Uganda (RHU)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,306,000	
Funding Source	**Funding Amount**
GHCS (State)	1,306,000

Sub Partner Name(s)

Action for Children	Capacity Systems Link (CSL)	

Overview Narrative

COMMUNITY BASED HIV PREVENTION CARE AND SUPPORT SERVICES is a 5-year program to be implemented as a joint initiative by three agencies: Reproductive Health Uganda (RHU) as lead agency; Action for Children (AFC); and Capacity Systems Link. The program complements the quality HIV/AIDS care provided by The AIDS Service Organization (TASO) with an integrated package of sexual and reproductive health services; child care, protection and development; and expanded home and community-based AIDS care and psychosocial support. The program also includes family-based HIV prevention interventions that are integrated in the different service components and settings. It provides an opportunity for institutional strengthening for indigenous organizations and other district service systems, to reinforce a sustained AIDS response that is integrated with all other development initiatives. The program approach to address HIV prevention cuts across the three key program elements: integrated SRH services, child care, protection and development; and AIDS care and psychosocial support. It builds on the principle of positive prevention -working with and through persons living with HIV to promote HIV prevention.

Over the five-year life-time of the program, it will deliver the following outputs:

• Provide HIV-related care and support to 18,000 adults and 2,000 children infected by HIV;

• 130 individuals trained to provide HIV care and support

• 27,000 female and 18,000 male individuals reached through community outreach that promotes

HIV/AIDS prevention working through HIV positive individuals
• 27 female and 18 male individuals trained to promote HIV/AIDS prevention, working through HIV positive individuals
• Improved quality of life of 1,048 HIV positive children and their households
• 1,455 OVC living in PHA households supported to access at least 3 OVC services
• Capacity for the 3 core partners, 12 Implementing sub-grantees, and 60 other indigenous organizations, faith-based institutions and local community leadership structures will be strengthened

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12479**		
Mechanism Name:	**Comprehensive Community Based HIV/AIDS Prevention Care & support**		
Prime Partner Name:	**Reproductive Health Uganda (RHU)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	660,000	

Narrative:

RHU - Care: Adult Care and Support

Through this mechanism, RHU intends to improve the quality of life of 18,000 HIV-positive adults and their households or families with AIDS Care and Psychosocial support services integrated sexual reproductive health services. RHU expects that the intervention will provide an opportunity for strengthening and integration of the AIDS care and psychosocial support package in both models by:
• Developing an integrated training package that enables development of the basic skills for AIDS psychosocial support for adults and children among all the different categories of community resource persons
• Building skills within the district development system (health workers, schools teachers, community

development officers etc.) for delivering the AIDS psychosocial support training, and providing on-going support supervision for the community resource persons
• Strengthening referral and technical support linkages between the community-based AIDS psychosocial support and specialist centers (e.g., TASO services, Mental Health and Clinical Psychologists in the health care system, etc)
• Providing support for integrated SRH/HIV service delivery including providing STI drugs, FP supplies and equipment, prophylactic Septrine, nutrition support
• Provision of water purification tablets/solutions

Adults living with HIV and AIDS have unique and special needs for care and support and this thematic area targets them. This therefore addresses how to ensure positive living among the HIV positive adults and building capacity for health workers (in both facility and community-based settings) to effectively and efficiently address care needs of adults through various recognized strategies that are stipulated in the National HIV and AIDS Strategic Plan (NSP). The following activities will be implemented:
• Provide comprehensive HIV-related care (ART, OI, and nutritional support)
• Train Health workers to provide HIV care and support.
• Carry out Diagnostic tests for HIV, TB, Syphilis, Pregnancy, STI and Malaria
• Screen blood and other donated specimens for HIV.
• Provide integrated SRH/PMTCT services
• Provide HCT, Treatment literacy campaigns,
• Provide Palliative Care and home-based care.
• Provide nutrition support
• Conduct resistance monitoring and lab testing
• Build a referral mechanism to ensure a continuum of care.
• Conduct outreaches to extend HIV AIDS care services to remote areas.
• Carry out Support Supervision
• Procure drugs, supplies and equipment

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	200,000	

Narrative:

RHU - Care: OVC

Orphan and Other Vulnerable Children.

The impact of HIV and AIDS epidemic has contributed to increased numbers of OVCs who have

enormous health, social, economic, spiritual needs that have to be addressed. This program intends to contribute to the realization of government policies and strategies addressing the needs of OVCs as stipulated in the NSSPI.

RHU and its sub-partner AFC will use a family-based Child Care, Protection and Development model to deliver services to about 5,000 children. This model provides for an integrated package of family-based child development services, delivered in a three-phase process usually lasting 3-5 years. The program interventions in this model are fully based in the community, both at institutions such as schools, ECD centers and other community development centers, and within the households of supported families. The program provides for technical support to the community empowerment process, through:

• Training of the community resource persons in service management and delivery;

• Institutional capacity building for community groups, leadership structures and organizations involved in program delivery; and

• Strengthening linkages between community-based services and development initiatives to local government systems and other providers of development services

The program will focus on the following activities: a) conduct mapping exercise for TASO child clients (identifying infected children, households where they live, schools attended, current point of TASO service); b) Formation of children clubs for OVC; c) Recruit, deploy OVC care and support teams (zone leaders, HBC counsellors, community child counsellors etc.) to designated centers; d) Provide high nutritional value snack at break at ECD centers; e) Provide supplementary food rations for households with needs (malnourished children, bed ridden caregivers, etc.) through home-based care; f) Provide non-food items for OVC households with such needs (clothing, beddings, utensils, mosquito nets, etc.); g) Plan and conduct Music, Dance and Drama annual competitions and quarterly community shows on child rights, AIDS-stigma, HIV status disclosure to CLWA; and h) Train all Children club members in stigma reduction, disclosure, positive living, sexual and reproductive health.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	100,000	

Narrative:

RHU - Care: Pediatric Care and Support

Through this new mechanism, RHU intends to improve the quality of life of 2,000 HIV positive children with AIDS Care and psychosocial support services. The HIV/AIDS psychosocial support is an integral element in the household support that includes vulnerable children as members. RHU expects that the intervention will provide an opportunity for strengthening and integration of the AIDS care and

psychosocial support package in both models by:
• Developing an integrated training package that enables development of the basic skills for AIDS psychosocial support for children among all the different categories of community resource persons
• Building skills within the district development system (health workers, schools teachers, community development officers etc.) for delivering the AIDS psychosocial support training, and providing on-going support supervision for the community resource persons
• Strengthening referral and technical support linkages between the community-based AIDS psychosocial support and specialist centers (e.g., TASO services, Mental Health and Clinical Psychologists in the health care system, etc.

Adults living with HIV and AIDS have unique and special needs for care and support and this thematic area targets them. This therefore addresses how to ensure positive living among the HIV-positive adults and building capacity for health workers (in both facility and community-based settings) to effectively and efficiently address care needs of adults through various recognized strategies that are stipulated in the National HIV and AIDS Strategic Plan (NSP). The following activities will be implemented:
• Provide comprehensive HIV-related care (OI, and nutritional support)
• Train health workers to provide HIV care and support.
• Carry out diagnostic tests for HIV, TB, STI and Malaria
• Screen blood and other donated specimens for HIV.
• Provide HCT, Treatment literacy campaigns.
• Provide Palliative Care and home-based care.
• Provide nutrition support
• Conduct resistance monitoring and lab testing
• Build a referral mechanism to ensure a continuum of care.
• Conduct outreaches to extend HIV/AIDS care services to remote areas.
• Carry out Support Supervision

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	146,000	

Narrative:

RHU - Sexual Prevention: AB

There are a number of concerns especially around new infections that have pointed to the emergence of higher infection rates among married or recently married individuals (constituting 42% of new infections) and resurgence of individuals having multiple sexual partners and engaging in casual sex and commercial sex. Abstinence and Being Faithful strategies are therefore addressed by this project to try to

contribute to the reversal of the above trends. 10,900 female and 7,272 male individuals will be reached through community outreach that promotes HIV/AIDS prevention through behavior change other than abstinence and/or being faithful. The following activities will be implemented by this program:

• Conduct a situation analysis and knowledge awareness survey
• Conduct capacity needs assessment on organizational and service delivery.
• Organize community sensitization meetings
• Carry out awareness education campaigns
• Train community health workers, peer educators and youth in negotiations and communication skill (Life skill education).
• Conduct Single and Couple counseling and testing
• Conduct Focus Group Discussions on HIV Prevention
• Conduct Peer education in behavior change communication
• Conduct Peer education Meeting for Youth and married couples.
• Hold radio talk shows and jingles on HIV prevention
• Support HIV prevention drama groups
• Produce and distribute information education and communication materials
• Carry out meetings and seminars for high-risk groups and population concentration centers such as bar and disco halls.
• Translate messages into local languages.
• Carry out support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	200,000	

Narrative:

RHU - Sexual Prevention: Other sexual prevention

Other Prevention – Condom Use.
Condom use (both female and male types) remains an important aspect of prevention of new infections as well as re-infection. This thematic area addresses prevention strategies including prevention with positives as well as areas of empowerment of females who are more disproportionately infected/ affected than males. The following activities will be implemented:

• Supported 9 condom service outlets in year one.
• Mobilize communities for improved health care seeking behavior
• Establish condom service outlets

• Train condom distributors • Conduct community outreach on condom use and other HIV prevention methods. • Conduct training on HIV/AIDS prevention through behavior change other than abstinence and/or being faithful • Procure condoms and vending machines • Train CBOs service providers in HIV and STI prevention, • Train CBO service providers in HCT • Train Service providers in PMTCT • Provide Integrated RH/PMTCT services • Support Universal precaution implementation at service delivery points • Train and support HIV/TB collaborative activities

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12480	**Mechanism Name: HS20/20**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 274,000	
Funding Source	**Funding Amount**
GHCS (State)	274,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a principal USAID technical service resource in health finance, governance and operations. Health Systems 20/20 focuses on four goals:

1. Finance: increase access to PHN priority services by reducing financial barriers, increase financing for health, and ensure that health resources are rationally allocated to maximize health impact.

2. Governace:Improve health governance,particulary in fragile states, by helping policymakers increase the use of evidence in defining cost-effective health strategies and investments to improve health(NHA institutionalization and demand creation for information, improve reporting to parliaments and finance ministries),increase transparency and accountability in the health sector and encourage and support citizens to participate in shaping PHN priority services.
3. Operations: Ensure that health systems effectively plan, account for, and report on priority programs by using effective financial management systems(budget planning,reporting,transparency and compliance)human resources(policy,planning,training,deployment,productivity/incentives),effective planning and oversight; effective information systems; and monitoring and evaluation systems.
4. Institutional capacity development; Build developing county institutional capacity in finance, governance and operations, continue to support health impact by enabling developing country stakeholders to solve health system constraints to achieve the global health agenda, build local sources of ongoing support in health financing, governance and operations.
Means of access: Field support and Associate Awards.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12480**		
Mechanism Name:	**HS20/20**		
Prime Partner Name:	**Abt Associates**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	274,000	
Narrative:			
1.0 Purpose HSS TWG shall seek the services of a highly qualified contractor or cooperative partner, to conduct a detailed health systems assessment in Uganda. Following the Health Systems Assessment Approach			

proposed by the FY10 PEPFAR HSS Technical Considerations, the Health systems assessment shall include a thorough situation analysis as well as assessment subcomponents targeted at understanding the effectiveness of key existing HSS programs, in order to arrive at a clear identification of priority gap areas for interventions in health systems strengthening by HS building blocks.

2.0 Background:
PEPFAR II emphasized on health systems strengthening. As per PEPFAR Technical considerations, "priorities for intervention across the six key health systems functions should be determined at the country level. The strength of health systems vary from country to country. As country teams are encouraged to apply a broad-based HSS perspective to their programs, implementation of comprehensive health system assessments will help to identify system gaps and bottlenecks, and establish priorities for intervention. A standard protocol for the health system assessment approach has been developed by the USG and its partners (Available at http://www.healthsystems2020.org/content/resource/detail/528/); the process includes means for stakeholder involvement in its deployment, analysis, and interpretation of results for setting priorities." This exercise has not been done in Uganda so far and this statement of work expects to cover this exercise.

3.0 Statement of Work
3.1 Tasks
3.1.1 To conduct a detailed health system assessment in Uganda.
Following the Health Systems Assessment Approach proposed by the FY10 PEPFAR HSS Technical Considerations, the Health systems assessment should include a thorough situation analysis as well as assessment subcomponents targeted at understanding the effectiveness of key existing HSS programs, in order to arrive at a clear identification of priority gap areas for interventions in health systems strengthening by HS building blocks.
3.1.2. To identify priority gap areas for HSS interventions by HS building blocks, with the involvement of key GOU, multilateral and bilateral HSS stakeholders, and develop a clear process or protocol for routine ongoing national HSS M&E and results-based program planning.

3.2 Deliverables
3.2.1 Inception reports, for HS Assessment and facilitated national stakeholder engagement for results-based HSS program planning, to be reviewed and approved by the USG Mission. The report will include the team's proposed methodology and a detailed work plan with clear time line.
3.2.2 A final health systems assessment report, with detailed situation analysis covering all the past, ongoing and planned HSS initiatives, with clearly identifying the type, coverage, and the outputs of these initiatives. This report is also expected to identify priority gap areas with specific recommendations for

interventions by health system building blocks. Finally, this report is expected to include a clear process or protocol for routine ongoing national HSS M&E and results-based program planning, engaging national HSS stakeholders. 3.3 Proposed methodology Health Systems assessment should be Uganda specific design adopting the guidance provided in the Health Systems Assessment Approach tool, available at http://www.healthsystems2020.org/content/resource/detail/528/ 3.4 Team Composition The team will be comprised a minimum of two international experts and two national experts with sound knowledge and experience in health systems performance and strengthening.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12481	**Mechanism Name: STRENGTHENING DECENTRALIZATION FOR SUSTAINABILITY (SDS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

USAID/Uganda plans to award a five-year contract to Strengthen Decentralization for Sustainability (SDS). The purpose of the SDS project is to improve the results and sustainability of decentralized service delivery, with initial emphasis on health and HIV/AIDS services, at Local Government levels in Uganda through:

• Improved coordination among all USAID-supported partners at the district level;
• Strengthened capacity of districts and sub-counties to plan, budget, implement/coordinate, monitor and evaluate decentralized services by efficiently utilizing the Government of Uganda's administrative and fiscal decentralization framework;
• Provision of grants to districts to complement resources needed for effective and efficient management of programs and services; and
• Facilitated strategic innovations to improve district leadership and sustainable financing of health, HIV/AIDS and other social sector services.

The proposed activities are to be done with full collaboration of the Ministry of Local Government, the Local Government Finance Commission, relevant line ministries, local governments, and existing or planned USAID implementing district-based partners providing technical assistance to decentralized service delivery. USAID District Based Technical Assistance (DBTA) partners will include but are not limited to the Northern Uganda Malaria, AIDS and Tuberculosis (TB) project (NUMAT), the two recently-awarded cooperative agreements to Management Sciences for Health (Strengthening TB and HIV/AIDS Responses in Eastern Uganda – STAR East) and John Snow (Strengthening TB and HIV/AIDS Responses in East Central Uganda – STAR East Central) to strengthen service delivery for HIV/AIDS and TB in selected districts in the their respective regions, a planned award to cover HIV and TB services in the South Western Region of the country, STOP Malaria, as well as other USAID-supported activities with a district focus. Initial activities will focus on approximately 45 districts. Expansion to additional districts will depend on availability of funds and progress made under the terms of this award.

The SDS project will focus on effective, efficient and sustainable results by:

• Putting financial resources and support as close to implementers and beneficiaries as possible (that is, at district and sub-district levels and below);
• Improving local government management and accountability for financial inputs, including those from USAID/Uganda;
• Improving local government management of limited resources with the expectation that these improvements will produce better programs and services, and better health outcomes for people;
• Improving local government ownership, leadership, governance, and management innovation.

Specific roles and responsibilities for the SDS project will include but not be limited to:

Coordination
• Coordinate and collaborate with all USAID partners working at district level to improve synergy and impact of USAID supported activities.
• Take the lead in facilitating and tracking coordination among USAID partners and between USAID partners and districts and other stakeholders.

District work plans and budgets
• Provide grants to local governments to complement the technical assistance being provided by the DBTA partners (approximately 45 grants – one/district).
• Develop one agreed-upon costed work plan reflecting the work of all USAID activities to be funded through the districts; ensure that USAID partners' work plans and budgets fit into the district development plans (DDPs) and budgets.
• Facilitate USAID activities supporting but not funded through the districts to be captured through the DDPs and budgets.

Technical Assistance
• Provide technical assistance to local governments in the area of resource management (including but not limited to participatory planning, budgeting, managing funds flow and procurements, coordination at service delivery levels, monitoring and supportive supervision and measuring outputs and results).

Sustainability
• Take lead in developing innovative approaches in close partnership with local governments, DBTA partners, and other key partners to strengthen local leadership and facilitate sustainability of USAID supported activities.
• Develop meaningful exit strategies, with clearly defined expectations and results, for each district supported.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12481		
Mechanism Name:	STRENGTHENING DECENTRALIZATION FOR SUSTAINABILITY (SDS)		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

SDS will expand delivery of HIV/AIDS care and treatment services by strengthening district leadership and management, health management information systems (HMIS), as well as improvements in human resources for health, supply chain management systems, strategic information, infrastructure and laboratories. The primary emphasis will be on strengthening care and treatment service delivery systems at health center IV's, III's and work with other district-based programs to build community outreaches that serve to provide intermediate care and generate demand for facility based services. SDS will also work with facilities on other initiatives aimed at improving quality and efficiency of care and treatment services within health facilities, promote community-facility linkages to enhance referrals as a way of improving access to, coverage of and utilization of care and treatment services.

Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

The primary emphasis by the SDS project will be strengthening care and treatment service delivery systems at health center IV's and III's. The program will also support systems that work with facilities on other initiatives aimed at improving quality and efficiency of care and treatment services within health facilities and community organizations, building of community-facility linkages to enhance referrals as a way of improving access to and coverage of and utilization of care and treatment services. In addition to supporting expanding delivery of HIV/AIDS services, SDS will support the capacity of decentralized health delivery systems to improve uptake of services at lower level facilities. Support will focus on areas of leadership, management, health management information systems (HMIS), and human resources for health, supply chain management, strategic information, infrastructure and laboratories.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

The SDS project will support the national efforts to improve the systems that monitor the quality, utilization and sustainability of services delivered in the areas of counseling and testing in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the SDS project will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, SDS will continue to work through local governments, the private sector, other USG and non-USG implementing partners and civil society organizations (including faith-based and community based organizations) towards improved quality of life and increased equitable access to preventive and clinical services at both district and lower-level facilities. Key activities at the district level include technical support at the policy and technical level, systems strengthening including quality assurance, M&E and support supervision as well as financial resources for services delivery.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

Several district-based programs have previously made significant progress of increasing access to HIV care and treatment for children. The SDS project will further support some best practices to be incorporated into district work plans. Best practices include: integration of ART and PMTCT services in all public facilities; assessment of infants and children for ART eligibility in every clinic visit under district supervision; routine counseling of adults to encourage the testing of children, intensified case findings of exposed infants within immunization units, scheduling the same appointment dates for children and parents/caretakers, and introduction of specific clinic days for children. SDS will support districts and health facilities to implement proven innovations and practices.

Rolling out of pediatric HIV/AIDS care and treatment to lower level facilities is hampered by lack of adequate counseling and clinical skills among health workers and suboptimal access to laboratory services and suboptimal linkage to services. SDS activities will build the skills of health workers on pediatric care, and treatment through didactic and on-the-job trainings, clinical mentoring and availing simplified tools and aides.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

Several programs have made significant progress of increasing access to HIV care and treatment for children. SDS will support district systems that promote some of the best practices which include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling of adults on bringing children for testing, intensified case findings of exposed infants within immunization units, scheduling the same appointment dates for children and parents/caretakers, and introduction of specific clinic days for children. The SDS activity will support districts and health facility systems to implement proven innovations and practices.

The roll out of pediatric HIV/AIDS care and treatment to lower level facilities is hampered by lack of adequate counseling and clinical skills among health workers and suboptimal access to laboratory services and suboptimal linkage to services. The SDS activity will build the skills of health workers on pediatric care, and treatment through didactic and on-the-job trainings, clinical mentoring and availing simplified tools and aides

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	HVSI	Redacted	Redacted

Narrative:

The SDS project is intended to assist the local government to conduct assessments of the district systems (M&E, procurement, etc) that need to be enhanced. The results of these assessments should help design district-specific system improvement plans. Some of the district systems improvement may include development of simple monitoring tools and institutionalizing these so that multi-sectoral data can be captured and used for monitoring service delivery and making district planning evidence-based. The process of conducting these systems assessments will involve training of at least two relevant district staff on identifying and understanding key M&E/information concepts and principles as applied to district program planning (total 90 trained in strategic information).

In order to promote evidence-based planning, SDS will work in partnership with the STAR – E project that will support the Government of Uganda to institutionalize the carrying out of the Lots Quality Assurance Sampling (LQAS) at national level and ensure that the data generated is used. The SDS project will also support the key national HIV/AIDS data use (including reporting) processes and activities taking place at the district in order to build sustainability. Evidence-based planning and decision making will be achieved through regular measurement of program performances and progress at the districts and lower levels. Regular and timely feedback to the supported local governments, non-governmental organizations and civil service organizations will be provided through systems strengthening of district-level monitoring and reporting systems including HMIS and PMMP. While the LQAS results will be used to inform district-level work planning in order to identify intervention areas and sub-counties on which to focus in the future, this USG investment goes beyond this and achieves one other objective i.e. support is to ensure that these district-based programs support the existing national data collection, collation, use, and reporting systems at the district and lower levels for purposes of building sustainability i.e. strengthening the local government's capacity to coordinate the collation, management, and use of multi-sectoral data for monitoring performance of service delivery as well as for the overall district planning. Coordination at the district also includes ensuring that the existing supply of, and demand for, ICT (information, communication, and technology) resources (that includes human) are optimized.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration

and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

Since a supportive policy environment is very important for the implementation of activities, the SDS activity will complement the efforts of the Ministry of Health (MOH), Ministry of Gender, Labor and Social Development (MGLSD) and other national bodies like Uganda AIDS Commission and National TB and Leprosy Programs towards the dissemination of policies that are relevant to the activities that the program will support. For example, SDS will support the continued roll out of the revised policies of PMTCT, RCT, ART, TB and any other policies as they get approved. SDS will also build on past efforts by the AIDS District Model (AIM) project, Uganda Program for Human and Holistic Development (UPHOLD) and Uganda AIDS Control Program (UACP) to strengthen district planning through continued support to the District AIDS Committees. The support will facilitate streamlining district capacity to manage HIV/AIDS structural plan development, coordination of activities and monitoring progress. Other activities to be supported will include:

• Once completed, the dissemination of the following policies and/or guidelines will be undertaken: integrated TB/HIV management, management of opportunistic infections, scaling up of the utilization of co-trimoxazole prophylaxis among people living with HIV/AIDS (PLHAs) as well as the provision of isoniazd prophylaxis in PLHAs at high risk of acquiring tuberculosis.
• Supporting the printing and distribution of policies and implementation guidelines and the re-training and orientation of health workers to improve service delivery in HIV/AIDS management targeting private and public health facilities. The training will benefit at least 500 persons (health workers and CSO staff).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This

activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

SDS support in the area of sexual prevention: Abstinence and Be faithful will focus on supporting the district education system and civil society to improve on the gains attained through the existing abstinence programs for the 10 -19 year olds, through a combination of in-school and out-of-school programs, media and community mobilization approaches. The in-school abstinence programs that will be closely monitored by the district education office will be complemented by other USG partners programs that focus on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

The SDS project will use its financial and technical support to provide resources to district offices like the fisheries department, education department, health department and agricultural department to monitor and make sure that the district based projects are providing adequate services to the most-at-risk populations with HIV/AIDS education, counseling and testing as well as condom education and distribution services in collaboration with other key stakeholders such as Ministry of Health and organizations involved in social marketing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district-based activities and other key stakeholders supporting district activities. The SDS project is intended to eliminate duplication and improve complementarity among USAID-supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

SDS support in the area of PMTCT will focus on expanding delivery of PMTCT services in districts by strengthening systems in the areas of district leadership and management, health management information systems (HMIS), as well as improvements in human resources for health, supply chain management systems, strategic information, infrastructure and laboratories. The primary emphasis in districts will be to directly support PMTCT program systems to provide Opt-out HIV counseling and testing, ARV prophylaxis, HAART, psychosocial support, community follow-up and mobilization, training, adequate counselor and laboratory technician staff, upgraded laboratory facilities and counseling rooms, management information systems and strengthened MCH/FP services. The above technical assistance will be provided through direct technical assistance (TA) and grants depending on the prevailing need.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

It is expected that SDS will work in close partnership with the Ministry of Local Government, Local Governments (LGs), relevant line ministries, USAID implementing partners supporting district based activities and other key stakeholders supporting district activities. SDS project is intended to eliminate duplication and improve complementarity among USAID supported partners and improve collaboration and communication with local governments and other stakeholders working at the district level. This activity will facilitate USAID implementing partners to ensure that their support to districts is timely, supportive of the district planning and budgeting processes and integrated into district development plans

and budgets. The partner will work equally closely with respective GOU counterparts and other implementing partners supporting national initiatives at the district level through complementary and congruous efforts including but not limited to leadership, local government resource management and governance, and overall systems strengthening.

SDS will expand delivery of TB/HIV/AIDS care and treatment services by strengthening health management information systems (HMIS), as well as improvements in human resources for health, supply chain management systems, strategic information, infrastructure and laboratories. The primary emphasis will be on strengthening support supervision for care and treatment service delivery systems at health center IV's and III's. SDS will also provide support supervision facilities aimed at improving quality and efficiency of care and treatment services within health facilities and ensuring that community-facility linkages to enhance referrals as a way of improving access to, coverage of and utilization of care and treatment services by district based programs is done.

SDS will also support integrated support supervision conducted quarterly within each health sub district; work with district based partners to establish or maintain facility based quality improvement teams; and introduction of continuous ART quality improvement tools in coordination with HCI or HIVQUAL.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12482	**Mechanism Name: Demographic & Health Survey 2011**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

One of the key sources of indicator data used in measuring the impact of USG/Uganda HIV/AIDS program is the demographic and health survey (DHS). The last DHS in Uganda was conducted in 2006. The purpose of this activity is to provide technical support to the GOU to implement the HIV/AIDS module of the DHS. It is planned that GOU staff from MOH, UBOS, UAC, and other relevant staff from the line ministries will be trained in the whole continuum of survey planning, instrument development, pre-testing, questionnaire administration, field data quality control, data management, analysis, and use. The TBD partner will be expected to develop a short training program that is built upon the standard DHS research assistant training to put together a package that covers these themes which go beyond field data collection. In total, 100 (including DHS research assistants) will be trained in strategic information.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12482**		
Mechanism Name:	**Demographic & Health Survey 2011**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted
Narrative:			
One of the key sources of indicator data used in measuring the impact of USG/Uganda HIV/AIDS program is the demographic and health survey (DHS). The last DHS in Uganda was conducted in 2006. The purpose of this activity is to provide technical support to the GOU to implement the HIV/AIDS module of the DHS. It is planned that GOU staff from MOH, UBOS, UAC, and other relevant staff from the line ministries will be trained in the whole continuum of survey planning, instrument development, pre-testing,			

questionnaire administration, field data quality control, data management, analysis, and use. The TBD partner will be expected to develop a short training program that is built upon the standard DHS research assistant training to put together a package that covers these themes which go beyond field data collection. In total, 100 (including DHS research assistants) will be trained in strategic information.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12483	**Mechanism Name: AFFORD Follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

This activity will build up on the achievements of the AFFORD project.

This activity has the following four objectives:

• Expanded availability of quality health products and services to prevent, control and manage diseases or conditions of major public health and or development concern;

• Enhance and sustain healthy behaviors and lifestyles through innovative communication;

• Enhance public-private partnerships that will develop and expand consumer markets for a broad range of health products (e.g. basic care package, condom, contraceptives, diarrhea and malaria prevention and treatment products, etc); and

• Ensure sustainability of the Uganda Health Marketing Group (UHMG).

This activity will build upon the achievements of the AFFORD social marketing group and will take it to the next level by ensuring sustainability, increased diversity of public health products and services, expanded reach within the private sector and strengthened demand for services and products. The activity will also provide targeted subsidies and/or free products to vulnerable populations and non-governmental and not-for-profit organizations.

This activity will support distribution and marketing of HIV/AIDS, Family Planning (FP) and Child Survival (CHS) commodities through established distribution networks that reach the private clinics, private not-for-profit and public health facilities. This will include distribution and marketing of existing public health commodities or launching new products based on need, demand and evidence.

One of the main achievements of the AFFORD project has been the establishing of the Good Life Clinics (GLC) networks in the private sector which have been the main mechanisms for provision of quality HIV Counseling and Testing (HCT) and basic palliative care services. This activity will build on this achievement through several approaches including:
• Accreditation
• Certification
• Expanded coverage
• Continuous medical education and training
• Supportive supervision
• Supporting private sector self-monitoring and regulation through association of private medical practitioners.

Moreover, this activity will enhance healthy behaviors and lifestyles through innovative and proven communication approaches which will include but not be limited to:
• Interpersonal communication through Popular Opinion Leaders
• The Good Life Campaign: This is a highly popular TV, radio and experiential road show assisted by "the four tent model" which enables smaller groups to interact with the road show team and engage in dialogue on different intervention areas (HIV/AIDS, Family Planning, Child Survival and Malaria).
System strengthening: This activity will build on the achievements of the AFFORD project in improving efficiencies and contribution of the private sector in addressing major public health issues. This activity will establish a sound monitoring and reporting mechanism between private sector, districts and MoH to enable private sector data to be captured and integrated in the district and national HMIS. Moreover, the mechanism will ensure sustained optimal coordination and partnership between the public and private sector in implementing policies, guidelines and standard operating procedures.
Sustainability: Over the first two years, USG will phase out or significantly reduce product injection into

the social marketing mechanism. USG will support a competent social marketing group to effectively market wide range HIV/AIDS, FP, malaria and child survival products to expanded network of private facilities nationwide. This will increase efficiency and cost-effectiveness.

During this period, USG will work with the social marketing group to ensure establishment of a self-sustaining mechanism for procurement and distribution of products.

Services, which will be supported through this mechanism will include:
• Behavior Change Communication for prevention
• HIV sexual prevention targeting couples, most at risk populations, and large workplace settings (existing-plantation and emerging-oil exploration)
• HIV counseling and testing
• Palliative care
• Positive living
• Treatment literacy and adherence (HIV and TB)
• Expanded Basic Care products (cotrimoxazole, safe water, water vessel, acyclovir, condom, FP products, Long Lasting Insecticide Treated bed Nets)
• Reach more than 50,000 condom outlets with consistent supply of product and appropriate communication materials

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	REDACTED.
Water	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12483**
Mechanism Name:	**AFFORD Follow-on**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	Redacted	Redacted

Narrative:

This activity will build on the achievements of the AFFORD project through scaling up of HIV care and support services through existing 600 Good Life Clinic (GLC) networks of service outlets and expanding coverage in terms of geographic distribution and number of service outlets. A total of 700 clinics in all 80 districts will be included in GLC network that provides HIV/AIDS care and support services and products including basic care package commodities (cotrimoxazole prophylaxis, condom, nutrition counseling and supplementation, water vessel and water treatment products, family planning and child survival services). At least 500 of these facilities will be supported to deliver HCT services.

The GLC clinic network will be supported to provide quality services based on standards set by the GLC network. The private providers will be supported to establish a strong association that will provide quality monitoring, mentoring, training and supportive supervision of member clinics. Qualified GLC clinics will be accredited and certified through the association of private health care providers which will allow them to access basic public health commodities through the GLC network. GLC providers will also be linked with public health facilities within their respective catchment area for referral and linkage. This will ensure continuity of care for their clients.

A major area for linkage includes access to advanced and comprehensive HIV/AIDS care and treatment services and advanced laboratory services. This activity will also procure and distribute key Opportunistic Infection (OI) and basic care products like cotrimoxazole , acyclovir, LLINs, condoms, aqua safe (water purification product), and multivitamin. This activity will continue to leverage the existence of products supported with child survival funds. This includes Aqua safe, Zinc ORS and LLINs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

This activity will build on the achievements of the AFFORD project through scaling up of HIV care and support services through existing 600 Good Life Clinic (GLC) network of service outlets and expanding coverage in terms of geographic distribution and number of service outlets. A total of 700 clinics will be included in GLC network that provides HIV/AIDS care and support services and products including basic care package commodities (cotrimoxazole prophylaxis, condom, nutrition counseling and supplementation, water vessel and water treatment products, family planning and child survival services). At least 500 of these facilities will be supported to deliver HCT services.

The GLC clinic network will also be supported to provide quality of services based on standards set by the GLC network. The private providers will be supported to establish a strong association that will provide quality monitoring, mentoring, training and supportive supervision of member clinics. Qualified GLC clinics will be accredited and certified through the association of private health care providers which will allow them to access basic public health commodities through the GLC network. GLC providers will also be linked with public health facilities within their respective catchment area for referral and linkage. This will ensure continuity of care for their clients.

This activity will use multiple communication channels, such as TV shows, radio, and road shows to increase awareness on pediatric HIV care and treatment within family context. The activity will also link private providers with public and private facilities with the DNA-PCR capacity to diagnose HIV among exposed infants. The GLC network clinics will be trained, supervised and mentored on pediatric HIV/AIDS care.

This mechanism will also address psychosocial and reproductive health issues of adolescents living with HIV/AIDS. The project will start by assessing the challenges and needs of HIV positive adolescents (in and out of schools) and develop appropriate and comprehensive interventions to address developmental, physical and psychosocial issues among this group. Moreover, this activity will socially market and distribute existing and new products in dosage and quantities suitable for HIV positive children and adolescents. Products will include co-trimoxazole and other selected OIs, zinc, multivitamins, ORS, and IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

This activity will increase HIV/AIDS risk perception, prevention behavior and safe life styles among communities, with a particular focus on men and women of reproductive age, those in multiple concurrent partnership, youth, most-at-risk populations and the general public through multiple communication channels including:

• Client-centered communication at service delivery points and product outlets;

• Multiple Good Life Communication (GLC) channels including, Good life TV and radio shows, street shows and interpersonal communication.

The main strategy will revolve around interactive street shows with four tents (a four-tent-model), educating on different health topics under the category of HIV/AIDS, family planning, malaria, and child

survival which allows community members to get information and product through direct interaction and asking questions. This activity will be nationwide focusing on populations with high prevalence and increasing trend in HIV/AIDS incidence. Increased focus will be given to partner reduction and faithfulness, particularly amongst men.

The AB messages will be integrated in all communications through the Good Life Campaign. In addition, this activity will integrate new evidence and scientific findings as they become available. Potential sources of new evidence include the AIDS Indicator Survey which is under planning and the multiple concurrent partnership formative assessment being finalized by the Family Health International.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This activity will increase HIV/AIDS risk perception, prevention behavior and safe life styles among communities, with a particular focus on men and women of reproductive age, discordant couples who are the most at-risk populations, through multiple communication channels including:
• Client-centered communication at service delivery points and product outlets;
• Multiple Good Life Communication (GLC) channels including, Good life TV and radio shows, street shows and interpersonal communication.

The most at risk populations targeted through this activity include commercial sex workers and their clients, uniformed personnel, people living in fishing communities, long distance truck drivers, and workplaces with large numbers of mobile and sexually active men with disposable income.

This activity will build on the achievements of AFFORD project and enhance the following approaches for sexual prevention:
Increased condom outlets and product distribution: In a bid to make condoms even more readily accessible at high risk locations, the project will support stocking condoms in as many bars as possible in all the regions of the country and will carry out direct condom promotion in these locations. This, coupled with increasing condom availability in corner shops (dukas) will increase the condom outlets to more than 50,000.
Targeting Most At Risk Populations (MARPS): Using community outreach and interpersonal communication, the project will reach fishermen in several fishing communities, commercial sex workers in major urban areas in the country, the military, police and other private security agencies. The MARPS program will include HIV counseling and testing, STI diagnosis and treatment, family planning services, condom promotion and productive skills training as alternative means of income generation for sex

workers who would like to transition to safer lifestyles.
The Good Life Campaign: Formative research revealed that Ugandans equate "wellness" with material wealth rather than physical health. This insight led to the development of the Good Life platform, designed to promote the simple things Ugandans can do everyday to keep healthy and save money, thereby improving overall quality of life. This Good Life campaign which was launched by the AFFORD project will continue to be supported for increased TV, radio and roadside shows.
Addressing Alcohol and Sexual Violence: The activity will reach out to bar and lodge owners to promote condom use at the work place, STI and HIV referral, and address sexual violence with staff and patrons. This will enhance bar and lodge owners' knowledge of the relationship between alcohol consumption, sexual violence and HIV transmission in order for them to promote and enforce key HIV/AIDS prevention practices and basic workplace polices in their establishments.
Workplace programs: The activity will continue to support workplace programs targeting major companies including mining, sugar and tea plantation workers.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12484	**Mechanism Name: Comprehensive HIV/AIDS Prevention**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this program is to scale up a comprehensive and integrated package of HIV prevention interventions and services in selected districts in the republic of Uganda. Those districts include but are not limited to: Kalangala, Mubende, Mityana, Luwero, Nakaseke, Wakiso, Nakasongola, Apach and are selected because of high HIV prevalence (>8%) and are currently implementing district-wide door to door HIV confidential counselling and testing (HCT) programs through PEPFAR support. Door to door HCT is an excellent approach for accessing confidential HIV counselling and testing services to couples and families. It identifies many discordant couples, improves disclosure of sero-status, reduces stigma and therefore has a significant impact on HIV prevention.

The comprehensive HIV prevention strategy will be based on the synergies obtained from the door to door VCT program and other HIV/AIDS program activities in these districts. The awardee of this program will develop and implement a broad range of HIV prevention services and activities as a "package" to be delivered to the population of these districts in a consistent manner.

The comprehensive prevention package of services will address the major risk factors, behaviors, populations and social contextual factors that drive the HIV epidemic in Uganda following national guidelines for HIV prevention. The program activities will focus on sexual prevention and Male Medical Circumcision (MMC) interventions targeting general population and high risk groups where the epidemic is concentrated based on the needs of each district.

The overall goal of this program is to reduce the number of new HIV infections and sexually transmitted infections (STI's) in these districts and specifically to;

• counsel and provide of safe medical male circumcision services as part of a comprehensive prevention intervention
• improve the capacity of health facilities and health service providers to be able to avail services for medical male circumcision in the districts.
• promote knowledge of one's sero-status and actively facilitate mutual disclosure to sexual partners and appropriate household members
• work with communities to determine how to reduce the number of multiple sexual partners
• promote consistent and correct Condom use with any sexual partner whose sero-status is not known
• promote safer sexual behaviors and sexual norms
• work with health facilities to improve diagnosis and treatment of sexually transmitted infections
• integrate new technologies and for HIV prevention if they are approved by WHO during the project period

The successful applicant of this award will work with the district HIV/AIDS structures that will be responsible for the implementation of this project through sub-granting mechanism; and will provide financial, programmatic and technical assistance as appropriate.

The program will collaborate and integrate with Home-based HCT, ART, OVC, PITC, HSS, Care and Support programs being implemented in the districts and the following principles will guide the implementation of this program and contribute to health systems strengthening, cost efficiency and

sustainability:
• Multi-sectoral approaches bringing on board all potential stakeholders and actors
• Mainstreaming and integration to facilitate comprehensive and multi-pronged approaches to assure a continuum of social, health and HIV/AIDS services
• Partnerships and common approaches to eliminate fragmentation and duplication of efforts while emphasizing delivery of common messages and utilization of all existing systems for wider coverage
• Evidence-based approaches that take into account dynamics of the epidemic and contexts of population groups to enhance service targeting
• Quality assurance informed by central policy guidelines and standards
• Accelerating HIV/AIDS prevention in the context of universal access to prevention, treatment, care and services
• Human rights, equity and gender
• Partnerships with PHAs for their greater involvement in the national response
Monitoring and Evaluation
The awardee of this program will provide regular TA for M &E through site visits to monitor and supervise the process of program implementation, identify strengths and weaknesses and improve program implementation. Secondly the awardee will develop and maintain capacity for a robust plan for conducting both quantitative and qualitative evaluations of this project's performance.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.
Gender: Reducing Violence and Coercion	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12484**		
Mechanism Name:	**Comprehensive HIV/AIDS Prevention**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	CIRC	Redacted	Redacted

Narrative:

According to the Modes of Transmission studies (2008) there were about 91,500 new adult HIV infections reported in Uganda in 2008. A spectrum estimate of the number of new infections due to Mother to Child HIV Transmission during the same period was approximately 21,500. The total number of new infections in 2008 was therefore estimated to be 113,000. This level of infections is unacceptably high and requires innovative evidence proven cost-effective approaches such as medical male circumcision to reduce them in the population. In Uganda the proportion of adult men that are circumcised is estimated at only 25%. REDACTED.

Within this TBD mechanism, MMC will be integrated as part of the comprehensive HIV prevention package which includes the provision of HIV testing and Counseling and Prevention with Positives interventions within the clinical settings. In 2010 program will cover the 6 districts in the central region and will provide MMC services to 10,000 adults through 15 facilities following the catch up strategy. Funds under this budget code will be used specifically for the following activities:

• Training of health service providers including medical officers, clinical officers, nurses, surgical assistants, counselors and support staffs in hospitals, HC IVs

• MMC service delivery

Providing MMC information to women (spouses) and use MMC activities as an opportunity to address gender norms such as polygamy, multiple sexual partners and early marriages

• Supporting the development of long-term sustainable and integrated VMMC capacity in health facilities within the targeted districts, including capacity for provision of neo-natal and pediatric MC services in PMTCT and MCH settings in line with national policy/guidelines.

• Improving the capacity of health facilities and health service providers to be able to avail services for medical male circumcision in the districts

• Facilitating referrals and linkages of Voluntary MMC services to other HIV/AIDS prevention, care and treatment services.

• Supporting the Health Ministry towards the development of MMC policy guidelines and strengthening of an effective and efficient M&E system for the VMMC program

• Developing health infrastructure to sustain role out of male medical circumcision at the health facilities

• Implementing IEC/BCC mobilization campaigns for MMC

• Supervision and quality assurance

The proportion of adult Ugandan men that are circumcised is estimated at only 25%. REDACTED.

The objectives of this funding are to scale up delivery of MMC services, integrated as part of the comprehensive HIV prevention package which includes the provision of HIV testing and counseling, offer of MMC targeting HIV negative males, risk reduction counseling including knowing partners HIV sero-status, partner reduction. In FY 2010 the program will cover the 8 high HIV prevalence districts in the

central and northern region and will provide MMC services to 10,000 adults through 15 facilities using the catch up strategy. Funds under this budget code will specifically be used for the following activities:
• Training of health service providers including medical officers, clinical officers, nurses, surgical assistants, counselors and support staffs in hospitals, and HCIVs in the provision of safe medical circumcision services within a frame work of comprehensive HIV prevention services
• MMC service delivery
• Providing MMC information to women (spouses) and use MMC activities as an opportunity to address gender norms such as polygamy, multiple sexual partners, and early marriages
• Supporting the development of long-term sustainable and integrated VMMC capacity in health facilities within the targeted districts, including capacity for provision of neonatal and pediatric MC services in PMTCT and MCH settings in line with national policy/guidelines.
• Improving the capacity of health facilities to provide MMC services in the supported districts
• Facilitating referrals and linkages of voluntary MMC services to other HIV/AIDS prevention services.
• Developing health infrastructure to sustain role out of male medical circumcision at supported health facilities
• Implementing IEC/BCC mobilization campaigns for MMC in partner districts
• Strengthen M&E, supervision, and quality assurance of MMC services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

The National Strategic Plan 2007-12 recommends implementation of a two pronged strategy that maintains the well established comprehensive ABC approach complemented with a refocus on the most cost effective prevention interventions balancing care, treatment and support costs and embracing new prevention technologies. This program TBD will strengthen comprehensive programming for sexual prevention for adults and out schools in the in the high HIV prevalence districts in the Central region. The program will build on the work existing USG supported activities especially the district wide door to door HCT program and the new Comprehensive care and treatment program- TBD. The grantee will focus on developing targeted prevention intervention for out of school youth and adults in the general population. The program will promote community dialogue and behavior change campaign in the general population with a view to address risk taking behaviors such as the increase in the number of concurrent sexual partners, low and inconsistent condom use among others. Training will be provided to stakeholders including civil society groups, faith based organization, PHA networks and private sector organizations to support the rapid roll out of prevention activities in communities, work place and facility levels. In addition, the program will district systems for coordination of HIV prevention activities to ensure comprehensive proper targeting,

comprehensive program and leveraging resources across programs. Through community dialogue and mapping, the program will support the district to develop programs that are tailored to the needs of the targeted community groups. To ensure comprehensive programming, this activity is linked to corresponding activities in the Other Sexual Prevention and Male Medical Circumcision technical areas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

The National Strategic Plan 2007-12 recommends implementation of a two pronged strategy that maintains the well established comprehensive ABC approach complemented with a refocus on the most cost effective prevention interventions balancing care, treatment and support costs and embracing new prevention technologies. This program TBD will strengthen comprehensive programming for sexual prevention for adults and out schools in the in the high HIV prevalence districts in the Central region. The program will build on the work existing USG supported activities especially the district wide door to door HCT program and the new Comprehensive care and treatment program- TBD. The grantee will focus on developing targeted prevention intervention for out of school youth and adults in the general population. The program will develop behavior change communication interventions that discourage risky taking behaviors such as; excessive alcohol consumption, concurrent multiple sexual partnerships, low and inconsistent condom use. In addition to programs for the general population, interventions for known high risk groups including; commercial sex workers and their partner, truckers, Men who have sex with men , security personnel and vulnerable groups like boda boda riders, students in higher institutions of learning and street children will be supported and implemented with other stakeholders in area. The program will strengthen coordination of HIV programming through district systems in order to increase coverage, proper targeting and efficiency resource utilization... This activity is linked to corresponding activities in the Other Prevention and Male Medical Circumcision sections.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12485	**Mechanism Name: Expanding the role of PHA networks in Uganda**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Uganda is one of the countries that have embraced the GIPA principle which seeks to maximize the rights and responsibilities of PLHA through creating an environment that allows self expression and participation in key HIV/AIDS decision making processes as well as service delivery. Currently, thousands of PLHA groups and organizations exist in Uganda, working in a variety of forms and contexts, to improve access to HIV/AIDS services, advocate for rights of PLHA and reducing further transmission of HIV. Overtime, PHA groups have grown in prominence Uganda and given that they are home grown and community based, they have evolved as essential bridges between service providers and communities.

In further consolidation of this principle, USAID/Uganda has supported a three year program to mobilize and strengthen community based PLHA groups to coordinate and increase their role in HIV/AIDS advocacy and service delivery at community, sub-district and district level. The activity, implemented by the International HIV/AIDS Alliance, has improved the visibility of PLHA groups and demonstrated the immense capability that these groups have in providing services directly to their members, facilitating referrals and linkages between communities and facilities as well as influencing community action on HIV/AIDS. Using a network approach, the program mobilized and trained community based PHA groups to serve as community HIV/AIDS resource persons and key points of referral for HIV/AIDS information and education.

Being predominantly led by expert PLHA, these groups also offered intermediate care to their members and used personal experiences to eliminate stigma that in many ways inhibited HIV/AIDS service seeking behavior. Consequently, the greatest contribution of this program was acknowledged in creation of demand for services delivered at district and sub-district health facilities as well as other private and non-governmental organizations. In FY 2009 the program contributed to the remarkable increase in adults, children and their families accessing care and treatment services in health facilities through mobilization of communities, raising HIV/AIDS awareness and facilitating referrals and linkages to various services in

the districts of operation. The PHA groups have also played a critical role in supporting the ART program through provision of ART education, ART adherence counseling and following up clients in their homes to ensure that drugs are appropriately taken. In addition, through the project, the Alliance has linked the PHA groups with the CDC funded PACE Program which has provided basic care commodities including safe water vessels, water treatment solutions, insecticide treated nets and condoms, which enhance individual quality of life by minimizing the onset of opportunistic infections. Working in partnership with NuLIFE , the program is also training NSA in integration of nutrition in care and support programs for PHA.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12485**		
Mechanism Name:	**Expanding the role of PHA networks in Uganda**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
As of March 2009, the program had trained 1,302 Network Support Agents (NSA) who are positioned at health facilities (HCIII and HCIV) to facilitate entry of PLHA into care services. A total of 745 individual PHA groups were supported in 40 districts of Uganda. Through increased mobilization, education and referrals by NSAs and PHA groups, the health facilities reported increased uptake of care and support services. The Alliance program ended in July 2009 but left behind one of the most creative models for scaling up access to HIV/AIDS services in resource constrained contexts. Therefore, USAID is designing a follow-on program (TBD) that will consolidate and take to scale the Alliance model for AIDS care and support.			

The new program, anticipated to be awarded by March 2010, will build upon the achievements of the Alliance activity to continue creating demand for HIV/AIDS services at community level, while at the same time consolidating community based service delivery. The project will also continue supporting post test clubs because they facilitate transition of individuals from counseling and testing to care, treatment and prevention services. The capacity of groups will be strengthened to facilitate and manage referral systems and linkages between home/community based care and health facility-based care.

Gender norms and practices are a barrier to people accessing care and support services. The program will conduct BCC campaigns and gender awareness sessions aimed at challenging the traditional roles of men as they can provide support as caregivers and improving men's health seeking behavior. A family centered approach to care and support will be employed to ensure that the project targets both men and women in the target households while promoting family planning among families affected by HIV.

The role of NSAs will particularly be strengthened and their capacity further built to assume more roles in facility-based services in order to increase time available for physicians and clinicians to offer intensive care to PLHA. They will be trained to assume more of the non-clinical tasks at the health facilities such as records management, pre-test counseling, triaging of clients and dispensing of prophylactic cotrimoxazole.

In order to enhance quality and sustainability of the program, activities will be scaled down to focus on fewer districts, especially given that most of those covered by the ending program have been absorbed into other USAID-funded care and treatment programs. The new program will continue to pay particular attention to building capacity of the PHA groups to strengthen their coordination and to empower them to engage and influence HIV/AIDS policy and programming at district and national level. The program is anticipated to work creatively with the various PHA groups to initiate innovative approaches that increase opportunities for further growth and sustainability of these initiatives at community level. Efforts will also be made to strengthen the national level PHA chapters to enable them to provide leadership and inspiration to lower level groups as they all strive to address HIV/AIDS issues and challenges at their various levels.

The major focus of this activity will be to create demand for HIV/AIDS care and treatment services that will largely be delivered by PEPFAR-supported facilities. The activity will not provide any direct services, other than home-based care, which will also be an auxiliary service to those delivered at static facilities. The NSAs and PHA group members will continue to provide leadership and guidance aimed at demystifying HIV/AIDS and ultimately make care and support services a normal health care activity. Therefore, notwithstanding the incredible role the PHA groups play in increasing access to care and support services, no targets will be set. Program achievements will be reported in narrative form,

including best practices and or case stories.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

The OVC will be a significant component of the new program. The new program, will facilitate PHA groups and networks in communities to actively engage in social protection of OVC using a variety of approaches and interventions. Most importantly, the PHA networks are predominantly led by expert PLHA who are open about their HIV-positive status and are therefore in a pivotal position to influence service delivery for OVC and minimize the risk of HIV transmission to children. As organized groups, PHA networks also provide the best contexts for addressing child protection, education, health and pyschosocial support for OVC. They are also able to provide mutual counseling on HIV prevention, support each other to disclose status to spouses and to adopt appropriate behaviours such as treatment adherence for those on ART, all of which minimize risk of HIV transmission.

In FY 2010 this activity will support at least 500 clusters of PHA groups and networks to deliver comprehensive and quality OVC services through family and community interventions. Capacities of PHA groups will be strengthened in the areas of needs identification, OVC programming and monitoring and evaluation, reporting and resource mobilization in order to deliver adequate and appropriate protection, care and support services. In addition, members of PHA groups and other OVC care givers will be trained in caring for OVC. Financial support will continue to be provided to groups to provide direct inputs as well as ensure economic viability of vulnerable households so that they are able to meet the varied needs of the OVC including education, health care, food and nutrition among others. Gender issues in relation to economic enterprises will be addressed to provide women with support systems for their productive and reproductive roles since they shoulder the major burden of care for OVC. The project therefore will conduct gender awareness sessions for groups and support groups to link up with organizations that implement family life programs and or train on labor saving technologies.

Through the community engagement strategy, the project will promote community ownership of the OVC challenge and develop linkages between PHA groups, church groups, school authorities, NGOs (including grantees of the civil society fund) and CBOs providing care and support to OVC. Developing linkages will provide opportunities for the children and their families to have access to a range of services that they need

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The TBD Program, anticipated to be awarded by March 2010, will continue to facilitate delivery of HCT services since it is an entry point into prevention, care, treatment and other services. In consideration of the acute manpower constraints facing most health facilities in Uganda, the role of NSAs will particularly be strengthened and their capacity further built to assume more roles both at community and facility levels. They will be further trained and facilitated to carry out pre-test and post-test counseling, rapid HIV testing, running of post-test clubs and management of referrals and linkages to care, treatment and prevention services. The new program will continue to pay particular attention to building capacity of the PHA groups to strengthen their coordination and to empower them to engage and influence HIV/AIDS policy and programming at district and national level. The program is anticipated to work creatively with the various PHA groups to initiate innovative approaches that increase opportunities for further growth and sustainability of these initiatives at community level.

The PHA groups and networks will play a key role in community mobilization for HCT through conducting dramas, public dialogues and HCT campaigns. Particular attention will be paid to increasing uptake of counseling and testing among men, as well as promotion of couple counseling and testing, disclosure of sero-status to spouses and support for discordant couples. PHA groups will also be facilitated to link up with several HCT providers namely AIC, PREFA, JCRC and TASO to provide community outreaches for HCT services within their respective communities as one cost-effective way of providing services to those confronting challenges with accessing facility-based services. The groups and the NSAs will ensure that all those that test positive for HIV are linked to care and treatment services. They will also continue providing community-level intermediate care and support to those that test positive in order to successfully carry them through the coping journey.

In order to enhance quality and sustainability of the program, activities will be scaled town to focus on fewer districts, especially given that most of those covered by the ended program have been absorbed into other USAID funded care and treatment programs. Efforts will also be made to strengthen the national level PHA chapters to enable them to provide leadership and inspiration to lower level groups as they all strive to address HIV/AIDS issues and challenges at their various levels.

The major focus of this activity will be to create demand for HIV/AIDS counseling and testing that will largely be delivered by PEPFAR supported facilities. The activity will not provide any direct services, other than pre-test and post-test counseling, which will be auxiliary services to those delivered at static facilities. The NSAs and PHA group members will continue to provide leadership and guidance aimed at demystifying HIV/AIDS and ultimately make counseling and testing a normal health care activity. Therefore, notwithstanding the incredible role the PHA groups play in increasing access HCT, no targets will be set. Program achievements will be reported in narrative form, including best practices and or case

stories.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

The new program, will build upon the achievements of the Alliance activity to continue creating demand for HIV/AIDS services at community level, while at the same time consolidating community based service delivery. The new program will continue to support integration of TB/HIV activities at health service delivery points. Their key role will be to identify individuals with high risk of TB infection and refer them to the health facilities for diagnosis and treatment. They will also continue to enlighten the communities on TB as a treatable infection, emphasize its strong association with HIV, encourage early diagnosis and treatment, reduce stigma and defaulter rates as well as promote preventive and care aspects of tuberculosis. Through routine home visits, PHA groups members and NSAs will spearhead adherence monitoring for those on treatment and provide on-going counseling to enhance treatment adherence. Defaulter cases and symptoms of treatment failure will be reported to the health units through the established network referral mechanisms. NSAs and identified group members will be trained as focal persons on CB-DOTS using national TB/HIV collaborative guidelines and provided with relevant materials and logistical support to improve drug adherence and defaulter tracing. All identified TB/HIV patients will be enrolled in the HIV/AIDS care and support program for the PHA groups.

At facility level, the NSAs will work with health workers to ensure that they strengthen infection control measures particularly by limiting the time that known TB patients spend at the facility and to ensure that HIV/AIDS services are delivered in spacious and well ventilated premises. NSAs will also liaise with health workers to ensure that all individuals diagnosed with TB have access to HIV counseling and testing. The role of NSAs will particularly be strengthened and their capacity further built to assume more roles in facility based services in order to increase time available for physicians and clinicians to offer intensive care to PLHA. They will be trained to assume more of the non-clinical tasks at the health facilities that relate to TB management such as records management, conducting of health education talks, screening of patients using standard job cards, collection of samples and facilitating access to diagnostic facilities for those requiring laboratory examinations.

The new program will continue to pay particular attention to building capacity of the PHA groups to strengthen their coordination and to empower them to engage and influence HIV/AIDS policy and programming at district and national level. The program is anticipated to work creatively with the various PHA groups to initiate innovative approaches that increase opportunities for further growth and

sustainability of these initiatives at community level. Efforts will also be made to strengthen the national level PHA chapters to enable them to provide leadership and inspiration to lower level groups as they all strive to address HIV/AIDS issues and challenges at their various levels. The major focus of this activity will be to create demand for HIV/AIDS care and treatment and to ensure that TB is given priority attention in HIV/AIDS settings. The actual treatment services will be delivered by PEPFAR-supported facilities. The activity will not provide any direct services, other than community-level care and adherence monitoring, which are auxiliary services to those delivered at static facilities. Therefore, notwithstanding the incredible role the PHA groups play in increasing access to TB care and support services, no targets will be set. Program achievements will be reported in narrative form, including best practices and or case stories.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12486	**Mechanism Name: Scaling Up Community Based OVC Response (SCORE)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

Scaling up Community based OVC response

1.2 million of the estimated seven million orphans in Uganda are attributed to HIV/AIDS. The number of orphans and other vulnerable children (OVC) is projected to continue increasing for at least the next decade. Traditionally, the extended family structure in Uganda used to provide an effective safety net for orphans, but as the number of orphans and vulnerable children increases, the extended family structure is overstretched and the family and community coping mechanism starts collapsing. Households whose resources are already constrained are obliged to take in more orphans. In many cases, the caregivers are grandparents and older siblings, thus orphans and vulnerable other children (OVC) and their caregivers often have increased psychosocial and economic needs such as food, education, health care, shelter and social support.

REDACTED. The project will contribute towards achievement of results in USAID/Uganda's technical sectors of health, education, and economic growth and to broader US Mission strategic objectives. The proposed program shall be aligned with and support effective implementation of the yet to be revised national strategic plan and national OVC policy. REDACTED.

The project will support direct provision of services to OVC and their families, provide home based care and support activities, enhance access to health care, protection of rights and increased livelihood for OVC and their caregivers, and, capacity building for indigenous community based organizations and communities to sustain service provision and enable families respond to the challenges of HIV/AIDS impact.

The primary beneficiaries of this program are households with OVC up to 18 years and the secondary beneficiaries include caregivers and community resource persons within and around the primary target population.

Broadly, the goal of the program is to improve children's comprehensive care and protection within a secure family and community setting. At the end of this five year program, key intended results include:

1. Vulnerable children in targeted areas benefit from direct essential care and services, especially in livelihoods, food and nutrition, education, health, psychosocial support and shelter
2. Households caring for vulnerable children are better able to protect and meet basic needs of children (e.g. improved household incomes, access to health care and education, and better parenting skills).
3. Significantly increased capacity is developed among community groups such as, Child Caring Committees (CCC) and women's groups, youth groups, and district/sub county Community development officers (CDO) for identification of child abuse cases and legal protection of vulnerable children.
4. A supportive and safe environment is developed for vulnerable children through increased public knowledge of and support for child protection resources, laws, and policies.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12486**		
Mechanism Name:	**Scaling Up Community Based OVC Response (SCORE)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	Redacted	Redacted

Narrative:

Scaling up community-based OVC response coverage and areas of interventions

REDACTED. To provide the necessary geographic coverage, the program will develop a service provider matrix to identify severely underserved and hard to reach communities and finally to identify those communities that will be covered by this program. Technically, areas of expertise and experience relevant to the anticipated project include:

• Social assistance provision, particularly case work with families and vulnerable children, arranging appropriate health, education, and psychosocial support services;
• Training of community volunteers and social workers;
• Action to improve household food and nutrition practices;
• Action to improve quality of care, parenting and guardianship skills;
• Work with families and communities to increase vulnerable children's access to all essential services;
• Deinstitutionalization work and reintegrating children from streets;
• Economic strengthening of especially vulnerable households;
• Capacity building and, where necessary, mobilization of community groups and organizations concerned with vulnerable children and families;

• Prevention of HIV transmission among OVC; and • Monitoring and evaluation.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12487	**Mechanism Name: Strengthening National OVC Response (SNOR)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

According to the 2006 Uganda Demographic and Health Survey (DHS), 56 percent of Uganda's 27.4 million people are under 18 years of age. Single or double orphans total 2.3 million children making up 15 percent of the total child population. An estimated 7,583,675 children (45%) are considered vulnerable. HIV/AIDS, is the root cause of approximately 46% of orphans and the rest are orphaned and or vulnerable primarily due to conflict. The Ministry of Gender, Labour and Social Development (MGLSD) is mandated by the Government of Uganda to lead, manage and coordinate programmes and services for Orphans and other Vulnerable Children. Specifically, the MGLSD is responsible for Policy formulation and Strategic direction, Planning and coordination, Monitoring and Evaluation, Quality Assurance and Improvement, capacity building and technical support to Local governments, CSOs and FBOs, resource mobilization and management, communication and advocacy and assessment and documentation.

Both UNICEF and USAID have worked in partnership with the Ministry of Gender, Labor, Social Development (MGLSD) to improve the quality of lives of orphans and other vulnerable children, especially those infected and affected by HIV and AIDS. This partnership between UNICEF, USAID and the Government of Uganda has provided both local (district government) and central (MGLSD) technical support to interventions to mitigate the impact of HIV and AIDS on the lives of the most vulnerable children in Uganda through the development of the National OVC Policy (NOP) and the attendant National Strategic Program Plan of Interventions (NSPPI) for OVC, the development of National Quality Standards for the Protection, Care and Support of OVC, initiating a management information system and development of various other national training guidelines and manuals. UNICEF has also supported the MGLSD to develop child participation guidelines and worked with the Ministry at national and sub-national levels to develop and implement a capacity building program for child protection. By working together as counterparts, UNICEF, USAID and the Government of Uganda have provided a framework and guided the interventions for OVC across the country with lessons learnt from the process and outcomes being shared across the sub-Saharan region.

Since 2004, USAID, through the CORE Initiative and other development partners, has supported the MGLSD in developing the following tools, standards and guidelines for strengthening the national OVC program:

• The National OVC Policy (NOP)
• The National Strategic Programme Plan of Interventions
• The National Support Supervision Guide for OVC Programmes
• The National OVC Quality Standards
• The National OVC Service Quality Standards-Guidelines for Implementers
• The toolkit for Assessing and Improving Quality of Interventions for OVC service delivery
• The National OVC Programme Performance Indicators
• The National M & E system including data collection and reporting modules and tools
• The Guide for Community Mapping of OVC
• Capacity Assessment and Analysis tool for OVC CSOs
• The Advocacy Strategy for MGLSD OVC Program

However, despite the progress, the response to the OVC situation to date is not commensurate with the magnitude of the need. There is still limited progress in coverage, reach and impact of services to the most vulnerable children and their households. The current national strategic program plan of interventions (NSPPI) for OVC response (2004 - 2005) has expired and a new one has to be developed and disseminated to all stakeholders. At the same time, a new monitoring and evaluation plan needs to be devloped and disseminated. UNICEF, in partnership with USAID, will support the MGLSD to maintain

the focus of the national response.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12487		
Mechanism Name:	Strengthening National OVC Response (SNOR)		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	Redacted	Redacted

Narrative:

REDACTED.

1. UNICEF builds and enhances the capacity of the MGLSD to lead and coordinate a functioning multi-sectoral national OVC response that is linked to district coordination mechanisms and directed by an updated National Strategic Program Plan of Interventions (NSPPI) for OVC
2. UNICEF strengthens the capacity of the MGSLD to routinely utilize data from the OVC MIS (and other relevant data sources) to inform central planning and to monitor and evaluate the OVC response.
3. UNICEF supports the MGSLD through advocacy strategies to increase the GOU budget allocation for the OVC response

Illustrative intermediate results:
• OVC secretariat in MGLSD in consultation with all stakeholders develop the new priorities for NSPPI (2);
• Technical Resource Committee (TRC) and Thematic Working Groups (TWGs) guide and coordinate the NSPPI development process are constituted;
• National and regional consultative meetings with relevant Ministries, local governments, agencies,

children and stakeholders to participate in the NSPPI (2) development process are organized and conducted;
• A national level consensus workshop to discuss and approve the new draft NSPPI (2) and M&E plan is organized and a National OVC Steering Committee Meeting to endorse the final version of the NSPPI (2) is held;
• MGLSD institutional capacity to utilize the OVC MIS strengthened;
• Semi-annual and annual reports generated and routinely discussed in national coordination committees to inform planning and management at national and district level;
• MGLSD staff trained, where needed, in OVC MIS;
• A functional national coordination mechanism is established to regularly review progress and performance against planned interventions and redirect investments by different development partners;
• The national coordination mechanism is linked to district OVC coordination mechanisms;
• Lessons learned and best practices are shared with other partners supporting coordination to ensure a continuum of care for OVC and their families; and
• The MGLSD budget allocation for OVC activities at central level and to district substantially increases.

End of project Deliverables:
• NSPPI (2) and M&E plan 2009/10 – 2014/15 is developed and approved by the Minister of Gender Labor and Social Development to guide the national OVC response in the next five years
• NSPPI (2) and M&E plan is disseminated to all stakeholders and local governments for use in planning and implementation of OVC programs at community, district and national levels.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12488	**Mechanism Name: TBCAP follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**

Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Building on the success of TBCAP and other programs, the USG is proposing a follow-on mechanism that will continue to support integration of TB-HIV/AIDS activities in three primary areas: a) enhancing the working relationships between NTLP and the AIDS Control Program (ACP); b) assisting the National Coordination Committee to develop National Program implementation plans; and c) providing supervisory and technical support at district and facility levels to improve TB/HIV collaborative activities. The proposed program will continue to leverage non-PEPFAR USAID funding for expansion of Community-Based (CB)-DOTS in PEPFAR-supported districts. These non-PEPFAR funds will provide district level support of CB-DOTS supervisors to oversee linkages between community and facility-based care, and between TB and HIV activities. In addition, the program will also increase focus on key technical priorities: improvement of Provider-Initiated HIV Counseling and Testing as well as linkage and referral of HIV-infected TB patients to HIV prevention, care and treatment; strengthening routine TB screening in PLHA; strengthening laboratory services to support TB diagnosis and treatment (including introduction of new technologies); TB Infection control; strengthening surveillance and management of multi-drug resistant TB; and strengthening program monitoring and evaluation.

This proposed program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of the NTLP and health facilities to ensure access to quality TB and HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities for more appropriate/sensitive programming and also to link clients, were feasible, to health-related wrap-around services such as child survival activities, family planning, malaria treatment and safe motherhood programs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12488**		
Mechanism Name:	**TBCAP follow-on**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	Redacted	Redacted

Narrative:

The proposed new mechanism will be a USG flagship project for implementing TB control and TB/HIV activities in Uganda. It will be funded by USAID child survival infectious disease and GHCS funds. The program will focus on improving quality TB/HIV integrated activities as well as leverage and complement ongoing or planned non-PEPFAR USAID funding for TB and TB/HIV activities. In addition, the program will continue to provide support to National Tuberculosis and Leprosy Program (NTLP) and AIDS Control Program under the MOH, districts and USG implementing partners to roll out the TB/HIV integration policy guidelines and communication strategy. Based on assessment of population size, treatment success and case detection rates as well as presence of USG partner, the geographical coverage will cover, but not be limited to, 22 districts: Kampala, Wakiso, Mukono, Masaka, Kasese, Mubende, Nebbi, Masindi, Kibaale, Soroti, Arua, Mbarara, Mpigi, Kyenjojo, Hoima, Tororo, Luwero, Moyo, Yumbe, Adjumani, Mbale and Kayunga.

At the national level, the program will provide technical and financial support to the National Collaboration Committee on TB/HIV to roll out and monitor the TB/HIV national integration plan. The program will provide technical support to NTLP and ACP to set and monitor national targets for number and proportion of TB patients receiving HIV/AIDS Counseling and Testing (HCT) and, for those with TB/HIV co-infection, the number and proportion receiving co-trimoxazole prophylaxis and anti-retroviral therapy.

In the 22 districts, the program will provide technical support to the Directorate of District Health Services (DDHS) to form TB/HIV integration coordination committees, develop district plans and budgets and implement these plans. The districts will receive support to improve recording and reporting processes and provide regular/quarterly support supervision. At targeted health facilities, the program will provide financial and technical support to establish infection control committees within each facility to develop TB infection control action plans and implement infection control procedures. TB infection control activities will also be coordinated and integrated with other ongoing infection controls activities in the health facilities such as injection safety practices, blood safety etc. Provider-Initiated HIV Counseling and Testing (PICT) among TB patients will be scaled-up through training and provision of TB national guidelines to all health workers within TB clinics and wards. It is estimated that through support to these service outlets, 80% of registered TB patients will receive HIV/AIDS Counseling and Testing services and receive their test results and at least 80% of HIV-infected clients attending palliative care services will be

screened and treated for TB. All the TB/HIV co-infected patients will receive co-trimoxazole prophylaxis and at least 40% of TB/HIV eligible clients will be initiated on ART. The program will continue to support laboratory services to strengthen TB diagnostic capabilities through fortifying existing sputum smear microscopy networks as well as introduction of new technologies, where feasible. The program will ensure that external quality assurance is conducted in supported laboratories. Additional support will be provided to the national reference laboratories to provide quality assurance, mycobacterial culture and TB drug susceptibility testing including introduction of newer diagnostic methods for rapid detection of MDR TB. Laboratory workers and health staff will continue to be trained to carry out HIV/AIDS counseling and rapid HIV-testing. In order to support the expansion of CB-DOTS, the program will provide technical support to the districts TB/HIV focal persons and continue to integrate CB-DOTS with HIV care and treatment programs. Follow-up and adherence support of TB/HIV co-infected patients will be strengthened using a combination of family support and community support mechanisms. The program will engage regional medical officers to mentor district TB and HIV focal persons, CB-DOTS supervisor and the Community Health and Outreach officers in initiating, implementing and monitoring TB/HIV integration activities. The program will provide technical support and coordination to USG HIV/AIDS care and treatment partners to plan and implement complete TB package and TB/HIV collaborative activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12489	**Mechanism Name: District MIS Coordination**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new activity that aims to build the capacity of the local governments. It's end goal is to coordinate the implementation of the various sectoral management information systems (MIS) at the district and ensure that multi-sectoral data is collated and used to inform the district HIV/AIDS planning. The various GOU departments and sectors have built information systems intended to address verticalized data demands. Responding to GOU requests, USG and other development partners have supported the development of these parallel information systems which have continued to place heavy data management burden to service providers in health and education. There has also been considerable waste of ICT and human capital resources due to duplication and redundancies. These parallel systems, though initiated as separate entities at the central level, all meet at the district where a limited pool of resources exist . This proposed activity is intended to address this problem by supporting the capacity of local governments to coordinate and rationalize the available MIS resources and match these to the multi-sectoral data needs. The desired end result is an institutionalized system of data collation, management, and use of multi-sectoral data for monitoring performance of service delivery, informing district planning, and streamlining reporting to the central level. Ideally, the project activities will initially cover about 30 districts previously supported through the ACE Project. The process of building the local government capacity will involve training of at least 2 relevant district staff on basic but important M&E/information concepts and principles as applied to district level program monitoring and planning (with a total of 60 trained staff in strategic information).

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12489**		
Mechanism Name:	**District MIS Coordination**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Other	HVSI	Redacted	Redacted

Narrative:

This is a new activity that aims to build the capacity of the local governments. It's end goal is to coordinate the implementation of the various sectoral management information systems (MIS) at the district and ensure that multi-sectoral data is collated and used to inform the district HIV/AIDS planning. The various GOU departments and sectors have built information systems intended to address verticalized data demands. Responding to GOU requests, USG and other development partners have supported the development of these parallel information systems which have continued to place heavy data management burden to service providers in health and education. There has also been considerable waste of ICT and human capital resources due to duplication and redundancies. These parallel systems, though initiated as separate entities at the central level, all meet at the district where a limited pool of resources exist . This proposed activity is intended to address this problem by supporting the capacity of local governments to coordinate and rationalize the available MIS resources and match these to the multi-sectoral data needs. The desired end result is an institutionalized system of data collation, management, and use of multi-sectoral data for monitoring performance of service delivery, informing district planning, and streamlining reporting to the central level. Ideally, the project activities will initially cover about 30 districts previously supported through the ACE Project. The process of building the local government capacity will involve training of at least 2 relevant district staff on basic but important M&E/information concepts and principles as applied to district level program monitoring and planning (with a total of 60 trained staff in strategic information).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12490	**Mechanism Name: Strengthening local government response to vulnerable children (SLGRVC)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

Since 2004, USAID has enhanced the Ministry of Gender, Labor, and Social Development's (MGLSD) capacity to lead, plan and manage the national OVC response. The MGLSD is mandated by the Government of Uganda to lead, manage and coordinate programs and services for orphans and other vulnerable children. The MGLSD is also responsible for providing strategic direction, coordination and monitoring of Uganda's response to OVC needs, from the national to the household level, working through Community Based Services Departments (CBSD) at the district level. In 2007, with USAID support through the CORE Initiative, the MGLSD initiated partnerships with eight regional Technical Services Organizations (TSOs) that were contracted to: 1) Assist the MGLSD in rolling out national level policies, strategies, standards, principles, guidelines, quality assurance systems, and data collection systems; and 2) Provide technical support to Districts (local government and civil society), strengthening capacity to design, plan, implement, manage and evaluate OVC services.

Despite the progress made by the above-mentioned key initiatives, the response to date does not match the magnitude of the need. Coverage, reach and impact of services to the most vulnerable children and their households remains significant, with only 23% of OVC reached to date. During the last five years, activities focused on developing national level policies and guidelines, and initiated rollout of tools, through the TSOs, at the district level. Nonetheless, in its endeavor to contribute to the roll out of the OVC response, the national OVC program continues to face the following critical gaps and challenges:

• Weak coordination mechanism at national and local government levels;
• District OVC strategic and annual planning remain largely unfunded and not implemented;
• Inadequate resource allocations to implement OVC plans at all levels;
• Absence of management of information system with functional data bases at national and district level;
• Absence of quality of care in OVC programs and inadequate implementation of standard tools to measure quality of care improvement;
• Absence of district level communication and advocacy strategy;
• Absence of monitoring and evaluation plans at district level;
• Absence of guidelines and resources to facilitate support supervision of implementing organizations at the district and lower levels;

• Lack of knowledge and understanding of the magnitude of the OVC burden in each district;
• Presence of civil society organizations with limited human, financial, and technical capacity to implement and sustain service delivery to OVC households;
• Lack of innovative models to support family based and comprehensive care to OVC and child participation on OVC programs is limited.

REDACTED.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**12490** **Strengthening local government response to vulnerable children (SLGRVC)** **TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	Redacted	Redacted
Narrative:			
The TBD SLGRV activity technical assistance will foster increased capacity of districts and lower local governments to lead, plan, manage and implement a decentralized OVC response and ensure OVC quality and comprehensive care. The applicant will recognize the value of strengthened linkages between Government of Uganda (GOU), local governments, civil society, faith-based and community based organizations. The overarching programmatic goal of this activity will be to strengthen and facilitate the creation of operational district-level systems. To address some of the challenges identified above, this project shall focus on the fulfillment of the following four objectives: 1. Strengthen the capacity of local governments to lead the planning, coordination and management of comprehensive OVC care at parish, sub-county, and district levels			

2. Increase the use of demand-driven multi-sectoral data in decision-making by central and local government for: coordinated, comprehensive and cost-effective OVC response; and for effective overall district social sector planning.
3. Capacity of government and civil society strengthened to facilitate and monitor provision of quality care to OVC and their families.
4. Increased advocacy and resource mobilization capacity among local government and civil society.

The development and strengthening of systems and capacity building of district officials and service providers, through this activity, is expected to deliver high quality and comprehensive care to more than one million vulnerable children. It is also envisaged that the Department of Community-based Services—receiving its mandate from the Children Act (1996) and OVC policy (2004)—will be strengthened. This will lead to the provision of up to 50,000 vulnerable children with child protection services. At the end of five years, USAID expects that the following results would have been achieved:
• All districts will have government-led management of the overall response to OVC in accordance with district OVC plan.
• All districts will have a referral system in place to facilitate and track the number of OVC receiving priority services and support in accordance with district OVC plans.
• 80% of districts participating in this program have their capacity built to effectively monitor and evaluate OVC programs.
• 80% of districts can effectively manage information systems and report on key OVC and health indicators to the MGLSD and MOH and have functional OVC MIS and HMIS databases that provide routine OVC and health services data to inform planning at central and local government levels.
• 80% of local government and civil society organizations have capacity to monitor and measure improvement in quality of care.
• 50% of local government capacity strengthened to identify and cost resource gaps and to effectively advocate and mobilize resources for management needs and on behalf of OVC and families and each district has trained staff to provide coordinated care to OVC and their families.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12491	**Mechanism Name: Purchase, Distribution and Tracking of Cotrimoxazole, HIV/AIDS Related Laboratory Commodities and Supplies in the Republic of Uganda under the President's**

	Emergency Plan for AIDS Relief (PEPFAR)
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

National Medical Stores (NMS) is an autonomous government corporation established in 1993 to procure, store and distribute essential medicines and medical supplies to government heath facilities throughout Uganda. National Medical Stores has developed a countrywide distribution supply chain for essential medicines and supplies as well as for the HIV/AIDS-related Laboratory materials provided through PEPFAR funding. Health facilities and HIV Counseling and Testing Centers can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. REDACTED.

NMS has had previous PEPFAR support under the cooperative agreement: "Purchase, Distribution and Tracking of Supplies to Support HIV/AIDS- Related Laboratory Services in the Republic of Uganda". This cooperative agreement focused on establishment and procurement of a national list of 28 commodities and six rounds of HIV-related laboratory reagents and supplies; implementation of a national credit line laboratory logistic system; design and distribution of logistics data collection tools; and training of health facility and district laboratory staff in health commodity logistics system and management.

National Medical Stores will work to further strengthen its services with particular focus on system strengthening; sustainability; M&E; and capacity building. On top of program implementation, NMS will develop methods to create and build the capacity of its own and other organizations responsible for HIV laboratory commodities. In particular NMS will work with MOH (pharmacy division and the Central Public Health Laboratory) and other organizations to build district capacity for forecasting, procurement, and

distribution of HIV laboratory commodities and Cotrimoxazole. NMS will also identify mechanisms of working with districts to strengthen systems for delivery of supplies from district stores to lower level health facilities.

Further more NMS will foster development and implementation of its own budgeting and financial system to ensure a sustainable program through annual budget allocation. ?and will seek to establish incremental government commitment and solicitation of additional funding for its own support and governance as well as enhanced management, responsibility and authority for HIV related laboratory commodities and services.

NMS will demonstrate efforts to promote sustainability of supply of identified commodities and supplies in collaboration with MOH and other USG and non-USG organizations, including a documented plan for continued, high-quality interventions and services at the end of the 5 year PEPFAR funding. NMS will develop, maintain capacity for and implement a robust program monitoring and evaluation system, and use the results for ongoing improvement of program performance.

Also NMS be supported to expand and sustain the procurement and distribution of HIV related laboratory supplies and services in the context of existing national policies and strategies including the National Drug Policy, the Public Procurement and Disposal of Public Assets (PPDA) Act and other national policies that promote procurement and distribution activities. The procurements and supplies will also supports the implementation of the Uganda National HIV/AIDS Strategic Plan 2007/8-2011/2012 and Health Sector Strategic Plan II.
The objectives of this program are to;
1. Contribute to the availability of the national requirement of HIV test kits and related laboratory supplies to support Opportunistic Infections (OI) diagnosis, HIV counseling and testing (HCT) as well as Prevention of Mother to Child Transmission (PMTCT) services country wide. These commodities include: HIV test kits, Routine Reproductive Health tests e.g. Syphilis, HB, Urinalysis; supplies for Early Infant Diagnosis (EID), reagents for CD4 tests and OI diagnosis, including tuberculosis.
2. Contribute to a sustained supply of cotrimoxazole to support HIV basic care and treatment services in health facilities through out the country.
3. Contribute to building capacity of district health systems to adequately forecast and utilize available commodities.
4. Establish concrete governance, finance and accountability systems to ensure program sustainability.
5. Demonstrate increase in soliciting and obtaining Government of Uganda direct budget support.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12491**		
Mechanism Name:	**Purchase, Distribution and Tracking of Cotrimoxazole, HIV/AIDS Related Laboratory Commodities and Supplies in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

The procurement and distribution of cotrimoxazole by the National Medical Stores will be a supportive function to the basic care and treatment program areas. Cotrimoxazole enhances both adult and pediatric care and support activities/services and complements ARV treatment programs. Distribution and utilization of cotrimoxazole is guided by the Ministry of Health – through a cotrimoxazole access and utilization policy and care and treatment guidelines. NMS will procure and distribute cotrimoxazole to eligible health centers to support care and treatment for HIV+ persons. Currently there are over 980 health facilities in the country accredited to distribute cotrimoxazole, most of which access their supplies form the National Medical Stores (NMS).

REDACTED. These activities will continue to contribute to the success of HIV care and support and treatment programs by ensuring continuous supply of needed medicines to HIV+ patients.

NMS will also be supported to base its forecasts, quantifications and tendering processes for the cotrimoxazole requirements on clear procurement plans and will have a number of contract frameworks to enable it have alternative sources of products. Additionally NMS will work to improve its procurements and distribution mechanisms by supporting management staff training in supply chain management and building district capacity to forecast and utilize products.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The Uganda National HIV/AIDS Strategic Plan of 2007/8 – 2011/12 recommends for universal access to HIV counseling and testing for the population. The UDHS of 2006 and UHSBS 2004/5 showed a 70% unmet needs for HCT. In an attempt to increase demand for HCT, Uganda is currently using several strategies to HIV testing including; Voluntary Counseling and Testing (VCT), Provider Initiated Counseling and Testing (PICT) and Home Based Counseling and Testing (HBCT). Over 980 health facilities and 60 organizations across the country provide counseling and testing services to the population. These facilities and organizations require HIV/AIDS related laboratory commodities and supplies and HIV test kits to facilitate their activities and the national Medical stores and its subsidiary the Joint medical Stores have been mandated to ensure the availability of essential medicines supplies including Counseling and testing commodities and requirements. The National Medical Stores will therefore be supported to perform procurement and distribution functions to support services provision in government health facilities and faith based facilities/organizations to perform HIV counseling and testing.

REDACTED. These activities will continue to contribute to the success of HIV prevention, care and support and treatment programs.

NMS will also be supported to base its forecasts, quantifications and tendering processes for HIV/AIDS related laboratory commodities and supplies and HIV test kit requirements on clear procurement plans and will have a number of contract frameworks to enable it have alternative sources of products. Additionally NMS will work to improve its procurements and distribution mechanisms by supporting management staff training in supply chain management and building district capacity to forecast and utilize products.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

The procurement and distribution of cotrimoxazole by the National Medical Stores will be a supportive function to the basic care and treatment program areas. Cotrimoxazole enhances both adult and pediatric care and support activities/services and complements ARV treatment programs. Distribution and utilization of cotrimoxazole is guided by the Ministry of Health – through a cotrimoxazole access and utilization policy and care and treatment guidelines. NMS will procure and distribute cotrimoxazole to eligible health centers to support care and treatment for HIV+ persons. Currently there are over 980

health facilities in the country accredited to distribute cotrimoxazole, most of which access their supplies form the National Medical Stores (NMS).

Using the MOH principles on the distribution of essential medicines under the national credit line, 20% cotrimoxazole procurement and distribution will be through JMS for faith-based and mission health facilities, NGOs and the private sector and 80% of the allocations will support cotrimoxazole procurement and distributions to government health facilities. These activities will continue to contribute to the success of HIV care and support and treatment programs by ensuring continuous supply of needed medicines to HIV+ patients.

NMS will also be supported to base its forecasts, quantifications and tendering processes for the cotrimoxazole requirements on clear procurement plans and will have a number of contract frameworks to enable it have alternative sources of products. Additionally NMS will work to improve its procurements and distribution mechanisms by supporting management staff training in supply chain management and building district capacity to forecast and utilize products.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

The Ministry of Health (MOH) has accredited a number health facility laboratories to perform PMTCT HIV testing and other associated laboratory tests such as urinalysis examinations, stool examinations, blood hemoglobin concentration and syphilis tests for antenatal services. At least eight hundred and thirty (830) health facilities currently provide PMTCT services throughout the country. Seventy three percent (73%) of these facilities have received PEPFAR support in the past years. A lot of emphasis is being made on making PMTCT services available and accessible to more mothers who require them. To that effect, The National HIV/AIDS Strategic Plan 2007/8 – 2011/12 advocates for expanding HCT for pregnant mothers and their partners as a mechanism to reduce mother to child and identification of HIV + woman and men in need of treatment. In essence PMTCT programs will complement the uptake of other HIV/AIDS services of basic care and treatment. The facilities providing these services will therefore require consistent and regular supply of quality PMTCT commodities to ensure uninterrupted service provision and uptake. The National Medical Stores and the subsidiary Joint Medical Stores will be supported to procure and distribute PMTCT HIV test kits and associated commodities.

NMS will receive PMTCT HIV test kit orders prepared by individual PMTCT testing sites and ensure that packaging and delivery to District stores are done. The distribution of theses supplies will be integrated with the commodities that support the other program areas of laboratory commodities, HCT test kits and

supplies, and cotrimoxazole for adult and pediatric care and support. Faith based health facilities, NGOs and the private sector will access PMTCT commodities through the JMS system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

The National Medical Stores will be funded to avail HIV/AIDS related laboratory reagents and commodities to enable health centers perform HIV testing and patient monitoring. Eligible functional laboratories in public, NGO / FBO and armed forces health facilities across the country will receive these commodities from the National Medical Stores and Joint Medical Stores (JMS) – the mandated organizations for the distribution of essential medicines and supplies for government and the faith based health systems. Currently there are over 1,300 functional laboratories that are accredited to perform HIV/AIDS testing and patient monitoring. The HIV/AIDS related laboratory testing will support prevention, care and treatment programs.

Using an established laboratory credit line mechanism which allows for Health Centers IIIs, Health Centers IVs, and Hospitals including the Armed Forces to access commodities, NMS and JMS will procure and distribute laboratory commodities according to approved requisition levels/needs. Currently the approved laboratory credit line commodities list include HIV/AIDS/TB reagents, gram staining reagents, malaria reagents, complete blood count reagents, clinical chemistry reagents, HIV test accessories, blood collection materials and laboratory waste management materials. Other commodities that support STI testing for HIV+ patients, infant test commodities and accessories and CD3/CD4/CD8 remunerations are also included. In addition both NMS and JMS will support training of their management and support staff in order to build internal human resource capacity to improve the supply chain system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12492	**Mechanism Name: Provision of the Basic care package in the Republic of Uganda under the President's Emmergency Plan for AIDS Relief**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview Narrative

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. At least 135,000 new HIV infections occur in Uganda each year of these 80% are adults. Currently, the number of PHA accessing care and antiretroviral treatment (ART) nationally is estimated at 357,108 and 193,746 (60% of eligible) respectively; with adults comprising 91.5 % of recipients at 350 facilities countrywide. However, the number of people in need of ART is approximately 358,000 implying an unmet need of more than 50% (UNAIDS). Access to PMTCT services is estimated at 48% among pregnant women, and only 21% of the pregnant women eligible for HAART received treatment in the year ending June 2009. Every year an estimated 149,000 new HIV infections occur in Uganda. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV care and treatment services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and treatment services nationally, only about 60% of the need is being met. There are several challenges encountered in the delivery of HIV/AIDS services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

The basic care package (BCP) was developed and standardized by CDC Uganda and the MOH in 2004. BCP interventions prolong and improve the quality of life of PHA by preventing opportunistic infections (OI); and preventing transmission of HIV through Prevention with Positives interventions (PWP). In addition, the BCP is affordable, easy to use, readily available, beneficial to family members and complementary to ART. It currently comprises: identification of PHA through couple and family based counseling and testing; daily cotrimoxazole prophylaxis, safe water system (household water treatment

chlorine solution, a filter cloth, and water vessel for safe water storage) for prevention of diarrheal diseases, long lasting insecticide-treated mosquito nets for malaria prevention, and condoms supplies. PWP strives to avert HIV transmission to sexual partners and unborn children through: partner testing and supported disclosure, partner discordance counseling; management of sexually transmitted infections; family planning, prevention of mother to child transmission of HIV (PMTCT); safer sex practices including abstinence; fidelity with correct and consistent use of condoms. Recent BCP components being addressed through training and information education and communication (IEC) materials are TB/HIV, nutrition, pain and symptom management. Documented research related to the BCP show it improves the quality of life of persons with HIV/AIDS (PHA), delays progression to AIDS and the need to initiate ART overall prolonging survival. Studies showed use of the BCP results in 35% reduction in diarrhea among HIV-infected persons and their household members; 15-70% reduction in malaria, clinic visits and hospitalizations; and a 46% reduction in death. Additionally, it has been observed that BCP helps decrease stigma, increase the retention of PHA in pre-ART in care; increases adherence to cotrimoxazole prophylaxis and ART.

Under PEPFAR I, the BCP served as the minimum HIV/AIDS care service provided to about 250,000 PHA through 198 PEPFAR supported sites [(public and private hospitals, community based organizations (CBO), faith based organizations (FBO), and non-governmental organizations (NGO)] in 68 of the 82 districts of Uganda. Provision of the BCP did not involve direct service provision to PHA, but was done through the existing health system; using 17 PEPFAR supported HIV/AIDS prevention, care and treatment programs. Key program activities included: distribution of health commodities [(BCP starter kit containing two long lasting insecticide treated bed nets, safe water system, condoms (optional) and important health information on PWP, nutrition, TB/HIV integration, pain and symptom relief; distribution of commodity refills; and support for improved cotrimoxazole supply chain between National and Joint Medical Stores and facilities to ensure sustained availability of cotrimoxazole for prophylaxis. BCP training curricula was developed, and used training and capacity building of HIV/AIDS health care providers and peer educators in the implementation of the BCP services. Additionally a national print and electronic media behavior change communications campaign was developed and implemented to complement BCP activities.

This mechanism will continue to support the implementation of a multi-faceted program aimed at educating PHA on how to prevent OI and HIV transmission, while living longer and healthier lives. Systems for the manufacture, packaging and distribution of the BCP have been established but need to be strengthened for a sustainable basic care program to ensure that BCP commodities are available and accessible to all identified persons with HIV/AIDS. Partnerships will be fostered with the local manufacturers and other relevant partners to ensure availability of BCP commodities in the public and commercial sectors. It is intended that all these commodities will be available nationwide through

sustainable channels. In PEPFAR II, the focus will be to build on the achievements of the basic care activities, with emphasis on better integration with the public health systems and coverage of services particularly in the public and private health sectors (especially in hard to reach areas); strengthening systems for the supply chain of BCP commodities, and evaluation of the current and potential BCP components.

Cross-Cutting Budget Attribution(s)

Water	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12492**		
Mechanism Name:	**Provision of the Basic care package in the Republic of Uganda under the President's Emmergency Plan for AIDS Relief**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. At least 135,000 new HIV infections occur in Uganda each year of these 80% are adults. Currently, the number of PHA accessing care and antiretroviral treatment nationally is estimated at 357,108 and 193,746 (60% of eligible) respectively; with adults comprising 91.5 % of recipients at 350 facilities countrywide. However, the number of people in need of ART is approximately 358,000 implying an unmet need of more than 50% (UNAIDS). Access to PMTCT services is estimated at 48% among pregnant women, and only 21% of the pregnant women eligible for HAART received treatment in the year ending June 2009. Every year an estimated 149,000 new HIV infections occur in Uganda. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV care and treatment services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to

scale up HIV/AIDS care and treatment services nationally, only about 40% of the need is being met. There are several challenges encountered in the delivery of HIV/AIDS services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

Under PEPFAR I, the BCP served as the minimum HIV/AIDS care service provided to about 250,000 PHA through 198 PEPFAR supported sites [(public and private hospitals, community based organizations (CBO), faith based organizations (FBO), and non-governmental organizations (NGO)] in 68 of the 82 districts of Uganda. Provision of the BCP was done through the 17 existing PEPFAR supported HIV/AIDS prevention, care and treatment programs. Key program activities included: distribution of health commodities- a BCP starter kit containing two long lasting insecticide treated bed nets, safe water system, condoms (optional) and important health information on PWP, nutrition, TB/HIV integration, pain and symptom relief; distribution of commodity refills; and support for improved cotrimoxazole supply chain between National and Joint Medical Stores and facilities to ensure sustained availability of cotrimoxazole for prophylaxis. BCP training curricula was developed and used for training and capacity building of HIV/AIDS health care providers and peer educators in the implementation of the BCP services. Additionally a national print and electronic media behavior change communications campaign was developed and implemented to complement BCP activities.

In PEPFAR II, this mechanism will provide for continued support for the existing 250,000 PHA through 198 PEPFAR supported sites in 68 of the 82 districts of Uganda. It is expected that a total of 60,000 new BCP starter kits will be distributed, with 85% (51,000) targeting adult PHA in HIV prevention, PMTCT, care and treatment programs. There will be continued implementation of a multi-faceted program aimed at educating PHA on how to prevent OI and HIV transmission, while living longer and healthier lives. Systems for the manufacture, packaging and distribution of the BCP have been established but need to be strengthened for a sustainable basic care program to ensure that BCP commodities are available and accessible to all identified persons with HIV/AIDS. The focus will be to build on the achievements of the basic care activities, with emphasis on better integration with the public health systems and coverage of services particularly in the and private health sectors public (especially in hard to reach areas); strengthening systems for the supply chain of BCP commodities, and evaluation of the current and potential BCP components. Program monitoring will include support supervision and use of program data to track program implementation and evaluate program activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. At least 135,000 new HIV infections occur in Uganda each year of these 80% are adults. Currently, the number of PHA accessing care and antiretroviral treatment (ART) nationally is estimated at 357,108 and 193,746 (60% of eligible) respectively at 350 facilities countrywide. Children in HIV/AIDS care and treatment currently comprise approximately 15 % and 10 % respectively. Only 39% of the estimated 42,140 children in urgent need of ART are receiving it, compared to 63% of eligible adults. Access to PMTCT services remains low, about 48% of pregnant women, and only 21% of these eligible for HAART received treatment in the year ending June 2009. It is estimated that only 17% of infants were able to access early infant diagnosis in the past year and yet the national guidelines recommend ART of all infants below 12 months. Every year an estimated 149,000 new HIV infections occur in Uganda. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and treatment services nationally, only about 40% of the need is being met. There are several challenges encountered in the delivery of HIV/AIDS services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

Under PEPFAR I, the BCP served as the minimum HIV/AIDS care service provided to about 250,000 PHA including children, through 198 PEPFAR supported sites [(public and private hospitals, community based organizations (CBO), faith based organizations (FBO), and non-governmental organizations (NGO)] in 68 of the 82 districts of Uganda. Provision of the BCP was done through the 17 existing PEPFAR supported HIV/AIDS prevention, care and treatment programs. Key program activities included: distribution of health commodities- a BCP starter kit containing two long lasting insecticide treated bed nets, safe water system, and important health information on PWP, nutrition, TB/HIV integration, pain and symptom relief for children infected with HIV/ADS; and support for improved cotrimoxazole supply chain between National and Joint Medical stores and facilities to ensure sustained availability of cotrimoxazole for prophylaxis. BCP training curricula was developed and used for training and capacity building of HIV/AIDS health care providers, care takers and peer educators in the implementation of the BCP services with a focus on pediatric HIV/AIDS. Additionally, a national print and electronic media behavior change communications campaign was developed and implemented to complement BCP activities. PHA including parents, care takers of the children and adolescents have been actively involved in interpersonal communication activities at sites including giving health talks and participating in community sensitization on HIV/AIDS prevention, care and treatment.

In PEPFAR II, this mechanism will provide for continued support for the existing estimated 53,566 children in care (16,833 on ART) and their families through 198 PEPFAR supported sites (public and private hospitals, CBO, FBO, and NGO facilities) in 68 of the 82 districts of Uganda. There are increased

efforts to identify and enroll children with HIV/AIDS into care and treatment under the national Early Infant Diagnosis program and other initiatives. It is expected that a total of 60,000 new BCP starter kits will be distributed, through HIV prevention, PMTCT, care and treatment programs, about 15% (9,000) of the new BCP starter kits will be target children living with HIV/AIDS and their families, those in rural and hard to reach areas will be prioritized. There will be continued implementation of a multi-faceted program aimed at educating PHA on how to prevent OI and HIV transmission, while living longer and healthier lives. Systems for the manufacture, packaging and distribution of the BCP have been established but need to be strengthened for a sustainable basic care program to ensure that BCP commodities are available and accessible to all identified persons with HIV/AIDS. The focus will be to build on the achievements of the basic care activities, with emphasis on better integration with the public health systems and coverage of services particularly in the public and private health sectors (especially hard to reach areas) to achieve universal access to basic care for all PHA identified nationally; strengthening systems for the supply chain of BCP commodities, and evaluation of the current and potential BCP components. Program monitoring will include support supervision and use of program data to track program implementation and evaluate program activities In addition to distribution of the BCP kits and commodity refills, the mechanism will review and revise related training and IEC materials, to better cater for pediatric issues; as well as the BCC media campaign in collaboration with the MOH and other stakeholders as necessary. To improve access to BCP, the mechanism will train HIV/AIDS health care providers, care takers and peer educators in the implementation of the BCP services with a focus on the unique needs of children. Through communication campaigns and interpersonal communication, awareness will be created among the general public about the BCP and its use will be promoted in both the public and private health sectors to address sustainability issues.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. At least 135,000 new HIV infections occur in Uganda each year of these 80% are adults. Currently, the number of PHA accessing care and antiretroviral treatment nationally is estimated at 357,108 and 193,746 (60% of eligible) respectively; with adults comprising 91.5 % of recipients at 350 facilities countrywide. However, the number of people in need of ART is approximately 358,000 implying an unmet need of more than 50% (UNAIDS). Access to PMTCT services is estimated at 48% among pregnant women, and only 21% of the pregnant women eligible for HAART received treatment in the year ending June 2009. Every year an estimated 149,000 new HIV infections occur in Uganda, mainly through sexually transmission. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV care and

treatment services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and treatment services nationally, only about 60% of the need is being met. There are several challenges encountered in the delivery of HIV/AIDS services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

Under PEPFAR I, the BCP served as the minimum HIV/AIDS care service provided to over 250,000 PHA through 198 PEPFAR supported sites [(public and private hospitals, community based organizations (CBO), faith based organizations (FBO), and non-governmental organizations (NGO)] in 68 of the 82 districts of Uganda. Provision of the BCP was done through the 17 existing PEPFAR supported HIV/AIDS prevention, care and treatment programs. Key program activities included: distribution of health commodities- a BCP starter kit containing two long lasting insecticide treated bed nets, safe water system, condoms (optional) and important health information on PWP, nutrition, TB/HIV integration, pain and symptom relief; distribution of commodity refills; and support for improved cotrimoxazole supply chain between National and Joint Medical Stores and facilities to ensure sustained availability of cotrimoxazole for prophylaxis. Distribution of condoms to sexually active PHA occurred through provision the BCP starter kits and condom supplies at facilities and in the communities.
BCP training curricula was developed and used for training and capacity building of HIV/AIDS health care providers and peer educators in the implementation of the BCP services. The training aimed to promote HIV/AIDS prevention beyond abstinence and being faithful, to include correct and consistent use of condoms. PHA have been actively involved in interpersonal communication activities at facilities, which comprised health talks and community sensitization on HIV/AIDS prevention. Additionally a national print and electronic media behavior change communications campaign was developed and implemented to complement BCP activities.

In PEPFAR II, this mechanism will provide for continued support for the existing 250,000 PHA through 198 PEPFAR supported sites in 68 of the 82 districts of Uganda. It is expected that a total of 60,000 new BCP starter kits will be distributed to PHA in HIV prevention, PMTCT, care and treatment programs. This mechanism will work through the already identified sites and scale up to other underserved areas to achieve universal access to basic care for all PHA identified nationally. The sexual and other behavioral prevention activity will continue to ensure regular and constant availability of condoms supplies to sexually active PHA, and to promote proper and consistent condom use through condom distribution outlets. Regular and constant supply of condoms will be achieved through the distribution of the BCP starter kit and regular replenishment of condom supplies as required. The Ministry of Health regularly maintains national condom supplies through funding from AIDS Development partners and other sources. This mechanism will allocate funds to supplement the MOH supplies. Specifically this funding

will enable the procurement, shipping and handling of commodities; conduct post shipment testing, packaging, and distribution of condoms. This will ensure continued access to condoms by PHA, as MOH supply may be unpredictable and may fall short of the national requirements, resulting in disruption of condom supplies.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12493	**Mechanism Name: Supporting National Blood Transfusion Service (NBTS) in the implementation and strengthening of blood safety services in the Republic of Uganda**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

TBD		

Overview Narrative

The goal of the National Blood Transfusion Services (NBTS) is to achieve a safe, efficient and sustainable national blood transfusion service based on healthy volunteer blood donors and able to meet the needs of Uganda's health care system. The specific objectives include:

1. To expand the blood transfusion infrastructure
2. To increase the annual blood collection necessary to meet the blood requirements of all patients in the transfusing health units throughout the whole country.

3. To test all blood for transfusion-transmissible infections (TTIs) and operate an effective, nationwide Quality Assurance Programme that ensures safety of the entire blood transfusion process
4. To ensure continuous education and training in Blood Safety.

The NBTS contributes to the fulfilment of PEPFAR goals of reducing transmission of HIV, Uganda's Health Sector goals and the United Nations Millennium Development Goals [MDG] (in particular MDG4: reduce child mortality, MDG5: combat HIV/AIDS, malaria and other diseases and MDG6: improve maternal health).

The estimated hospital blood requirement is 200,000 units of blood annually to be able to handle all emergencies that need blood. 140,000 units of blood were collected in FY09 and distributed to 220 health facilities. 50% of all these collections were transfused to children; 25% to pregnant women and 25% to accidents and surgical/medical cases.

The NBTS has an important task of meeting the increased demand for safe blood transfusion especially at Health Centre IVs located in rural areas where most of the population lives. This will involve expanding the blood transfusion service including community education, recruitment of low risk voluntary non-remunerated blood donors, and infrastructure. The NBTS aims to increase blood collection to 6 units per 1,000 population per year, and by 20% in subsequent years. In a quality assured manner 100% of collected blood will be tested for HIV, hepatitis B surface antigen, hepatitis C antibodies and syphilis.

The NBTS operates through a network of seven regional and six blood collection centers. While the national blood bank at Nakasero prepares all blood components including fresh frozen plasma, platelets and cryoprecipitate other blood banks are only able to prepare paediatric packs of blood concentrates and issues all blood for treatment of adult patients.

To support appropriate use of blood, clinical guidelines will be disseminated to hospital blood transfusion committees and clinicians, and documentation of blood use will be enhanced. Training in all areas of blood safety will continue to be a key activity.

Monitoring & evaluation activities will implemented. Support supervision through regular visits to regional facilities and collection centres will be conducted. The use of reports and forms designed to capture required data has been institutionalized. The data management unit at the national office will analyze the information and compile it into a quarterly reporting format. Feed back will be provided as basis for subsequent planning, training, and improving performance.

Some of the challenges the NBTS continues to face include:

• Relatively high level of TTIs in collected blood especially Hepatitis B and C causing a significant quantity of blood to be discarded.
• Small, restricted premises at five of the seven regional blood banks that negate efficiency.
• The cost of blood collection and testing supplies continues to rise in the bckdrop of level funding. This will severely restrict efforts to increase blood collections.
• Reliance on PEPFAR as the main funding agency restricts operations, and does not foster ownership and sustainability of the program

This mechanism will also support the UBTS in attaining autonomy status with an adequate government financed budget, necessary legislation and regulation, management team, responsibility and authority for blood transfusion services.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12493**		
Mechanism Name:	**Supporting National Blood Transfusion Service (NBTS) in the implementation and strengthening of blood safety services in the Republic of Uganda**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	Redacted	Redacted
Narrative:			
The purpose of the Blood Safety program is to reduce HIV transmission through the transfusion of safe blood and decreasing the HIV prevalence among blood donors. The grantee will support the National Blood Transfusion Service (NBTS) in the provision of safe and adequate supply of blood and blood products to health facilities in Uganda. Under PEPFAR I the Blood Safety Program was implemented by			

the Uganda Blood Transfusion Service (UBTS) in partnership with the Uganda Red Cross Society (URCS). This will continue under PEPFAR II through a single eligibility mechanism to the Uganda Blood Transfusion Service (UBTS) as it is the mandated body responsible for the blood transfusion services nationally.

The UBTS has an established network with national coverage comprising 7 regional blood banks and 6 blood collection centers with oversight from the administration, program and referral laboratory headquarters in the capital city, Kampala. The UBTS with URCS recruits voluntary non-remunerated blood donors (VNRD) through this blood banking network to obtain blood for transfusion to supply over 220 health facilities in the country. In particular, the UBTS will support activities to improve blood donations from regular VNRD; ensure safety through a centralized testing system; promote appropriate use of blood and blood components among the main beneficiaries, of which persons with HIV/AIDS are a part.

In order to increase awareness of blood safety activities, blood donor mobilization, education and motivation the program will improve and explore innovative information, education and communication (IEC) with the blood donor community and general public. This is intended to help expand the pool of low-risk, repeat VNRD beyond educational institutions, and retain them through improved donor motivation, screening, recruitment & retention and communication strategies. Priorities for blood collection include: development and support for the sustainability of blood donor clubs, provision of a standard package for HIV prevention; ensure safe blood collection procedures including donor selection and deferral, donor care and confidentiality; and improve the efficiency of post donation counseling services and referrals, by developing, implementing and sustaining a donor notification program for provision of test results and initiate linkages to HIV/AIDS care and treatment and other referrals for those with reactive results.

The mechanism will continue to ensure adequate supplies for maintenance of cold chain as well as blood processing, storage and transportation, particularly as new purpose built infrastructure is completed at all the regional blood banks. Additionally screening of all donated blood for transfusion transmissible infections (TTIs), including HIV, hepatitis B and C viruses and syphilis will be maintained. Existing protocols for the testing, selection and evaluation of appropriate screening assays are to be revised and reviewed to accommodate current best practices in blood safety.

This mechanism will ensure an efficient logistics management system for the timely procurement, supply, central storage and distribution of reagents and materials for continuity in blood testing and processing at the UBTS laboratories. Supplies for this mechanism will be purchased under the established national procurement regulations and supply chain, with the Ministry of Health continuing to provide for blood bags.

To realize the above, the UBTS will ensure adequate numbers of well trained staff to support blood

collection, processing, storage and distribution activities. Under PEPFAR I, the UBTS and URCS maintained a fleet of vehicles for donor mobilization, blood collection, pre and post- donation counseling activities. Funds will be budgeted to ensure this continues, and the necessary vehicle replacements are made. The provision of adequate infection control, post-exposure prophylaxis and waste management will continue, particularly as the UBTS attains improved purpose built infrastructure throughout the country. The required training to support these activities will be planned for and implemented.

This mechanism will support the establishment of autonomy status of the UBTS with which it is envisioned the organization will be better positioned to advocate for and obtain funds from multiple sources for blood safety activities in the country. The UBTS will also explore other potential funding sources, including cost recovery within the health sector. Additionally, the UBTS will advocate for government commitment through an incremental direct and continuous financial and budgetary allocation, and foster development and implementation of its own budgeting and finance system to ensure a sustainable blood safety program through annual budget allocation. ? The UBTS will also promote sustainability through developing a plan for continued, high-quality interventions and services; and implement a robust program monitoring and evaluation system, using the results for ongoing improvement of program performance.

Other key priorities include coordination with key partners in policy development, technical assistance, reporting, support supervision, M&E (MOH departments, District Health Systems, HMIS); establishment and promotion of linkages among all stakeholders in Blood Safety including local, regional and international partners and donor agencies; and strengthen collaborations with HHS/CDC, other U.S. government agencies and their implementing partners (Injection Safety, President's Malaria initiative, Maternal& Child health, Laboratory, Infrastructure, HIV/AIDS Care and treatment programs) to address gaps in blood transfusion services and develop strategies for the blood safety program.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12494	**Mechanism Name: Provision of comprehensive, community-based HIV/AIDS Services and Capacity Building of Indigenous Organizations in the Republic of Uganda**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview narrative

Uganda has made significant progress towards providing HIV prevention, treatment, care and support. An estimated 135,000 new HIV infections occur in Uganda each year and about 80% of these are adults. With the scale up of HIV counseling, the number of Persons Living with HIV/AIDS (PHAs) who know their HIV status and therefore opt to access HIV care is increasing.

There are several challenges encountered in the delivery of HIV services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

Although the number of persons in active HIV care is unavailable nationally, by June 2009, 193,746 (60% of eligible) HIV positive clients were receiving ART with adults comprising 91.5 % of recipients at 350 service outlets are countrywide. However, the number of people in need of ART is approximately 358,000 (UNAIDS) implying an unmet need of more than 50%. Of the estimated 42,140 children in urgent need of antiretroviral treatment, only 39% are receiving it as compared to 63% of eligible adults. Access to PMTCT services is estimated at 48% among pregnant women, and only 21% of the pregnant women eligible for HAART received treatment in the year ending June 2009. It is estimated that only 17% of infants were able to access Early Infant Diagnosis in the pat year and yet the national guidelines recommend antiretroviral treatment of all infants below 12 months. In relation to TB and HIV, over 39% of all incident TB cases are HIV positive. According to the Uganda National TB Program report, the treatment success rate is 74% against a target of 85%, and the TB Case Detection Rate is 57% versus

the target of 70%.

The purpose of this mechanism is to support the provision of comprehensive, community-based HIV/AIDS services in Uganda. The mechanism will combine a facility- and community-based strategy to deliver HIV/AIDS services, in order to maximally reach entire communities while engaging them adequately to promote substantial community ownership of the program.

The main activities of this mechanism include:
1. Continued provision of comprehensive HIV care to an existing pool of 3,800 clients and 1700 on ART at Mbuya, Kinawataka and Banda in Kampala district and 350 clients in care and 30 on ART at Kasaala clinic, Luweero district; and expansion of the coverage of these HIV/AIDS services.
2. Training, mentorship, and capacity building of selected Ugandan HIV/AIDS care, support and treatment organizations, particularly non-governmental, community-based, and faith-based organizations in comprehensive, community-based HIV/AIDS service delivery.
3. Establishing a functional monitoring and evaluation system of community interventions in coordination and in line with the national HMIS and monitoring and evaluation systems

While maintaining facility-based services, this mechanism will focus on establishing a successful and sustainable community program with a high degree of community ownership. This program will be implemented by interacting with communities in such a way as to build them up, include them in each step of the program, and stimulate their own problem-solving and leadership. Such a community program may include, but not necessarily be limited to the following community strategies: direct health service delivery in communities or in homes, use of cultural interpreters or community ombudsmen to ensure culturally appropriate interventions, income generation, economic strengthening and/or microfinance activities, participatory community dialogues and facilitated problem-solving about health issues, community health groups and community health workers sustained by the community, community generation and use of health data, strong linkages between local public health facilities and community health groups and workers, a census-based approach to achieve ongoing access to all segments of the community by community health groups or workers, and support for empowerment of community members, especially women, in both health and non-health areas identified as priorities by the community.

The scope of activities will include all technical areas of PEPFAR including: Prevention of Mother to Child Transmission (PMTCT); Abstinence/Be Faithful; HIV Prevention including Medical Male Circumcision; Adult Care and Support; Pediatric Care and Support; Tuberculosis/HIV; Orphans and Vulnerable Children (OVC); Gender-based Violence (GBV); Prevention with Positives (PWP), HIV Counseling and Testing (HCT);: Antiretroviral Treatment, Laboratory Services; Strategic Information; and Other/Policy Analysis

and System Strengthening.

This program will promote community-based HIV/AIDS service delivery systems and activities, while supporting creative community-based HIV/AIDS initiatives particularly in the non-governmental (NGO), Community-based (CBO) and faith-based organization (FBO) settings. The program will also progressively expand the coverage, quality and range of interventions, as well as the population and geographic coverage for capacity building support for implementing partners, and demonstrate these achievements through measurable outcomes.

The mechanism will work closely with district health offices and the Ministry of Health, so that community activities and M&E systems are as much in line with national systems as possible. Also, through coordination with both the Ministry of Health and the US government PEPFAR team, the program will identify other indigenous organizations with whom to work to build capacity in community-based approaches to HIV/AIDS service delivery.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**12494** **Provision of comprehensive, community-based HIV/AIDS Services and Capacity Building of Indigenous Organizations in the Republic of Uganda** **TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
Some of the specific challenges facing provision of adult HIV care and support include high demand for services, weak heath infrastructure, poor coordination between providers of the various components with			

resultant inefficiencies, limited numbers of skilled providers, poor community linkages with loss-to-follow-up of clients in care, inadequate data management, and difficulties in monitoring the quality of care.

This program will support at least 4 health facilities and their surrounding communities in Luweero and Kampala district to implement a comprehensive adult HIV care and treatment services program including provision of basic care that comprises of OI prophylaxis using daily cotrimoxazole, use of clean water, insecticide treated bed nets, and condoms where appropriate. Apart from the basic care package, the program will provide OI diagnosis and treatment, TB screening and treatment, and routine assessment for ART eligibility. Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will implement strategies to promote adherence to ART and cotrimoxazole to minimize the likelihood of developing drug resistance. The program will also focus on the integration of HIV prevention with HIV care and implement positive prevention initiatives such as partner HIV testing, supported disclosure of HIV status, use of condoms among discordant couples, and STI care. All HIV care and support services will be linked to other HIV prevention services like PMTCT, HCT, ART, Medical Male Circumcision, Blood safety, Injection safety, and OVC care through active linkage by the same provider.

To date, there is an existing pool of over 3,800 clients in care and these 4 facilities and 1,700 of these are on ART. Services will also be scaled up to other facilities and eligible clients.

This program will focus on the following activities in the region of coverage;
1. Provide facility, home and/or community-based basic health care and support to alleviate clinical, psychosocial, physical, and spiritual distress for HIV-infected individuals and their families and caregivers; including Opportunistic Infection (OI) prevention, diagnosis and treatment, provision of the basic care package, nutrition and sustainable livelihoods.
2. Build capacity of other community organization to support the delivery of HIV care and support. Training health care providers to deliver HIV-related services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use

4. Strengthen linkages to ARV, TB, PMTCT, and HCT program activities.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of health facilities that offer HIV care

2. Number of health care providers trained in facility and/or community HIV care
3. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
4. Percent of adults and children with HIV known to be in active care at follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

Challenges of the OVC response in Uganda include weak co-ordination mechanisms at both national and local government levels; inadequate OVC management information systems at national and district levels; limited monitoring of quality of care in OVC programs; and high demand for services.

This program will address the needs of the identified Orphans and Vulnerable children as appropriate to age and gender including Care and Support, Education, psychosocial support, Food security, Economic strengthening, Basic health, Child protection and Legal support. The program will develop a census based approach to achieve access to these services to all segments of the vulnerable communities through collaboration with community development officers and related CBOs and CSOs, and use collected data to inform program strategies and activities.

This program will be implemented in the district of Luweero and Mbuya Parish, Kampala with possibility of expansion to other districts, facilities, and communities and build on the already achieved successes of offering the needed OVC services within the existing programs and increasing referral to other OVC providers who are mapped out within the district of operation. The target population will include all the Orphans and Vulnerable children including those affected and infected with HIV, street children, children under extreme labor conditions, and other forms of child abuse: physical, sexual, neglect among others and those in need of legal protection.

The major program goals will be;
1. To improve the lives of orphans and other vulnerable children and families affected by HIV/AIDS, with emphasis on strengthening communities to meet the needs of orphans and other vulnerable children affected by HIV/AIDS.
2. To identify HIV positive children through partnership with other community providers and district structures and ensure early access to clinical care and treatment linked with quality psychosocial care and other essential services.
3. Provide training to caregivers, or equipping communities to train local leaders, members of affected families, and caregivers in meeting specific needs of OVC

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

Total number of eligible children (OVC) provided services in 3 or more OVC core program areas beyond psychosocial/spiritual support disaggregated by sex and age
Number of OVC care givers trained in comprehensive HIV management
Total Number of eligible clients who received food and/or food security disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

This program will support at least 4 health facilities and their surrounding communities in Luweero and Kampala district to implement a comprehensive adult HIV care and treatment services program. All Clients in active HIV care will routinely receive prophylaxis for opportunistic infections using daily cotrimoxazole, psychosocial support, screening for TB, and regular assessment for ART eligibility. Clients eligible for ART as per national guidelines will receive treatment through this program or be referred to existing clinics. The program will ensure that these patients continue to be supported with quality care including adherence support to minimize the likelihood of developing ARV drug resistance. All clients on ART will receive regular laboratory monitoring using CD4. Health providers will be trained and mentored to provide the necessary services and their knowledge updated through continuing medical education sessions. Continuous evaluation of programs will be continued with quality improvement teams to be supported in all the implementing sites. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites. For those on ART, the program will implement strategies to promote adherence to ART

To date, there is an existing pool of over 3,800 clients in care at these four (4) facilities and 1,700 of these are on ART. Services will also be scaled up to other facilities and eligible clients.

Major activities for this program will include:
1. Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines. The program will expand the number of health care facilities/sites providing basic health care and ART to HIV-infected people and increase the number of patients on ART at supported health care facilities/sites.
2. Training health care providers to deliver HIV-related services. The program will increase the number

of health care workers trained to deliver HIV-related clinical services and/or ART provision; increase the numbers of individuals provided with HIV-related basic health care services (including improving the prevention, diagnosis, and clinical management services for HIV/AIDS, sexually transmitted diseases [STDs]) and related opportunistic infections [OI], e.g., TB)
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs including PMTCT and TB. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms. The grantee will increase in the total number of HIV service points with active monitoring and evaluation and quality improvement programs

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of health facilities that offer HIV care and/or ART
2. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
3. Increase the total number of patients currently receiving ART at each health facility/site
4. Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within Luweero district and Mbuya, Kampala district to

implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. To date, there is an existing pool of over 3,800 clients in care and these 4 facilities and 1,700 of these are on ART. Services will also be scaled up to other facilities and eligible clients.

This program will continue to support identification of children and linking them into care from the MCH, OPD and pediatric departments. Integration of these services will be a core focus area for this program with the aim of increasing the number of children in care to about 15 percent of the total in care. The program will endeavor to create child friendly clinics at the health facilities and also address the special adolescent sexual and reproductive health needs through a program focusing on this age group. Providers will receive pediatric HIV counseling skills training to have at least one pediatric counselor at all the supported health facilities. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, enhance adherence and reduce loss to follow up.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis
4. Integrating HIV prevention initiatives within HIV care and treatment with a focus on adolescent sexuality issues
5. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV commodities
6. Strengthening data management

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of facilities that offer pediatric HIV care and support
2. Number of health care providers trained in facility and/or community HIV care
3. Number of children with advanced HIV infection in care / on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

This program will support 4 health facilities within Luweero and Mbuya, Kampala district to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

The program will provide support to the existing pool of about 200 pediatric patients with antiretroviral treatment (ART) services like CD4 monitoring and out source viral load (VL) services for those that will require VL measurements. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for staff in pediatric ART in collaboration with other partners. Peer support networks for children on HAART will be supported to reduce stigma and enhance adherence. ARV for pediatric will continue to flow through the MOH and Global fund mechanism.

Major activities for this program will include:

1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of health facilities that offer pediatric ART
2. Number of children with advanced HIV infection on ART disaggregated by age and sex
3. Percent of children on ART known to be on treatment 12 months after initiation of antiretroviral therapy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

The abstinence and Be faithful (AB) program will specifically focus on youth in and out of school less than 14 years of age and clients 15-49 years who test as a couple. Since the majority of the children below 15

as these are largely not yet sexually active, this will comprise the only prevention messaging to them. The school program will include life skills training and will complement the PIASCY program that is implemented through the Ministry of Education and Sports (MOES). Couples will be specifically targeted because majority of new infections in Uganda are occurring among married people in discordant relationships. The specific messaging will aim at reducing concurrent relationships with multiple partners promoting zero grazing. For clients below 15 years of age who are sexually active, further prevention messaging with strategies like condom use will be provided. This will also be the same for couples that are discordant for HIV.

AB prevention activities will be monitored and evaluated through the overall monitoring and evaluation framework of the program through the HIV prevention focal persons at the district health office.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This program will implement HIV prevention activities in support of the Government of Uganda, to scale up a comprehensive and integrated package of HIV interventions and services in the selected areas of Luweero District and Mbuya Parish. The comprehensive prevention package of services will address the major risk factors and contextual factors that drive the epidemic in Uganda following national guidelines for HIV prevention.

The program will focus on but not be limited to the following activities;

1. Expand the capacity of Ugandan communities and organizations to reduce HIV transmission through evidence-based, targeted prevention programs that focus on changing social norms to promote the delay of sexual debut, abstinence, and fidelity with HIV-tested partners, partner reduction, condoms and, medical male circumcision.
2. Support people living with HIV to reduce their risk of HIV transmission through positive prevention or "prevention with positives" interventions, particularly partner testing, and disclosure of HIV status
3. Promotion of gender equity and positive role models, and address negative social norms; gender based violence, stigma, and discrimination will be cross-cutting themes.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

• Total number of the targeted population reached with individual and /or small group level HIV prevention

intervention that are based on evidence and /or meet the minimum standards required
• Number of intended target population reached with individual and or /small group level interventions that are based on evidence and or meet a minimum standards
• Total number of the targeted population reached with individual and or small group level preventive interventions that are primarily focused on abstinence and /or being faithful, and are based on evidence and /or meet the minimum standards required
• Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
• Number of Most At Risk Populations (MARP) reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required disaggregated by age

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

Prevention of Mother to Child Transmission (PMTCT)

This program will implement PMTCT activities in support of the Government of Uganda, to scale up high quality, effective and comprehensive PMTCT services that are fully integrated into the national health system and will mainly focus on the following activities;
1. Provision of accessible, high-quality, comprehensive PMTCT services for HIV-infected women and their families through MCH/HIV integrated care, or establish reliable, active referral networks for PMTCT services.
2. Building the capacity of indigenous HIV/AIDS organizations and technical capacity of health care providers and community health workers to mobilize women and their partners for PMTCT services (rapid HIV counseling and testing in antenatal and maternity settings; combination short-course antiretroviral (ARV) prophylaxis for mother and infant and antiretroviral treatment (ART) for eligible mothers; counseling and support for infant feeding; link with wraparound services, such as nutrition, family planning services for women with HIV, and sustainable livelihood initiative); and strong links to care, treatment and support services.

In the first year, this program is expected to provide HIV testing to all pregnant women attending the antenatal clinics, identify a minimum of 300 HIV-infected pregnant women, provide antiretroviral therapy as per national guidelines, and community follow-up with deliveries supervise by qualified personnel. The program will be closely linked to other services like ART, pediatric care, nutritional support, laboratory infrastructure to ensure quality service delivery.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
• Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site
• Number of pregnant women with known HIV status
• Number of HIV positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission
• Number of HIV-positive pregnant women assessed for ART eligibility
• Number of eligible clients who received food and/or food security

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

This program will support the procurement of first and second line adult and pediatric ARV drugs for their patient population in accordance with the Uganda national policies and guidelines.

Funds will go towards support for the various stages of the ARV drugs' procurement cycle such as quantification of requirement, the procurement, storage and distribution, quality assurance and tracking of ARVs in close collaboration with HIV treatment providers, MOH Medicines and Supplies Department, MOH- AIDS Control Program, and institutions responsible for logistics and supplies chain management such as National Medical Stores, and Joint Medical Stores.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

This program will support 4 health facilities and surrounding communities to implement collaborative TB and HIV activities in the districts of Luweero and Mbuya Parish, Kampala with possibility of expansion to other districts, facilities, and communities. This will be part of a comprehensive HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

The major areas of focus will be the following;
1. Provision of routine TB screening among HIV clients, TB diagnosis and treatment for clients with active TB, or active linkage of clients to comprehensive HIV/TB care and treatment, in collaboration with specialized TB clinics, which follow national TB-treatment guidelines

2. Improving community support and clinical services for persons living with HIV and TB and their families 3. Promotion of TB/HIV information and literature for communities to improve knowledge on TB and reduce TB/ HIV-related stigma Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR; • Number of HIV-positive patients who were screened for TB in HIV care or treatment settings • Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment • Number of TB patients who had an HIV test result recorded in the TB register • Number HIV-positive incident TB cases that received treatment for TB and HIV

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12495	**Mechanism Name: Scaling up comprehensive HIV/AIDS services in Mulago University Teaching Hospital, its clinics and surrounding catchment area.**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Uganda has made significant progress towards providing care and support and ART to People Living with HIV/AIDS (PLHA). By March 31, 2009 PEPFAR funded HIV care and support for more than 350,000 people and provided ART to over 150,000 (87% of all ART recipients nationally). However, the number of people in need of ART is approximately 358,000 (UNAIDS), implying an unmet need of more than 50%. In addition, currently, only 9% of all persons on PEPFAR supported ART are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

Challenges for providing greater coverage of adult care and treatment services include high demand for HIV services, weak infrastructure with limited skilled human resources, weak laboratory support, and multiple uncoordinated logistics supply chain systems. There is limited access pediatric care and treatment with children comprising less than 9% of all clients in care and on treatment nationally. This has been linked to inadequate community education and mobilization for pediatric services, inadequate commodity supplies for pediatric care and treatment, limited coverage of Early Infant Diagnosis (EID) at 17%, continued MTCT estimated at about 15%, challenges of providing sexual and reproductive needs for adolescents, inadequate linkages between PMTCT and ART programs, pediatric and PMTCT programs as well as pediatric and OVC programs. In relation to PMTCT, access to services for pregnant women is estimated at 48% while only 21% of ART eligible pregnant women accessed treatment in the past year ending June 2009. There are inefficiencies in service provision and reporting as a result of poor coordination and linkages.

Mulago Hospital Complex is a national referral and University teaching Hospital with a bed capacity of 1,500. The hospital handles over 300,000 hospitalizations annually and over one million out-patient visits. About 65,000 women attend antenatal care at Mulago Hospital annually of which over 4,000 are HIV-infected (MOH report). The hospital has over 3,000 clinical and non-clinical staff and is host to several training schools for medical students and allied health workers. To date, over 20,000 HIV-infected individuals are in active HIV care, and 11,000 of these are on ART. Mulago Hospital provides TB treatment to over 4,000 patients annually and in the past year; over 200,000 individuals were reached with HIV testing in the various units.

The purpose of this program is to support Mulago Hospital to provide comprehensive HIV/AIDS services to patients within its clinics including Provider Initiated Testing and Counseling (PITC), TB/HIV, HIV basic care and support, PMTCT, OVC, and antiretroviral therapy (ART) for adults (including pregnant women) and children at Mulago Hospital. Currently, there are several specialized HIV clinics providing services such as Mulago ISS, Mulago Communicable Disease Clinic, Mulago TB/HIV clinic, Mulago Infectious Disease Clinics. There are two Mother and Child clinics (Upper and Lower Mulago). In addition, Butabika hospital is an extension of the referral services handling mental health but also providing general services.

The objectives of this program are to support:
1. Comprehensive care and treatment including: increase of coverage, scope of HIV/AIDS services for PHAs and their families; pediatric care and treatment services; strengthen linkages with PMTCT activities and OVC services; in the clinics to respond to existing gaps and minimize overlaps and duplication of services and reporting.
2. Secondly the program will also support Systems strengthening as follows: strengthen health facilities' capacity to effectively integrate HIV/AIDS services through support to M&E, Laboratory, staff capacity, infrastructure /space; training and routine supportive supervision of healthcare workers; and harmonized procurement of logistics and commodity supplies to enhance the comprehensive HIV/AIDS care, and treatment; support sustainability planning at health facilities' levels. The program will also support the recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. This procedure is to support sustainability of this program and avoid parallel service systems, with eventual absorption of such staff onto the government pay role.
3. The third objective is to strengthen monitoring and evaluation through support of health facilities to utilize the Ministry of Health Management Information System (HMIS), and other MOH/ACP registers to produce timely reports, ensure these reports are channeled along the Government of Uganda information flow system and use HIV/AIDS service data for ongoing improvement of program performance.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12495**
Mechanism Name:	**Scaling up comprehensive HIV/AIDS services in Mulago University Teaching Hospital, its clinics and surrounding catchment area.**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	Redacted	Redacted

Narrative:

This program will support Mulago Hospital Complex to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, opportunistic Infection (OI) prophylaxis, diagnosis and treatment, TB screening and treatment, and routine assessment for ART eligibility. Clients eligible for ART will receive treatment through this program as per national treatment guidelines or be referred to existing clinics within their communities. The program will implement strategies to promote adherence to ART to minimize the risk of developing ARV drug resistance. The program will establish quality improvement initiatives for adult HIV care and support in line with Ministry of Health guidelines. Linkages will be strengthened between HIV care and support, pediatric care and support, ART, PMTCT, HCT, and wraparound services such as nutritional support.

Adult care and treatment services within Mulago Hospital will be provided to an existing pool of 20,000 clients in active care 10,000 of whom are currently on ART. Services will also be scaled up to other facilities and eligible clients as they are identified through the HCT program.

For pediatric care and support, this program will work closely with Baylor- Uganda to identify HIV–infected children in the Mulago in patient wards, out-patient clinics, and families of index HIV infected clients that undergo home/ family based testing. These children will be actively linked to the Baylor-Uganda clinic or provided with HIV care and support in the existing clinics using a family model to HIV care. In order to enroll children into care as early as possible, the program will implement Early Infant Diagnosis in collaboration with the Ministry of Health. This will require collection of Dried Blood Spot (DBS) specimens from HIV-exposed infants in the post-natal, immunization clinics and wards implementing Routine HIV testing. The program will endeavor to improve follow-up of the HIV exposed mother-infant pair to ensure results are received and appropriate action taken. All exposed infants will be initiated on cotrimoxazole at 4-6 weeks as per national guidance and this will be continued until HIV infection can be reliably excluded. Children in care will receive OI prevention and care in addition to regular assessment for ART eligibility using both clinical and laboratory methods.
This program will also have a strong capacity building component through training of providers both pre-service and in-service. Trainees to be targeted may come other health facilities in the country, or the region. Continuing medical education will be organized to ensure provider skills are up-dated periodically. Providers will receive pediatric HIV counseling skills training. Children identified as vulnerable will be referred to OVC programs for additional support.

Major activities for this program will include:
1. Increasing access to HIV care, and support at facilities and within surrounding communities to HIV-infected persons clients in accordance with National guidelines

2. Training health care providers to deliver HIV-related services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of health facilities that offer HIV care and support
2. Number of health care providers trained in facility and/or community HIV care
3. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
4. Percent of adults and children with HIV known to be in active care at follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

Orphans and Vulnerable Children (OVC)

Challenges of the OVC response in Uganda include weak co-ordination mechanisms at both national and local government levels; inadequate OVC management information systems at national and district levels; limited monitoring of quality of care in OVC programs; and high demand for services.

This program will strengthen linkages between facility HIV care and existing OVC providers in the communities around Mulago Hospital. Children identified to be vulnerable in the facilities and home visits will be referred for OVC services while OVC providers will also refer children that need clinical HIV care to this program.

The major program goals will be;
1. To identify HIV positive children through partnership with other community providers and district structures and ensure early access to clinical care and treatment linked with quality psychosocial care and other essential services.

2. Provide training to caregivers, or equipping communities to train local leaders, members of affected families, and caregivers in meeting specific needs of OVC

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of OVC care givers trained in comprehensive HIV management
2. Total number of eligible clients who received food and/or food security disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

This program will support Mulago Hospital Complex to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, opportunistic Infection (OI) prophylaxis, diagnosis and treatment, TB screening and treatment, and routine assessment for ART eligibility.

Clients eligible for ART will receive treatment through this program at the various established accredited ART clinics as per national treatment guidelines or be referred to existing clinics within their communities. Categories of clients to be prioritized for ART will include pregnant women, patients with advanced HIV infection, and those co-infected with TB.

The program will implement strategies to promote adherence to ART to minimize the risk of developing ARV drug resistance. Laboratory monitoring for clients on treatment using CD4 will be supported in collaboration with other providers and in line with the National laboratory policy and ART guidelines. Clients on treatment will continue to receive prevention and treatment for opportunistic infections as appropriate. The program will endeavor to integrate prevention with treatment. Support for prevention among positives such as partner testing, disclosure of HIV status, condom use, family planning, and community follow-up will be provided as part of the treatment package. Quality improvement initiatives for adult HIV care and support will be implemented in line with Ministry of Health guidelines. The program will ensure regular up-dating of health workers knowledge through re-fresher trainings and continuing medical education sessions. Linkages will be strengthened between HIV care and support, pediatric care and support, ART, PMTCT, HCT, and wraparound services such as nutritional support. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites.

Adult care and treatment services within Mulago Hospital will be provided to an existing pool of 20,000 clients in active care 10,000 of whom are currently on ART. Services will also be scaled up to other facilities and eligible clients as they are identified through the HCT program.

For pediatric treatment, a specialized pediatric care and treatment clinic exists at Mulago Hospital through support from the Baylor College of Medicine Children's Foundation, Uganda Mulago Center of Excellence. This program will work closely with Baylor –Uganda and other existing providers at Mulago Hospital to support the delivery of quality pediatric HIV treatment and other related services. Linkages between PMTCT and pediatric treatment will be strengthened to minimize loss to follow-up of exposed mother-infant pairs through integration of HCT in the MCH clinics and improved referral. Training of health providers in pediatric treatment will be a major activity and this will be pre-service, in service and through continuous medical education. Major support will be through strengthening the systems for delivery of HIV treatment services such as the laboratory infrastructure, the referral systems for patients and laboratory specimens such as CD4, capacity building for health provider skills, logistics systems for management supplies. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing clinics and trainees facilities and provide mentorship and refresher training for staff in pediatric ART in collaboration with other partners.

Major activities for this program will include:
1. Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Integrating HIV prevention initiatives within HIV care and treatment program. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of health facilities that offer HIV care and/or ART
2. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and

sex, and pregnancy status for women
3. Increase the total number of patients currently receiving ART at each health facility/site
4. Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

HIV Counseling and Testing (HCT)

The program will work with the Mulago Hospital in-patient wards and out-patient clinics to offer HIV testing using various approaches. This program will build on the existing hospital wide program that has been implementing Provider Initiated HIV Testing (PITC) since 2004. This program will provide PITC in all units including OPD and inpatient wards, Voluntary Counseling and Testing (VCT), Couple testing, Early Infant Diagnosis for all HIV exposed infants, and HIV testing for household members of index clients (through selective home based programs, health visitors, or outreach programs). The hospital handles over 300,000 hospitalizations annually and over one million out-patient visits. About 65,000 women attend antenatal care at Mulago Hospital annually of which over 4,000 are HIV-infected (MOH report).

Clients identified as HIV-infected will be immediately initiated on cotrimoxazole and actively linked to existing HIV care and treatment services. Those found to be HIV negative will be encouraged to remain negative through provision of appropriate prevention messages and condoms. Discordant couples will be linked to psychosocial support groups or discordant couple clubs with the aim of reducing the risk of HIV transmission to the negative partner. The program will establish quality assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines.

This program will focus on the following activities;
1. Expand access to HIV counseling and testing through a variety of collaborative facility and community testing and counseling services
2. Provide couple counseling and testing, and ensure that persons testing HIV positive and discordant couples are provided with support and care, and facilitated disclosure
3. Integrate HIV prevention within HCT and establish clear linkages to ensure adequate referrals and follow-up services

Measurable outcomes of the program will be in alignment with the following performance goals for

PEPFAR;

1. Number of service outlets providing testing and counseling services
2. Number of individuals who received counseling and testing services for HIV and received their test results: by sex, age, HCT type and test results
3. The number of clients and family members receiving counseling and testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Abstinence and Be Faithful (AB)

The program will develop HIV prevention interventions that target; staff in the hospital including a large pool of causal laborers and their family members, the students from the various health training institutions attached to Mulago hospital, patients and their caters, and communities around the hospital. The program will leverage resources from HCT and care and treatment technical areas to develop and implement targeted AB prevention interventions. The grantee will develop will support the hospital to integrate comprehensive HIV prevention services and develop targeted behavior change communication messages at the work place and surrounding communities. This activity is linked to prevention activities in the sections for Other Prevention, Male Medical Circumcision and PMTCT.

This program will also reach clients identified as HIV negative in the routine HIV testing and counseling program that is supported though this mechanism. These clients will receive messaging focusing on how to remain negative through abstinence and Be faithful interventions. Trainees in the medical school within Mulago Hospital will also receive HCT and AB messaging.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

Other Prevention

This program will support Mulago Hospital health facilities/clinics and medical schools to implement a basic preventive care package for patients. All patients attending the hospital clinics will be offered HIV testing and counseling with their spouses and available family members. Couples identified to be discordant for HIV will be encouraged to use condoms and join discordant couple clubs for continued psychosocial and other support. Apart from partner testing, support will be provided for disclosure of HIV

status. Following HIV testing, clients will be provided with effective referral for medical male circumcision (MMC) when appropriate, and supported disclosure of HIV status to spouses and selected family members. Support will be provided to health facilities within Mulago Hospital to provide MMC or condoms using existing nationally approved training materials to ensure that effective prevention programs are instituted for all HIV-infected individuals including discordant couples and a comprehensive prevention program that combine MMC, condom use and Abstinence Be Faithful initiatives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

Prevention of Mother to Child Transmission (PMTCT)

This program will implement PMTCT activities in support of the Government of Uganda and Mulago Hospital and to scale up high quality, effective and comprehensive PMTCT services that are fully integrated into the national health system. About 65,000 women attend antenatal care at Mulago Hospital annually of which over 4,000 are HIV-infected (MOH report).

In collaboration with the existing providers, this program will establish and monitor active and effective linkages between PMTCT, Early Infant Diagnosis, Pediatric HIV/AIDS care and OVC services for comprehensive support to HIV positive pregnant women and their families. The program will also support the Maternal and Child health Clinics at Mulago as an important linkage to antenatal and HIV clinic for continued care of identified mother infant pairs.

The program will mainly focus on the following activities;
1. Provision of accessible, high-quality, comprehensive PMTCT services for HIV-infected women and their families through MCH/HIV integrated care, or establish reliable, active referral networks for PMTCT services.
2. Building the capacity of health providers to mobilize women and their partners for PMTCT services (rapid HIV counseling and testing in antenatal and maternity settings; combination short-course antiretroviral (ARV) prophylaxis for mother and infant and antiretroviral treatment (ART) for eligible mothers; counseling and support for infant feeding; link with wraparound services, such as nutrition, family planning services for women with HIV, and sustainable livelihood initiative); and strong links to care, treatment and support services.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR:

1. Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site
2. Number of pregnant women tested for HIV and received their results
3. Number of HIV positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission
4. Number of HIV-positive pregnant women assessed for ART eligibility
5. Number of eligible pregnant and lactating women who received food and/or food security

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

Laboratory Infrastructure

This program will be implemented in Mulago Hospital, a national referral and University teaching Hospital located in Kampala district. The program will focus on scaling up and strengthening laboratory activities that support HIV services' delivery in accordance with the Uganda national laboratory policies and guidelines. The scope of the laboratory support will address services such as HIV testing for infants, adults and children, diagnosis of opportunistic and other common infections, assessment for antiretroviral therapy eligibility for clients in active HIV care, and monitoring of response to treatment for clients on ART.

The PEPFAR program areas that require specific laboratory support include HIV counseling and testing (HCT), Prevention of Mother To Child Transmission (PMTCT), Biomedical HIV prevention, Adult Care and Support, Pediatric Care and Support, Adult treatment, and Pediatric Treatment.

The program will strengthen linkages between the laboratory and the various services and ensure timely delivery of laboratory results.

Major activities to be supported will focus on but not be limited to;

1. Developing and strengthening laboratory facilities in accordance with MoH laboratory strategic policies and plan to support HIV/AIDS-related activities including the purchase of equipment through competitive procurement
2. Provision of quality assurance, staff training and other technical assistance.
3. Supporting policies based on national and international best practices, training, waste-management

systems, advocacy and other activities to promote medical injection safety, including establishing a distribution/supply chain, and the safe and appropriate disposal of injection equipment and other related equipment and supplies.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests (CAPACITY depends on facility level as specified in MOH guidelines)
2. Number of testing facilities (laboratories) that are accredited according to national or international standards
3. Percent of testing facilities (laboratories) that are accredited according to national or international standards

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

ARV drugs

This program will procure ARV drugs for an existing pool of at least 11,000 clients currently on treatment at the 4 or more facilities in Mulago Hospital. This program will support the procurement of first and second line adult and pediatric ARV drugs for their patient population in accordance with the Uganda national policies and guidelines.

Funds will go towards support for the various stages of the ARV drugs' procurement cycle such as quantification of requirement, the procurement, storage and distribution, quality assurance and tracking of ARVs in close collaboration with HIV treatment providers, MOH Medicines and Supplies Department, MOH- AIDS Control Program, and institutions responsible for logistics and supplies chain management such as National Medical Stores, and Joint Medical Stores.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

Tuberculosis/HIV

This program will support Mulago Hospital complex, the national referral and University teaching hospital

to implement collaborative TB and HIV activities. This will be part of a comprehensive HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, and routine assessment for ART eligibility. In addition this program will support TB/HIV integrated activities of the National TB and Leprosy Program (NTLP) and the National TB Reference Laboratory (NTRL).

This program will build on the existing hospital wide routine HIV testing program that is providing TB screening concurrently to clients that are offered HIV testing irrespective of their HIV status. All clients that are offered HIV testing are also screened for TB using a symptom check list. Those suspected to have TB are then subjected to thorough TB investigation using sputum microscopy, chest radiology, ultra sound investigations, or analysis of lymph node or other fluid aspirates. Confirmed TB cases are referred to specialized TB clinic at Mulago that obtains TB medications through the National TB and Leprosy Program. All TB cases are offered HIV testing and those found to be infected initiated on cotrimoxazole, treated for TB and other inter-current opportunistic infections, and evaluated for ART eligibility. ARV drugs maybe initiated during the course of TB treatment in accordance with national treatment guidelines.

Within the five HIV clinics located at Mulago Hospital, all clients will be regularly screened for TB and treated accordingly. TB treatment and follow up using the DOTS strategy will be supported with sub county health workers facilitated to conduct support supervision to TB treatment supporters. The program will implement strategies that increase adherence to ART and TB. The program will ensure regular supplies of medications for TB and opportunistic infections like cotrimoxazole through the national system. Laboratory reagents for TB diagnosis will be procured through the national system. Data management will be strengthened through use of existing MOH data collection tools and provision of regular reports to the national TB program and MOH.

Staff will be trained in TB and diagnosis, and treatment of both conditions. Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported labs will participate in the National External quality assurance for sputum microscopy. Awareness among patients and communities about TB and HIV integration will be supported through dissemination of IEC materials and health promotion talks. Health workers will be trained in HIV/TB co management. Innovative approaches such as co-location of TB and HIV services will be applied. Staff in supported Health facilities will be supported in data management and analysis using the MOH tools. Support will also be provided to the existing district health systems in provision of support supervision, on job training and logistics for HIV/TB drugs and supplies.

The program will support the Ministry of Health's [MoH] National TB Reference Laboratory [NTRL] to conduct the national external quality assurance for TB microscopy; conduct laboratory staff trainings in

diagnosis and treatment of TB using smear microscopy; Support the NTRL with TB sputum referral system and surveillance of drug resistant TB, this activity will include procurement of reagents and supplies for TB culture, need for the MGIT ; ensure that the established mechanisms to provide TB patients with HIV screening are strengthened; institutionalize the "Three Is" of TB, with a major focus on infection control and intensive case finding. The MOH will be supported to strengthen supervision, monitoring and evaluation of TB/HIV activities in particular an M&E officer will be employed to improve the M & E capacity of the NTLP. Gaps in coordination of TB/HIV partners by the MOH will be facilitated through this program. The MOH will be supported in development and dissemination of National TB/HIV policies and guidelines.

The major areas of focus will be the following;
1. Provision of routine TB screening among HIV clients, TB diagnosis and treatment for clients with active TB, or active linkage of clients to comprehensive HIV/TB care and treatment, in collaboration with specialized TB clinics, which follow national TB-treatment guidelines
2. Improving community support and clinical services for persons living with HIV and TB and their families
3. Promotion of TB/HIV information and literature for communities to improve knowledge on TB and reduce TB/ HIV-related stigma

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of HIV-positive patients who were screened for TB in HIV care or treatment settings
2. Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment
3. Number of TB patients who had an HIV test result recorded in the TB register
4. Number HIV-positive incident TB cases that received treatment for TB and HIV

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12496	**Mechanism Name: Monitoring and Evaluation of Emergency Plan Progress (MEEPP II)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new activity aimed at supporting the monitoring and evaluation of the Presidential Emergency Plan for AIDS Relief (PEPFAR) and improving the reporting system for selected key indicators in the Uganda National HIV/AIDS Strategic Plan (NSP). The few NSP indicators targeted constitute all the national output/outcome, essential and reported PEPFAR indicators. The activity is designed to accomplish two broad objectives. The primary objective is to implement and maintain a comprehensive PEPFAR program performance management system- an 80% This is a new activity aimed at supporting the monitoring and evaluation of the Presidential Emergency Plan for AIDS Relief (PEPFAR) and improving the reporting system for selected key indicators in the Uganda National HIV/AIDS Strategic Plan (NSP). The few NSP indicators targeted constitute all the national output/outcome, essential and reported PEPFAR indicators. The activity is designed to accomplish two broad objectives. The primary objective is to implement and maintain a comprehensive PEPFAR program performance management system- an 80% level of effort. The second objective (LOE of 20%) is to support the Government of Uganda's (GOU) national monitoring and evaluation system for the overall HIV/AIDS response.

The activity will support, and work with, the Uganda's PEPFAR Inter-Agency Team which includes the Centers for Disease Control (CDC), the US Department of Defense (DOD), the US National Institute of Health (NIH), Peace Corps, United States Agency for International Development (USAID), and Walter Reed under the leadership of the Department of State (US Embassy) to accomplish the primary objective of improving PEPFAR's program performance management including results reporting to the Office of the Global AIDS Coordinator (OGAC). In addition, the project will work with relevant GOU agencies such as Uganda AIDS Commission (UAC), Ministry of Health (MOH), Ministry of Gender, Labor, and Social Development (MGSLD), and the Uganda Bureau of Statistics (UBOS) to increase GOU's capacity to report on key indicators and to use the data in strategic planning, while strengthening monitoring and evaluation of the national HIV/AIDS response.

Since 2005, PEPFAR has been utilizing the services of the current monitoring and evaluation project

(MEEPP) which is coming to an end in December 2009. MEEPP used proven portfolio management approaches to coordinate with, and complement, the monitoring activities of PEPFAR-funded Implementing Partners (IPs), facilitated harmonization and aggregation of data, and in collaboration with the PEPFAR Strategic Information Technical Workgroup and AIDS Development Partners, shares results with the Government of Uganda, PEPFAR Advisory Committee and Uganda AIDS Development Partners. By providing PEPFAR Country Team and PEPFAR-funded IPs with a unified picture of USG-funded HIV/AIDS activities, the MEEPP project has helped to maximize the extent of the USG resources in achieving PEPFAR targets and goals. Although the primary purpose of the MEEPP project is for PEPFAR reporting there has been a component of capacity building for Implementing Partners (IPs) which contributed to strengthening knowledge and systems for a sound, sustainable HIV/AIDS monitoring system among the PEPFAR-funded IPs.

Following the successes of the MEEPP Project and the growing need for high quality performance data, USG/Uganda plans to award a follow-on project (MEEPP II). Although the MEEPP project helped build some national M&E capacity, the project's main focus has been focused on PEPFAR reporting. Indeed, the perception of many GOU partners has been that MEEPP was a parallel system. While to a large degree this perception is also a reflection of reality, the available data in the national M&E system could not fully meet PEPFAR's reporting requirements. However, with the increasing need to support sustainable national M&E and information systems, and the experiences gathered from the current project, it is feasible for USG to make contribution towards improved quality of the outcomes of the national reporting system. In the context of the three ones, it is expected that there will be collaborated efforts between MEEPP II and other USG support at the national, district, and service delivery levels to contribute to the improved functioning of the national M&E reporting system. The ideal being a linked multi-sectoral system at Uganda AIDS Commission (UAC) that can be relied upon to address the various stakeholders' information needs. Under this activity about 100 USG IPs and 30 GOU staff will be trained in the relevant aspects of strategic information.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12496**		
Mechanism Name:	**Monitoring and Evaluation of Emergency Plan Progress (MEEPP II)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted

Narrative:

This is a new activity aimed at supporting the monitoring and evaluation of the Presidential Emergency Plan for AIDS Relief (PEPFAR) and improving the reporting system for selected key indicators in the Uganda National HIV/AIDS Strategic Plan (NSP). The few NSP indicators targeted constitute all the national output/outcome, essential and reported PEPFAR indicators. The activity is designed to accomplish two broad objectives. The primary objective is to implement and maintain a comprehensive PEPFAR program performance management system- an 80% level of effort. The second objective (LOE of 20%) is to support the Government of Uganda's (GOU) national monitoring and evaluation system for the overall HIV/AIDS response.

The activity will support, and work with, the Uganda's PEPFAR Inter-Agency Team which includes the Centers for Disease Control (CDC), the US Department of Defense (DOD), the US National Institute of Health (NIH), Peace Corps, United States Agency for International Development (USAID), and Walter Reed under the leadership of the Department of State (US Embassy) to accomplish the primary objective of improving PEPFAR's program performance management including results reporting to the Office of the Global AIDS Coordinator (OGAC). In addition, the project will work with relevant GOU agencies such as Uganda AIDS Commission (UAC), Ministry of Health (MOH), Ministry of Gender, Labor, and Social Development (MGSLD), and the Uganda Bureau of Statistics (UBOS) to increase GOU's capacity to report on key indicators and to use the data in strategic planning, while strengthening monitoring and evaluation of the national HIV/AIDS response.

Since 2005, PEPFAR has been utilizing the services of the current monitoring and evaluation project (MEEPP) which is coming to an end in December 2009. MEEPP used proven portfolio management approaches to coordinate with, and complement, the monitoring activities of PEPFAR-funded Implementing Partners (IPs), facilitated harmonization and aggregation of data, and in collaboration with the PEPFAR Strategic Information Technical Workgroup and AIDS Development Partners, shares results with the Government of Uganda, PEPFAR Advisory Committee and Uganda AIDS Development Partners. By providing PEPFAR Country Team and PEPFAR-funded IPs with a unified picture of USG-funded HIV/AIDS activities, the MEEPP project has helped to maximize the extent of the USG resources

in achieving PEPFAR targets and goals. Although the primary purpose of the MEEPP project is for PEPFAR reporting there has been a component of capacity building for Implementing Partners (IPs) which contributed to strengthening knowledge and systems for a sound, sustainable HIV/AIDS monitoring system among the PEPFAR-funded IPs.

Following the successes of the MEEPP Project and the growing need for high quality performance data, USG/Uganda plans to award a follow-on project (MEEPP II). Although the MEEPP project helped build some national M&E capacity, the project's main focus has been focused on PEPFAR reporting. Indeed, the perception of many GOU partners has been that MEEPP was a parallel system. While to a large degree this perception is also a reflection of reality, the available data in the national M&E system could not fully meet PEPFAR's reporting requirements. However, with the increasing need to support sustainable national M&E and information systems, and the experiences gathered from the current project, it is feasible for USG to make contribution towards improved quality of the outcomes of the national reporting system. In the context of the three ones, it is expected that there will be collaborated efforts between MEEPP II and other USG support at the national, district, and service delivery levels to contribute to the improved functioning of the national M&E reporting system. The ideal being a linked multi-sectoral system at Uganda AIDS Commission (UAC) that can be relied upon to address the various stakeholders' information needs. Under this activity about 100 USG IPs and 30 GOU staff will be trained in the relevant aspects of strategic information.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12497	**Mechanism Name: Scaling up of comprehensive HIV/AIDS services in Central districts facilities including public and private not for profit health facilities and the surrounding catchment areas.**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Uganda has made significant progress towards providing care and support and ART to People Living with HIV/AIDS (PLHA). Of the estimated 1,200,000 people living with HIV/AIDS (PHA) in Uganda, the number of adults in active HIV care nationally is unknown due to gaps in reporting. By March 2009, PEPFAR was supporting over 350,000 Persons living with HIV/AIDS (PHAs) in active HIV care with adults comprising over 90%, with children comprising less than 10%. By June 2009, 193,746 (60% of eligible) HIV positive clients were receiving ART nationally with adults comprising 91.5 % of recipients, with children comprising 8.5 % of recipients. An estimated 42,140 children are in urgent need of antiretroviral treatment. Over 350 service outlets are actively providing ART countrywide. The proportion of HAART eligible HIV-infected pregnant women receiving treatment is still low with only 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009.

However, the number of people in need of ART is approximately 358,000 (UNAIDS estimate using the CD4<200 cut off), implying an unmet need of more than 50%. In addition, currently, only 9% of all persons on PEPFAR supported ART are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

Of the estimated Ugandans living with HIV/AIDS about 38% (456,000) are aware of their HIV status. In order to improve access to HIV testing, Uganda has embraced various approaches including Voluntary client -initiated counseling and testing (VCT), and Provider Initiated Counseling and Testing (PICT) for example Routine Testing in clinical settings (RCT), and Family based counseling and testing. However, access to HIV counseling and testing is still low.

Challenges for providing greater coverage of adult care and treatment services include: limited human resources, limited access to counseling and testing, incoherent measurement of HIV care and treatment outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems. In addition to challenges affecting adult care and treatment, limited access to pediatric care and treatment is linked to inadequate community education and mobilization for pediatric services, inadequate commodity supplies for pediatric care and treatment, limited coverage of Early Infant Diagnosis (EID) at 16%, continued MTCT estimated at about 15%, challenges of providing sexual and reproductive needs for adolescents, inadequate linkages between PMTCT and ART programs, pediatric and PMTCT programs as well as pediatric and OVC programs. Additional challenges arise from poor coordination resulting in several supply chains, uncoordinated quantification of drugs, and thus gross inefficiencies in service

provision and reporting. Thus making programs more comprehensive in scope and coverage is an endeavor to address the above challenges. The program will ensure coordinated and cost efficient comprehensive service provision in support of the national health systems.

The Central districts comprehensive HIV services program will cover public and private not for profit health facilities in the districts of Wakiso, Mukono, Luwero, Nakaseke, Nakasongola, Mityana, Mubende Mpigi, Masaka, Lyantonde, Rakai and Kalangala. These districtshave an estimated total population of 5,959,000 people and with a regional HIV sero-prevalence of 8.5%, about 506,515 are expected to be HIV infected. Curerently about 20% of the population know their HIV status thus about 101,000 people may be seeking care and treatment services in this region. The total number of health services outlets planned to have chronic care units are 261 ranging from district hospitals to HCIIIs. The regional Hospitals found in this region will not be part of the scope of this program, being covered by other programs. The services will include comphrehensive HIV care and treatment to an existing pool of more than 17,000 clients in care and 8,000 on ART.

The objectives of this program are to support 1) Comprehensive care and treatment including: increase of coverage, scope of HIV/AIDS services for PHAs and their families; pediatric care and treatment services; strengthen linkages with PMTCT and OVC services; in the clinics to respond to existing gaps and minimize overlaps and duplication of services and reporting. Secondly the program will also support Systems strengthening as follows: strengthen health facilities' capacity to effectively integrate HIV/AIDS services through support to M&E, Laboratory, staff capacity, infrastructure /space; training and routine supportive supervision of healthcare workers; harmonized procurement of logistics and commodity supplies to enhance the comprehensive HIV/AIDS care, and treatment; and support sustainability planning at health facilities' levels. Further more, the program will support the recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. Thus will ensure sustainability of this program and avoid parallel service systems, with eventual absorption of such staff onto the government pay role. The third objective is to strengthen monitoring and evaluation through support of health facilities to utilize the Ministry of Health Management Information System (HMIS); and other MOH/ACP registers to produce timely reports, ensure these reports are channeled along the Government of Uganda information flow system; aligned with goals and outcomes of CDC/Global AIDS Program and PEPFAR and use HIV/AIDS service data for ongoing improvement of program performance. In all these activities the program will work in close collaboration with other providers to ensure improved coordination and leverage of resources.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12497**
Mechanism Name:	**Scaling up of comprehensive HIV/AIDS services in Central districts facilities including public and private not for profit health facilities and the surrounding catchment areas.**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	Redacted	Redacted

Narrative:

This program will support health facilities within Central districts mentioned above, including outreach services to lower level health facilities (HC III) as appropriate; to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will implement strategies to promote adherence to ART to minimize the likelihood of developing ARV drug resistance. Care and treatment services within these Central districts will be provided to an existing pool of 17000 clients in active care 8000 of whom are currently on ART. Services will also be scaled up to other facilities and eligible clients.

Major activities for this program will include: Increasing access to HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines; Training health care providers to deliver HIV-related services; Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use; Supporting the Central districts' health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of

HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR: Number of health facilities that offer HIV care; Number of health care providers trained in facility and/or community HIV care; Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women; and Percentage of adults and children with HIV known to be in active care and follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

The goal of the National Orphans and other vulnerable children policy is to provide a frame work for the enjoyment of rights and fulfillment of responsibilities of the orphans and other vulnerable children; to ensure that the legal, policy, and institutional frame work for child protection is developed and strengthened at all levels; to establish linkages between public and private not for profit health facilities CSOs and CBOs; to promote sustainable livelihood interventions ,income generation ,Economic strengthening and /or microfinance activities; to develop participatory community dialogues and facilitated problem solving about OVC issues.

The partner will address the needs of the identified Orphans and Vulnerable children as appropriate to age and gender including Care and Support, Education, psychosocial support, Food security, Economic strengthening, Basic health, Child protection and Legal support. They will develop a census based approach to achieve access of these services to all segments of the vulnerable communities through collaboration with community development officers and related CBOs and CSOs, and use collected data to inform program strategies and activities.
The program will build on the already achieved successes of offering the needed OVC services within the existing programs and the increasing referral to other OVC providers who are mapped out within the districts. They will also endeavor to address the challenges of the OVC response which include weak co-ordination mechanisms at both national and local government levels; Hardly any OVC management of information systems with functional data bases at national and district levels; Limited monitoring of quality of care in OVC programs especially the family centered approach; and inadequate implementation of standard tools to measure quality of care and improvement.
The target population will include all the Orphans and vulnerable children including those affected and infected with HIV, street children, children under extreme labor conditions, and other forms of child abuse: physical, sexual, neglect among others and those in need of legal protection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

This program will support health facilities within Central Districts to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will ensure that these patients continue to be supported with quality care. This care will include adherence support and regular CD4 monitoring for all patients on ART and those on not yet on HAART. The program will ensure regular up dating of health workers knowledge through re-fresher trainings and continuing medical education sessions. Continuous evaluation of programs will be continued with quality improvement teams to be supported in all the implementing sites. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites. Performance based financing programs that are both equitable and encouraging will be encouraged. For those on ART, the program will implement strategies to promote adherence to ART to minimize the likelihood of developing ARV drug resistance.

Care and treatment services within Central districts will be provided to an existing pool of 17,000 clients in active care of which 8000 are currently on ART at their facilities. Services will also be scaled up to other health facilities and eligible clients.

Major activities for this program will include: Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines; Training health care providers to deliver HIV-related services; Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use; Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR: Number of health facilities that offer HIV care and/or ART; Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women; Increase the total number of patients currently receiving ART at each health facility/site;

percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The partner will work with implementing health facilities to offer PITC in all units including OPD and inpatient wards, Couple testing, Early Infant Diagnosis for all HIV exposed infants, and HCT for household members of index clients (through selective home based programs, health visitors, or outreach programs). In partnership with Uganda Virus Research Institute, establish Quality Assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines. They will conduct effective repeat HIV testing and reporting to minimize wastage of resources and double counting. The partner will also establish and monitor active and effective linkage to care and treatment for all HIV-infected clients identified through PITC activities, and address adherence issues to minimize loss to follow up to less that 10% using case managers, medicine companions, or other effective strategies;
Existing community structures including VHTs, PHA networks, and others, will be utilized to mobilize communities to access HIV/AIDS services and follow-up of HIV-infected individuals to ensure that they receive appropriate care, treatment, and support services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

An estimated 42,140 children are in urgent need of antiretroviral treatment. Without ART, 50% of HIV infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). By June 2009, approximately 16,495 children (39% of eligible) were on ART representing 8.5% of the national total of 193, 746 on ART with a male to female ratio of 1:1.
Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within Central Districts to implement a comprehensive adult HIV

care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. This program will continue to support identification of children and linking them into care from the MCH, OPD and pediatric departments. Integration of these services will be a core focus area for this program with the aim of increasing the number of children in care to about 15 percent of the total in care. The program will endeavor to create child friendly clinics at the health facilities and also address the special adolescent sexual and reproductive health needs through a program focusing on this age group. Providers will receive pediatric HIV counseling skills training to have at least one pediatric counselor at all the supported health facilities. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, enhance adherence and reduce loss to follow up.

Major activities for this program will include: Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines; Training health care providers to deliver HIV-related services; Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis; Integrating HIV prevention initiatives within HIV care and treatment with a focus on adolescent sexuality issues; The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV commodities; and strengthening data management. Measurable outcomes of the program will be in alignment with PEPFAR goals including: Number of facilities that offer pediatric HIV care and support ; Number of health care providers trained in facility and/or community HIV care and Number of children with advanced HIV infection in care / on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

In Uganda, an estimated 42,140 children are in urgent need of antiretroviral treatment. Without ART, 50% of HIV infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). By June 2009, approximately 16,495 children (39% of eligible) were on ART representing 8.5% of the national total of 193, 746 with a male to female ratio of 1:1. Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and

EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within Central Districts to implement a comprehensive pediatric HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. The program will provide support to the existing pool of about 350 pediatric patients with antiretroviral treatment (ART) services like CD4 monitoring and out source viral load (VL) services for those that will require VL measurements. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for staff in pediatric ART in collaboration with other partners. Peer support networks for children on HAART will be supported to reduce stigma and enhance adherence. ARV for pediatric will continue to flow through the MOH and Global fund mechanism.

Major activities for this program will include: Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines; Training health care providers to deliver HIV-related services; Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

Within the central distict facilities and the surrounding communities, the implementing partner will support health facilities to implement a basic preventive care package for patients and staff; Offer counseling and effective referral for medical male circumcision when appropriate and supported disclosure;Support partner health facilities to provide family based HCT, comprehensive reproductive health services to existing female HIV-infected clients of reproductive age, including use of family planning methods, effective ARV prophylaxis for pregnant or postpartum women and their babies, infant feeding counseling and ongoing support, cervical cancer screening, STI diagnosis and treatment, in a family-centered approach. They will use existing nationally approved training materials to ensure that effective Prevention with Positives programs are instituted for all HIV-infected individuals including discordant couples

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

The program will focus on scaling up and strengthening laboratory activities that support HIV services' delivery in accordance with the Uganda national laboratory policies and guidelines. The scope of the laboratory support will address services such as HIV testing for infants, adults and children, diagnosis of opportunistic and other common infections, assessment for antiretroviral therapy eligibility for clients in active HIV care, and monitoring of response to treatment for clients on ART. Some of the program areas that require specific laboratory support include HIV counseling and testing (HCT), Prevention of Mother To Child Transmission (PMTCT), Biomedical HIV prevention, Adult Care and Support, Pediatric Care and Support, Adult treatment, and Pediatric Treatment. The program will strengthen linkages between the laboratory and the various services.

The existing health facilities within the Central districts have some laboratory capacity that will need to be supported with staff or kits for HIV/AIDS diagnosis and monitoring depending on their capacity level. The program will work with other laboratory stakeholders through the district laboratory focal persons to improve laboratory functions at the facilities. The aim will be to have laboratories performing the expected range of diagnostics tests for their level to support service delivery.

The major activities to be supported will focus on but not be limited to; Developing and strengthening laboratory facilities in accordance with MOH laboratory strategic policies and plan to support HIV/AIDS-related activities including the purchase of equipment through competitive procurement; Providing quality assurance, staff training and other technical assistance; Supporting policies based on national and international best practices, training, waste-management systems, advocacy and other activities to promote medical injection safety, including establishing a distribution/supply chain, and the safe and appropriate disposal of injection equipment and other related equipment and supplies.

Measurable outcomes of the program will be in alignment with the following PEPFAR performance goals: Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests as specified in MOH guidelines and Number of testing facilities (laboratories) that are accredited according to national or international standards

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

This program will procure ARV drugs for an existing pool of at least 8000 clients currently on treatment in the estimated 50 health facilities in the Central districts. The program will also support facilities to improve their logistics management capacity to draw down on the National credit line. Activities shall include support to the quantification of ARV drug need, procurement, and storage, dispensing, plus reporting. Working closely with the MOH, the program will help standardize ARV regimens and formulations used at ART sites and harmonize these with the national treatment guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

For TB/HIV integration, the aim of this funding will be to: Provide intensified case finding among clients in HIV care and treatment ensuring at least 100% of them are screened for TB; Institute TB Infection Control in measures; Support provider-initiated counseling and testing in T.B clinics and wards; Enhance cross referral and linkages between HIV and T.B clinics; Strengthen HIV Care and treatment for T.B patients; and promote directly observed treatment (DOT) for T.B HIV co- infected patients.

Activities will include: TB screening of the HIV positive clients in care and treatment at each visit; provider Initiated Counseling and testing will be offered to all TB patients, and those found to be HIV positive will be linked to HIV care and treatment. Health facility staff will be trained in TB Infection control, and facilitated to conduct risk assessment of health facilities, develop TB infection control plans and implement work practice and administrative control measures, and feasible environmental measures such as promoting natural ventilation in waiting and examination rooms. Staff in supported Health facilities will be supported in data management and analysis using the MOH tools. Support will also be provided to the existing district health systems in provision in provision of support supervision, on job training and logistics for HIV/TB drugs and supplies. TB treatment and follow up using the DOTS strategy will be supported with sub county health workers facilitated to conduct support supervision to TB treatment supporters. Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported labs will participate in the National External quality assurance for sputum microscopy. Awareness among patients and communities about TB and HIV integration will be supported through dissemination of IEC materials and health promotion talks. Health workers will be trained in HIV/TB co management. Innovative approaches such as co-location of TB and HIV services will be applied.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12498	**Mechanism Name: Scaling up of Comprehensive HIV/AIDS services in Eastern Districts health facilities and the surrounding catchment areas.**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview narrative

Uganda has made significant progress towards providing care and support and ART to People Living with HIV/AIDS (PLHA). Of the estimated 1,200,000 people living with HIV/AIDS (PHA) in Uganda, the number of adults in active HIV care nationally is unknown due to gaps in reporting. By June 2009, 193,746 (60% of eligible) HIV positive clients were receiving ART nationally with adults comprising 91.5 % of recipients, and children comprising 8.5 % of recipients. An estimated 42,140 children are in urgent need of antiretroviral treatment. Over 350 service outlets are actively providing ART countrywide. The proportion of HAART eligible HIV-infected pregnant women receiving treatment is still low with only 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009.

However, the number of people in need of ART is approximately 358,000 (UNAIDS estimate using the CD4<200 cut off), implying an unmet need of more than 50%. In addition, currently, only 9% of all persons on PEPFAR supported ART are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

Of the estimated Ugandans living with HIV/AIDS about 38% (456,000) are aware of their HIV status.

(Performance Report STD/ACP 2008) In order to improve access to HIV testing, Uganda has embraced various approaches including Voluntary client -initiated counseling and testing (VCT), and Provider Initiated Counseling and Testing (PICT) for example Routine Testing in clinical settings (RCT), and Family based counseling and testing. However, access to HIV counseling and testing is still low.

As part of the comprehensive HIV prevention package which includes the provision of HIV testing and Counseling, Prevention with Positives interventions, ABC interventions, and other evidence based preventive mechanism like safe Male Medical circumcision will be adopted within the national context. The Program will promote voluntary Medical Male Circumcision in the general population (currently at 25%) with a "catch-up" strategy focusing on older adolescents and sexually active adult males with the goal of reducing incidence by 40% by 2012

Challenges for providing greater coverage of services include: limited human resources, limited access to counseling and testing, incoherent measurement of HIV care and treatment outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems. Additional challenges arise from poor coordination of service provision resulting in several partners at health facilities. This has resulted in several supply chains, uncoordinated quantification of drugs, and gross inefficiencies in service provision and reporting.

The objectives of this program include but are not limited to:

1. Supporting the provision of comprehensive HIV care and treatment with increase in coverage and scope of existing HIV/AIDS services for PHAs and their families. Services include HIV Counseling and testing, adult and pediatric basic palliative care and support, PMTCT, ART, TB/HIV. The program will also focus on strengthening linkages between HIV prevention, care, treatment and support services in response to existing gaps and minimize overlaps and duplication of services and reporting.

2. Secondly, the program will support Health Systems Strengthening efforts to promote effective integration of HIV/AIDS services at facilities and surrounding communities. Areas to be supported shall include monitoring and evaluation (M&E), laboratory, infrastructure /space, staff capacity in terms of training and routine supportive supervision, and procurement of logistics and commodity supplies to enhance the delivery of comprehensive HIV/AIDS services. The program will work with the District Health Office to support recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. This will ensure sustainability of this program and avoid parallel service systems, with eventual absorption of such staff onto the government payroll.

3. The third objective is to strengthen program monitoring and evaluation through support of health

facilities to utilize the national Health Management Information System (HMIS) to produce timely reports, and ensure these reports are channeled along the Government of Uganda information flow system; aligned with goals and outcomes of CDC/Global AIDS Program and PEPFAR and use HIV/AIDS service data for ongoing improvement of program performance.

In all these activities the program will work in close collaboration with the MOH, district health management, and other providers to ensure improved coordination and leveraging of available resources.

This program, Comprehensive Eastern-Scaling up comprehensive HIV/AIDS services in Eastern districts' health facilities and the surrounding catchment areas covers the Eastern Uganda districts of Amuria, Katakwi, Kaberamaido, Soroti, Kumi, Mbale and Tororo. This program will build on progress made so far with over 10,000 patients being supported under PEPFAR in these districts. By March 2009 10,942 HIV-positive clients had been identified and linked to supported health facilities (District hospitals and HC IVs). These patients will continue to be supported with cotrimoxazole prophylaxis basic care kits and other care and support. The program will also support capacity building efforts through training and strengthening logistics systems and the referral system for HIV-positive persons. The program will ensure coordinated and cost efficient comprehensive service provision in support of the national health systems
Working through the District Health Offices (DHO's) the program will support the strengthening of comprehensive HIV/AIDS services in the existing District Hospitals and Health Center IVs and IIIs. This program will work to strengthen existing HIV/AIDS services to make them more comprehensive in scope and coverage care.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12498**
Mechanism Name:	**Scaling up of Comprehensive HIV/AIDS services in Eastern Districts**
Prime Partner Name:	**health facilities and the surrounding catchment areas.**

	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

Adult Care and support

The program will support districts hospitals and health centers IV and III to implement a basic care and support package for patients. It will assist them to provide comprehensive adult HIV care and treatment services, including outreach services to lower level health facilities (HC III) as appropriate and this will include; the provision of basic care packages to an existing pool of more than 20,000 clients in care. Other support services will include OI diagnosis and treatment including STI diagnosis and management in additional to the traditional care and support that includes OI prevention with prophylaxis, TB screening and treatment, routine assessment for ART eligibility, psychosocial support and prevention with positives interventions

Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will implement strategies to promote adherence to cotrimoxazole and use of the basic care package to delay progression to AIDS and the need for ART. Services will also be scaled up to other facilities and eligible clients as appropriate.

Major activities for this program will include:
1. Increasing access to HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related care services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the KCC health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of health facilities that offer HIV care
2. Number of health care providers trained in facility and/or community HIV care
3. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
4. Percent of adults and children with HIV known to be in active care at follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

OVC

The goal of the National Orphans and other vulnerable children policy is to provide a framework for the enjoyment of rights and fulfillment of responsibilities of the orphans and other vulnerable children; to ensure that the legal, policy, and institutional framework for child protection is developed and strengthened at all levels; to establish linkages between public and private not for profit health facilities Civil Society Organizations (CSOs) and Community based Organizations (CBOs); to promote sustainable livelihood interventions, income generation, economic strengthening and /or microfinance activities; to develop participatory community dialogues and facilitated problem solving about OVC issues.

Challenges of the OVC response in Uganda include weak co-ordination mechanisms at both national and local government levels; inadequate OVC management information systems at national and district levels; limited monitoring of quality of care in OVC programs; and high demand for services.

This program will address the needs of the identified Orphans and Vulnerable children as appropriate to age and gender including Care and Support, Education, psychosocial support, Food security, Economic strengthening, Basic health, Child protection and Legal support. The program will develop a census based approach to achieve access to these services to all segments of the vulnerable communities through collaboration with community development officers and related (CBOs) and CSOs, and use collected data to inform program strategies and activities.

The program will build on the already achieved successes of offering the needed OVC services within the existing programs and increasing referral to other OVC providers who are mapped out within the Eastern Districts.

The target population will include all the Orphans and Vulnerable children including those affected and infected with HIV, street children, children under extreme labor conditions, and other forms of child

abuse: physical, sexual, neglect among others and those in need of legal protection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

This program will support health facilities within the program districts to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility and adherence support. Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will ensure that the existing pool of 10,000 patients currently receiving HAART in this region continue to be supported with quality care and follow up.

The program will ensure regular CD4 monitoring for all patients on ART and those not yet on HAART. The program will ensure regular up dating of health workers knowledge through re-fresher trainings and continuing medical education sessions. Continuous evaluation of programs will be continued with quality improvement teams to be supported in all the implementing sites. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites. Performance based financing programs that are both equitable and encouraging will be encouraged. For those on ART, the program will implement strategies to promote adherence to ART to minimize the likelihood of developing ARV drug resistance.

Major activities for this program will include:
1. Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for

PEPFAR;
1. Number of health facilities that offer HIV care and/or ART
2. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
3. Increase the total number of patients currently receiving ART at each health facility/site
4. Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therap

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The program will work with implementing health facilities to offer Provider Initiated HIV Testing and Counselling (PITC) in all units including OPD and inpatient wards, Couple testing, Early Infant Diagnosis for all HIV exposed infants, and HCT for household members of index clients (through selective home based programs, health visitors, or outreach programs). The HCT program will establish Quality Assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines. They will conduct effective repeat HIV testing and reporting to minimize wastage of resources and double counting. The program will also establish and monitor active and effective linkage to care and treatment for all HIV-infected clients identified through PITC activities.
Existing community structures including VHTs, PHA networks, and others, will be utilized to mobilize communities to access HIV/AIDS services and follow-up of HIV-infected individuals to ensure that they receive appropriate care, treatment, and support services. The program will establish quality assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines.

This program will focus on the following activities;
1. Expand access to HIV counseling and testing through a variety of collaborative facility and community testing and counseling services
2. Provide couple counseling and testing, and ensure that persons testing HIV positive and discordant couples are provided with support and care, and facilitated disclosure
3. Integrate HIV prevention within HCT and establish clear linkages to ensure adequate referrals and follow-up services

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of service outlets providing testing and counseling services

2. Number of individuals who received counseling and testing services for HIV and received their test results: by sex, age, CT type and test results
3. Number of people living with HIV/AIDS (PHAs) reached with a minimum package of prevention with positives (PWP) interventions
4. The number of clients and family members receiving counseling and testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

Pediatric care and support

The Eatern districts currently provide care for about 1300 children below 15 years.This is still below the national target of atleast 15 percent of clients in care being below 15 years.
Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, inadequate sexual and reproductive health services for HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within these districts to implement a comprehensive pediatric HIV care and treatment services program including, timely HIV diagnosis among children, provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

This program will continue to support identification of children and linking them into care from the MCH, OPD and pediatric departments. Integration of these services will be a core focus area for this program with the aim of increasing the number of children in care to about 15 percent of the total in care. The program will endeavor to create child friendly clinics at the health facilities and also address the special adolescent sexual and reproductive health needs through a program focusing on this age group.
Providers will receive pediatric HIV counseling skills training to have at least one pediatric counselor at all the supported health facilities. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, enhance adherence and reduce loss to follow up.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis
4. Integrating HIV prevention initiatives within HIV care and treatment with a focus on adolescent sexuality issues
5. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV commodities
6. Strengthening data management

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
• Number of facilities that offer pediatric HIV care and support
• Number of health care providers trained in facility and/or community HIV care
• Number of children with advanced HIV infection in care / on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

In Uganda, an estimated 42,140 children are in urgent need of antiretroviral treatment. Without ART, 50% of HIV infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). By June 2009, approximately 16,495 children (39% of eligible) were on ART representing 8.5% of the national total of 193, 746 with a male to female ratio of 1:1.

Only a few of the health facilities in the Eastern Districts provide pediatric care and treatment. Currently about 1,300 children below 17 years are accessing care but figures of those accessing ART are unavailable.The Eastern comprehensive program will provide support to the existing pool of about 1300 pediatric patients with ART treatment services like CD4 monitoring and Viral Load measurements/DNA PCR. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for staff in pediatric ART. Peer support networks for children on HAART will be supported to reduce stigma and enhance adherence. ARVs for pediatrics will continue to flow through the MOH and Global fund mechanism. Pediatric treatment:

Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities to implement a comprehensive pediatric HIV treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility and adherence support.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

The abstinence and Be faithful program will specifically focus on youth out of school less than 14 years and clients 15-49 who test as a couple. This will comprise the only prevention messaging to children below 15 as these are largely not yet sexually active. This will have the aim of primary prevention of HIV in this population. The focus will be youth out of school and those in casual employment like boda boda cyclers as these are not reached by the school program. Special emphasis will be put on the females as the have higher HIV pravalence compared to their male peers. Couples will be specifically targeted because most new infections are occuring among married people. The specific messaging will aim at reducing concurrent relationships with multiple partners promoting zero grazing. For patients below 15 years who are sexually active further prevention messaging with strategies like condom use will be provided. This will also be the same for discordant couples. AB prevention activities will be monitored and evaluated through the overall monitoring and evaluation frame work of the program through the

prevention focal persons at the district health office.Abstinence and Be Faithful (AB)

The abstinence and Be faithful (AB) program will specifically focus on youth out of school less than 15 years and clients aged 15-49 years who test as a couple. This will comprise the only prevention messaging to children below 15 as these are largely not yet sexually active.

The major aim of this program component is primary prevention of HIV in this population. The focus will be youth out of school and those in casual employment like 'boda boda' (motor) cyclists as these are not reached by the school program implemented by the Uganda Ministry of Education and Sports, also called the PIASCY program or President Initiative AIDS Strategy Communication for Youth.. Special emphasis will be put on the females as they have higher HIV prevalence compared to their male peers. Couples will be specifically targeted because majority of new infections in Uganda are occurring among married people in discordant relationships. The specific messaging will aim at reducing concurrent relationships with multiple partners promoting zero grazing.

For clients below 15 years of age who are sexually active, further prevention messaging with strategies like condom use will be provided. This will also be the same for couples that are discordant for HIV.

AB prevention activities will be monitored and evaluated through the overall monitoring and evaluation framework of the program through the HIV prevention focal persons at the district health office.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

In the districts of Amuria, Katakwi, Kaberamaido, Soroti, Kumi, Mbale and Tororo and the surrounding communities, this program will support health facilities to implement a basic preventive care package for patients, offer counseling and effective referral for medical male circumcision (MMC) when appropriate, supported disclosure of HIV status to spouses and selected family members. Support will be provided to health facilities within the district hospitals and health centers IV and III to provide MMC or condoms using existing nationally approved training materials to ensure that effective prevention programs are instituted for all HIV-infected individuals including discordant couples with a comprehensive prevention program that combines MMC, condom use and Abstinence Be Faithful initiatives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

TB remains a major challenge in Uganda contributing to significant morbidity and mortality. The estimated TB incidence of all forms of TB is 330 new cases per 100,000 pop/ year with an incidence of 128 new cases per 100,000 pop /year among HIV positive persons. Over 39% of all incident TB cases are HIV positive. Prevalence of all forms of TB is 426 cases per 100,000 population. Mortality is 93 deaths per 100,000 pop /year. The estimated Multidrug resistant -TB (MDR-TB) rate among all new TB cases is 0.5%. (Global Tuberculosis control WHO report 2009). The Uganda TB control indicators remain below target despite implementation of DOTS throughout the country. Treatment success rate is 74% against a target of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. The TB Case Detection Rate is 57% versus the target of 70%.

This program will promote integration of TB and HIV through the following activities:
1. Provide intensified case finding among clients in HIV care and treatment ensuring 100% of them are screened for TB;
2. Institute TB Infection Control measures in health facilities;
3. Support provider-initiated counseling and testing in TB clinics and wards;
4. Enhance cross referral and linkages between HIV and TB clinics;
5. Strengthen HIV Care and treatment for TB patients through provision of OI prophylaxis such as cotrimoxazole, regular assessment for ART eligibility, and provision of ART for those eligible according to national treatment guidelines;
6. Promote directly observed treatment (DOTS) for TB HIV co- infected patients.

The program will provide TB screening for HIV positive clients in care and treatment at each visit; offer HIV Counseling and testing to all TB patients, and those found to be HIV positive will be linked to HIV care and treatment. TB treatment and follow up using the DOTS strategy will be supported with sub county health workers facilitated to conduct support supervision to TB treatment supporters.

Health facility staff will be trained in TB Infection control, and facilitated to conduct risk assessment of health facilities, develop and implement TB infection control measures such as promoting natural ventilation in waiting and examination rooms. Health workers will be trained in HIV/TB co-management. Innovative approaches such as co-location of TB and HIV services will be applied.

Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported labs will participate in the National External Quality Assurance for sputum microscopy. Staff in supported Health facilities will be supported in data management and analysis using the existing Ministry of Health (MOH) tools.

Measurable outcomes of the program will be in alignment with the following performance goals for

PEPFAR • Number of service outlets providing treatment for TB to HIV-infected individuals in a palliative care setting • Percent of TB patients who had an HIV test result recorded in the TB register • Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings • Percent of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12499	**Mechanism Name: Scaling up of Comprehensive HIV/AIDS Services in Kampala City Council including its five divisions and their health facilities (10 KCC clinics)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview narrative

Uganda has made significant progress towards providing care and support and ART to People Living with HIV/AIDS (PLHA). Of the estimated 1,200,000 people living with HIV/AIDS (PHA) in Uganda, the number

of adults in active HIV care nationally is unknown due to gaps in reporting. By June 2009, 193,746 (60% of eligible) HIV positive clients were receiving ART nationally with adults comprising 91.5 % of recipients, and children comprising 8.5 % of recipients. An estimated 42,140 children are in urgent need of antiretroviral treatment. Over 350 service outlets are actively providing ART countrywide. The proportion of HAART eligible HIV-infected pregnant women receiving treatment is still low with only 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009.

However, the number of people in need of ART is approximately 358,000 (UNAIDS estimate using the CD4<200 cut off), implying an unmet need of more than 50%. In addition, currently, only 9% of all persons on PEPFAR supported ART are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

Of the estimated Ugandans living with HIV/AIDS about 38% (456,000) are aware of their HIV status. (Performance Report STD/ACP 2008) In order to improve access to HIV testing, Uganda has embraced various approaches including Voluntary client -initiated counseling and testing (VCT), and Provider Initiated Counseling and Testing (PICT) for example Routine Testing in clinical settings (RCT), and Family based counseling and testing. However, access to HIV counseling and testing is still low.

As part of the comprehensive HIV prevention package which includes the provision of HIV testing and Counseling, Prevention with Positives interventions, ABC interventions, and other evidence based preventive mechanism like safe Male Medical circumcision will be adopted within the national context. The Program will promote voluntary Medical Male Circumcision in the general population (currently at 25%) with a "catch-up" strategy focusing on older adolescents and sexually active adult males with the goal of reducing incidence by 40% by 2012

Challenges for providing greater coverage of services include: limited human resources, limited access to counseling and testing, incoherent measurement of HIV care and treatment outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems. Additional challenges arise from poor coordination of service provision resulting in several partners at health facilities. This has resulted in several supply chains, uncoordinated quantification of drugs, and gross inefficiencies in service provision and reporting.

Since 2005, KCC has been receiving support from PEPFAR to implement HIV prevention, care, treatment and support initiatives such as HIV counseling and testing, (HCT), palliative care for adults and children, antiretroviral therapy for adults and children, laboratory infrastructure strengthening, Prevention of Mother To Child Transmission (PMTCT), and OVC. The scale-up of services within KCC was supported through

several implementing partners such as Mulago-Mbarara Joint AIDS Program (MJAP), Infectious Diseases Institute (IDI), Protecting Families Against AIDS (PREFA), Baylor College of Medicine Children's Foundation –Uganda (Baylor-Uganda) –PIDC, AIDS Information Center (AIC), and TB-CAP among others.

Some of the challenges encountered include poor coordination of the various services with duplication and overlap in reporting, and quantification of required supplies especially drugs and test kits. Linkages between the various services are weak with a number of missed opportunities and inefficiencies. There is a lack of ownership by the KCC leadership with inadequate integration of the HIV services into health existing systems with no clear sustainability, or exit plans.

Making the program more comprehensive in scope and coverage is an endeavor to address the above challenges. The program will ensure coordinated and cost efficient comprehensive service provision in support of the national health systems.
The Kampala City Council (KCC) Comprehensive HIV services program will cover public and private not for profit health facilities in its five divisions of Central, Kawempe, Makindye, Rubaga, and Nakawa. Together these divisions have an estimated total population of 3,077,200 people and with a regional HIV sero-prevalence of 8.5%, about 276,948 people are expected to be HIV infected. Currently about 38% of the population know their HIV status therefore about 105,240 people may be seeking care and treatment services in this region.

Approximately 80% of this population may be already seeking care and treatment in the Kampala hospitals; leaving an HIV care burden of 20% (21,048) to the KCC clinics. The total number of health services outlets planned to have chronic care units within the KCC sub-region are about 30 comprising mainly of HC IVs and HC IIIs. The NGO hospitals found in this region will not be part of the scope of this program, being covered by other programs. The comprehensive HIV services will include care and treatment services to an existing pool of more than 10,652 clients in care and 4,020 on ART.
This program will work with the district health management of KCC to ensure coordinated and cost-efficient comprehensive HIV care service provision in support of the national health systems.

The objectives of this program include but are not limited to:

1. Supporting the provision of comprehensive HIV care and treatment with increase in coverage and scope of existing HIV/AIDS services for PHAs and their families. Services include HIV Counseling and testing, adult and pediatric basic palliative care and support, PMTCT, ART, TB/HIV. The program will also focus on strengthening linkages between HIV prevention, care, treatment and support services in response to existing gaps and minimize overlaps and duplication of services and reporting.

2. Secondly, the program will support Health Systems Strengthening efforts to promote effective integration of HIV/AIDS services at facilities and surrounding communities. Areas to be supported shall include monitoring and evaluation (M&E), laboratory, infrastructure /space, staff capacity in terms of training and routine supportive supervision, and procurement of logistics and commodity supplies to enhance the delivery of comprehensive HIV/AIDS services. The program will work with the District Health Office to support recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. This will ensure sustainability of this program and avoid parallel service systems, with eventual absorption of such staff onto the government payroll.

3. The third objective is to strengthen program monitoring and evaluation through support of health facilities to utilize the national Health Management Information System (HMIS) to produce timely reports, and ensure these reports are channeled along the Government of Uganda information flow system; aligned with goals and outcomes of CDC/Global AIDS Program and PEPFAR and use HIV/AIDS service data for ongoing improvement of program performance.

In all these activities the program will work in close collaboration with the MOH, district health management, and other providers to ensure improved coordination and leveraging of available resources.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12499**
Mechanism Name:	**Scaling up of Comprehensive HIV/AIDS Services in Kampala City Council including its five divisions and their health facilities (10 KCC clinics)**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	Redacted	Redacted

Narrative:

Adult Care and support

Kampala City Council (KCC) has an estimated population of 3.1 million, and an HIV prevalence of 8.5% in the five divisions of Kawempe, Makindye, Rubaga, Nakawa, and Kampala Central. With a regional HIV sero-prevalence of 8.5%, about 276,948 people are expected to be HIV infected. Currently about 38% of the population know their HIV status therefore about 105,240 people may be seeking care and treatment services in this region.

This program will support health facilities within Kampala City Council (KCC) to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility and prevention with positives interventions.

Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will implement strategies to promote adherence to cotrimoxazole and use of the basic care package to delay progression to AIDS and the need for ART. Care and treatment services within KCC will be provided to an existing pool of 10,000 clients in active care and about 4,000 of whom are currently on ART. Services will also be scaled up to other facilities and eligible clients.

Major activities for this program will include:
1. Increasing access to HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related care services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the KCC health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for

PEPFAR;
1. Number of health facilities that offer HIV care
2. Number of health care providers trained in facility and/or community HIV care
3. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
4. Percent of adults and children with HIV known to be in active care at follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

Adult Treatment

This program will support health facilities within Kampala City Council (KCC) to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will ensure that these patients continue to be supported with quality care and follow up.

The program will ensure regular CD4 monitoring for all patients on ART and those not yet on HAART. The program will ensure regular up dating of health workers knowledge through re-fresher trainings and continuing medical education sessions. Continuous evaluation of programs will be continued with quality improvement teams to be supported in all the implementing sites. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites. Performance based financing programs that are both equitable and encouraging will be encouraged. For those on ART, the program will implement strategies to promote adherence to ART to minimize the likelihood of developing ARV drug resistance.

Care and treatment services within KCC will be provided to an existing pool of over 10,000 clients in active care of which over 4,000 are currently on ART at 8 facilities. Services will also be scaled up to other health facilities and eligible clients.

Major activities for this program will include:
1. Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services

3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of health facilities that offer HIV care and/or ART
2. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
3. Increase the total number of patients currently receiving ART at each health facility/site
4. Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

HIV Counseling and Testing (HCT)

Kampala City Council (KCC) has an estimated population of 3.1 million, and an HIV prevalence of 8.5%. KCC comprises of five divisions of Kawempe, Makindye, Rubaga, Nakawa, and Kampala Central. There are several health facilities under the municipal council both private and public. An estimated 50% of the population is aged 15 years and below.

The program will work with health facilities to offer PITC in all units including OPD and inpatient wards, Couple testing, Early Infant Diagnosis for all HIV exposed infants, and HCT for household members of index clients (through selective home based programs, health visitors, or outreach programs). The program will establish quality assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines.

This program will focus on the following activities;
1. Expand access to HIV counseling and testing through a variety of collaborative facility and community

testing and counseling services
2. Provide couple counseling and testing, and ensure that persons testing HIV positive and discordant couples are provided with support and care, and facilitated disclosure
3. Integrate HIV prevention within HCT and establish clear linkages to ensure adequate referrals and follow-up services

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of service outlets providing testing and counseling services
2. Number of individuals who received counseling and testing services for HIV and received their test results: by sex, age, CT type and test results
3. Number of people living with HIV/AIDS (PHAs) reached with a minimum package of prevention with positives (PWP) interventions
4. The number of clients and family members receiving counseling and testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

Pediatric care and support

Of the estimated Kampala population of 3.1 million, about 50% of the population is aged 15 years and below. Currently about 2,000 children below 17 years are accessing care through the existing 8 KCC HIV programs and about 600 children are receiving ART

Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the sub-urban areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, inadequate sexual and reproductive health services for HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within Kampala City Council (KCC) to implement a comprehensive pediatric HIV care and treatment services program including, timely HIV diagnosis among children, provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

This program will continue to support identification of children and linking them into care from the MCH, OPD and pediatric departments. Integration of these services will be a core focus area for this program with the aim of increasing the number of children in care to about 15 percent of the total in care. The program will endeavor to create child friendly clinics at the health facilities and also address the special adolescent sexual and reproductive health needs through a program focusing on this age group. Providers will receive pediatric HIV counseling skills training to have at least one pediatric counselor at all the supported health facilities. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, enhance adherence and reduce loss to follow up.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis
4. Integrating HIV prevention initiatives within HIV care and treatment with a focus on adolescent sexuality issues
5. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV commodities
6. Strengthening data management

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
• Number of facilities that offer pediatric HIV care and support
• Number of health care providers trained in facility and/or community HIV care
• Number of children with advanced HIV infection in care / on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

Pediatric treatment:

In Uganda, an estimated 42,140 children are in urgent need of antiretroviral treatment. Without ART, 50%

of HIV infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). By June 2009, approximately 16,495 children (39% of eligible) were on ART representing 8.5% of the national total of 193, 746 with a male to female ratio of 1:1.

Only a few of the health facilities under the municipal council both private and public provide pediatric care and treatment. The KCC HIV program currently provides HIV care for about 2000 children below 17 years with about 600 accessing HAART.

Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the sub-urban areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within Kampala City Council (KCC) to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

The program will provide support to the existing pool of about 600 pediatric patients with antiretroviral treatment (ART) services like CD4 monitoring and out source viral load (VL) services for those that will require VL measurements. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for staff in pediatric ART in collaboration with other partners. Peer support networks for children on HAART will be supported to reduce stigma and enhance adherence. ARV for pediatric will continue to flow through the MOH and Global fund mechanism.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted

Narrative:

TBD- Kampala City Council (KCC) Comprehensive HIV services program will cover public and private not for profit health facilities in five divisions of Central, Kawempe, Makindye, Rubaga, and Nakawa. Together these divisions have an estimated total population of 3,077,200 people and with a regional HIV sero-prevalence of 8.5%. About 49% of this population is males of whom 15% are adult males. In Uganda the proportion of adult men that are circumcised is estimated at only 25%. The National Strategic Plan for HIV/AIDS has set a target to increase the proportion of circumcised adult males to 50% by 2011/12 and contribute to national goal of reducing the incidence rate by 40% by 2012.
TBD-Comprehensive HIV/AIDS program will implement MMC activities as part of the comprehensive HIV prevention package which includes the provision of HIV testing and Counseling, Prevention with Positives interventions, BCC, partner reduction and other evidence based preventive interventions according to national and international guidelines. The Program will promote voluntary Medical Male Circumcision in the general population with a "catch-up" strategy focusing on older adolescents and HIV negative sexually active adult males.
Objectives
• Support the Government of Uganda in ensuring provision of safe voluntary medical male circumcision (VMMC) services in Kampala City Council
• Implement and scale up high quality voluntary and safe male circumcision services as an added HIV prevention intervention in Kampala City Council
• Ensure that VMMC services are integrated and implemented as a package of comprehensive HIV prevention, care and treatment services.
• Provide health education on safe VMMC to communities
Funds under this budget code will be used specifically for the following activities:

• Advocacy, community sensitization/mobilization, and education to create informed demand for VMMC services
• Facilitate referrals and linkages of VMMC services to other HIV/AIDS prevention, care and treatment services.
• Promoting sustainability with continued, high-quality, evidence-based interventions
• Training of health service providers including medical officers, clinical officers, nurses, surgical assistants, counselors and support staffs in hospitals, HC IVs according to national and international guidelines
• MMC service delivery Provision of circumcision to 3,000 men through 3 sites and train 15 service providers in Kampala City Council

• Providing MMC information to women (spouses) and use MMC activities as an opportunity to address gender norms such as polygamy, multiple sexual partners and early marriages
• Supporting the development of long-term sustainable and integrated VMMC capacity in health facilities within the targeted districts, including capacity for provision of neo-natal and pediatric MC services in PMTCT and MCH settings in line with national policy/guidelines.
• Improving the capacity of health facilities and health service providers to be able to avail services for medical male
• REDACTED.
• Procure and keep track of the necessary supplies
• Conduct post operative follow up for ~90% of the circumcised men
• Monitoring adverse event rates

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Abstinence and Be Faithful (AB)
Kampala City Council (KCC) has an estimated population of 3.1 million and 50% of this population is aged 15 years and below. The abstinence and Be faithful (AB) will be coordinated by the KCC District Health Office and implemented in collaboration with the divisional health office and health Centers. The program will specifically focus preventing HIV among out of school youth and adult in the general population especially the large pool of patients and care takers visiting the health centers and their caretakers, health facility staff including causal laborers and their family members, and communities in the surrounding communities. Through this support, AB activities will be integrated in the comprehensive HIV prevention plans for the district and technical assistance will be provided to design and implement targeted BBC messages for the various interest groups including; boda boda riders, discordant couples, family members of patients in care, staff and their family members. In addition, the program wills linkages and referral to other technical areas to ensure integration and delivery of comprehensive prevention, care and treatment services. Monitoring and evaluation of program activities will be supported by strengthening existing structures

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

Other Prevention
Kampala City Council (KCC) has an estimated population of 3.1 million and 50% of this population is aged 15 years and below. The Other Sexual Prevention (OP) program will focus on providing IEC for

basic preventive care to; people living with HIV including discordant couples, high risk groups, care takers of patients, health facility staff and the family members, and the general population in the surrounding communities. The program will promote knowledge of family planning including condom use, STI prevention and management in the general population and strengthen integration of sexual reproductive services in the prevention, care and treatment services for people living with HIV/AIDS. In addition, the program will support divisional health offices to establish functional post test clubs and discordant couples in their respective area. The program will leverage resources from other technical areas to offer comprehensive and integrated HIV prevention, care and treatment services. Technical assistance will be extended to the KCC and its division offices to strengthen programming, monitoring and evaluation HIV/AIDS activities through existing structures..

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

Laboratory Infrastructure

The program will focus on scaling up and strengthening laboratory activities that support HIV services' delivery in accordance with the Uganda national laboratory policies and guidelines. The scope of the laboratory support will address services such as HIV testing for infants, adults and children, diagnosis of opportunistic and other common infections, assessment for antiretroviral therapy eligibility for clients in active HIV care, and monitoring of response to treatment for clients on ART. Some of the program areas that require specific laboratory support include HIV counseling and testing (HCT), Prevention of Mother To Child Transmission (PMTCT), Biomedical HIV prevention, Adult Care and Support, Pediatric Care and Support, Adult treatment, and Pediatric Treatment. The program will strengthen linkages between the laboratory and the various services.

The existing clinics in Kampala City council (KCC) have some laboratory capacity that will need to be supported with staff or kits for HIV/AIDS diagnosis and monitoring. The program will work with other laboratory stakeholders through the district laboratory focal persons to improve laboratory functions at the facilities. The aim will be to have laboratories performing the expected range of diagnostics tests for their level to support service delivery.

The major activities to be supported will focus on but not be limited to;

1. Developing and strengthening laboratory facilities in accordance with MOH laboratory strategic policies and plan to support HIV/AIDS-related activities including the purchase of equipment through competitive

procurement
2. Provision of quality assurance, staff training and other technical assistance
3. Supporting policies based on national and international best practices, training, waste-management systems, advocacy and other activities to promote medical injection safety, including establishing a distribution/supply chain, and the safe and appropriate disposal of injection equipment and other related equipment and supplies.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests as specified in MOH guidelines
2. Number of testing facilities (laboratories) that are accredited according to national or international standards

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

ARV drugs

This program will procure ARV drugs for an existing pool of at least 4,000 clients currently on treatment at the 8 facilities in Kampala City Council. The program will also support facilities to improve their logistics management capacity to draw down on the National credit line. Activities shall include support to the quantification of ARV drug need, procurement, and storage, dispensing, plus reporting. Working closely with the MOH, the program will help standardize ARV regimens and formulations used at ART sites and harmonize these with the national treatment guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

TB/HIV

TB remains a major challenge in Uganda contributing to significant morbidity and mortality. The estimated TB incidence of all forms of TB is 330 new cases per 100,000 pop/ year with an incidence of 128 new cases per 100,000 pop /year among HIV positive persons. Over 39% of all incident TB cases are HIV positive. Prevalence of all forms of TB is 426 cases per 100,000 population. Mortality is 93

deaths per 100,000 pop /year. The estimated Multidrug resistant -TB (MDR-TB) rate among all new TB cases is 0.5%. (Global Tuberculosis control WHO report 2009). The Uganda TB control indicators remain below target despite implementation of DOTS throughout the country. Treatment success rate is 74% against a target of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. The TB Case Detection Rate is 57% versus the target of 70%.

This program will promote integration of TB and HIV through the following activities:
1. Provide intensified case finding among clients in HIV care and treatment ensuring 100% of them are screened for TB;
2. Institute TB Infection Control measures in health facilities;
3. Support provider-initiated counseling and testing in TB clinics and wards;
4. Enhance cross referral and linkages between HIV and TB clinics;
5. Strengthen HIV Care and treatment for TB patients through provision of OI prophylaxis such as cotrimoxazole, regular assessment for ART eligibility, and provision of ART for those eligible according to national treatment guidelines;
6. Promote directly observed treatment (DOTS) for TB HIV co- infected patients.

The program will provide TB screening for HIV positive clients in care and treatment at each visit; offer HIV Counseling and testing to all TB patients, and those found to be HIV positive will be linked to HIV care and treatment. TB treatment and follow up using the DOTS strategy will be supported with sub county health workers facilitated to conduct support supervision to TB treatment supporters.

Health facility staff will be trained in TB Infection control, and facilitated to conduct risk assessment of health facilities, develop and implement TB infection control measures such as promoting natural ventilation in waiting and examination rooms. Health workers will be trained in HIV/TB co-management. Innovative approaches such as co-location of TB and HIV services will be applied.

Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported labs will participate in the National External Quality Assurance for sputum microscopy. Staff in supported Health facilities will be supported in data management and analysis using the existing Ministry of Health (MOH) tools.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR

• Number of service outlets providing treatment for TB to HIV-infected individuals in a palliative care setting

• Percent of TB patients who had an HIV test result recorded in the TB register • Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings • Percent of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12500	**Mechanism Name: Scaling up of comprehensive HIV/AIDS services in West Nile districts' health facilities and the surrounding catchment areas.**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) know their HIV status. At least 135,000 new HIV infections occur in Uganda each year of these 80% are adults. Currently, the number of PHA accessing care and antiretroviral treatment (ART) nationally is estimated at 357,108 and 193,746 (60% of eligible) respectively; with adults comprising 91.5 % of recipients at 350 facilities countrywide. However, the number of people in need of ART is approximately 358,000 implying an unmet need of more than 50% (UNAIDS). Of the estimated 42,140 children in urgent need of antiretroviral treatment, only 39% are receiving it as compared to 63% of eligible adults. In relation to TB/ HIV, over 39% of all incident TB cases are HIV positive. According to the Uganda National TB Program report, the treatment success rate is 74% against a target of 85%, and the TB Case Detection Rate is

57% versus the target of 70%. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV care and treatment services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and treatment services nationally, only about 60% of the need is being met. There are several challenges encountered in the delivery of HIV/AIDS services. These include high demand for services, weak health infrastructure (human resource, monitoring and evaluation, laboratory systems, logistics management systems) and poor coordination and linkages among providers, with resultant duplication in reporting, and inequitable access to services.

This mechanism is comprehensive in scope and coverage in an effort to address the above challenges. The program will ensure coordinated and cost efficient comprehensive HIV/AIDS service provision in support of the national and district health systems. Support will be provided for comprehensive HIV prevention, care, support and treatment services in public and private not for profit health facilities in 7 districts in the West Nile region of Uganda, namely Arua, Moyo, Adjumai, Maracha, Koboko, Yumbe and Nebbi. These districts have an estimated total population of 2,543,900 people, with a regional HIV sero prevalence of 2.3%; about 58,510 are estimated to be HIV infected. Currently about 20% of the population know their HIV status, therefore potentially about 11,702 PHA will seek HIV/AIDS care and treatment services in this region. The total number of health service facilities planned to have HIV/AIDS services are 140, ranging from district hospitals to HC IIIs. The regional hospitals found will not be included in this mechanism as they are being covered by other programs.

The objectives of this mechanism are to support: Comprehensive HIV/AIDS care and treatment including: increase of coverage, scope of HIV/AIDS services for PHA and their families; pediatric care and treatment services; strengthen linkages across PMTCT, OVC, care and treatment services; Respond to existing gaps and minimize overlaps and duplication of services and reporting; Support systems strengthening as follows: improve the capacity of facilities to effectively integrate HIV/AIDS services through support to M&E, laboratory, infrastructure /space; training and routine supportive supervision of healthcare workers; harmonized procurement of logistics and commodity supplies to enhance comprehensive HIV/AIDS care and treatment; and support sustainability planning at the health facility level. Furthermore, the mechanism will support human resources for health through the recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. Eventually, these staff will be absorbed onto the government pay roll to ensure sustainability of services and avoid parallel systems. The mechanism will also strengthen monitoring and evaluation through support of health facilities to utilize the Ministry of Health Management Information System (HMIS) and other MOH/ACP registers to produce timely reports and ensure these reports are channeled along the MOH information system. The mechanism M&E will align with goals and outcomes of CDC/Global AIDS Program and PEPFAR, using data for ongoing improvement of HIV/AIDS services. In all these activities the mechanism will work in close collaboration

with other providers to ensure improved coordination and leverage of resources and ensuring comprehensive care for families affected by HIV/AIDS while avoiding multiple partners at facilities and service duplication. The mechanism will be implemented in close collaboration with the MOH, district health management, and other providers to ensure improved coordination and leverage of available resources.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12500**		
Mechanism Name:	**Scaling up of comprehensive HIV/AIDS services in West Nile districts' health facilities and the surrounding catchment areas.**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. Currently, the number of PHA accessing care and support nationally is estimated at 357,108; with adults comprising 91.5 % of recipients at 350 facilities countrywide. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV/AIDS care and support services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and support services nationally, only about 60% of the need is being met. Challenges to providing greater coverage of adult care and support services include: limited human resources, limited access to HIV counseling and testing, incoherent measurement of HIV/AIDS care and support outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems.
This mechanism will support MOH, the district health services and other stakeholders to implement

comprehensive HIV/AIDS care and support services in the West Nile region using a variety of approaches. Effective and active linkages to care and support for all HIV-infected adults identified through PITC activities will be established. The coverage and scope of available HIV/AIDS services for PHA and their families under this mechanism will be increased, working with other stakeholders providing similar services in the identified geographical locations to respond to existing gaps in order to minimize overlaps and duplication of services and reporting. Implementation of comprehensive HIV/AIDS care and support activities in health facilities will support the Ministry of Health to scale up and ensure high quality of effective HIV/AIDS care services that are fully integrated into the national health system and will mainly focus on the following activities:
Use existing nationally approved training materials to ensure that effective HIV/AIDS care, support and Prevention with Positives (PWP) programs are instituted for all HIV-infected individuals and their families, including discordant couples; Support the delivery of comprehensive HIV/AIDS care and support services including; OI management, TB management, pain management, psychosocial support, PWP, nutrition management and sustainable livelihood interventions; Establish effective laboratory networks with other related programs, to ensure health facilities have adequate laboratory services for HCT, ART monitoring, TB and OI diagnosis, in line with Ministry of Health Laboratory Services policy; Support functions of the National TB Reference Laboratory including National External Quality Assurance for TB microscopy, and TB drug resistance surveillance in HIV care and treatment settings; Utilize existing community structures including village health teams (VHT) and PHA networks to mobilize communities to access HIV/AIDS services and conduct community follow up of PHA; Support health facilities to provide comprehensive reproductive health services to existing female HIV-infected clients of reproductive age, including support for family planning method use, effective ARV prophylaxis for pregnant or postpartum women and their babies, infant feeding counseling and ongoing support, cervical cancer screening, partner HCT, STI diagnosis and treatment, infant diagnosis, care and treatment and a family-centered approach; Offer counseling and effective referral for medical male circumcision when appropriate and supported disclosure.
The mechanism will also support the improvement of existing infrastructure and systems. This will include the improvement of data management and reporting to all stakeholders within the district structure; strengthening of logistics management information system and internal technical support supervision by health managers in facilities. In order to further mitigate the human resource gaps in the facilities, the program will implement in-service training for staff including task shifting and implementing a strategy for involvement of PHA in aspects of patient care and follow up.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR: Number of eligible adults and children provided with a minimum of two care services, one clinical and one non-clinical (including cotrimoxazole prophylaxis, CD4 count, OI management, TB/HIV and on-going counseling), Number of eligible adults and children provided/receiving with a minimum of

one care service; Number of PHA receiving cotrimoxazole prophylaxis; Number of PHA clinically malnourished clients who received therapeutic/ supplementary food and /or nutrition services; Proportion of sexually active female HIV clients using family planning; Number of HIV positive pregnant women newly enrolled into HIV care and support services; Number and percentage of facilities providing care and treatment integrated with PWP; Number of health facilities with operational Home Based Care services; Number of health facilities with capacity to provide a minimum palliative care package (minimum is HCT, TB diagnosis [smear] and treatment, oral morphine and cotrimoxazole prophylaxis)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

The goal of the National Orphans and other Vulnerable Children (OVC) Policy is to provide a frame work for the enjoyment of rights and fulfillment of responsibilities of the orphans and other vulnerable children; to ensure that the legal, policy, and institutional frame work for child protection is developed and strengthened at all levels; to establish linkages between public and private not for profit health facilities, civil society organizations (CSO) and community based organizations (CBO); to promote sustainable livelihood interventions, income generation, economic strengthening and /or microfinance activities; to develop participatory community dialogues and facilitate problem solving about OVC issues. Challenges of the OVC response in Uganda include weak coordination mechanisms at both national and local government levels; inadequate national and district level OVC management information systems; limited monitoring of quality of care in OVC programs especially the family centered approach; and high demand for services.

This mechanism will be implemented in facilities and communities of the West Nile districts, building on existing OVC services and improving referral systems across the mapped OVC providers in the districts. The target population will include the following OVC; children affected and infected with HIV, street children, children under extreme labor conditions and other forms of child abuse. The needs of OVC as appropriate to age and gender will be addressed, including HIV/AIDS care and support, education, psychosocial support, food security, economic strengthening, basic health care, child protection and legal support. The mechanism will support the development of a census based approach to achieve access of these services to all segments of the vulnerable communities through community development officers, relevant CBO and CSO, using collected data to inform strategies and activities. Major activities include:
1. Improve the lives of OVC and families affected by HIV/AIDS, with emphasis on strengthening communities to meet the needs of OVC affected by HIV/AIDS.
2. Identify HIV positive children through partnerships with other community providers and district structures and ensure early access to clinical care and treatment linked with quality psychosocial care

and other essential services.
3. Provide training to caregivers, equipping communities to train local leaders, members of affected families, and caregivers in meeting specific needs of OVC

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR; Number of eligible children (OVC) provided services in 3 or more OVC core program areas beyond psychosocial/spiritual support; Number of eligible children (OVC) provided services in 3 or more OVC core program areas beyond psychosocial/spiritual support; Number of eligible clients who received food and/or food security; Number of eligible clients who received food and/or other nutrition services

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

By June 2009, 193,746 (60% of eligible) persons with HIV/AIDS (PHA) were receiving ART nationally; a significant increase from 40% in June 2008. PEPFAR contributed 153,024 to the national total by March 2009. Of the PHA receiving ART, adults comprised 91.5 % of recipients at 350 service outlets are countrywide. The national target for ART is 203,000 PHA by September 2009 while that of PEPFAR is 164,397. However, the number of people in need of ART is approximately 358,000 (UNAIDS) implying an unmet need of more than 50%. Children comprise 8.5% of national ART recipients against a target of 15%. The proportion of ART eligible HIV-infected pregnant women receiving treatment is still low; 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009.

This mechanism will support the national ART program, the district health services and other stakeholders to implement HIV/AIDS treatment services in the West Nile region. Effective and active linkages to treatment for clients receiving PMTCT, care and support services will be established. Health facilities will provide adult treatment services, including community and outreach services to lower level health facilities as appropriate. The coverage and scope of available HIV/AIDS services for PHA and their families under this mechanism will be increased, working with other stakeholders providing similar services in the identified geographical locations to respond to existing gaps in order to minimize overlaps and duplication of services and reporting.

Implementation of HIV/AIDS treatment activities in health facilities will support the Ministry of Health, to scale up and ensure high quality of effective HIV/AIDS treatment that are fully integrated into the national health system and will mainly focus on the following activities: Expand the number of health care facilities/sites providing ART to PHA and their families; Provide ART to current recipient PHA and increase the number of PHA newly initiating ART at supported health care facilities/sites in accordance

with PEPFAR and National guidelines; Increase the total number of HIV treatment sites with active monitoring, evaluation and quality improvement programs; Ensure the availability of post exposure prophylaxis services for occupational and non-occupational exposure; Establish a logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ART and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

The mechanism will reinforce adherence counseling and support and follow up of ART patients through current adherence support mechanisms at all clinics and in the community. As a quality improvement strategy, stable PHA on ART may be attended to at pharmacy-only and nurse-only visits. Routine ART monitoring tests and related activities will be conducted including CD4 cell count for both pre-ART and ART PHA, hematology, blood chemistries, TB screening, prevention with positives counseling, support for couples including HIV testing for partners and family members.

The program will provide comprehensive HIV/AIDS care and treatment for families including children in collaboration with other providers where applicable. HIV positive pregnant women will be evaluated for ART eligibility and provided with ART in accordance with the national PMTCT guidelines. HIV/AIDS care and support services will be provided to complement the ART and where necessary, referrals made for specialized care. The clinic based activities will be further supported by community initiatives and home based care to conduct follow up visits to PHA, support disclosure, trace treatment defaulters, provide support on home care for PHA, counsel and test family members and refer those identified HIV positive to the clinics for further care.

This mechanism will support the procurement of first and second line adult ARV drugs in accordance with the Uganda national policies and guidelines. Funding will support various stages of the ARV drug procurement and distribution cycle, in collaboration with other HIV/AIDS treatment providers, MOH Medicines and Supplies Department, MOH- AIDS Control Program, National Medical Stores, Joint Medical Stores and Medical Access. The mechanism will also support the improvement of existing infrastructure and health systems. This will include the improvement of data management and reporting to all stakeholders within the district structure; strengthening of logistics management information system and internal technical support supervision by health managers in the supported facilities. In order to further mitigate the human resource gaps in the facilities, the program will implement in-service training for staff including task shifting and implementing a strategy for greater involvement of PHA in aspects of service provision.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR; Number of adults with advanced HIV infection newly enrolled on ART; Number Pregnant

women with advanced HIV infection newly enrolled on ART; Number of adults with advanced HIV infection receiving antiretroviral therapy (ART); Number of adults with HIV known to be on treatment 12 months after initiation of antiretroviral therapy; Percent of adults with HIV known to be on treatment 12 months after initiation of antiretroviral therapy; Number of naïve adults with advanced HIV-infection who ever started on ART (excludes all transfer-in clientele); Percent of adults with advanced HIV infection receiving antiretroviral therapy; Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. At least 135,000 new HIV infections occur in Uganda each year; of these 80% are adults.

This mechanism will implement HCT activities in support of the Ministry of Health, district health services and other stakeholders to scale up high quality and effective HCT services that are fully integrated into the national health system and will mainly focus on the following activities:

1. Expand access to HIV counseling and testing through a variety of collaborative community testing and counseling services; Provider initiated testing and counseling (PITC) in facility units including outpatient departments and inpatient wards; HCT for household members of index clients (through selected home based programs, health visitors, or outreach programs); Early Infant Diagnosis for all HIV exposed infants

2. Provide couple and family based counseling and testing; and ensure that identified HIV positive persons and discordant couples are provided with support, facilitated disclosure and appropriately referred for HIV care and treatment

3. Provide services that should include provision of appropriate prevention messages, and clear linkages should be established to ensure adequate referrals and follow-up services.

This mechanism will support partnership with Uganda Virus Research Institute to establish quality assurance systems for HIV counseling and testing at all levels of care in line with Ministry of Health guidelines. Effective repeat HIV testing and reporting will be conducted to minimize wastage of resources and double counting. Additionally the mechanism will establish and monitor active and effective linkages to HIV care and treatment services for all HIV-infected clients identified through HCT activities.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR: Number of Service outlets providing Testing and Counseling (T&C) services; Number of

individuals who received counseling and testing services for HIV and received their test results; Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results; Number of clients and family members receiving counseling and testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

It is estimated that 1,200,000 Ugandans are living with HIV/AIDS and about 38% (456,000) have tested and know their HIV status. Currently, the number of PHA accessing care and support nationally is estimated at 357,108; with adults comprising 91.5 % of recipients at 350 facilities countrywide. With the introduction of various models to scale up HIV counseling and testing; the number of PHA identified and therefore need to access HIV/AIDS care and support services continues to increase. Although efforts have been made by the Ministry of Health (MOH), PEPFAR and other stakeholders to scale up HIV/AIDS care and support services nationally, only about 60% of the need is being met. Challenges to providing greater coverage of general HIV/AIDS care and support services include: limited human resources, limited access to HIV counseling and testing, incoherent measurement of HIV/AIDS care and support outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems. In addition, challenges specific to pediatric care and support include; limited access to pediatric care and support due to inadequate community education and mobilization for pediatric services, inadequate commodity supplies for pediatric care and support, limited coverage of Early Infant Diagnosis (EID), only at 16%, continued MTCT estimated at about 15%, challenges of providing sexual and reproductive needs for adolescents, inadequate linkages between PMTCT and ART programs, pediatric and PMTCT programs as well as pediatric and OVC programs.

This mechanism will support MOH, the district health services and other stakeholders to implement comprehensive pediatric HIV/AIDS care and support services in the West Nile region. Support will be provided for the identification of HIV exposed and infected children and linking them to care from the family based counseling and testing services, maternal and child health clinics, out-patient and pediatric departments. This will be a core focus area for the mechanism with the aim of increasing the number of children provided care and support to about 15% of the PHA in HIV/AIDS care. The mechanism will support the creation of child friendly clinics at health facilities and also address the special adolescent sexual and reproductive health needs through interventions focusing on this age group. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, and minimize loss to follow up. Health workers will receive training in pediatric HIV counseling skills to have at least one pediatric counselor at all the supported health facilities.

The coverage and scope of available HIV/AIDS services for children with HIV/AIDS and their families under this mechanism will be increased, working with other stakeholders providing similar services in the identified geographical locations to respond to existing gaps in order to minimize overlaps and duplication of services and reporting
Implementation of comprehensive pediatric HIV/AIDS care and support activities in health facilities will support the Ministry of Health, to scale up and ensure high quality of effective HIV/AIDS care services that are fully integrated into the national health system and will mainly focus on the following activities: Use existing nationally approved training materials to ensure that effective care and support and Prevention with Positives (PWP) programs are instituted for children with HIV/AIDS and their families; Scale up pediatric care services by strengthening effective linkages with PMTCT, EPI, Pediatric HIV/AIDS care and OVC services for proper management of infected/affected children especially those under one year in accordance with Ugandan MOH and WHO ART guidelines; Support the delivery of comprehensive pediatric HIV/AIDS care and support services including; OI management, TB management, pain management, psychosocial support, PWP, nutrition management and sustainable livelihood interventions; Establish effective laboratory networks with other related programs to ensure health facilities have adequate laboratory services for HCT, ART monitoring, TB/HIV and OI diagnosis, in line with Ministry of Health Laboratory Services policy; Support functions of the National TB Reference Laboratory including National External Quality Assurance for TB microscopy, and TB drug resistance surveillance in HIV care and treatment settings; Utilize existing community structures including village health teams (VHT) and PHA networks to mobilize communities to access HIV/AIDS pediatric services and conduct community follow-up of children with HIV/AIDS and their families to ensure that they receive appropriate care and support services; and Support health facilities to provide comprehensive services including effective ARV prophylaxis for pregnant or postpartum women and their babies, infant feeding counseling and ongoing support, family based HCT, infant diagnosis, care and support using a family-centered approach.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR; Number of infants born to HIV positive women who received an HIV test within 12 months of birth; Number of infants born to HIV positive women who received an HIV test within 12 months of birth; Number of infants born to HIV positive pregnant women who are started on CTX prophylaxis within two months of birth; Overall percent of infants born to positive women who received an HIV test within 12 months of birth; Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth; Number of infants born to HIV-Positive pregnant women who are started on CTX prophylaxis within two months of birth; Percent of infants born to HIV-Positive pregnant women who are started on CTX prophylaxis within two months of birth.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDTX	Redacted	Redacted

Narrative:

By June 2009, 193,746 (60% of eligible) persons with HIV/AIDS (PHA) were receiving ART nationally; a significant increase from 40% in June 2008. PEPFAR contributed 153,024 to the national total by March 2009. Of the PHA receiving ART, adults comprised 91.5 % of recipients at 350 service outlets are countrywide. The national target for ART is 203,000 PHA by September 2009 while that of PEPFAR is 164,397. However, the number of people in need of ART is approximately 358,000 (UNAIDS) implying an unmet need of more than 50%. Children comprise 8.5% of national ART recipients against a target of 15%. Of the estimated 42,140 children in urgent need of antiretroviral treatment, only 39% are receiving it as compared to 63% of eligible adults. In addition, currently, only 9% of all PHA on ART under PEPFAR support are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions. The proportion of ART eligible HIV-infected pregnant women receiving treatment is still low; 5,263 (21%) of the estimated eligible 25,000 by June 2009.

This mechanism will support the national ART program, the district health services and other stakeholders to implement pediatric HIV/AIDS treatment services in the West Nile region. Effective and active linkages will be strengthened between pediatric treatment pediatric HIV/AIDS care, PMTCT, EPI and OVC services for proper management of infected/affected children especially those under one year in accordance with Ugandan and WHO ART guidelines. Health facilities will provide pediatric treatment services, including community and outreach services to lower level health facilities as appropriate. The coverage and scope of available HIV/AIDS services for children and their families under this mechanism will be increased, working with other stakeholders providing similar services in the identified geographical locations to respond to existing gaps in order to minimize overlaps and duplication of services and reporting.

The West Nile comprehensive program will support the implementation of HIV/AIDS treatment activities in health facilities will support the Ministry of Health, to scale up and ensure high quality of effective pediatric HIV/AIDS treatment that are fully integrated into the national health system and will mainly focus on the following activities: Expand the number of health care facilities/sites providing ART to children with HIV/AIDS and their families; Continue provision of ART to the current pediatric recipients and increase the number of children newly initiating ART at supported health care facilities/sites in accordance with PEPFAR and National guidelines; Train and build capacity of health workers and care providers to support children on ART and enhance adherence; Disseminate revised pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for health workers in pediatric ART; Strengthen peer support networks for children on ART to reduce stigma and enhance adherence; Increase the total number of HIV treatment sites with active monitoring, evaluation and quality improvement programs; Ensure the availability of post exposure prophylaxis services for occupational

and non-occupational exposure; Establish a logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ART and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

The mechanism will also support the improvement of existing infrastructure and systems. This will include the improvement of data management and reporting to all stakeholders within the district structure; strengthening of logistics management information system and internal technical support supervision by health managers in the supported facilities. ARV for pediatric treatment will continue to flow through the MOH and Global fund mechanism. In order to further mitigate the human resource gaps in the facilities, the program will implement in-service training for staff including task shifting.

Measurable outcomes of this mechanism will be in alignment with the following performance goals for PEPFAR; Number of children with advanced HIV infection newly enrolled on ART; Number of children with advanced HIV infection receiving ART; Number of children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy; Percent of children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy; Number of naïve children with advanced HIV-infection who ever started on ART (excludes all transfer-in clientele); Percent of children with advanced HIV infection receiving antiretroviral therapy; Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Under this mechanism, the Abstinence and Be faithful (AB) interventions will specifically focus on youth both in and out of school under 15 years and persons 15-49 years who test as a couple. For youth under 15 years, interventions will comprise only prevention messaging as the majority are not yet sexually active. This is aimed at primary prevention of HIV among this population. For those under 15 years and sexually active, further prevention messaging with strategies like condom provision will be implemented. School interventions will include life skills training, complementing the PIASCY program currently implemented through the Ministry of Education and Sports (MOES).

Couples will be specifically targeted as the majority of new infections in Uganda are occurring among couples in discordant relationships. Specific messaging will aim at reducing concurrent relationships with multiple partners, promoting zero grazing. The mechanism will place special emphasis on females, as they have higher HIV prevalence compared to their male peers; discordant couples; as well as youth out of school and in casual employment not reached by the school programs.

AB prevention activities will be monitored and evaluated through the overall M&E framework using

HIV/AIDS prevention focal persons at the district health offices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This mechanism will support HIV prevention interventions within the West Nile region most of which is on the border with neighboring countries. Health facilities and surrounding communities will be supported to implement a basic prevention package; Offer HIV counseling, testing and supported disclosure; support health facilities to provide family based HCT, provide condoms; offer medical male circumcision or provide effective referrals, provide comprehensive reproductive health services to HIV-infected women of reproductive age including: family planning, effective ARV prophylaxis for pregnant women and their babies, infant feeding counseling and ongoing support, cervical cancer screening, STI diagnosis and treatment in a family-centered approach. Prevention services will be supported for PHA including discordant couples and will combine MMC, condom use and AB. Prevention with Positives interventions will also be instituted for all HIV-infected individuals including discordant couples. Health worker capacity will be built using the existing nationally approved training materials and guidelines. The mechanism will implement activities in support of the Government of Uganda, to scale up a comprehensive and integrated package of HIV interventions and services in the selected areas. The comprehensive prevention package of services will address the major risk factors and contextual factors that drive the epidemic in Uganda following national guidelines for HIV prevention. The mechanism will focus on following activities;

• Expand the capacity of communities and Ugandan organizations to reduce HIV transmission through evidence-based, targeted prevention programs that focus on changing social norms to promote the delay of sexual debut, abstinence, and fidelity with HIV-tested partners, partner reduction, condom use and medical male circumcision.

• Support PHA to reduce their risk of HIV transmission through positive prevention or "prevention with positives" interventions, particularly partner testing.

• Promote gender equity and positive role models, and address negative social norm; gender based violence, stigma, and discrimination will be cross-cutting themes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

The Uganda TB control indicators remain below target despite implementation of DOTS throughout the country. According to the Uganda National TB and Leprosy Program (NTLP) report, the TB case detection rate is 57% versus the target of 70%, while the treatment success rate is 74% against a target

of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. In the West Nile region, the 2009 MEEPP Semi Annual Progress Report estimates 4,875 TB/HIV patients in the region, which accounts for 12-25% of the HIV positive population.

The coverage and scope of available TB/HIV services for PHA and their families under this mechanism will be increased, working with other stakeholders providing similar services in the identified geographical locations to respond to existing gaps in order to minimize overlaps and duplication of services and reporting. Under this mechanism for TB/HIV integration, the aim of this funding will be to: Provide intensified case finding among clients in HIV/AIDS care and treatment ensuring at least 100% of them are screened for TB; Institute TB Infection Control measures in facilities; Support provider-initiated counseling and testing in TB clinics and wards; Enhance cross referral and linkages between HIV and TB clinics; Strengthen HIV/AIDS care and treatment for TB patients; and promote DOTS for TB/HIV co infected patients.

Implementation of TB/HIV activities in health facilities will support the Ministry of Health NTLP, to scale up and ensure high quality of effective TB/HIV services that are fully integrated into the national health system and will mainly focus on the following activities: Routine TB screening of PHA in HIV/AIDS care and treatment at every clinic visit; Provider Initiated Counseling and Testing will be offered to all TB patients, and linking to HIV/AIDS care and treatment identified HIV/TB co-infected patients; Train and build capacity of health workers in facilities in TB Infection control and in conducting risk assessments; Develop TB infection control plans and implement work practice and administrative control measures, and feasible environmental measures including promoting natural ventilation in waiting and examination rooms.

Health workers in facilities will be supported in data management and analysis using the MOH reporting tools. Existing district health workers will be facilitated to conduct support supervision, on job training and logistics for HIV/TB drugs and supplies. Training in HIV/TB co management is also planned for, and the application of innovative approaches such as co-location of TB and HIV services. TB treatment and follow up using the DOTS strategy will be strengthened with sub county health workers being facilitated to conduct support supervision to TB treatment supporters. Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported laboratories will participate in the national external quality assurance for sputum microscopy. Awareness among patients and communities about TB and HIV integration will be improved through dissemination of IEC materials and behavior change communication activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12501	**Mechanism Name: Scaling up comprehensive HIV/AIDS services in Mbarara district and Mbarara University teaching hospital and its surrounding public sector catchment areas.**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Overview narrative: Uganda has made significant progress towards providing care and support and ART to People Living with HIV/AIDS (PLHA). Of the estimated 1,200,000 people living with HIV/AIDS (PHA) in Uganda, the number of adults in active HIV care nationally is unknown due to gaps in reporting. By June 2009, 193,746 (60% of eligible) HIV positive clients were receiving ART nationally with adults comprising 91.5 % of recipients, and children comprising 8.5 % of recipients. An estimated 42,140 children are in urgent need of antiretroviral treatment. Over 350 service outlets are actively providing ART countrywide. The proportion of HAART eligible HIV-infected pregnant women receiving treatment is still low with only 5,263 (21%) of the estimated eligible 25,000 in the year ending June 2009.

However, the number of people in need of ART is approximately 358,000 (UNAIDS estimate using the CD4<200 cut off), implying an unmet need of more than 50%. In addition, currently, only 9% of all persons on PEPFAR supported ART are children. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

Of the estimated Ugandans living with HIV/AIDS about 38% (456,000) are aware of their HIV status.

(Performance Report STD/ACP 2008) In order to improve access to HIV testing, Uganda has embraced various approaches including Voluntary client -initiated counseling and testing (VCT), and Provider Initiated Counseling and Testing (PICT) for example Routine Testing in clinical settings (RCT), and Family based counseling and testing. However, access to HIV counseling and testing is still low.

As part of the comprehensive HIV prevention package which includes the provision of HIV testing and Counseling, Prevention with Positives interventions and ABC interventions, other evidence based preventive mechanism like safe Male Medical circumcision will be adopted within the national context. The Program will promote voluntary Medical Male Circumcision in the general population (currently at 25%) with a "catch-up" strategy focusing on older adolescents and sexually active adult males with the goal of reducing incidence by 40% by 2012

Challenges for providing greater coverage of services include: limited human resources, limited access to counseling and testing, incoherent measurement of HIV care and treatment outcomes, weak laboratory infrastructure and several uncoordinated logistics supply chain systems. Additional challenges arise from poor coordination of service provision resulting in several partners at health facilities. This has resulted in several supply chains, uncoordinated quantification of drugs, and gross inefficiencies in service provision and reporting.

The Mbarara comprehensive HIV services program will cover 20 public and private not for profit health facilities in Mbarara district including the Mbarara national referral hospital, Mbarara Municipal Council clinic, Mbarara ISS, Mbarara TB/HIV clinic, Bwizibwera HC IV, Kinoni HCIV, Ruharo HC IV and other HC IIIs in the district which are accredited to provide care and treatment services. This district has an estimated total population of 427,200 people and with a regional HIV sero-prevalence of 6.9%, about 29,463 are expected to be HIV infected. With a national estimate of about 38% of the population knowing their HIV status, about 11,200 people may seek care and treatment services from Mbarara distict alone; and in addition to this number, an estimated 3,000 clients will seek care and treatment from the Mbarara national referral center in this region. The total number of health services outlets planned to have chronic care units are 10 and include the national referral hospital and all the HC VIs and accredited HC IIIs. The program will provide comprehensive HIV care services to an existing pool of more than 13,000 clients in care and 7,000 patients on ART

Some of the challenges encountered include poor coordination of the various services with duplication and overlap in reporting, and quantification of required supplies especially drugs and test kits. Linkages between the various services are weak with a number of missed opportunities and inefficiencies. There is a lack of ownership by the district leadership with inadequate integration of the HIV services into health existing systems with no clear sustainability, or exit plans.

Making the program more comprehensive in scope and coverage is an endeavor to address the above challenges. The program will ensure coordinated and cost efficient comprehensive service provision in support of the national health systems.
Therefore this program will work with the district health offices of this region to ensure coordinated and cost-efficient comprehensive HIV care service provision in support of the national health systems.

The objectives of this program include but are not limited to:

1. Supporting the provision of comprehensive HIV care and treatment with increase in coverage and scope of existing HIV/AIDS services for PHAs and their families. Services include HIV Counseling and testing, adult and pediatric basic palliative care and support, PMTCT, ART, TB/HIV. The program will also focus on strengthening linkages between HIV prevention, care, treatment and support services in response to existing gaps and minimize overlaps and duplication of services and reporting.
2. Secondly, the program will support Health Systems Strengthening efforts to promote effective integration of HIV/AIDS services at facilities and surrounding communities. Areas to be supported shall include monitoring and evaluation (M&E), laboratory, infrastructure /space, staff capacity in terms of training and routine supportive supervision, and procurement of logistics and commodity supplies to enhance the delivery of comprehensive HIV/AIDS services. The program will work with the District Health Office to support recruitment of additional staff where applicable, using the Government of Uganda public service salary scales. This will ensure sustainability of this program and avoid parallel service systems, with eventual absorption of such staff onto the government payroll.
3. The third objective is to strengthen program monitoring and evaluation through support of health facilities to utilize the national Health Management Information System (HMIS) to produce timely reports, and ensure these reports are channeled along the Government of Uganda information flow system; aligned with goals and outcomes of CDC/Global AIDS Program and PEPFAR and use HIV/AIDS service data for ongoing improvement of program performance. In all these activities the program will work in close collaboration with the MOH, district health management, and other providers to ensure improved coordination and leveraging of available resources.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12501**		
Mechanism Name:	**Scaling up comprehensive HIV/AIDS services in Mbarara district and Mbarara University teaching hospital and its surrounding public sector catchment areas.**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

Adult care and support
With an estimated population of 427,000 and an HIV prevalence of 6.9 % in this region about 29,463 people are expected to be HIV infected. Currently about 38% of the population know their HIV status (162,260) therefore about 11,195 people may be seeking care and treatment services in this district plus an additional estimated 3,000 clients who are referred to the national referral hospital from surrounding districts..

This program will support health facilities in this region to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility and prevention with positives interventions.

Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will implement strategies to promote adherence to cotrimoxazole and use of the basic care package to delay progression to AIDS and the need for ART. Care and treatment services within this region will be provided to an existing pool of 13,000 clients in active care and 7,000 on ART. Services will also be scaled up to other facilities and eligible clients.

Major activities for this program will include:
1. Increasing access to HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related care services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure

availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the district health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of health facilities that offer HIV care
2. Number of health care providers trained in facility and/or community HIV care
3. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
4. Percent of adults and children with HIV known to be in active care at follow-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	Redacted	Redacted

Narrative:

OVC

The goal of the National Orphans and other vulnerable children policy is to provide a framework for the enjoyment of rights and fulfillment of responsibilities of the orphans and other vulnerable children; to ensure that the legal, policy, and institutional framework for child protection is developed and strengthened at all levels; to establish linkages between public and private not for profit health facilities CSOs and CBOs; to promote sustainable livelihood interventions, income generation, economic strengthening and /or microfinance activities; to develop participatory community dialogues and facilitated problem solving about OVC issues.

Challenges of the OVC response in Uganda include weak co-ordination mechanisms at both national and local government levels; inadequate OVC management information systems at national and district levels; limited monitoring of quality of care in OVC programs; and high demand for services.

This program will address the needs of the identified Orphans and Vulnerable children as appropriate to age and gender including Care and Support, Education, psychosocial support, Food security, Economic strengthening, Basic health, Child protection and Legal support. The program will develop a census

based approach to achieve access to these services to all segments of the vulnerable communities through collaboration with community development officers and related CBOs and CSOs, and use collected data to inform program strategies and activities.

The program will build on the already achieved successes of offering the needed OVC services to an existing pool of over 2000 OVCs within the existing programs and increasing referral to other OVC providers who are mapped out within Mbarara District.

The target population will include all the Orphans and Vulnerable children including those affected and infected with HIV, street children, children under extreme labor conditions, and other forms of child abuse: physical, sexual, neglect among others and those in need of legal protection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

Adult Treatment

This program will support health facilities within this region to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility. Clients eligible for ART will receive treatment through this program as per national guidelines or be referred to existing clinics. The program will ensure that these patients continue to be supported with quality care and follow up.

The program will ensure regular CD4 monitoring for all patients on ART and those not yet on HAART. The program will ensure regular up dating of health workers knowledge through re-fresher trainings and continuing medical education sessions. Continuous evaluation of programs will be continued with quality improvement teams to be supported in all the implementing sites. Data demand and use at the health facilities will be enhanced with regular cohort analyses to asses the performance of sites. Performance based financing programs that are both equitable and encouraging will be encouraged. For those on ART, the program will implement strategies to promote adherence to ART to minimize the likelihood of developing ARV drug resistance.

Care and treatment services within this region will be provided to an existing pool of over 13,000 clients in active care of which over7,000 on ART at the existing health facilities. Services will also be scaled up to other health facilities and eligible clients in the catchment area.

Major activities for this program will include:

1. Increasing access to HIV care, treatment, and support at facilities and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Integrating HIV prevention initiatives within HIV care and treatment. The program will ensure availability of post exposure prophylaxis services for occupational and non-occupational exposure, prevention with positives interventions like partner testing, condom use, contraceptive use
4. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between the various care programs. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV testing commodities, laboratory supplies, ARV drugs, and OI drugs with National Medical Stores and/or using existing public and private sector procurement mechanisms.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of health facilities that offer HIV care and/or ART
2. Number of adults and children with advanced HIV infection in care / on ART disaggregated by age and sex, and pregnancy status for women
3. Increase the total number of patients currently receiving ART at each health facility/site
4. Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

HIV Counseling and Testing (HCT)
The Mbarara district has an estimated population of 427,000 and an HIV prevalence of 6.9%. An estimated 50% of the population is aged 15 years and below.
About 23 health facilities in this district will provide HIV counseling and testing for both children and adults. The program will work with health facilities to offer PITC in all units including OPD and inpatient wards, Couple testing, Early Infant Diagnosis for all HIV exposed infants, and HCT for household members of index clients (through selective home based programs, health visitors, or outreach programs). The program will establish quality assurance mechanisms for both HIV counseling and testing at all levels of care in line with Ministry of Health guidelines.

This program will focus on the following activities;
1. Expand access to HIV counseling and testing through a variety of collaborative facility and community testing and counseling services
2. Provide couple counseling and testing, and ensure that persons testing HIV positive and discordant couples are provided with support and care, and facilitated disclosure
3. Integrate HIV prevention within HCT and establish clear linkages to ensure adequate referrals and follow-up services

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
1. Number of service outlets providing testing and counseling services
2. Number of individuals who received counseling and testing services for HIV and received their test results: by sex, age, CT type and test results
3. Number of people living with HIV/AIDS (PHAs) reached with a minimum package of prevention with positives (PWP) interventions
4. The number of clients and family members receiving counseling and testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

Pediatric care and support

Of the estimated population of 427,000 people in this district about 50% is aged 15 years and below. Currently about 1,800 HVI infected children below 17 years are accessing care through the existing facilities.
Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the sub-urban and rural areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, inadequate sexual and reproductive health services for HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within this region to implement a comprehensive pediatric HIV care and treatment services program including, timely HIV diagnosis among children, provision of basic

care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

This program will continue to support identification of children and linking them into care from the MCH, OPD and pediatric departments. Integration of these services will be a core focus area for this program with the aim of increasing the number of children in care to about 15 percent of the total in care. The program will endeavor to create child friendly clinics at the health facilities and also address the special adolescent sexual and reproductive health needs through a program focusing on this age group. Providers will receive pediatric HIV counseling skills training to have at least one pediatric counselor at all the supported health facilities. A family centered approach to managing pediatric patients will be implemented to provide support for this particularly vulnerable group, enhance adherence and reduce loss to follow up.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis
4. Integrating HIV prevention initiatives within HIV care and treatment with a focus on adolescent sexuality issues
5. The program will strengthen the logistics and commodity supplies system through harmonized procurement of HIV commodities
6. Strengthening data management

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;
• Number of facilities that offer pediatric HIV care and support
• Number of health care providers trained in facility and/or community HIV care
• Number of children with advanced HIV infection in care / on ART disaggregated by age and sex

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

Pediatric treatment

In Uganda, an estimated 42,140 children are in urgent need of antiretroviral treatment. Without ART, 50% of HIV infected infants will die before their second birthday and 75% before their fifth birthday (UNAIDS, 2005). By June 2009, approximately 16,495 children (39% of eligible) were on ART representing 8.5% of the national total of 193, 746 with a male to female ratio of 1:1.

Only a few of the health facilities in this district both private and public provide pediatric care and treatment. The Mbarara program currently provides HIV care for about 1,800 children below 17 years with about 700 accessing HAART.

Some of the challenges specific to the provision of pediatric care, treatment, and support include limited access to services especially in the sub-urban areas, delays in diagnosis of HIV, limited health provider skills, inadequate commodity supplies for pediatric care and treatment, data gaps on the burden of pediatric HIV nationally, continued mother to child transmission of HIV estimated at 15%, addressing sexual and reproductive health needs of HIV infected adolescents, poor linkages between pediatric care and other programs like PMTCT, OVC, and EID. There is also lack of nutritional support, and inadequate community awareness, mobilization and support.

This program will support health facilities within this district to implement a comprehensive adult HIV care and treatment services program including provision of basic care and support package for all clients, OI prophylaxis, diagnosis and treatment, TB screening and treatment, routine assessment for ART eligibility.

The program will provide support to the existing pool of about 700 pediatric patients with antiretroviral treatment (ART) services like CD4 monitoring and out source viral load (VL) services for those that will require VL measurements. Care providers will be trained to support children on ART at all the sites to enhance adherence. The program will disseminate pediatric treatment guidelines to all implementing facilities and provide mentorship and refresher training for staff in pediatric ART in collaboration with other partners. Peer support networks for children on HAART will be supported to reduce stigma and enhance adherence. ARV for pediatric will continue to flow through the MOH and Global fund mechanism.

Major activities for this program will include:
1. Increasing access to pediatric HIV care, and support at facilities, and within communities to HIV-infected persons clients in accordance with National guidelines
2. Training health care providers to deliver HIV-related services
3. Supporting the health systems for HIV care and treatment services delivery and strengthening linkages between pediatric care and the various care programs such as PMTCT, ART, OVC, Early Infant Diagnosis

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted

Narrative:

TBD –Comprehensive HIV/AIDS Mbarara will provide Medical Male Circumcision as a component of comprehensive HIV/AIDS care and treatment services in Mbarara district.
In Uganda the proportion of adult men that are circumcised is estimated at only 25%. The National Strategic Plan for HIV/AIDS has set a target to increase the proportion of circumcised adult males to 50% by 2011/12 and contribute to national goal of reducing the incidence rate by 40% by 2012.
Mbarara district has an estimated total population of 427,200 people and with a regional HIV sero-prevalence of 6.9%. About 50% of this population is males and about 14,000 of them are adults. TBD-comprehensive HIV services Mbarara program will cover 20 public and private not for profit health facilities in Mbarara district including the Mbarara national referral hospital, Mbarara Municipal Council clinic, Mbarara ISS, Mbarara TB/HIV clinic, Bwizibwera HC IV, Kinoni HCIV, Ruharo HC IV and other HC IIIs in the district which are accredited to provide care and treatment services.
In FY2010 this TBD will initiate MMC services at Bwizibwera HC IV, Kinoni HCIV, Ruharo HC IV and Mbarara regional referral hospital targeting HIV negative sexually active adult males and older adolescents, STI patients, uninfected men in HIV discordant couples and neonates.

Objectives
• Support the Government of Uganda in ensuring provision of safe voluntary medical male circumcision (VMMC) services in Mbarara district
• Implement and scale up high quality voluntary and safe male circumcision services as an added HIV prevention intervention in Mbarara district
• Ensure that VMMC services are integrated and implemented as a package of comprehensive HIV prevention, care and treatment services.
• Provide health education on safe VMMC to communities

Funds under this budget code will be used specifically for the following activities:
• Advocacy, community sensitization/mobilization, and education to create informed demand for VMMC services
• Facilitate referrals and linkages of VMMC services to other HIV/AIDS prevention, care and treatment services.
• Promoting sustainability with continued, high-quality, evidence-based interventions
• Training of health service providers including medical officers, clinical officers, nurses, surgical assistants, counselors and support staffs in hospitals, HC IVs according to national and international guidelines

• Provision of circumcision to 4,000 men through 4 sites and train 20 service providers in Mbarara district
• Providing MMC information to women (spouses) and use MMC activities as an opportunity to address gender norms such as polygamy, multiple sexual partners and early marriages
• Supporting the development of long-term sustainable and integrated VMMC capacity in health facilities within the targeted districts, including capacity for provision of neonatal and pediatric MC services in PMTCT and MCH settings in line with national policy/guidelines.
• Improving the capacity of health facilities and health service providers to be able to avail services for medical male circumcision
• REDACTED.
• Procure and keep track of the necessary supplies
• Conduct post operative follow up for ~90% of the circumcised men
• Monitoring adverse event rates

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Abstinence and Be Faithful (AB)
The abstinence and Be faithful (AB) program will specifically focus on youth out of school less than 15 years and clients aged 15-49 years who test as a couple. This will comprise the only prevention messaging to children below 15 as these are largely not yet sexually active. This district has an estimated population of 427,000 thousand and 50% (213,500) of this population is aged 15 years and below.

The major aim of this program component is primary prevention of HIV in this population. The focus will be youth out of school and those in casual employment like 'boda boda' (motor) cyclists as these are not reached by the school program implemented by the Uganda Ministry of Education and Sports, also called the PIASCY program or President Initiative AIDS Strategy Communication for Youth.. Special emphasis will be put on the females as they have higher HIV prevalence compared to their male peers. Couples will be specifically targeted because majority of new infections in Uganda are occurring among married people in discordant relationships. The specific messaging will aim at reducing concurrent relationships with multiple partners promoting zero grazing. For clients below 15 years of age who are sexually active, further prevention messaging with strategies like condom use will be provided. This will also be the same for couples that are discordant for HIV. AB prevention activities will be monitored and evaluated through the overall monitoring and evaluation framework of the program through the HIV prevention focal persons at the district health office.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	Redacted	Redacted

Narrative:

Other Prevention

This program will support health facilities in this district to implement a basic preventive care package for patients, offer counseling and effective referral for medical male circumcision (MMC) among discordant couples when appropriate, supported disclosure of HIV status to spouses and selected family members. Support will be provided to health facilities within the district to provide MMC and condoms using existing nationally approved training materials to ensure that effective prevention programs are instituted for all HIV-infected individuals including discordant couples and a comprehensive prevention program that combines MMC, condom use and Abstinence Be Faithful initiatives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

Laboratory Infrastructure

The program will focus on scaling up and strengthening laboratory activities that support HIV services' delivery in accordance with the Uganda national laboratory policies and guidelines. The scope of the laboratory support will address services such as HIV testing for infants, adults and children, diagnosis of opportunistic and other common infections, assessment for antiretroviral therapy eligibility for clients in active HIV care, and monitoring of response to treatment for clients on ART. Some of the program areas that require specific laboratory support include HIV counseling and testing (HCT), Prevention of Mother To Child Transmission (PMTCT), Biomedical HIV prevention, Adult Care and Support, Pediatric Care and Support, Adult treatment, and Pediatric Treatment. The program will strengthen linkages between the laboratory and the various services.

The existing clinics in this region have some laboratory capacity that will need to be supported with staff or kits for HIV/AIDS diagnosis and monitoring. The program will work with other laboratory stakeholders through the district laboratory focal persons to improve laboratory functions at the facilities. The aim will be to have laboratories performing the expected range of diagnostics tests for their level to support service delivery.

The major activities to be supported will focus on but not be limited to;

1. Developing and strengthening laboratory facilities in accordance with MOH laboratory strategic policies

and plan to support HIV/AIDS-related activities including the purchase of equipment through competitive procurement
2. Provision of quality assurance, staff training and other technical assistance
3. Supporting policies based on national and international best practices, training, waste-management systems, advocacy and other activities to promote medical injection safety, including establishing a distribution/supply chain, and the safe and appropriate disposal of injection equipment and other related equipment and supplies.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR;

1. Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests as specified in MOH guidelines
2. Number of testing facilities (laboratories) that are accredited according to national or international standards

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

ARV drugs

This program will procure ARV drugs for an existing pool of at least 7,000 clients currently on treatment in the existing facilities. The program will also support facilities to improve their logistics management capacity to draw down on the National credit line and scale up ARV services to underserved areas. Activities shall include support to the quantification of ARV drug need, procurement, and storage, dispensing, plus reporting. Working closely with the MOH, the program will help standardize ARV regimens and formulations used at ART sites and harmonize these with the national treatment guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

TB/HIV

TB remains a major challenge in Uganda contributing to significant morbidity and mortality. The estimated TB incidence of all forms of TB is 330 new cases per 100,000 pop/ year with an incidence of

128 new cases per 100,000 pop /year among HIV positive persons. Over 39% of all incident TB cases are HIV positive. Prevalence of all forms of TB is 426 cases per 100,000 population. Mortality is 93 deaths per 100,000 pop /year. The estimated Multidrug resistant -TB (MDR-TB) rate among all new TB cases is 0.5%. (Global Tuberculosis control WHO report 2009). The Uganda TB control indicators remain below target despite implementation of DOTS throughout the country. Treatment success rate is 74% against a target of 85% due to high proportion of patients who either die, default or whose treatment outcome is not evaluated. The TB Case Detection Rate is 57% versus the target of 70%.

This program will promote integration of TB and HIV through the following activities:
1. Provide intensified case finding among clients in HIV care and treatment ensuring 100% of them are screened for TB;
2. Institute TB Infection Control measures in health facilities;
3. Support provider-initiated counseling and testing in TB clinics and wards;
4. Enhance cross referral and linkages between HIV and TB clinics;
5. Strengthen HIV Care and treatment for TB patients through provision of OI prophylaxis such as cotrimoxazole, regular assessment for ART eligibility, and provision of ART for those eligible according to national treatment guidelines;
6. Promote directly observed treatment (DOTS) for TB HIV co- infected patients.

The program will provide TB screening for HIV positive clients in care and treatment at each visit; offer HIV Counseling and testing to all TB patients, and those found to be HIV positive will be linked to HIV care and treatment. TB treatment and follow up using the DOTS strategy will be supported with sub county health workers facilitated to conduct support supervision to TB treatment supporters.

Health facility staff will be trained in TB Infection control, and facilitated to conduct risk assessment of health facilities, develop and implement TB infection control measures such as promoting natural ventilation in waiting and examination rooms. Health workers will be trained in HIV/TB co-management. Innovative approaches such as co-location of TB and HIV services will be applied.

Laboratory capacity for TB diagnosis will be built through training of laboratory technicians in TB sputum microscopy and equipping of laboratories. All supported labs will participate in the National External Quality Assurance for sputum microscopy. Staff in supported Health facilities will be supported in data management and analysis using the existing Ministry of Health (MOH) tools.

Measurable outcomes of the program will be in alignment with the following performance goals for PEPFAR

• Number of service outlets providing treatment for TB to HIV-infected individuals in a palliative care setting • Percent of TB patients who had an HIV test result recorded in the TB register • Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings • Percent of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12502	**Mechanism Name: Comprehensive PMTCT (Central)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objectives of the TBD Comprehensive PMTCT program are to:
1) Provide, through the Government of Uganda district systems, comprehensive PMTCT services throughout the antenatal, maternity, postnatal and infant periods, including HIV screening, diagnosis, staging and ART prophylaxis for HIV-infected pregnant women and their newborn infants and HAART initiation for those eligible for treatment. The comprehensive services include: RH, TB screening, Family planning, coordination of lab services (EID, CD4 tests), nutrition, IYCF and primary prevention.
2) Strengthen linkages and coordination between PMTCT and reproductive health at the national and local levels

The program under this mechanism will target pregnant women and their families in the districts of:Mubende, Mityana, Nakaseke, Kalangala, Luwero, Rakai, Sembabule, Mpigi, Lyantonde, Nakasongola, Mukono, Wakiso. The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH)

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12502**		
Mechanism Name:	**Comprehensive PMTCT (Central)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	Redacted	Redacted

Narrative:

The national PMTCT policy guidelines (2006-2010) focus on supporting the implementation of the 4-pronged WHO PMTCT strategy (primary prevention, family planning, provision of ARV prophylaxis, and care and support). The overall goal of the PMTCT program under this mechanism is to scale up integrated, effective and sustainable PMTCT services in the Central region of Uganda. The program will target pregnant women and their families in the districts of: Mubende, Mityana, Luwero, Nakasongola, Wakiso, Nakaseke, Kalangala, Masaka, Sembabule, Lyantonde, Sembabule, Mukono, Mpigi, Rakai and Kampala. In these districts about 420,862 (5.2%) women are expected to be pregnant and about 27,356 (6.5%) of them are expected to be HIV positive. The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH).

The FY2010 goals are to: reach about 80% of all HIV-positive women with ARV prophylaxis; strengthen RH systems; improve efficiency and quality of PMTCT services and service delivery systems; increase utilisation, demand and accessibility of PMTCT services. This mechanism will work with district and

contribute to the achievement of national and PEPFAR goals for PMTCT. The FY2010 targets are to: provide PMTCT services through 297 health facilities, counsel and test 371,370 (80%) pregnant women and give them results, and provide ARV prophylaxis to 24,137 (80%) HIV-positive women (4,827 [20%] HAART, 19,309 [80%) Combivir). SD NVP will only be provided to HIV positive pregnant women who present at the first ANC visit with advance gestation age. In addition this mechanism will assess all the 24,137 HIV positive pregnant women for ARV services and 19,309 (64%) of HIV exposed infants will receive PMTCT ARVs. Further, this mechanism will target to reach 19,309 HIV exposed infants with Early Infant HIV diagnosis (EID) from 6 weeks of age and will provide nutritional supplementation to 9,051(30%) of HIV positive pregnant women. Funds will be used to implement the following activities:
• Continued scale up of PMTCT services to all Health Center III's in the selected districts
Providing Antenatal ART services
• Scaling up combined therapy and improving adherence support
• Strengthening EID and linkage to Pediatric care and treatment
• Integrating Family planning into PMTCT services
• Strengthening M&E with a focus on program outcomes
• Infant and Young Child Feeding (IYCF)
• Supporting maternal nutrition (macro & micro) to reduce Anemia
• Integrating TB screening in ANC/MCH
• Integrating PMTCT with MCH
• Increasing support for primary in ANC prevention

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12503	**Mechanism Name: Comprehensive PMTCT (Eastern)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**

Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objectives of the TBD Comprehensive PMTCT program are to:
1) Provide, through the Government of Uganda district systems, comprehensive PMTCT services throughout the antenatal, maternity, postnatal and infant periods, including HIV screening, diagnosis, staging and ART prophylaxis for HIV-infected pregnant women and their newborn infants and HAART initiation for those eligible for treatment. The comprehensive services include: RH, TB screening, Family planning, coordination of lab services (EID, CD4 tests), nutrition, IYCF and primary prevention.
2) Strengthen linkages and coordination between PMTCT and reproductive health at the national and local levels
The program under this mechanism will target pregnant women and their families in the districts of: Amuria, Katakwi, Kaberamaido, Soroti, Kumi, Jinja. The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH)

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12503**		
Mechanism Name:	**Comprehensive PMTCT (Eastern)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	Redacted	Redacted

Narrative:

The national PMTCT policy guidelines (2006-2010) focus on supporting the implementation of the 4-pronged WHO PMTCT strategy (primary prevention, family planning, provision of ARV prophylaxis, and care and support). The overall goal of the PMTCT program under this mechanism is to scale up integrated, effective and sustainable PMTCT services in the Central region of Uganda. The program will target pregnant women and their families in the districts of: Mubende, Mityana, Luwero, Nakasongola, Wakiso, Nakaseke, Kalangala, Masaka, Sembabule, Lyantonde, Sembabule, Mukono, Mpigi, Rakai and Kampala. In these districts about 420,862 (5.2%) women are expected to be pregnant and about 27,356 (6.5%) of them are expected to be HIV positive. The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH).

The FY2010 goals are to: reach about 80% of all HIV-positive women with ARV prophylaxis; strengthen RH systems; improve efficiency and quality of PMTCT services and service delivery systems; increase utilisation, demand and accessibility of PMTCT services. This mechanism will work with district and contribute to the achievement of national and PEPFAR goals for PMTCT. The FY2010 targets are to: provide PMTCT services through 297 health facilities, counsel and test 371,370 (80%) pregnant women and give them results, and provide ARV prophylaxis to 24,137 (80%) HIV-positive women (4,827 [20%] HAART, 19,309 [80%) Combivir). SD NVP will only be provided to HIV positive pregnant women who present at the first ANC visit with advance gestation age. In addition this mechanism will assess all the 24,137 HIV positive pregnant women for ARV services and 19,309 (64%) of HIV exposed infants will receive PMTCT ARVs. Further, this mechanism will target to reach 19,309 HIV exposed infants with Early Infant HIV diagnosis (EID) from 6 weeks of age and will provide nutritional supplementation to 9,051(30%) of HIV positive pregnant women. Funds will be used to implement the following activities:

• Continued scale up of PMTCT services to all Health Center III's in the selected districts

Providing Antenatal ART services

• Scaling up combined therapy and improving adherence support

• Strengthening EID and linkage to Pediatric care and treatment

• Integrating Family planning into PMTCT services

• Strengthening M&E with a focus on program outcomes

• Infant and Young Child Feeding (IYCF)

• Supporting maternal nutrition (macro & micro) to reduce Anemia

• Integrating TB screening in ANC/MCH

• Integrating PMTCT with MCH

• Increasing support for primary in ANC prevention

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12504	**Mechanism Name: Comprehensive PMTCT (West Nile)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objectives of the TBD Comprehensive PMTCT program are to:
1) Provide, through the Government of Uganda district systems, comprehensive PMTCT services throughout the antenatal, maternity, postnatal and infant periods, including HIV screening, diagnosis, staging and ART prophylaxis for HIV-infected pregnant women and their newborn infants and HAART initiation for those eligible for treatment. The comprehensive services include: RH, TB screening, Family planning, coordination of lab services (EID, CD4 tests), nutrition, IYCF and primary prevention.
2) Strengthen linkages and coordination between PMTCT and reproductive health at the national and local levels
The program under this mechanism will target pregnant women and their families in the districts of: Arua, Nebbe, Maracha, Addjuman, Moyo, Koboko, Yumbe. The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH)

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12504		
Mechanism Name:	Comprehensive PMTCT (West Nile)		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	Redacted	Redacted

Narrative:

The national PMTCT policy guidelines (2006-2010) focus on supporting the implementation of the 4-pronged WHO PMTCT strategy (primary prevention, family planning, provision of ARV prophylaxis, and care and support). The PMTCT program under TBD Comprehensive PMTCT (WestNile) will follow national guidelines with the overall goal of scaling up integrated, effective and sustainable PMTCT services in the West Nile region of Uganda. The program will target pregnant women and their families in the districts of: Arua, Nebbi, Maracha, Adjumani, Moyo, Koboko, and Yumbe. In this region about 146,312 (5.2%) women are expected to be pregnant in FY 2010 and about 9,510 (6.5%) of them are expected to be HIV positive.The program will be implemented through the national systems by the district health teams under the supervision and coordination of the Ministry of health (MOH).

The FY2010 goals are to: reach about 80% of all HIV-positive women in this region with ARV prophylaxis; strengthen RH systems; improve efficiency and quality of PMTCT services and service delivery systems; increase utilisation, demand and accessibility of PMTCT services. This mechanism will work with district and contribute to the achievement of national and PEPFAR goals for PMTCT. The FY2010 targets are to: provide PMTCT services through 108 health facilities, counsel and test 117,049 pregnant women and give them results, and provide ARV prophylaxis to 7,608 HIV-positive women (1,522 [20%] HAART; 6,086 [80%) Combivir). SD NVP will only be provided to HIV positive pregnant women who present at the first ANC visit with advance gestation age. In addition this mechanism will assess all the 7,608 HIV positive pregnant women for ARV services and 6,086 (64%) of HIV exposed infants will receive PMTCT ARVs. Further, this mechanism will target to reach 6,086 HIV exposed infants with Early Infant HIV diagnosis (EID) from 6 weeks of age and will provide food supplementation to 2,853 (30%) of HIV positive pregnant women. Funds will be used to implement the following activities:

• Continued scale up of PMTCT services to all Health Center III's in the selected districts Providing Antenatal ART services • Scaling up combined therapy and improving adherence support • Strengthening EID and linkage to Pediatric care and treatment • Integrating Family planning into PMTCT services • Strengthening M&E with a focus on program outcomes • Infant and Young Child Feeding (IYCF) • Supporting maternal nutrition (macro & micro) to reduce Anemia • Integrating TB screening in ANC/MCH • Integrating PMTCT with MCH • Increasing support for primary in ANC prevention

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12505	**Mechanism Name: Ugandan AIDS Commission PMMP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2008, UAC received USG technical assistance through the ACE Project (Chemonics) which contributed to a number of achievements including the completion of a new five year national HIV/AIDS strategic plan, a national Performance Monitoring and Management Plan (PMMP) and its operational

guide. Once the M&E system is in place, UAC will be able to collate, analyze, and disseminate multi-sectoral information that is needed to inform the HIV/AIDS response at strategic, management, and operational levels. The support for UAC demonstrates USG commitment to the "three one" principle in Uganda.

In FY 2009, the Population Council (through Project Search) was contracted to support the Uganda AIDS Commission (UAC), with a mandate to study the key issues and requirements for operationalizing the PMMP at the District level i.e. studying/outlining 'what it takes to roll-out PMMP at the District'. The activity examined factors needed to make the multi-sectoral M&E System and its accompanying information flow system fully operational. Given that USG is only one of the several development partners assisting the UAC, the support was focused on identifying the key institutional and process issues to be addressed in order to stimulate the local government management to take responsibility and create a functional M&E and Information system; three districts were picked for this activity.

Results from the FY 2009 support indicated that a focused program of training and advocacy was needed at the district level in order to make the multi-sectoral M&E System functional. The results also revealed that there was significant interest by the local government actors to participate in the multi-sectoral HIV M&E system. The FY 2010 support will take these results forward and carry out a "research-to-practice" activity in five districts i.e. Population Council will work with UAC to demonstrate that the results they generated can be translated into practice. The FY 2010 activity will involve implementing a capacity building program at the district that will lead to collation and use of multi-sectoral data at the district as well as reporting to UAC headquarters. The capacity building activity, for individuals and organizations, will train at least ten 10 individuals per district (a total of 50 will receive in-service training in strategic information).

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12505**

Mechanism Name:	Ugandan AIDS Commission PMMP		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted

Narrative:

In FY 2008, UAC received USG technical assistance through the ACE Project (Chemonics) which contributed to a number of achievements including the completion of a new five year national HIV/AIDS strategic plan, a national Performance Monitoring and Management Plan (PMMP) and its operational guide. Once the M&E system is in place, UAC will be able to collate, analyze, and disseminate multi-sectoral information that is needed to inform the HIV/AIDS response at strategic, management, and operational levels. The support for UAC demonstrates USG commitment to the "three one" principle in Uganda.

In FY 2009, the Population Council (through Project Search) was contracted to support the Uganda AIDS Commission (UAC), with a mandate to study the key issues and requirements for operationalizing the PMMP at the District level i.e. studying/outlining 'what it takes to roll-out PMMP at the District'. The activity examined factors needed to make the multi-sectoral M&E System and its accompanying information flow system fully operational. Given that USG is only one of the several development partners assisting the UAC, the support was focused on identifying the key institutional and process issues to be addressed in order to stimulate the local government management to take responsibility and create a functional M&E and Information system; three districts were picked for this activity.

Results from the FY 2009 support indicated that a focused program of training and advocacy was needed at the district level in order to make the multi-sectoral M&E System functional. The results also revealed that there was significant interest by the local government actors to participate in the multi-sectoral HIV M&E system. The FY 2010 support will take these results forward and carry out a "research-to-practice" activity in five districts i.e. Population Council will work with UAC to demonstrate that the results they generated can be translated into practice. The FY 2010 activity will involve implementing a capacity building program at the district that will lead to collation and use of multi-sectoral data at the district as well as reporting to UAC headquarters. The capacity building activity, for individuals and organizations, will train at least ten 10 individuals per district (a total of 50 will receive in-service training in strategic information).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12506	**Mechanism Name: CONTINOUS QUALITY IMPROVEMENT**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the Quality Improvement Center (QIC) is to implement a quality improvement program in health care facilities that provide care for people with HIV/AIDS in countries funded under the PEPFAR, in partnership with the Ministries of Health (MOH) and US government in-country teams.

The QIC is to provide a simple, systematic way to monitor and improve HIV/AIDS care over time using a sampling strategy that promotes self-assessment. The Quality Improvement program will contain at least three core components: performance measurement, quality improvement and infrastructure support for quality management. This project will be accomplished through on-site technical assistance, use of quality indicators, and assistance to ambulatory health care facilities with data collection and data analysis on national continuous quality improvement. The QIC will provide software which is compatible with PEPFAR grantees' existing systems to allow for voluntary submission of data. The cooperative agreement will provide individualized technical assistance on the concepts, tools and various approaches to implementing quality management.

This project will provide a defined system for quality improvement, including 1) sampling of patient and other organizational records, 2) planning for baseline measurements, 3) definition of specific areas to be addressed by quality improvement, 4) design of interventions, 5) measurement of the effect of

interventions on specified outcomes, 6) analysis of improvement, 7) design of strategies to sustain improvements, and 8) planning for cycles to improve additional outcomes.

The QIC is to provide a comprehensive approach that uses reliable performance data and minimizes variation in the delivery of healthcare services and implement these activities at HIV health care facilities in participating countries. The QIC will involve healthcare teams at such facilities, including physicians, nurses, pharmacists, social workers, health administrators and other health care personnel in implementing changes and emphasize effective use of limited resources. A successful program will result in strengthened and sustainable quality improvement infrastructure and improved health outcomes and will support implementation of national guidelines.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12506**		
Mechanism Name:	**CONTINOUS QUALITY IMPROVEMENT**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	Redacted	Redacted
Narrative:			
The selected QIC will lead quality improvement activities across a network of ambulatory health care facilities. The grantee will assess system capabilities and assist in developing infrastructure that is essential to quality improvement (QI) success. On a health facility level, the QIC will facilitate quality improvement activities by providing training, management support and technical assistance. Further, the QIC will provide the necessary quality improvement technology required for facility, health care worker and patient tracking, as well as the required training and technical assistance needed to support the system.			

A key aim of the QIC is to help establish and promote longstanding QI programs that foster development and sustainability of human capacity and services to people with HIV/AIDS. Upon completion of the cooperative agreement, the countries in which the QIC is working will have a core group of local experts able to offer QI technical assistance (TA) to participating health care facilities. It will be necessary for the QIC to adapt existing paper-based and software data collection systems to meet specific facility needs to assess and influence quality of care. The QIC may use training, TA, consultants, communications and information supports, telemedicine/telehealth, and other methods to accomplish these objectives. The QIC will not support direct costs of service commodities, such as drugs or health care personnel. The QIC will work with the MOH and USG in-country to choose appropriate facilities, clinical care practices of focus, and as indicated, work toward the development of an infrastructure for QI activities. The QIC will also implement a work plan which includes training health care workers and providing TA to participating sites. Proposed activities, tools, and software programs should be evidence based and easy to use in a variety of settings. At the conclusion of this cooperative agreement, the health systems, organizations, and a group of health care workers will have increased quality improvement capacity, and, the ability to offer high quality adult ART services by national and international standards.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted

Narrative:

The selected QIC will lead quality improvement activities across a network of ambulatory health care facilities, and the activities extend to Pediatric services. The grantee will assess system capabilities and assist in developing infrastructure that is essential to quality improvement (QI) success. On a health facility level, the QIC will facilitate quality improvement activities by providing training, management support and technical assistance. Further, the QIC will provide the necessary quality improvement technology required for facility, health care worker and patient tracking, as well as the required training and technical assistance needed to support the system.

A key aim of the QIC is to help establish and promote longstanding QI programs that foster development and sustainability of human capacity and services to people with HIV/AIDS. Upon completion of the cooperative agreement, the countries in which the QIC is working will have a core group of local experts able to offer QI technical assistance (TA) to participating health care facilities. It will be necessary for the QIC to adapt existing paper-based and software data collection systems to meet specific facility needs to assess and influence quality of care. The QIC may use training, TA, consultants, communications and information supports, telemedicine/telehealth, and other methods to accomplish these objectives. The QIC will not support direct costs of service commodities, such as drugs or health care personnel. The QIC will work with the MOH and USG in-country to choose appropriate facilities, clinical care practices of focus, and as indicated, work toward the development of an infrastructure for QI activities. The QIC will

also implement a work plan which includes training health care workers and providing TA to participating sites. Proposed activities, tools, and software programs should be evidence based and easy to use in a variety of settings. At the conclusion of this cooperative agreement, the health systems, organizations, and a group of health care workers will have increased quality improvement capacity, and, the ability to offer high quality pediatric ART services by national and international standards.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12507	**Mechanism Name: Prevention Track one follow on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Uganda has a mature & generalised epidemic with a prevalence of 6.4 %. The epidemic is evolving and becoming more complex. Annual new infections are exceeding AIDS deaths; the epidemic is disproportionately affecting women; burden is shifting to adults and individuals in long standing relationships. According to the mode of transmission study, the major sources of HIV infection in Uganda include: multiple sexual partnerships (including partners) 37.3 %; Mutually Monogamous partnerships at 35.1%; Mother-to-Child at 18.1 %; Sex Work (Including partners, clients and partners of clients) at 8.7 %. Given current evidence from the sero behavioural survey and mode of transmission study, an expanded HIV Prevention programme will be implemented focusing on combination HIV prevention. This will include a mix of strategies and risk reduction approaches that use current epidemiological and programmatic

evidence to target different audiences with simultaneous behavioral, biomedical, social normative and structural interventions that respond to local realities. This prevention programme is contributing to the NSP goal of reducing HIV incidence by 40 % by 2012.

In addition to reaching out to the young people and the general public, the programme will target those sections of the population where new HIV infections are originating from. . These include Most at Risk Populations (Fisher fork and their partners, Commercial Sex workers and their partners, internally displaced populations, uniformed personnel, Long distance track drivers, couples and those in long term relationships, discordant couples.

Cross-Cutting Budget Attribution(s)

Education	REDACTED.
Gender: Reducing Violence and Coercion	REDACTED.

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12507**		
Mechanism Name:	**Prevention Track one follow on**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	Redacted	Redacted
Narrative:			
Uganda has a mature and generalised epidemic with a prevalence of 6.4%. Anecdotal reports indicate that new infections are rising annually. There have been shifts in epidemiological patterns, with new infections now occurring more in married and co-habiting couples than in youth, as was the case a few years ago. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in the conflict regions are the most severely affected. Of the adults in married and co-habiting relationships, forty percent of those who are HIV positive have an HIV negative spouse. The recently concluded mode			

of transmission study indicates that key drivers of the epidemic include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviors due to antiretroviral treatment (ART). The study also pointed to serious flaws in programming by government and its partners as most data generated over the years have not been utilized in designing new prevention interventions that address the current realities of the epidemic. For instance, although available evidence indicates that that medical male circumcision greatly reduces the risk of acquiring HIV among men, it has not been adopted nationally as a prevention strategy. Uganda has not yet reached consensus regarding the efficacy of the intervention and hence there is no government policy as yet. Public awareness and correct knowledge of the intervention also remains limited.

Despite the lack of strategic clarity, the demand for medical male circumcision has been high with the majority of those receiving services being adults. This activity will focus on addressing HIV prevention using a combination of biomedical and behavioural interventions targeted at adult populations. The activity will particularly aim to take to scale medical male circumcision as a critical HIV prevention strategy. Given the fact that there is no government policy as yet and public awareness is limited, activities will be focused on advocacy to access accurate information to the public, eliminate myths and foster general community appreciation of the strategy. A variety of communication strategies will be used including interactive mobile SMS messaging, mass media, community social networks, religious institutions and where possible outdoor advertising.

The program will also strive to train health workers and improving health facility preparedness to ensure that the intervention is undertaken with utmost professionalism and safety. This will entail rehabilitation and equipment of minor theatres and refurbishment of premises to create safe and spacious waiting areas. The program will also join other partners in their engagement with government to fast track the development and ratification of the national policy and guidelines to offer strategic direction to the intervention.

The activity will be complemented by sexual and other behavioral risk prevention activities will be geared towards increasing personal perception of risk of HIV transmission and utilization of prevention services through behavior change communication (BCC) programs to enable youth assess their risk for HIV infection, promote behaviors to reduce their risk and acquire skills to overcome and avoid risky behaviors.

Targets:

Number of locations providing MC surgery as part of the minimum package of MC for HIV prevention

services within the reporting period 20
Number of males circumcised as part of the minimum package of MC for HIV prevention service 3500
Number of males circumcised as part of the minimum package of MC for HIV prevention service disaggregated by age
<5 years 500
5 -17 years 2,000
18+ years 1,000

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Uganda has a mature and generalised epidemic with a prevalence of 6.4%. Anecdotal reports indicate that new infections are rising annually. There have been shifts in epidemiological patterns, with new infections now occurring more in married and co-habiting couples than in youth, as was the case a few years ago. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in the conflict regions are the most severely affected. Of the adults in married and co-habiting relationships, forty percent of those who are HIV positive have an HIV negative spouse. The recently concluded mode of transmission study indicates that key drivers of the epidemic include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviors due to antiretroviral treatment (ART). The study also pointed to serious flaws in programming by government and its partners as most data generated over the years have not been utilized in designing new prevention interventions that address the current realities of the epidemic. Consequently, populations at a higher risk of HIV infection are not served with the kind of services that they ideally need.

Based on the current evidence from the sero behavioural survey and mode of transmission study, USAID intends to launch an expanded and comprehensive HIV prevention programme to directly address the identified drivers of the epidemic using evidence based strategies. This will include a mix of strategies and risk reduction approaches that use current epidemiological and programmatic evidence to target different audiences with behavioral, social, normative and structural interventions that respond to local realities. The new program will build upon the progress and achievements realised through the five-year interventions implemented through centrally funded Track 1.0 partners. The program will contribute to the NSP goal of reducing HIV incidence by 40 % by 2012.

This activity will focus on promoting abstinence and mutual faithfulness among youth and adults in

marriage and cohabiting relationships. With regard to adults, interventions will aim to consolidate approaches that increase personal awareness and responsibility, as well as risk perception. These will include among others, improvement in couple communication and trust, strengthening of traditional family and community networks and structures around the ethos of personal and social responsibility, further empowerment of women particularly enhancing their active role in family decisions, encouraging frank, open disclosure and discussion in situations where couples renege on their marital obligations and creating a sense of community, especially in urban areas to create a culture where individuals know each other, to facilitate mutual understanding and support. The program will also target behaviours and practices that heighten risk and exposure to HIV infection such as alcoholism and alcohol abuse, inappropriate gender and cultural norms, domestic violence, and the desire for quick solutions to personal needs which often breeds irrational sexual decision making. The program will further strengthen community based networks of volunteers such as PHA networks, religious leaders, women leaders, and youth associations to serve as enduring sources of HIV prevention information at community level. They will be facilitated to work with communities to challenge social and cultural norms that increase vulnerability and risk to HIV infection, in particular those regarding gender, power and sexuality. These community based volunteers will also serve as referral hubs directing people to facilities where essential services such as counselling and testing can be sought.

Besides reaching out to adult individuals in married and cohabiting relationships, the program will also target the youth with abstinence messages. The shifting of the epidemic to the older people presents an opportunity to consolidate HIV prevention among youth. Interventions under this program will directly target behaviours that increase risk among youth such as transactional and cross-generational sex, inappropriate and apathetic personal goals, low self esteem and efficacy as well as engagement in potentially risky relationships. Sexual and other behavioral risk prevention activities will be geared towards increasing personal perception of risk of HIV transmission and utilization of prevention services through behavior change communication (BCC) programs to enable youth assess their risk for HIV infection, promote behaviors to reduce their risk and acquire skills to overcome and avoid risky behaviors.

Other activities will include use of different communication channels (e.g. radio, drama, music, and TV) to help promote and reinforce positive behaviours; use of interpersonal communication to help individuals internalise the messages, HIV counselling and testing to enable individuals know their status and where applicable, engagement of the MOH and UAC on policy related matters.

Targets:

Number of the targeted population reached with individual and/or small group level preventive

interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards:

10-14 years 100,000
15-24 years 800,000
25+ years 600,000

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

Uganda has a mature and generalised epidemic with a prevalence of 6.4%. Anecdotal reports indicate that new infections are rising annually. There have been shifts in epidemiological patterns, with new infections now occurring more in married and co-habiting couples than in youth, as was the case a few years ago. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in the conflict regions are the most severely affected. Of the adults in married and co-habiting relationships, forty percent of those who are HIV positive have an HIV negative spouse. The recently concluded mode of transmission study indicates that key drivers of the epidemic include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and relaxed sexual behaviors due to antiretroviral treatment (ART). The study also pointed to serious flaws in programming by government and its partners as most data generated over the years have not been utilized in designing new prevention interventions that address the current realities of the epidemic. Consequently, populations at a higher risk of HIV infection are not served with the kind of services that they ideally need.

Based on the current evidence from the sero behavioural survey and mode of transmission study, USAID intends to launch an expanded and comprehensive HIV prevention programme to directly address the identified drivers of the epidemic using evidence based strategies. This will include a mix of strategies and risk reduction approaches that use current epidemiological and programmatic evidence to target different audiences with behavioral, social, normative and structural interventions that respond to local realities. The program will contribute to the NSP goal of reducing HIV incidence by 40 % by 2012.

This activity will focus on addressing HIV prevention using a combination of biomedical and behavioural interventions targeted at adult populations with particular emphasis on those living and/or operating in high risk situations. These include fisher folk and their partners, commercial sex workers and their partners, internally displaced populations, uniformed personnel, long distance track drivers, individuals in

multiple sexual relationships and discordant couples. The program will target behaviours and practices that heighten risk and exposure to HIV infection such as alcoholism and alcohol abuse, inappropriate gender and cultural norms, domestic violence, and the desire for quick solutions to personal needs which often breeds irrational sexual decision making. The program will further strengthen community based networks of volunteers such as PHA networks, women leaders, and community leaders to serve as enduring sources of HIV prevention information at community level. They will be facilitated to work with communities to challenge social and cultural norms that increase vulnerability and risk to HIV infection, in particular those regarding gender, power and sexuality. These community based volunteers will also serve as referral hubs directing people to facilities where essential services such as counselling and testing can be sought.

Sexual and other behavioral risk prevention activities will be geared towards increasing personal perception of risk of HIV transmission and utilization of prevention services through behavior change communication (BCC) programs to enable youth assess their risk for HIV infection, promote behaviors to reduce their risk and acquire skills to overcome and avoid risky behaviors. Other activities will include use of different communication channels (e.g. radio, drama, music, and TV) to help promote and reinforce positive behaviours; use of interpersonal communication to help individuals internalise the messages, and where applicable, engagement of the MOH and UAC on policy related matters.

Safe sex messages will be particularly emphasised to ensure that individuals make informed decisions. The program will facilitate expansion in access to and utilization of biomedical products such as condoms and family planning devices to minimise HIV transmission. Trained community volunteers will be facilitated to serve as sources of these devices at community level. In addition, the program will network with other USAID funded social marketing programs to ensure wide accessibility to condoms and family planning devices through the commercial sector.

Targets:

Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards:

10-14 years 0
15-24 years 100,000
25+ years 300,000

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				258,010		258,010
ICASS				780,000		780,000
Institutional Contractors				471,528		471,528
Management Meetings/Professional Developement				115,050		115,050
Non-ICASS Administrative Costs				529,600		529,600
Staff Program Travel				717,720		717,720
USG Staff Salaries and Benefits				5,224,702		5,224,702

Total	**0**	**0**	**0**	**8,096,610**	**0**	**8,096,610**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		258,010
ICASS		GHCS (State)		780,000
Management Meetings/Professional Developement		GHCS (State)		115,050
Non-ICASS Administrative Costs		GHCS (State)		529,600

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
ICASS				31,780		31,780
Institutional Contractors				245,000		245,000
Non-ICASS Administrative Costs				17,838		17,838
Staff Program Travel				34,448		34,448
USG Staff Salaries and Benefits				48,800		48,800
Total	**0**	**0**	**0**	**377,866**	**0**	**377,866**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount

ICASS		GHCS (State)		31,780
Non-ICASS Administrative Costs		GHCS (State)		17,838

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing				330,000		330,000
Computers/IT Services				710,000		710,000
ICASS				1,400,000		1,400,000
Institutional Contractors			999,970			999,970
Management Meetings/Professional Developement			350,000	380,000		730,000
Non-ICASS Administrative Costs			1,196,895	748,352		1,945,247
Staff Program Travel			360,752	336,687		697,439
USG Staff Salaries and Benefits			5,132,383	1,850,000		6,982,383
Total	**0**	**0**	**8,040,000**	**5,755,039**	**0**	**13,795,039**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount

Capital Security Cost Sharing		GHCS (State)		330,000
Computers/IT Services		GHCS (State)		710,000
ICASS		GHCS (State)		1,400,000
Management Meetings/Professional Developement		GAP		350,000
Management Meetings/Professional Developement		GHCS (State)		380,000
Non-ICASS Administrative Costs		GAP		1,196,895
Non-ICASS Administrative Costs		GHCS (State)		748,352

U.S. Department of State

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing				90,125		90,125
Computers/IT Services				10,000		10,000
ICASS				29,997		29,997
Management Meetings/Professional Developement				234,458		234,458
Non-ICASS Administrative Costs				10,000		10,000

Staff Program Travel				15,000		15,000
Total	**0**	**0**	**0**	**389,580**	**0**	**389,580**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHCS (State)		90,125
Computers/IT Services		GHCS (State)		10,000
ICASS		GHCS (State)		29,997
Management Meetings/Professional Developement		GHCS (State)		234,458
Non-ICASS Administrative Costs		GHCS (State)		10,000

U.S. Peace Corps

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Non-ICASS Administrative Costs				29,800		29,800
Staff Program Travel				13,200		13,200
USG Staff Salaries and Benefits				300,700		300,700
Total	**0**	**0**	**0**	**343,700**	**0**	**343,700**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Non-ICASS Administrative Costs		GHCS (State)		29,800