

---

# Populated Printable COP

2009

Uganda

Generated 9/28/2009 12:07:06 AM

## Table 1: Overview

### Executive Summary

File Name	Content Type	Date Uploaded	Description	Uploaded By
Ug COP09 Tbl1 - Executive Summary.doc	application/msword	11/13/2008		MAStrong

### Country Program Strategic Overview

Will you be submitting changes to your country's 5-Year Strategy this year? If so, please briefly describe the changes you will be submitting.

Yes  No

Description:

### Ambassador Letter

File Name	Content Type	Date Uploaded	Description	Uploaded By
Ug COP09 Spt Docs A. Ambassadors Ltr.pdf	application/pdf	11/10/2008		MAStrong

### Country Contacts

Contact Type	First Name	Last Name	Title	Email
PEPFAR Coordinator	Michael	Strong	PEPFAR Coordinator	strongmichaela@state.gov
DOD In-Country Contact	Monica	Millard	Country Program Director, Walter Reed	mmillard@muwrp.org
DOD In-Country Contact	Vincent	Golembeski	Security Cooperation Chief	golembeskivs@state.gov
HHS/CDC In-Country Contact	Kevin	McNeill	Country Director	fqq5@cdc.gov
Peace Corps In-Country Contact	McGrath	Thomas	Country Director	mthomas@ug.peacecorps.gov
USAID In-Country Contact	David	Eckerson	Mission Director	deckerson@usaid.gov
U.S. Embassy In-Country Contact	John	Hoover	Deputy Chief of Mission	hooverjf@state.gov
HHS/NIH In-Country Contact	Steve	Reynolds	Director	sreynol6@jhmi.edu
Global Fund In-Country Representative	Victor	Bampoe	Fund Portfolio Manager	victor.bampoe@theglobalfund.org

### Global Fund

What is the planned funding for Global Fund Technical Assistance in FY 2009? \$0  
Does the USG assist GFATM proposal writing? Yes  
Does the USG participate on the CCM? Yes

**Table 2: Prevention, Care, and Treatment Targets**

**2.1 Targets for Reporting Period Ending September 30, 2009**

	National 2-7-10	USG Downstream (Direct) Target End FY2009	USG Upstream (Indirect) Target End FY2009	USG Total Target End FY2009
<b>Prevention</b>				
<b>End of Plan Goal</b>	164,194			
1.2 - Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	0	705,027	338,663	1,043,690
1.3 - Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	0	49,152	17,660	66,812
<b>Care (1)</b>				
<b>End of Plan Goal</b>	300,000			
6.2 - Total number of individuals provided with HIV-related palliative care (including TB/HIV)	0	357,038	134,500	491,538
***7.2 - Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)	0	14,815	7,436	22,251
8.1 - Number of OVC served by OVC programs	0	285,030	428,390	713,420
9.2 - Number of individuals who received counseling and testing for HIV and received their test results (including TB)	0	1,595,944	934,371	2,530,315
<b>Treatment</b>				
<b>End of Plan Goal</b>	60,000			
11.4 - Number of individuals receiving antiretroviral therapy at the end of the reporting period	0	164,397	22,481	186,878
<b>Human Resources for Health</b>				
<b>End of Plan Goal</b>	0			
Number of new health care workers who graduated from a pre-service training institution within the reporting period.	0	0	0	0

## 2.2 Targets for Reporting Period Ending September 30, 2010

	USG Downstream (Direct) Target End FY2010	USG Upstream (Indirect) Target End FY2010	USG Total Target End FY2010
<b>Prevention</b>			
<b>End of Plan Goal</b>			
1.2 - Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	995,347	157,974	1,153,321
1.3 - Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	66,461	7,523	73,984
<b>Care (1)</b>			
<b>End of Plan Goal</b>			
6.2 - Total number of individuals provided with HIV-related palliative care (including TB/HIV)	361,078	178,809	539,887
***7.2 - Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)	14,859	910	15,769
8.1 - Number of OVC served by OVC programs	307,784	504,112	811,896
9.2 - Number of individuals who received counseling and testing for HIV and received their test results (including TB)	1,749,565	1,345,090	3,094,655
<b>Treatment</b>			
<b>End of Plan Goal</b>			
11.4 - Number of individuals receiving antiretroviral therapy at the end of the reporting period	177,280	35,446	212,726
<b>Human Resources for Health</b>			
<b>End of Plan Goal</b>			
Number of new health care workers who graduated from a pre-service training institution within the reporting period.	0	50	50

---

(1) Total Care represents number of OVC served by an OVC program during the reporting period and the number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care, including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis(TB).

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: National Laboratory System Infrastructure Improvement Initiative**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 5793.09  
**System ID:** 9146  
**Planned Funding(\$):** [REDACTED]  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: PEPFAR/PMI Collaboration**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7631.09  
**System ID:** 9236  
**Planned Funding(\$):** [REDACTED]  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** No

**Mechanism Name: TBD - EMRG**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 12194.09  
**System ID:** 12194  
**Planned Funding(\$):** [REDACTED]  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: TBD - HOPE**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 12193.09  
**System ID:** 12193  
**Planned Funding(\$):** [REDACTED]  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: TBD - SHARE**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 12192.09  
**System ID:** 12192  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: TBD - STATUS**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 12191.09  
**System ID:** 12191  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: Technical Assistance for data use/M&E systems strengthening for Implementing Partners**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 8655.09  
**System ID:** 11051  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: Western Region / PMTCT**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 9832.09  
**System ID:** 9832  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** No  
  
Sub-Partner: Jinja District Health Services, Uganda  
Planned Funding: \$84,000  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kiruhura District Health Services

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Rakai District Health Services, Uganda

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Rukungiri District

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kasese District Health Services

Planned Funding: \$22,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: PDX - Treatment: Pediatric Treatment

Sub-Partner: Sembabule District Health Services

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Ntungamo District

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kabarole District Health Services, Uganda

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kabale District Health Services, Uganda

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No



**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kibaale District

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Isingiro District Health Services

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Ibanda District Health Services

Planned Funding: \$62,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDX - Treatment: Pediatric Treatment

Sub-Partner: Mbarara District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Bushenyi District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Mukono District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Iganga District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Mpigi District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Mayuge District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Masaka District Health Services

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Lyantonde District HIV/AIDS Committee

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: World Harvest Mission, Bundibugyo

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Namutumba District Health Office

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Johns Hopkins University/Makerere University

Planned Funding: \$937,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Hoima District Health Office

Planned Funding: \$84,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDX - Treatment: Pediatric Treatment

Sub-Partner: Kamwenge District Health Office

Planned Funding: \$84,000

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment  
Sub-Partner: Kanungu District Health Office  
Planned Funding: \$62,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDTX - Treatment: Pediatric Treatment  
Sub-Partner: Kisoro District Health Office  
Planned Funding: \$62,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDTX - Treatment: Pediatric Treatment  
Sub-Partner: Bundibugyo District Health Office  
Planned Funding: \$62,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, PDTX - Treatment: Pediatric Treatment

**Mechanism Name: Capacity Building/Leadership and Management Program/ACE-Follow-on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9482.09  
**System ID:** 9482  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: Community-based Care and Support/TASO Follow on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9320.09  
**System ID:** 9433  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 3327.09  
**System ID:** 9412  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** No

**Mechanism Name: Monitoring & Evaluation of the Emergency Plan Program/MEEPP Follow On**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9479.09  
**System ID:** 9479  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: Support to OVC Services/CORE Follow-on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 1030.09  
**System ID:** 9440  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

Sub-Partner: Save the Children Uganda  
Planned Funding: \$540,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Uganda Women's Efforts to Save Orphans  
Planned Funding: \$470,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Pathfinder International  
Planned Funding: \$270,000  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Agency for Cooperation and Research in Development, Gulu

Planned Funding: \$270,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Uganda Project Implementation and Management Center

Planned Funding: \$270,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Transcultural Psychosocial Organization

Planned Funding: \$270,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Africare

Planned Funding: \$270,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: National Implementation Unit-Government of Uganda

Planned Funding: \$100,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

**Mechanism Name: TBD - Districts South-Southwest**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 7253.09

**System ID:** 10331

**Planned Funding(\$):** ██████████

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** To Be Determined

**New Partner:** Yes

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: TBD - HCT/AIC Follow on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9220.09  
**System ID:** 9367  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: TBD - SWEPT**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 12190.09  
**System ID:** 12190  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: TBD/Drug Logistics**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 4961.09  
**System ID:** 9451  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Mechanism Name: Technical Management Agent/Civil Society Fund**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9462.09  
**System ID:** 9462  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** Yes

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7207.09  
**System ID:** 9359  
**Planned Funding(\$):** ██████████  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** To Be Determined  
**New Partner:** No

**Mechanism Name: Laboratory Services Strengthening at Health Center IV and Above**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 583.09  
**System ID:** 8948  
**Planned Funding(\$):** \$641,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** African Medical and Research Foundation  
**New Partner:** No

**Mechanism Name: Community-Based Orphan Care, Protection and Empowerment (COPE) (Africare OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1116.09  
**System ID:** 9431  
**Planned Funding(\$):** \$464,874  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Africare  
**New Partner:** No

Sub-Partner: Appropriate Revival Initiative for Strategic Empowerment  
Planned Funding: \$100,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Ntungamo District Network of People Living with HIV/AIDS  
Planned Funding: \$100,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Integrated Development Options  
Planned Funding: \$100,000  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Foundation for AIDS Orphaned Children

Planned Funding: \$100,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

**Mechanism Name: Tuberculosis/HIV Intergration Activities**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 5246.09

**System ID:** 9124

**Planned Funding(\$):** \$593,922

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Prime Partner:** AIDS Information Centre

**New Partner:** No

**Mechanism Name: NU APPROACH/NPI**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 9858.09

**System ID:** 9858

**Planned Funding(\$):** \$0

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** American Refugee Committee

**New Partner:** No

**Mechanism Name: Food Security and Nutrition Support for OVC Households (APEP follow-on)**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 7261.09

**System ID:** 9426

**Planned Funding(\$):** \$300,000

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Associates in Rural Development

**New Partner:** No



**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Increased access and care for OVC in great lakes region (AVSI OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded

**Mechanism ID:** 1118.09

**System ID:** 9432

**Planned Funding(\$):** \$1,440,000

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** Central GHCS (State)

**Prime Partner:** Associazione Volontari per il Servizio Internazionale

**New Partner:** No

Sub-Partner: Meeting Point

Planned Funding: \$37,400

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Mother Kevin Secondary School

Planned Funding: \$80,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Kakira Sugar Works

Planned Funding: \$13,500

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Meeting Point Hoima

Planned Funding: \$34,700

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Meeting Point Kitgum

Planned Funding: \$16,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 5739.09  
**System ID:** 8955  
**Planned Funding(\$):** \$7,119,948  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Baylor College of Medicine Children's Foundation/Uganda  
**New Partner:** No

**Mechanism Name: The Core Initiative**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11121.09  
**System ID:** 11121  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** CARE International  
**New Partner:** No

Sub-Partner: International Center for Research on Women  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: International HIV/AIDS Alliance  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Johns Hopkins University Center for Communication Programs  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Ministry of Gender ,Labour and Social Development  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Affirming Life, Avoiding Risk (CRS ABY Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded

**Mechanism ID:** 1059.09

**System ID:** 9427

**Planned Funding(\$):** \$295,406

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** Central GHCS (State)

**Prime Partner:** Catholic Relief Services

**New Partner:** No

Sub-Partner: Kampala Archdiocese

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Gulu Archdiocese

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Mbarara Archdiocese

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Kasana Luwero Diocese

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Masaka Diocese

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Catholic Relief Services - Uganda

Planned Funding: \$106,577

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Fort Portal Diocese HIV/AIDS Focal Point

Planned Funding: \$9,489

Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

**Mechanism Name: AIDSRelief**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 5342.09  
**System ID:** 9122  
**Planned Funding(\$):** \$6,264,675  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Health Resources Services Administration  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Catholic Relief Services  
**New Partner:** No

Sub-Partner: Kamwokya Christian Caring Community  
Planned Funding: \$136,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: St. Mary's Hospital, Lacor  
Planned Funding: \$100,530  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Comboni Samaritans of Gulu  
Planned Funding: \$101,054  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Christian HIV/AIDS Prevention and Support  
Planned Funding: \$14,989  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Meeting Point Kitgum  
Planned Funding: \$15,917  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Virika Hospital  
Planned Funding: \$92,069  
Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Villa Maria Hospital
Planned Funding: \$96,461
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Kabarole Hospital
Planned Funding: \$58,687
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Kyamuhanga Comboni Hospital, Bushenyi
Planned Funding: \$79,393
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Kalongo Hospital
Planned Funding: \$49,883
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Katungu Medical Center
Planned Funding: \$87,185
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Kabwohe Medical Center
Planned Funding: \$122,447
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Kasanga Health Center
Planned Funding: \$72,590
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs
Sub-Partner: Constella Futures

**Table 3.1: Funding Mechanisms and Source**

Planned Funding: \$275,736  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment

Sub-Partner: Children's AIDS Fund  
Planned Funding: \$108,635  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: University of Maryland, Institute of Human Virology  
Planned Funding: \$1,069,911  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Nsambya Hospital  
Planned Funding: \$259,552  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Nyenga Hospital  
Planned Funding: \$35,719  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Amai Community Hospital  
Planned Funding: \$43,482  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: St. Joseph's Hospital  
Planned Funding: \$59,274  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Aber Hospital  
Planned Funding: \$29,430  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Family Hope Clinic - Kampala  
Planned Funding: \$237,149  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Nkozi Hospital  
Planned Funding: \$29,849  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

Sub-Partner: Family Hope Clinic - Jinja  
Planned Funding: \$1,066,180  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HTXD - ARV Drugs

**Mechanism Name: AIDSRelief**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1290.09  
**System ID:** 9123  
**Planned Funding(\$):** \$12,158,598  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Health Resources Services Administration  
**Funding Source:** GHCS (State)  
**Prime Partner:** Catholic Relief Services  
**New Partner:** No

Sub-Partner: Christian HIV/AIDS Prevention and Support  
Planned Funding: \$30,429  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Meeting Point  
Planned Funding: \$32,314  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Villa Maria Hospital  
Planned Funding: \$195,836  
Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Kalongo Hospital  
Planned Funding: \$101,273  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: University of Maryland, Institute of Human Virology  
Planned Funding: \$2,172,125  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: The Futures Group International  
Planned Funding: \$559,799  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Comboni Samaritans  
Planned Funding: \$205,159  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Nsambya Hospital  
Planned Funding: \$306,818  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Kamwokya Christian Caring Community  
Planned Funding: \$276,347  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs



**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: St. Mary's Hospital, Lacor
Planned Funding: \$204,096
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Kasanga Health Center
Planned Funding: \$147,373
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Katungu Medical Center
Planned Funding: \$177,001
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Kabwohe Medical Center
Planned Funding: \$248,591
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Children's AIDS Fund
Planned Funding: \$220,550
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Kabarole Hospital
Planned Funding: \$119,145
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs
Sub-Partner: Virika Hospital
Planned Funding: \$186,909

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: Kyamuhanga Comboni Hospital, Bushenyi  
Planned Funding: \$161,183  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: Nyenga Hospital  
Planned Funding: \$72,516  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: Amai Community Hospital  
Planned Funding: \$88,275  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: St. Joseph's Hospital  
Planned Funding: \$120,337  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: Family Hope Clinic - Kampala  
Planned Funding: \$265,003  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs  
Sub-Partner: Aber Hospital  
Planned Funding: \$59,748  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Nkozi Hospital

Planned Funding: \$60,600

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Family Hope Clinic - Jinja

Planned Funding: \$216,457

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

**Mechanism Name: AIDS Capacity Enhancement Program (ACE)**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 3370.09

**System ID:** 11122

**Planned Funding(\$):** \$0

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Chemonics International

**New Partner:** No

Sub-Partner: Training Resources Group

Planned Funding: \$0

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes:

Sub-Partner: IT Shows

Planned Funding: \$0

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

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

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9326.09  
**System ID:** 9370  
**Planned Funding(\$):** \$2,000,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Chemonics International  
**New Partner:** No

**Mechanism Name: Preserving the African Family in the face of HIV/AIDS (CAF ABY Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 9713.09  
**System ID:** 9713  
**Planned Funding(\$):** \$1,724,870  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Children's AIDS Fund  
**New Partner:** No  
  
Sub-Partner: Uganda Youth Forum  
Planned Funding: \$250,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

**Mechanism Name: Community-based care of OVC (CA OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1122.09  
**System ID:** 9443  
**Planned Funding(\$):** \$306,794  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Christian Aid  
**New Partner:** No  
  
Sub-Partner: Concerned Parents Association  
Planned Funding: \$50,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:  
  
Sub-Partner: Aids Care Education & Training - Uganda  
Planned Funding: \$50,000  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes:

Sub-Partner: Youth with a Mission

Planned Funding: \$50,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes:

**Mechanism Name: Commodity Security Logistics (CSL)**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 631.09

**System ID:** 9422

**Planned Funding(\$):** \$2,000,000

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Commodity Security Logistics

**New Partner:** No

**Mechanism Name: UNITY**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 7306.09

**System ID:** 9423

**Planned Funding(\$):** \$4,364,357

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Creative Associates International Inc

**New Partner:** No

**Mechanism Name: Financial Management Agent/ Civil Society Fund (FMA/CSF)**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 6181.09

**System ID:** 9424

**Planned Funding(\$):** \$7,761,892

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Deloitte Touche Tohmatsu

**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: HIPS (Health Initiatives in the Private Sector)**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 5028.09  
**System ID:** 9428  
**Planned Funding(\$):** \$2,606,500  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Emerging Markets  
**New Partner:** No  
  
Sub-Partner: Johns Hopkins University Center for Communication Programs  
Planned Funding: \$300,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

**Mechanism Name: SPRING (Stability, Peace and Reconciliation In Northern Uganda)**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7274.09  
**System ID:** 9449  
**Planned Funding(\$):** \$595,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Emerging Markets  
**New Partner:** No

**Mechanism Name: Contraceptive and Reproductive Health Technologies and Utilization (CRTU)**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 5033.09  
**System ID:** 10445  
**Planned Funding(\$):** \$550,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Family Health International  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Roads to a Healthy Future/ROADS II-SafeTStop Project**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 1258.09

**System ID:** 9429

**Planned Funding(\$):** \$2,160,000

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Family Health International

**New Partner:** No

Sub-Partner: Amalgamated Transport and General Workers Union

Planned Funding: \$140,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: The Uganda Red Cross Society

Planned Funding: \$65,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Frontline AIDS Support Network

Planned Funding: \$65,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Program for Appropriate Technology in Health

Planned Funding: \$75,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Family Health International

Planned Funding: \$776,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

Sub-Partner: Bajjabasaaga Marachi Community Development Association

Planned Funding: \$56,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Malaba Kyosimb'onanya Community Developm't Association

Planned Funding: \$53,000

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Howard University/PACE Center  
Planned Funding: \$105,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

Sub-Partner: Friends of Christ Revival Ministries  
Planned Funding: \$85,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

Sub-Partner: Tororo Network of AIDS Service Organizations  
Planned Funding: \$85,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

Sub-Partner: Voices for Humanity  
Planned Funding: \$100,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Solidarity Center  
Planned Funding: \$60,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Johns Hopkins University  
Planned Funding: \$150,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: PDCS - Care: Pediatric Care and Support

Sub-Partner: Development Alternatives, Inc  
Planned Funding: \$250,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, HKID - Care: OVC



**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: North Kigezi Diocese  
Planned Funding: \$105,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HKID - Care: OVC

Sub-Partner: JHPIEGO  
Planned Funding: \$125,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC, HVCT - Prevention: Counseling and Testing

Sub-Partner: Kamuganguzi People Living with HIV/AIDS  
Planned Funding: \$85,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

Sub-Partner: Kamuganguzi Bakyala Tukorehamwe  
Planned Funding: \$50,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: North Star Foundation  
Planned Funding: \$205,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HBHC - Care: Adult Care and Support, HVCT - Prevention: Counseling and Testing

**Mechanism Name: HOSPICE**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 1124.09  
**System ID:** 9430  
**Planned Funding(\$):** \$1,386,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** HOSPICE AFRICA, Uganda  
**New Partner:** No

Sub-Partner: Palliative Care Association of Uganda  
Planned Funding: \$261,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HBHC - Care: Adult Care and Support

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7406.09  
**System ID:** 9762  
**Planned Funding(\$):** \$2,179,933  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Infectious Disease Institute  
**New Partner:** No

**Mechanism Name: Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 9212.09  
**System ID:** 9233  
**Planned Funding(\$):** \$820,102  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Integrated Community Based Initiatives  
**New Partner:** No

**Mechanism Name: Integrated Community-Based Initiatives/NPI**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 9847.09  
**System ID:** 9847  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Integrated Community Based Initiatives  
**New Partner:** No

Sub-Partner: West Ankole Diocese  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Good Care and Family Support  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HKID - Care: OVC

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 5740.09  
**System ID:** 11050  
**Planned Funding(\$):** \$868,231  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Integrated Community Based Initiatives  
**New Partner:** No

**Mechanism Name: Expanding the Role of Networks of People Living with HIV/AIDS in Uganda**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 3166.09  
**System ID:** 10471  
**Planned Funding(\$):** \$2,627,948  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** International HIV/AIDS Alliance  
**New Partner:** No

**Mechanism Name: Refugee HIV/AIDS services in Kyaka II Settlement**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 3834.09  
**System ID:** 10706  
**Planned Funding(\$):** \$283,345  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** Department of State / Population, Refugees, and Migration  
**Funding Source:** GHCS (State)  
**Prime Partner:** International Medical Corps  
**New Partner:** No

**Mechanism Name: Empowering Africa's Young People Initiative (EAYPI) (IYF ABY Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1060.09  
**System ID:** 9720  
**Planned Funding(\$):** \$622,444  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** International Youth Foundation  
**New Partner:** No

Sub-Partner: The Uganda Red Cross Society

Planned Funding: \$75,000

Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Uganda National Scout Association  
Planned Funding: \$75,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Uganda Girl Guides Association  
Planned Funding: \$75,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: The Source of the Nile  
Planned Funding: \$75,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Uganda Young Womens Christian Association  
Planned Funding: \$75,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

**Mechanism Name: IRCU**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11125.09  
**System ID:** 11125  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Inter-Religious Council of Uganda  
**New Partner:** No

Sub-Partner: St Francis Home Care Program  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Kumi Hospital  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Kiwoko Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kisiizi Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kuluva Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Iganga Islamic Medical Center
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Ishaka Adventist Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kyetume Church Based Health Care Program
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: AIDS Orphans Education Trust
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Church of Uganda
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Nyenga Hospital

**Table 3.1: Funding Mechanisms and Source**

Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Chain Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Friends of Cannon Gideon Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kiyinda-Mityana Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Busota Muslim Support Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Al Quadus
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Acholi Orphan Institute
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Ngombe Community Health Care Program
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Amucha Seventh Day Adventist Child Development Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No
Associated Program Budget Codes:
Sub-Partner: Bringing Hope to the Family Full Gospel Mission
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Uganda Muslim Network
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Lyantode Islamic Medical Center
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Holy Cross Hospital Namungona
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Campus Alliance to wipe out AIDS
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Uganda Youth Forum
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Uganda Christian AIDS Network
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Meeting Point
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Kampala Diocese HIV/AIDS Program
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Namirembe Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Karera Ecumenical Development Organization
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: West Ankole Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Nebbi Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Mary Amuke Solidarity Fund
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kasana Luwero Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Mbarara Archdiocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Family Concept Care and Support Project



**Table 3.1: Funding Mechanisms and Source**

Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Noor Islamic Institute
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: YOUTH ALIVE
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Catholic Secretariat of Uganda
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Nyapea Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Buluba Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kilembe Mines Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Mengo Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Meeting Point Kitgum
Planned Funding: \$0
Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No
Associated Program Budget Codes:
Sub-Partner: Comboni Samaritans
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Caritas Lugazi Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: St. Matia Mulumba Vocational Institute
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Church of Uganda, Bukedi Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Bishop Masereka Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Ray of Hope Ministries
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Masanafu Child and Family Support
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Islamic Outreach Centre
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Buddu Social Development Association
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Caritas Masaka Child Sponsorship Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Lango Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Agape Nyakibale
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Namisambya OVC Care and Support Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kampala Archdiocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Aber Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Katente Child Care Orphans Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kireku Health Program

**Table 3.1: Funding Mechanisms and Source**

Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Nankyama Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Phaida Parish Nebbi Catholic Center
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Arua Diocese
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Bugema University
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Efforts Integrated Development Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Family Impact Uganda
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Here is Life Fot Portal HIV/AIDS Focal Point
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Here is Life
Planned Funding: \$0
Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No
Associated Program Budget Codes:
Sub-Partner: Intergraded Health and Development Organization
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kaberamaido Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kakinga Child Development Project
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kidayo
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kigezi health Care Foundation
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kiwanyi Muslim Orphans Support initiative
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Kyangyennyi Parish OVC
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:
Sub-Partner: Namaliga Hospital
Planned Funding: \$0
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Namungona Christian Care initiative  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: North Ankole  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Pastoral Commission Kampala  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Saidina Abubaker islamic Hospital  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: TIDO  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: The Capacity Project**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 3312.09  
**System ID:** 9413  
**Planned Funding(\$):** \$1,251,252  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** IntraHealth International, Inc  
**New Partner:** No

Sub-Partner: JHPIEGO  
Planned Funding: \$25,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

Sub-Partner: Management Sciences for Health  
Planned Funding: \$25,000

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:  
  
Sub-Partner: Technical Resources Group  
Planned Funding: \$40,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: Partnership for Supply Chain Management**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 10313.09  
**System ID:** 10313  
**Planned Funding(\$):** \$6,600,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** John Snow International  
**New Partner:** No

**Mechanism Name: John Snow, Inc./Injection Safety/country funded**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 8348.09  
**System ID:** 9415  
**Planned Funding(\$):** \$382,500  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** John Snow, Inc.  
**New Partner:** No

**Mechanism Name: NUMAT**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7156.09  
**System ID:** 9416  
**Planned Funding(\$):** \$5,708,922  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** John Snow, Inc.  
**New Partner:** No  
  
Sub-Partner: AIDS Information Centre  
Planned Funding: \$420,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVCT - Prevention: Counseling and Testing

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: World Vision Uganda  
Planned Funding: \$650,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, HTXS - Treatment: Adult Treatment, PDCS - Care: Pediatric Care and Support, PDTX - Treatment: Pediatric Treatment

Sub-Partner: Associazione Volontari per il Servizio Internazionale  
Planned Funding: \$200,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: PDCS - Care: Pediatric Care and Support, PDTX - Treatment: Pediatric Treatment

**Mechanism Name: STAR-EC**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9221.09  
**System ID:** 9368  
**Planned Funding(\$):** \$5,141,172  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** John Snow, Inc.  
**New Partner:** No

**Mechanism Name: AFFORD**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 3340.09  
**System ID:** 9417  
**Planned Funding(\$):** \$5,813,900  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Johns Hopkins University Center for Communication Programs  
**New Partner:** No

Sub-Partner: Constella Futures  
Planned Funding: \$380,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support

Sub-Partner: Pulse Uganda  
Planned Funding: \$280,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support



**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Communication for Development Foundation Uganda  
Planned Funding: \$200,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support

Sub-Partner: Uganda Health Marketing Group  
Planned Funding: \$2,520,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support

**Mechanism Name: Health Communication Partnership**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 9833.09  
**System ID:** 9833  
**Planned Funding(\$):** \$3,168,337  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Johns Hopkins University Center for Communication Programs  
**New Partner:** No

Sub-Partner: Communication for Development Foundation Uganda  
Planned Funding: \$1,000,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

Sub-Partner: Makerere University Institute of Public Health  
Planned Funding: \$150,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: CIRC - Biomedical Prevention: Male Circ

Sub-Partner: Regional Center for Quality Health Care  
Planned Funding: \$434,250  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: PDTX - Treatment: Pediatric Treatment

Sub-Partner: Signal FM Radio Station  
Planned Funding: \$20,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: CIRC - Biomedical Prevention: Male Circ

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: TREAT (Timetable for Regional Expansion of ART)**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11126.09  
**System ID:** 11126  
**Planned Funding(\$):** \$100,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Joint Clinical Research Center, Uganda  
**New Partner:** No

**Mechanism Name: Provision of Full Access Home-based Confidential HIV Counseling and Testing and Basic Care Services in Kalangala District and the Surrounding Fishing Communities**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 8670.09  
**System ID:** 9125  
**Planned Funding(\$):** \$915,190  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Kalangala District Health Office  
**New Partner:** No

**Mechanism Name: Full Access Counseling and Testing**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1284.09  
**System ID:** 10336  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Kumi Director of District Health Services  
**New Partner:** No

**Mechanism Name: AIDS Indicator Survey Final Activities- MACRO**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7292.09  
**System ID:** 9444  
**Planned Funding(\$):** \$2,838,408  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Macro International  
**New Partner:** No

Sub-Partner: Ministry of Health, Uganda

Planned Funding: \$0

Funding is TO BE DETERMINED: No

**Table 3.1: Funding Mechanisms and Source**

New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: Mulago-Mbarara Teaching Hospitals - MJAP**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1107.09  
**System ID:** 9127  
**Planned Funding(\$):** \$13,420,305  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Makerere University Faculty of Medicine  
**New Partner:** No

Sub-Partner: Ministry of Health, National TB & Leprosy Control Program  
Planned Funding: \$500,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVTB - Care: TB/HIV

Sub-Partner: Central Public Health Laboratories  
Planned Funding: \$150,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVTB - Care: TB/HIV

Sub-Partner: STI Clinic  
Planned Funding: \$560,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVOP - Sexual Prevention: Other

Sub-Partner: Infectious Disease Institute  
Planned Funding: \$122,000  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HBHC - Care: Adult Care and Support, HTXS - Treatment: Adult Treatment, HTXD - ARV Drugs

**Early Funding Activities**

Program Budget Code	Activity ID	Early Funding Narrative	Early Funding Request	Planned Funds
15-HTXD	4035.20767.09	In FY09 the program will have a rapid scale-up of activities and thus a corresponding increase in ARV procurement. The early funding request is intended to provide both continuity and safe buffer stock zone for the transition period until FY09 funds are received.	\$1,867,789	\$4,242,541
16-HLAB	4037.20770.09	The early request funds will be used to ensure continuity of ART laboratory monitoring for current and new clients. These monies will cover procurement and staff salaries until FY09 funding is available.	\$225,000	\$800,000
02-HVAB	26300.09	To ensure continuity of activities until FY09 funding is received these early requested funds will support the procurement of supplies and cover staff salaries for AB counseling and outreach.	\$222,500	\$460,000
13-HKID	4372.20765.09	Early funds will be used to support the costs of outreach activities for continued OVC services in satellite sites. These monies will cover transport and personnel costs until FY09 funds are provided.	\$50,000	\$200,000
14-HVCT	4033.20766.09	FY09 early funds will cover procurement of test kits and supplies for continued CT activities until full funding is made available.	\$350,000	\$1,400,000
10-PDCS	4032.20762.09	Pediatric care and treatment at the two program sites, Mulago and Mbarara, has tremendously increased since inception two years ago. The increase in attendance of family clinic days which involves both care-givers and children has lead to a marked demand for services. This early fund request is intended to provide support for the continued demand for services at the two sites. The funds will support equipment and commodity procurement as well as personnel costs required in the acute phase of scale-up of pediatric care and treatment.	\$73,000	\$73,000
11-PDTX	4036.20769.09	Pediatric care and treatment at the two program sites, Mulago and Mbarara, has tremendously increased since inception two years ago. The increase in attendance of family clinic days which involves both care-givers and children has lead to a marked demand for services. This early fund request is intended to provide support for the continued demand for services at the two sites. The funds will support equipment and commodity procurement as well as personnel costs required in the acute phase of scale-up of pediatric care and treatment.	\$121,851	\$121,851

08-HBHC	4032.20761.09	In FY09 the program will expand adult care and treatment to four new sites. This expansion comes with need for space adjustment, staff capacity-building including hiring/training of new staff and training of existing staff, and procurement of equipment and supplies. These funds will ensure continuity of services at the existing sites as well as support start-up activities at the new sites.	\$564,175	\$1,387,000
09-HTXS	4036.20768.09	In FY09 the program will expand adult care and treatment to four new sites. This expansion comes with need for space adjustment, staff capacity-building including hiring/training of new staff and training of existing staff, and procurement of equipment and supplies. These funds will ensure continuity of services at the existing sites as well as support start-up activities at the new sites.	\$537,625	\$2,315,160
12-HVTB	4034.20763.09	In FY 2009, MJAP will work towards strengthening the TB/HIV clinic care in Mbarara Hospital. The current clinic running as an extension of the Mbarara ISS-HIV clinic will become a stand alone clinic. This will come with demand for resources to set-up the entire clinic and hiring of additional staff as well as procurement of supplies for the clinic. The early funding request is therefore meant to both provide the necessary supplies and improve service delivery at all TB/HIV sites of MJAP including the national Regional Referral Hospitals.	\$125,000	\$1,385,818

**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**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 5738.09

**System ID:** 9243

**Planned Funding(\$):** \$5,127,072

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Prime Partner:** Makerere University School of Public Health

**New Partner:** No

Sub-Partner: Rakai Health Sciences Program

Planned Funding: \$3,441,083

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, CIRC - Biomedical Prevention: Male Circ, HBHC - Care: Adult Care and Support, HTXS - Treatment: Adult Treatment, PDCS - Care: Pediatric Care and Support, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HVCT - Prevention: Counseling and Testing, HTXD - ARV Drugs

Sub-Partner: Johns Hopkins University Center for Clinical Global Health Education

Planned Funding: \$500,000

Funding is TO BE DETERMINED: No

New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HVTB - Care: TB/HIV

**Mechanism Name: Eastern Region - HIV/AIDS & TB Program**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7204.09  
**System ID:** 10330  
**Planned Funding(\$):** \$4,841,206  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Management Sciences for Health  
**New Partner:** Yes

**Mechanism Name: Randomized Trial of Home or Facility - Based AIDS Care**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1270.09  
**System ID:** 10436  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Medical Research Council of Uganda  
**New Partner:** No  
  
Sub-Partner: The AIDS Support Organization  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: HIV/AIDS Project**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1298.09  
**System ID:** 9131  
**Planned Funding(\$):** \$11,881,605  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Mildmay International  
**New Partner:** No  
  
Sub-Partner: Reach Out, Mbuya, Uganda  
Planned Funding: \$2,688,062  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT, HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, HTXS - Treatment: Adult Treatment, PDCS - Care: Pediatric Care and Support, PDTX - Treatment: Pediatric Treatment, HVTB - Care: TB/HIV, HKID - Care: OVC, HTXD - ARV Drugs

**Mechanism Name: Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1259.09  
**System ID:** 9244  
**Planned Funding(\$):** \$5,744,601  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Ministry of Health, Uganda  
**New Partner:** No

**Mechanism Name: NDA**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 5091.09  
**System ID:** 9445  
**Planned Funding(\$):** \$300,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** National Drug Authority  
**New Partner:** No

**Mechanism Name: Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 629.09  
**System ID:** 9133  
**Planned Funding(\$):** \$9,007,459  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** National Medical Stores  
**New Partner:** No  
  
Sub-Partner: Joint Medical Stores  
Planned Funding: \$1,801,492  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support, HVCT - Prevention: Counseling and Testing

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: National Family Planning Center/NPI**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 9836.09  
**System ID:** 9836  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Natural Family Planning Center  
**New Partner:** Yes  
  
Sub-Partner: Teen Star Uganda  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: Yes  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

**Mechanism Name: HIVQUAL**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 3444.09  
**System ID:** 10564  
**Planned Funding(\$):** \$482,500  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Health Resources Services Administration  
**Funding Source:** GHCS (State)  
**Prime Partner:** New York AIDS Institute  
**New Partner:** No  
  
Sub-Partner: John Snow, Inc.  
Planned Funding: \$125,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HTXS - Treatment: Adult Treatment, PDTX - Treatment: Pediatric Treatment

**Mechanism Name: Sustainable Income and Housing for OVC in Africa (OI OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1123.09  
**System ID:** 9418  
**Planned Funding(\$):** \$292,471  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Opportunity International  
**New Partner:** No  
  
Sub-Partner: Habitat for Humanity  
Planned Funding: \$100,000  
Funding is TO BE DETERMINED: No  
New Partner: No



**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Uganda Agency For Development Ltd. (UGAFODE)

Planned Funding: \$100,000

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

**Mechanism Name: Breaking Barriers: Ensuring the Future of OVC through Education, Psychosocial Support and Community-Based Care (PI OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded

**Mechanism ID:** 4895.09

**System ID:** 9419

**Planned Funding(\$):** \$1,540,000

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** Central GHCS (State)

**Prime Partner:** PLAN International

**New Partner:** No

Sub-Partner: Plan Uganda

Planned Funding: \$334,202

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Save the Children US

Planned Funding: \$362,705

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

Sub-Partner: Inter-Religious Council of Uganda

Planned Funding: \$120,962

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HKID - Care: OVC

**Mechanism Name: Project SEARCH**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 7273.09

**System ID:** 9357

**Planned Funding(\$):** \$1,350,000

**Procurement/Assistance Instrument:** Contract

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** Population Council

**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Uganda AIDS Commission  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: Basic Care Package Procurement/Disemination**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 699.09  
**System ID:** 9143  
**Planned Funding(\$):** \$4,442,718  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Population Services International  
**New Partner:** No

Sub-Partner: Straight Talk Foundation, Uganda  
Planned Funding: \$200,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HBHC - Care: Adult Care and Support, PDCS - Care: Pediatric Care and Support

**Mechanism Name: Scouting for Solutions (PATH ABY Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1061.09  
**System ID:** 9721  
**Planned Funding(\$):** \$653,613  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Program for Appropriate Technology in Health  
**New Partner:** No

Sub-Partner: Straight Talk Foundation, Uganda  
Planned Funding: \$30,669  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Uganda National Scout Association  
Planned Funding: \$600,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

Sub-Partner: Instituto Promundo  
Planned Funding: \$10,000

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HVAB - Sexual Prevention: AB

**Mechanism Name: Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 679.09  
**System ID:** 9144  
**Planned Funding(\$):** \$5,713,650  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Protecting Families Against AIDS  
**New Partner:** No

Sub-Partner: Islamic Medical Association of Uganda  
Planned Funding: \$165,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Ministry of Health, Uganda  
Planned Funding: \$112,743  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Amuria District Local Government  
Planned Funding: \$92,502  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Budaka District Local Government  
Planned Funding: \$54,926  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Bududa District Local Government  
Planned Funding: \$52,035  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Tororo District Local Government  
Planned Funding: \$312,434  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Bukedea District Local Government

Planned Funding: \$52,035

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Bukwo District Local Government

Planned Funding: \$30,354

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Busia District Local Government

Planned Funding: \$89,617

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Butaleja District Local Government

Planned Funding: \$63,599

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Kaberamaido District Local Government

Planned Funding: \$54,926

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Kalangala District Local Government

Planned Funding: \$30,478

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Kampala District Local Government

Planned Funding: \$448,614

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Kapchorwa District Local Government

Planned Funding: \$60,708

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: MTCT - Prevention: PMTCT

**Table 3.1: Funding Mechanisms and Source**

Sub-Partner: Katakwi District Local Government
Planned Funding: \$63,888
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Kiboga District Local Government
Planned Funding: \$98,289
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Kumi District Local Government
Planned Funding: \$112,744
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Luwero District Local Government
Planned Funding: \$132,980
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Manafwa District Local Government
Planned Funding: \$106,962
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Mbale District Local Government
Planned Funding: \$132,981
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Mityana District Local Government
Planned Funding: \$98,289
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Mubende District Local Government
Planned Funding: \$173,452
Funding is TO BE DETERMINED: No
New Partner: No
Associated Program Budget Codes: MTCT - Prevention: PMTCT
Sub-Partner: Nakaseke District Local Government
Planned Funding: \$54,926

**Table 3.1: Funding Mechanisms and Source**

Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Nakasongola District Local Government  
Planned Funding: \$73,717  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Pallisa District Local Government  
Planned Funding: \$156,106  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Sironko District Local Government  
Planned Funding: \$109,853  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Soroti District Local Government  
Planned Funding: \$214,212  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Wakiso District Local Government  
Planned Funding: \$384,485  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: Arua Regional Referral Hospital, Uganda  
Planned Funding: \$364,350  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: MTCT - Prevention: PMTCT

Sub-Partner: University of California at San Francisco  
Planned Funding: \$367,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: RPSO/Track 1.0**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11909.09  
**System ID:** 11909  
**Planned Funding(\$):** \$1,400,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** Department of State / African Affairs  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Regional Procurement Support Office/Frankfurt  
**New Partner:** No

**Mechanism Name: Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1255.09  
**System ID:** 9147  
**Planned Funding(\$):** \$1,758,987  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Research Triangle International  
**New Partner:** No  
  
Sub-Partner: AIDS Healthcare Foundation  
Planned Funding: \$300,000  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HBHC - Care: Adult Care and Support

**Mechanism Name: Community care programs for OVC (SA OVC Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1112.09  
**System ID:** 9420  
**Planned Funding(\$):** \$585,437  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Salvation Army  
**New Partner:** No  
  
Sub-Partner: Pact, Inc.  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Mobilizing, Equipping and Training (MET) (SP ABY Track 1)**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1062.09  
**System ID:** 9421  
**Planned Funding(\$):** \$1,182,748  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Samaritan's Purse  
**New Partner:** No

**Mechanism Name: Track 1.0**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 5457.09  
**System ID:** 9148  
**Planned Funding(\$):** \$500,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Sanquin Consulting Services  
**New Partner:** No

**Mechanism Name: MEEPP (Monitoring and Evaluation of the Emergency Plan Program)**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 3456.09  
**System ID:** 11127  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** Social and Scientific Systems  
**New Partner:** No  
  
Sub-Partner: Principia  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:



**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Strengthening Democratic Linkages in Uganda (Linkages)**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 5030.09  
**System ID:** 9435  
**Planned Funding(\$):** \$525,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** State University of New York  
**New Partner:** No  
  
Sub-Partner: Research Triangle Institute  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes:

**Mechanism Name: TB/HIV Integration Activity**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 4056.09  
**System ID:** 9437  
**Planned Funding(\$):** \$1,933,007  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** TB-CAP  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 5737.09

**System ID:** 9149

**Planned Funding(\$):** \$14,486,473

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Prime Partner:** The AIDS Support Organization

**New Partner:** No

**Early Funding Activities**

Program Budget Code	Activity ID	Early Funding Narrative	Early Funding Request	Planned Funds
08-HBHC	4054.20875.09	FY 2009 early funding will ensure no interruption in comprehensive care and treatment services to 23,000 adult clients on treatment and 73,000 in care at the 11 TASO Centers nationwide. This funding will sustain the core program components until complete funding is available.	\$580,000	\$684,000
10-PDCS	4054.20876.09	FY 2009 early funding will ensure no interruption in comprehensive care and treatment services to 2,600 pediatric clients on treatment and 8,000 in care at the 11 TASO Centers nationwide. This funding will sustain the core program components until complete funding is available.	\$145,000	\$146,000
09-HTXS	4057.20880.09	FY 2009 early funding will ensure no interruption in comprehensive care and treatment services to 23,000 adult clients on treatment and 73,000 in care at the 11 TASO Centers nationwide. This funding will sustain the core program components until complete funding is available.	\$580,000	\$3,154,880
11-PDTX	4057.20881.09	FY 2009 early funding will ensure no interruption in comprehensive care and treatment services to 2,600 pediatric clients on treatment and 8,000 in care at the 11 TASO Centers nationwide. This funding will sustain the core program components until complete funding is available.	\$145,000	\$788,720
15-HTXD	4056.20879.09	This early funding is to maintain an uninterrupted supply of adult and pediatric ARV regimes to ensure clients on treatment are continuously supplied as well as to maintain adequate pipeline and buffer stock to cover potential national stock-outs. This request is earmarked for the procurement of ARV drugs during the early months of FY 2009.	\$2,200,000	\$6,980,301

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Strengthening HIV Counselor Training**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 693.09  
**System ID:** 9150  
**Planned Funding(\$):** \$1,295,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** The AIDS Support Organization  
**New Partner:** No

**Mechanism Name: TASO**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11128.09  
**System ID:** 11128  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** The AIDS Support Organization  
**New Partner:** No

**Mechanism Name: Mid-term and End of Program Evaluations/UMEMS**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 7293.09  
**System ID:** 9452  
**Planned Funding(\$):** \$700,000  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** The Mitchell Group  
**New Partner:** Yes

**Mechanism Name: New Partners Initiative:Traditional & Modern Health Practioners**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 10934.09  
**System ID:** 10934  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Traditional & Modern Health Practitioners**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 9211.09  
**System ID:** 9235  
**Planned Funding(\$):** \$820,116  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda  
**New Partner:** No

**Mechanism Name: Rapid Strengthening of Blood Transfusion Services**

**Mechanism Type:** Central - Headquarters procured, centrally funded  
**Mechanism ID:** 1250.09  
**System ID:** 9151  
**Planned Funding(\$):** \$3,000,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** Central GHCS (State)  
**Prime Partner:** Uganda Blood Transfusion Services  
**New Partner:** No  
  
Sub-Partner: The Uganda Red Cross Society  
Planned Funding: \$749,858  
Funding is TO BE DETERMINED: No  
New Partner: No  
Associated Program Budget Codes: HMBL - Biomedical Prevention: Blood, HVCT - Prevention: Counseling and Testing

**Mechanism Name: HIV/AIDS Prison Survey**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7632.09  
**System ID:** 9237  
**Planned Funding(\$):** \$320,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Uganda Prisons Services  
**New Partner:** Yes

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: Laboratory Quality Assurance-Cooperative Agreement**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 3440.09  
**System ID:** 9152  
**Planned Funding(\$):** \$1,050,000  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** Uganda Virus Research Institute  
**New Partner:** No

**Mechanism Name: HCI (Health Care Improvement Project)**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 10444.09  
**System ID:** 10444  
**Planned Funding(\$):** \$2,605,500  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** University Research Corporation, LLC  
**New Partner:** No

**Mechanism Name: Health Care Improvement Project - HCI/NuLife**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7257.09  
**System ID:** 9438  
**Planned Funding(\$):** \$1,816,750  
**Procurement/Assistance Instrument:** Contract  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** University Research Corporation, LLC  
**New Partner:** No

**Mechanism Name: USAID IRM**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 11120.09  
**System ID:** 11120  
**Planned Funding(\$):** \$258,610  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Agency for International Development  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: USAID Management and Staffing**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 1373.09  
**System ID:** 9439  
**Planned Funding(\$):** \$7,058,000  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Agency for International Development  
**New Partner:** No

**Mechanism Name: CDC Base GAP**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 1257.09  
**System ID:** 9137  
**Planned Funding(\$):** \$8,040,000  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP  
**Prime Partner:** US Centers for Disease Control and Prevention  
**New Partner:** No

**Mechanism Name: CDC GHAI**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 3481.09  
**System ID:** 9136  
**Planned Funding(\$):** \$7,330,039  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Centers for Disease Control and Prevention  
**New Partner:** No

**Table 3.1: Funding Mechanisms and Source**

**Early Funding Activities**

Program Budget Code	Activity ID	Early Funding Narrative	Early Funding Request	Planned Funds
19-HVMS	16093.20839.09	HHS/CDC operational costs include expenses related to staff salary and benefits, essential travel, residential lease payments, contractual services, IT support and, laboratory and office supplies. The procurement lead times for services and commodities in the Uganda office is lengthy due to the ordering, shipping, clearance and distribution to points of service. This process requires early funding to ensure that there is no interruption in program and operation activities and payment of staff salaries and benefits.	\$116,658	\$116,658
16-HLAB	15738.20832.09	HHS/CDC operational costs include expenses related to staff salary and benefits, essential travel, residential lease payments, contractual services, IT support and, laboratory and office supplies. The procurement lead times for services and commodities in the Uganda office is lengthy due to the ordering, shipping, clearance and distribution to points of service. This process requires early funding to ensure that there is no interruption in program and operation activities and payment of staff salaries and benefits.	\$667,342	\$1,633,364
17-HVSI	27232.09	HHS/CDC operational costs include expenses related to staff salary and benefits, essential travel, residential lease payments, contractual services, IT support and, laboratory and office supplies. The procurement lead times for services and commodities in the Uganda office is lengthy due to the ordering, shipping, clearance and distribution to points of service. This process requires early funding to ensure that there is no interruption in program and operation activities and payment of staff salaries and benefits.	\$400,000	\$356,275
19-HVMS	26359.09	HHS/CDC operational costs include expenses related to staff salary and benefits, essential travel, residential lease payments, contractual services, IT support and, laboratory and office supplies. The procurement lead times for services and commodities in the Uganda office is lengthy due to the ordering, shipping, clearance and distribution to points of service. This process requires early funding to ensure that there is no interruption in program and operation activities and payment of staff salaries and benefits.	\$600,000	\$399,535

**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name:**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 690.09  
**System ID:** 9374  
**Planned Funding(\$):** \$1,397,103  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** Department of Defense  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of Defense  
**New Partner:** No

**Mechanism Name: HHS/CDC CSCS**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7349.09  
**System ID:** 9140  
**Planned Funding(\$):** \$470,000  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of State  
**New Partner:** No

**Mechanism Name: HHS/CDC ICASS**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7348.09  
**System ID:** 9139  
**Planned Funding(\$):** \$1,300,000  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of State  
**New Partner:** No

**Mechanism Name: ICASS**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 11952.09  
**System ID:** 11952  
**Planned Funding(\$):** \$30,880  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** Department of State / Office of the U.S. Global AIDS Coordinator  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of State  
**New Partner:** No



**Table 3.1: Funding Mechanisms and Source**

**Mechanism Name: State Department**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 1311.09  
**System ID:** 9375  
**Planned Funding(\$):** \$861,329  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** Department of State / African Affairs  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of State  
**New Partner:** No

**Mechanism Name: USAID ICASS**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 11118.09  
**System ID:** 11118  
**Planned Funding(\$):** \$780,000  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Department of State  
**New Partner:** No

**Mechanism Name: Peace Corps**

**Mechanism Type:** Local - Locally procured, country funded  
**Mechanism ID:** 1222.09  
**System ID:** 9376  
**Planned Funding(\$):** \$2,985,220  
**Procurement/Assistance Instrument:** USG Core  
**Agency:** Peace Corps  
**Funding Source:** GHCS (State)  
**Prime Partner:** US Peace Corps  
**New Partner:** No

**Mechanism Name: New Partners Initiative:Visions in Action**

**Mechanism Type:** HQ - Headquarters procured, country funded  
**Mechanism ID:** 7624.09  
**System ID:** 9141  
**Planned Funding(\$):** \$0  
**Procurement/Assistance Instrument:** Cooperative Agreement  
**Agency:** HHS/Health Resources Services Administration  
**Funding Source:** GHCS (State)  
**Prime Partner:** Visions in Action  
**New Partner:** No  
  
Sub-Partner: Family Life Network  
Planned Funding: \$0  
Funding is TO BE DETERMINED: No  
New Partner: No

**Table 3.1: Funding Mechanisms and Source**

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HVCT - Prevention: Counseling and Testing

Sub-Partner: Dyere Tek

Planned Funding: \$0

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HVCT - Prevention: Counseling and Testing

Sub-Partner: Health Alert

Planned Funding: \$0

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other, HVCT - Prevention: Counseling and Testing

**Mechanism Name: Makerere University Walter Reed Project (MUWRP)**

**Mechanism Type:** HQ - Headquarters procured, country funded

**Mechanism ID:** 1245.09

**System ID:** 8949

**Planned Funding(\$):** \$2,773,214

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Prime Partner:** Walter Reed

**New Partner:** No

**Mechanism Name: SPEAR**

**Mechanism Type:** Local - Locally procured, country funded

**Mechanism ID:** 7287.09

**System ID:** 9450

**Planned Funding(\$):** \$1,203,302

**Procurement/Assistance Instrument:** Cooperative Agreement

**Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Prime Partner:** World Vision International

**New Partner:** No

Sub-Partner: Research Triangle Institute

Planned Funding: \$365,423

Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Budget Codes: HVAB - Sexual Prevention: AB , HVOP - Sexual Prevention: Other

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
1116.09	9431	Africare	U.S. Agency for International Development	Central GHCS (State)	Appropriate Revival Initiative for Strategic Empowerment	N	\$100,000
1116.09	9431	Africare	U.S. Agency for International Development	Central GHCS (State)	Foundation for AIDS Orphaned Children	N	\$100,000
1116.09	9431	Africare	U.S. Agency for International Development	Central GHCS (State)	Integrated Development Options	N	\$100,000
1116.09	9431	Africare	U.S. Agency for International Development	Central GHCS (State)	Ntungamo District Network of People Living with HIV/AIDS	N	\$100,000
1118.09	9432	Associazione Volontari per il Servizio Internazionale	U.S. Agency for International Development	Central GHCS (State)	Kakira Sugar Works	N	\$13,500
1118.09	9432	Associazione Volontari per il Servizio Internazionale	U.S. Agency for International Development	Central GHCS (State)	Meeting Point	N	\$37,400
1118.09	9432	Associazione Volontari per il Servizio Internazionale	U.S. Agency for International Development	Central GHCS (State)	Meeting Point Hoima	N	\$34,700
1118.09	9432	Associazione Volontari per il Servizio Internazionale	U.S. Agency for International Development	Central GHCS (State)	Meeting Point Kitgum	N	\$16,000
1118.09	9432	Associazione Volontari per il Servizio Internazionale	U.S. Agency for International Development	Central GHCS (State)	Mother Kevin Secondary School	N	\$80,000
11121.09	11121	CARE International	U.S. Agency for International Development	GHCS (State)	International Center for Research on Women	N	\$0
11121.09	11121	CARE International	U.S. Agency for International Development	GHCS (State)	International HIV/AIDS Alliance	N	\$0
11121.09	11121	CARE International	U.S. Agency for International Development	GHCS (State)	Johns Hopkins University Center for Communication Programs	N	\$0
11121.09	11121	CARE International	U.S. Agency for International Development	GHCS (State)	Ministry of Gender ,Labour and Social Development	N	\$0
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Catholic Relief Services - Uganda	N	\$106,577
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Fort Portal Diocese HIV/AIDS Focal Point	N	\$9,489
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Gulu Archdiocese	N	\$9,489
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Kampala Archdiocese	N	\$9,489
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Kasana Luwero Diocese	N	\$9,489
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Masaka Diocese	N	\$9,489
1059.09	9427	Catholic Relief Services	U.S. Agency for International Development	Central GHCS (State)	Mbarara Archdiocese	N	\$9,489
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Aber Hospital	N	\$59,748
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Amai Community Hospital	N	\$88,275
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Children's AIDS Fund	N	\$220,550

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Christian HIV/AIDS Prevention and Support	N	\$30,429
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Comboni Samaritans	N	\$205,159
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Family Hope Clinic - Jinja	N	\$216,457
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Family Hope Clinic - Kampala	N	\$265,003
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kabarole Hospital	N	\$119,145
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kabwohe Medical Center	N	\$248,591
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kalongo Hospital	N	\$101,273
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kamwokya Christian Caring Community	N	\$276,347
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kasanga Health Center	N	\$147,373
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Katungu Medical Center	N	\$177,001
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Kyamuhanga Comboni Hospital, Bushenyi	N	\$161,183
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Meeting Point	N	\$32,314
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Nkozi Hospital	N	\$60,600
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Nsambya Hospital	N	\$306,818
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Nyenga Hospital	N	\$72,516
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	St. Joseph's Hospital	N	\$120,337
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	St. Mary's Hospital, Lacor	N	\$204,096
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	The Futures Group International	N	\$559,799
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	University of Maryland, Institute of Human Virology	N	\$2,172,125
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Villa Maria Hospital	N	\$195,836
1290.09	9123	Catholic Relief Services	HHS/Health Resources Services Administration	GHCS (State)	Virika Hospital	N	\$186,909
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Aber Hospital	N	\$29,430
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Amai Community Hospital	N	\$43,482
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Children's AIDS Fund	N	\$108,635
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Christian HIV/AIDS Prevention and Support	N	\$14,989
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Comboni Samaritans of Gulu	N	\$101,054
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Constella Futures	N	\$275,736
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Family Hope Clinic - Jinja	N	\$1,066,180

**Table 3.2: Sub-Partners List**

<b>Mech ID</b>	<b>System ID</b>	<b>Prime Partner</b>	<b>Agency</b>	<b>Funding Source</b>	<b>Sub-Partner</b>	<b>TBD Funding</b>	<b>Planned Funding</b>
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Family Hope Clinic - Kampala	N	\$237,149
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kabarole Hospital	N	\$58,687
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kabwohe Medical Center	N	\$122,447
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kalongo Hospital	N	\$49,883
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kamwokya Christian Caring Community	N	\$136,000
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kasanga Health Center	N	\$72,590
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Katungu Medical Center	N	\$87,185
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Kyamuhanga Comboni Hospital, Bushenyi	N	\$79,393
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Meeting Point Kitgum	N	\$15,917
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Nkozi Hospital	N	\$29,849
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Nsambya Hospital	N	\$259,552
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Nyenga Hospital	N	\$35,719
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	St. Joseph's Hospital	N	\$59,274
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	St. Mary's Hospital, Lacor	N	\$100,530
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	University of Maryland, Institute of Human Virology	N	\$1,069,911
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Villa Maria Hospital	N	\$96,461
5342.09	9122	Catholic Relief Services	HHS/Health Resources Services Administration	Central GHCS (State)	Virika Hospital	N	\$92,069
3370.09	11122	Chemonics International	U.S. Agency for International Development	GHCS (State)	IT Shows	N	\$0
3370.09	11122	Chemonics International	U.S. Agency for International Development	GHCS (State)	Training Resources Group	N	\$0
9713.09	9713	Children's AIDS Fund	U.S. Agency for International Development	Central GHCS (State)	Uganda Youth Forum	N	\$250,000
1122.09	9443	Christian Aid	U.S. Agency for International Development	Central GHCS (State)	Aids Care Education & Training - Uganda	N	\$50,000
1122.09	9443	Christian Aid	U.S. Agency for International Development	Central GHCS (State)	Concerned Parents Association	N	\$50,000

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
1122.09	9443	Christian Aid	U.S. Agency for International Development	Central GHCS (State)	Youth with a Mission	N	\$50,000
5028.09	9428	Emerging Markets	U.S. Agency for International Development	GHCS (State)	Johns Hopkins University Center for Communication Programs	N	\$300,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Amalgamated Transport and General Workers Union	N	\$140,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Bajjabasaaga Marachi Community Development Association	N	\$56,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Development Alternatives, Inc	N	\$250,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Family Health International	N	\$776,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Friends of Christ Revival Ministries	N	\$85,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Frontline AIDS Support Network	N	\$65,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Howard University/PACE Center	N	\$105,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	JHPIEGO	N	\$125,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Johns Hopkins University	N	\$150,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Kamuganguzi Bakyala Tukorerehamwe	N	\$50,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Kamuganguzi People Living with HIV/AIDS	N	\$85,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Malaba Kyosimb'onanya Community Developm't Association	N	\$53,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	North Kigezi Diocese	N	\$105,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	North Star Foundation	N	\$205,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Program for Appropriate Technology in Health	N	\$75,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Solidarity Center	N	\$60,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	The Uganda Red Cross Society	N	\$65,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Tororo Network of AIDS Service Organizations	N	\$85,000
1258.09	9429	Family Health International	U.S. Agency for International Development	GHCS (State)	Voices for Humanity	N	\$100,000
1124.09	9430	HOSPICE AFRICA, Uganda	U.S. Agency for International Development	GHCS (State)	Palliative Care Association of Uganda	N	\$261,000
9847.09	9847	Integrated Community Based Initiatives	U.S. Agency for International Development	GHCS (State)	Good Care and Family Support	N	\$0
9847.09	9847	Integrated Community Based Initiatives	U.S. Agency for International Development	GHCS (State)	West Ankole Diocese	N	\$0
1060.09	9720	International Youth Foundation	U.S. Agency for International Development	Central GHCS (State)	The Source of the Nile	N	\$75,000
1060.09	9720	International Youth Foundation	U.S. Agency for International Development	Central GHCS (State)	The Uganda Red Cross Society	N	\$75,000
1060.09	9720	International Youth Foundation	U.S. Agency for International Development	Central GHCS (State)	Uganda Girl Guides Association	N	\$75,000

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
1060.09	9720	International Youth Foundation	U.S. Agency for International Development	Central GHCS (State)	Uganda National Scout Association	N	\$75,000
1060.09	9720	International Youth Foundation	U.S. Agency for International Development	Central GHCS (State)	Uganda Young Womens Christian Association	N	\$75,000
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Aber Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Acholi Orphan Institute	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Agape Nyakibale	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	AIDS Orphans Education Trust	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	AI Quadus	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Amucha Seventh Day Adventist Child Development Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Arua Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Bishop Masereka Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Bringing Hope to the Family Full Gospel Mission	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Buddu Social Development Association	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Bugema University	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Buluba Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Busota Muslim Support Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Campus Alliance to wipe out AIDS	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Caritas Lugazi Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Caritas Masaka Child Sponsorship Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Catholic Secretariat of Uganda	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Chain Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Church of Uganda	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Church of Uganda, Bukedi Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Comboni Samaritans	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Efforts Integrated Development Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Family Concept Care and Support Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Family Impact Uganda	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Friends of Cannon Gideon Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Here is Life	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Here is Life Fot Portal HIV/AIDS Focal Point	N	\$0

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Holy Cross Hospital Namungona	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Iganga Islamic Medical Center	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Intergraded Health and Development Organization	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Ishaka Adventist Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Islamic Outreach Centre	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kaberaimaido Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kakinga Child Development Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kampala Archdiocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kampala Diocese HIV/AIDS Program	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Karera Ecumenical Development Organization	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kasana Luwero Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Katente Child Care Orphans Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kidayo	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kigezi health Care Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kilembe Mines Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kireku Health Program	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kisiizi Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kiwanyi Muslim Orphans Support initiative	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kiwoko Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kiyinda-Mityana Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kuluva Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kumi Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kyangyennyi Parish OVC	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Kyetume Church Based Health Care Program	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Lango Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Lyantode Islamic Medical Center	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Mary Amuke Solidarity Fund	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Masanafu Child and Family Support	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Mbarara Archdiocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Meeting Point	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Meeting Point Kitgum	N	\$0



**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Mengo Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Namaliga Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Namirembe Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Namisambya OVC Care and Support Project	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Namungona Christian Care initiative	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Nankyama Foundation	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Nebbi Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Ngombe Community Health Care Program	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Noor Islamic Institute	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	North Ankole	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Nyapea Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Nyenga Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Pastoral Commission Kampala	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Phaida Parish Nebbi Catholic Center	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Ray of Hope Ministries	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Saidina Abubaker islamic Hospital	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	St Francis Home Care Program	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	St. Matia Mulumba Vocational Institute	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	TIDO	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Uganda Christian AIDS Network	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Uganda Muslim Network	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	Uganda Youth Forum	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	West Ankole Diocese	N	\$0
11125.09	11125	Inter-Religious Council of Uganda	U.S. Agency for International Development	GHCS (State)	YOUTH ALIVE	N	\$0
3312.09	9413	IntraHealth International, Inc	U.S. Agency for International Development	GHCS (State)	JHPIEGO	N	\$25,000
3312.09	9413	IntraHealth International, Inc	U.S. Agency for International Development	GHCS (State)	Management Sciences for Health	N	\$25,000
3312.09	9413	IntraHealth International, Inc	U.S. Agency for International Development	GHCS (State)	Technical Resources Group	N	\$40,000
7156.09	9416	John Snow, Inc.	U.S. Agency for International Development	GHCS (State)	AIDS Information Centre	N	\$420,000
7156.09	9416	John Snow, Inc.	U.S. Agency for International Development	GHCS (State)	Associazione Volontari per il Servizio Internazionale	N	\$200,000
7156.09	9416	John Snow, Inc.	U.S. Agency for International Development	GHCS (State)	World Vision Uganda	N	\$650,000

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
3340.09	9417	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Communication for Development Foundation Uganda	N	\$200,000
3340.09	9417	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Constella Futures	N	\$380,000
3340.09	9417	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Pulse Uganda	N	\$280,000
3340.09	9417	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Uganda Health Marketing Group	N	\$2,520,000
9833.09	9833	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Communication for Development Foundation Uganda	N	\$1,000,000
9833.09	9833	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Makerere University Institute of Public Health	N	\$150,000
9833.09	9833	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Regional Center for Quality Health Care	N	\$434,250
9833.09	9833	Johns Hopkins University Center for Communication Programs	U.S. Agency for International Development	GHCS (State)	Signal FM Radio Station	N	\$20,000
7292.09	9444	Macro International	U.S. Agency for International Development	GHCS (State)	Ministry of Health, Uganda	N	\$0
1107.09	9127	Makerere University Faculty of Medicine	HHS/Centers for Disease Control & Prevention	GHCS (State)	Central Public Health Laboratories	N	\$150,000
1107.09	9127	Makerere University Faculty of Medicine	HHS/Centers for Disease Control & Prevention	GHCS (State)	Infectious Disease Institute	N	\$122,000
1107.09	9127	Makerere University Faculty of Medicine	HHS/Centers for Disease Control & Prevention	GHCS (State)	Ministry of Health, National TB & Leprosy Control Program	N	\$500,000
1107.09	9127	Makerere University Faculty of Medicine	HHS/Centers for Disease Control & Prevention	GHCS (State)	STI Clinic	N	\$560,000
5738.09	9243	Makerere University School of Public Health	HHS/Centers for Disease Control & Prevention	GHCS (State)	Johns Hopkins University Center for Clinical Global Health Education	N	\$500,000
5738.09	9243	Makerere University School of Public Health	HHS/Centers for Disease Control & Prevention	GHCS (State)	Rakai Health Sciences Program	N	\$3,441,083
1270.09	10436	Medical Research Council of Uganda	HHS/Centers for Disease Control & Prevention	GHCS (State)	The AIDS Support Organization	N	\$0
1298.09	9131	Mildmay International	HHS/Centers for Disease Control & Prevention	GHCS (State)	Reach Out, Mbuya, Uganda	N	\$2,688,062
629.09	9133	National Medical Stores	HHS/Centers for Disease Control & Prevention	GHCS (State)	Joint Medical Stores	N	\$1,801,492
9836.09	9836	Natural Family Planning Center	U.S. Agency for International Development	GHCS (State)	Teen Star Uganda	N	\$0
3444.09	10564	New York AIDS Institute	HHS/Health Resources Services Administration	GHCS (State)	John Snow, Inc.	N	\$125,000
1123.09	9418	Opportunity International	U.S. Agency for International Development	Central GHCS (State)	Habitat for Humanity	N	\$100,000
1123.09	9418	Opportunity International	U.S. Agency for International Development	Central GHCS (State)	Uganda Agency For Development Ltd. (UGAFODE)	N	\$100,000
4895.09	9419	PLAN International	U.S. Agency for International Development	Central GHCS (State)	Inter-Religious Council of Uganda	N	\$120,962
4895.09	9419	PLAN International	U.S. Agency for International Development	Central GHCS (State)	Plan Uganda	N	\$334,202
4895.09	9419	PLAN International	U.S. Agency for International Development	Central GHCS (State)	Save the Children US	N	\$362,705
7273.09	9357	Population Council	U.S. Agency for International Development	GHCS (State)	Uganda AIDS Commission	N	\$0
699.09	9143	Population Services International	HHS/Centers for Disease Control & Prevention	GHCS (State)	Straight Talk Foundation, Uganda	N	\$200,000

**Table 3.2: Sub-Partners List**

<b>Mech ID</b>	<b>System ID</b>	<b>Prime Partner</b>	<b>Agency</b>	<b>Funding Source</b>	<b>Sub-Partner</b>	<b>TBD Funding</b>	<b>Planned Funding</b>
1061.09	9721	Program for Appropriate Technology in Health	U.S. Agency for International Development	Central GHCS (State)	Instituto Promundo	N	\$10,000
1061.09	9721	Program for Appropriate Technology in Health	U.S. Agency for International Development	Central GHCS (State)	Straight Talk Foundation, Uganda	N	\$30,669
1061.09	9721	Program for Appropriate Technology in Health	U.S. Agency for International Development	Central GHCS (State)	Uganda National Scout Association	N	\$600,000
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Amuria District Local Government	N	\$92,502
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Arua Regional Referral Hospital, Uganda	N	\$364,350
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Budaka District Local Government	N	\$54,926
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Bududa District Local Government	N	\$52,035
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Bukedea District Local Government	N	\$52,035
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Bukwo District Local Government	N	\$30,354
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Busia District Local Government	N	\$89,617
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Butaleja District Local Government	N	\$63,599
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Islamic Medical Association of Uganda	N	\$165,000
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kaberamaido District Local Government	N	\$54,926
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kalangala District Local Government	N	\$30,478
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kampala District Local Government	N	\$448,614
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kapchorwa District Local Government	N	\$60,708
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Katakwi District Local Government	N	\$63,888
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kiboga District Local Government	N	\$98,289
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Kumi District Local Government	N	\$112,744
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Luwero District Local Government	N	\$132,980
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Manafwa District Local Government	N	\$106,962
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Mbale District Local Government	N	\$132,981
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Ministry of Health, Uganda	N	\$112,743
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Mityana District Local Government	N	\$98,289
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Mubende District Local Government	N	\$173,452
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Nakaseke District Local Government	N	\$54,926
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Nakasongola District Local Government	N	\$73,717
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Pallisa District Local Government	N	\$156,106
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Sironko District Local Government	N	\$109,853

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Soroti District Local Government	N	\$214,212
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Tororo District Local Government	N	\$312,434
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	University of California at San Francisco	N	\$367,000
679.09	9144	Protecting Families Against AIDS	HHS/Centers for Disease Control & Prevention	GHCS (State)	Wakiso District Local Government	N	\$384,485
1255.09	9147	Research Triangle International	HHS/Centers for Disease Control & Prevention	GHCS (State)	AIDS Healthcare Foundation	N	\$300,000
1112.09	9420	Salvation Army	U.S. Agency for International Development	Central GHCS (State)	Pact, Inc.	N	\$0
3456.09	11127	Social and Scientific Systems	U.S. Agency for International Development	GHCS (State)	Principia	N	\$0
5030.09	9435	State University of New York	U.S. Agency for International Development	GHCS (State)	Research Triangle Institute	N	\$0
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Africare	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Agency for Cooperation and Research in Development, Gulu	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	National Implementation Unit-Government of Uganda	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Pathfinder International	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Save the Children Uganda	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Transcultural Psychosocial Organization	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Uganda Project Implementation and Management Center	N	████████
1030.09	9440	To Be Determined	U.S. Agency for International Development	GHCS (State)	Uganda Women's Efforts to Save Orphans	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Bundibugyo District Health Office	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Bushenyi District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Hoima District Health Office	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Ibanda District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Iganga District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Isingiro District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Jinja District Health Services, Uganda	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Johns Hopkins University/Makerere University	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kabale District Health Services, Uganda	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kabarole District Health Services, Uganda	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kamwenge District Health Office	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kanungu District Health Office	N	████████

**Table 3.2: Sub-Partners List**

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kasese District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kibaale District	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kiruhura District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Kisoro District Health Office	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Lyantonde District HIV/AIDS Committee	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Masaka District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Mayuge District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Mbarara District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Mpigi District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Mukono District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Namutumba District Health Office	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Ntungamo District	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Rakai District Health Services, Uganda	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Rukungiri District	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	Sembabule District Health Services	N	████████
9832.09	9832	To Be Determined	U.S. Agency for International Development	GHCS (State)	World Harvest Mission, Bundibugyo	N	████████
1250.09	9151	Uganda Blood Transfusion Services	HHS/Centers for Disease Control & Prevention	Central GHCS (State)	The Uganda Red Cross Society	N	\$749,858
7624.09	9141	Visions in Action	HHS/Health Resources Services Administration	GHCS (State)	Dyere Tek	N	\$0
7624.09	9141	Visions in Action	HHS/Health Resources Services Administration	GHCS (State)	Family Life Network	N	\$0
7624.09	9141	Visions in Action	HHS/Health Resources Services Administration	GHCS (State)	Health Alert	N	\$0
7287.09	9450	World Vision International	U.S. Agency for International Development	GHCS (State)	Research Triangle Institute	N	\$365,423

### Table 3.3: Program Budget Code and Program Narrative Planning Table of Contents

Program Budget Code: 01 - MTCT Prevention: PMTCT

**Total Planned Funding for Program Budget Code: \$16,074,486**

#### Program Area Narrative:

The transmission of HIV from mother to child is the second most common means of HIV transmission in Uganda. The country has a very high fertility rate which will result in about 1.5 million pregnancies in 2009. With ANC HIV prevalence rate of 6.5% there will be about 97,500 pregnant HIV-positive women in 2009. About 94% of pregnant women attend ANC at least once. Only 42% of all deliveries take place in health facilities.

The Ministry of Health (MOH) started PMTCT services as a pilot intervention in 2000 and by end of 2007 had scaled up services to all districts. 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 national PMTCT program, under the leadership of the MOH, has a National PMTCT Advisory Committee, made up of major HIV/AIDS stakeholders. The PMTCT focal persons at the District Health Offices coordinate PMTCT activities at the district level.

The USG has supported the MOH to scale up PMTCT services since 2003 and is currently the main donor. Other donors include UNICEF, WHO, and the Global Fund. UNICEF supports MOH mainly with national-level staffing, inter-site co-ordination at district level, M&E, production of infant feeding policy guidelines, and IEC materials. WHO supports the development of an integrated training package for PMTCT and the training-of-trainers at the regional and district levels. Uganda uses Global Fund resources to procure ARVs for PMTCT.

Barriers to the national scale up of PMTCT services include inadequate human resource capacity; inconsistent availability of HIV test kits and ARVs; inadequate infrastructure, and poor quality of reproductive health services. Geographical inaccessibility also contributes to the preference for home deliveries, low uptake and utilization of services, as well as poor linkages to HIV care and treatment. Weak Maternal Child Health (MCH) including family planning (FP) services to prevent unintended pregnancies among HIV-positive women remain a critical bottleneck. Dissemination of the revised PMTCT policy to lower level staff has also been limited.

#### Services

The USG works with GOU and local and international Implementing Partners (IPs). Since FY07, PEPFAR has supported a process whereby the MOH coordinates IPs to support district-wide PMTCT scale up to improve coverage and efficiency. The IPs provide conditional financial grants and technical support directly to districts.

FY08 targets were to provide comprehensive PMTCT services through testing 678,576 pregnant women and give them results in 747 facilities, train 4,495 health providers, and provide a full course of ARV prophylaxis to 33,263 HIV-positive women. These goals have largely been met. The FY08 APR shows that PMTCT IPs provided services through 760 facilities, trained 3,493 health providers, tested 594,305 pregnant women and gave them results, and provided ARV prophylaxis to 34,660 HIV-positive women.

The national target for 2009 is to counsel and test 1,157,000 pregnant women and provide ARV prophylaxis to 75,217 HIV-positive. The USG team has set FY09 targets to: provide PMTCT services through 1,014 facilities, train 2,012 health providers, test 818,526 pregnant women and give them results, and provide ARV prophylaxis to 57,557 HIV-positive women.

These targets represent a significant increase over FY08 results and will require reaching 65% of all HIV-positive pregnant women with ARV prophylaxis nationally, compared to 38% in FY08. However, given the poor health-facility infrastructure, and the fact that about 42% of women currently deliver in a health facility, these targets still fall short of the desired goal of the PMTCT initiative, which is to provide 80% of all HIV-positive women with ARV prophylaxis and reduce MTCT by 40% by 2009.

The USG will use several strategies in FY09 to improve PMTCT coverage and help reduce transmission:

1. Support the full national scale up of PMTCT services in Health Center (HC) IIIs. Districts will be able to conduct outreaches to HC II where applicable. These were major gaps noted in the 2007 Service Provision Assessment Survey.
2. Expand Geographic coverage countrywide. Currently major partners support all district PMTCT programs except West Nile region, due to its relatively low HIV prevalence (2.3%). In FY09 the USG will support expansion of PMTCT services to West Nile region.
3. Strengthen routine opt-out HIV counseling and testing (HCT), with same day test results through group pre-test counseling followed by individual post-test counseling. Facilities will use lay counselors to build HCT capacity.
4. Improve integration of routine HCT into maternity and postnatal services. IPs will train midwives in HCT, in collaboration with

the HCT program.

5. Expand provision of more efficacious ARVs for PMTCT to help reduce transmission. Over the past 8 years, the principal regimen for PMTCT in Uganda has been single-dose Nevirapine (SD NVP). National EID results show an MTCT rate of 15%, which is unacceptably high (reflects low SD-NVP effectiveness), and the government has called for an urgent shift towards more efficacious ARV regimens. In FY09 the USG will ensure that all eligible pregnant mothers (CD4<350 cells/mm3) are provided with HAART. Combined ARV prophylaxis (Combivir or AZT + SD NVP) will be provided to mothers ineligible for HAART, and SD NVP will only be provided as a last resort, if the woman presents very late in pregnancy or early labor.

6. Support community strategies for PMTCT countrywide. In FY09, the USG will work to address psychosocial, cultural and institutional factors that hinder ANC, MCH and PMTCT uptake in the districts. They will also address gender issues, male partner involvement, stigma, community involvement and sensitization.

#### Wraparound with FP and PMI

Since FY08, the USG has supported the expansion of FP services at care and treatment sites to prevent unintended pregnancies among HIV-positive women. This support complements the current MOH FP services, and the new USAID funded RH program will strengthen the roll out of FP services within MCH units. The PMTCT program will also collaborate with PMI to prevent malaria among pregnant mothers and children under 5 years. Through the PMI program, all mothers attending MCH clinics will receive insecticide treated nets.

#### Linkages to adult care and treatment

In FY08 ART IPs started implementing PMTCT activities to strengthen linkages to care and treatment for HIV-positive pregnant women and their families. A major focus in FY09 will continue to be improving provision of HIV care and treatment to HIV-positive mothers and their families. All HIV-positive pregnant women are registered in pre-ART registers and assessed for ART eligibility (using CD4 and clinical staging) as close as possible to the time of diagnosis. IPs will coordinate specimen collection on a weekly basis, from HC III, HC IV and district hospitals, which do not have CD4 testing services, transport them to the nearest CD4 testing lab, and ensure results are quickly returned. Conversely, IPs will perform routine HCG tests among ART and care clients, and those found pregnant, linked to the PMTCT programs. The ART accredited sites will reserve ARV slots for eligible pregnant women within their catchment areas. Community lay providers and peer support clients will be trained to support active referrals to care and treatment including partner testing. Currently, ART is only available down to HC IVs while PMTCT services are scaling up to HC III levels. IPs will set up models of outreach ART services to HC IIIs, on a regular basis to initiate ART for eligible pregnant women. Their visit can coincide with return of CD4 results if these are done elsewhere. The HIV-positive pregnant women will be prioritized ahead of other HIV-positive patients in order to avoid delays in initiating HAART.

PEPFAR, in collaboration with MOH, will support coordination between PMTCT and ART programs at IPs levels, to ensure effective linkages to care and treatment. In the FY08 APR, 3,367 of the 13,686 eligible pregnant women (25%) received HAART mainly from the ART IPs. The FY09 goal will be to reach 8,798 of the 14,664 eligible women (60%).

#### Linkages to pediatric care and treatment

The PMTCT IPs will collaborate with the MOH and IPs supporting pediatric care to widen the "gateway" to children's HIV care and treatment. The target groups include HIV exposed children and children with unknown HIV status born to mothers with unknown HIV status. The key entry points into pediatric HIV care and treatment are through the postnatal, well child and immunization clinics, and sick child clinics (outpatient and inpatient services). In FY09, the ART and PMTCT IPs will strengthen linkages to the current EID program as well as provide cotrimoxazole to HIV-exposed infants from 6 weeks of age, and initiate HAART for all HIV-positive infants. IPs will ensure that health workers indicate PMTCT codes on Child Health Cards, to ease identification of infants in need of HIV care. They will also establish follow-up home visit teams to trace mothers who do not return for EID results and provide support on infant feeding. In addition, well child and immunization clinics within the MCH units, will be reorganized to offer HIV care/treatment services.

#### PMTCT supplies and logistics

To address the problem of commodity stock-outs the USG will support the national logistics system through MOH, National Medical Stores, SCMS, and Joint Medical Stores to strengthen the procurement and distribution of PMTCT commodities. Overall, the MOH pharmacy division will work to streamline the entire logistics system. The choice of which commodities to be used is made using national and international guidance but there is need to coordinate with Global Fund, ART partners and other partners who procure ARVs and other commodities for PMTCT. SCMS will provide technical assistance for forecasting and quantification of commodities at program management level. MOH will recruit an officer to assist with the logistics management and coordination of PMTCT commodities with different stakeholders.

#### Nutrition and infant feeding

In FY09, USG IPs will strengthen nutrition support for HIV-positive pregnant women and exposed children in order to reduce transmission through breast milk and ensure child health and survival. We will disseminate and implement the revised national infant and young child feeding (IYCF) policy guidelines HIV-positive mothers will be counseled to exclusively breastfeed for at least 6 months or until AFASS conditions for replacement feeding (acceptable, feasible, affordable, sustainable and safe) are met, after which they give other complementary foods up to age 2 years. Health workers will be trained to assess nutrition status of HIV-positive women in MCH and HIV/AIDS Care and Treatment settings. NuLife will work with IPs to provide Ready-to-Use Therapeutic Feeding or other supplementary foods to malnourished HIV-positive pregnant or lactating women and their exposed children. The women will be educated on the use of locally available nutritious supplemental foods to sustain breast-feeding for at least 6 months. In addition, IPs will train community-based volunteers to identify malnourished HIV-positive pregnant and lactating women and their children in the community and refer them. They will strengthen community linkages to follow-up of HIV-exposed children through Young Child Clinic visits, review optimal feeding practices and refer for livelihood assistance and/or food security programs.

### Strengthening MCH services

The integration of PMTCT activities into MCH provides a great opportunity for strengthening MCH services to provide comprehensive reproductive health (RH) to mothers. Through this collaboration the PMTCT program will support a basic essential RH services package including lab tests and equipment, STI screening, iron, multivitamins and folic acid supplements, intermittent preventive malaria treatment, de-worming and infection control, for all pregnant women attending ANC, maternity and post-natal care units.

### M&E

Current M&E challenges include frequent stock-outs of data collection tools (e.g., ANC and PNC cards and integrated registers), human resource constraints, barriers in communications, lack of district ownership and utilization of data, as well as incomplete and poor quality data. The PMTCT IPs will strengthen monitoring and reporting of PMTCT and pediatric care data (collection, processing, analysis and utilization) at all levels (e.g., central, regional, district, health facilities and communities), through appropriate training and regular supportive supervision. Districts will conduct routine monthly supervision and support to the PMTCT activities. IPs will support data dissemination including quarterly supervision reports at districts level. At national level, the USG will participate in the national M&E and quality assurance subcommittee. The USG will also support MOH to develop a comprehensive M&E framework to improve monitoring of PMTCT program activities annually.

### Policy

Uganda has standardized national PMTCT policies, guidelines, and training materials including IEC materials. The PMTCT package has been defined for different levels of health facilities. The USG will support the revision of the policy guidelines to update the PMTCT package for HC IIIs to include more efficacious regimens. Both population-based and facility expansion targets for the national programme exist in the National Priority Action Plan and the Health Sector Strategic Plan II. A pool of national trainers has been instrumental in rolling out in-service training to regional and district levels. The Ministry of Education and Sports, which runs medical education institutions, has integrated PMTCT into curricula and training manuals. In FY09 it will scale-up pre-service training among nursing, midwifery, tutor and Clinical Officers training schools to enhance PMTCT implementation.

### Sustainability

The national PMTCT program is fundamentally donor funded. Over three quarters of the districts implementing PMTCT are PEPFAR funded. All PMTCT managers are donor funded, and there are now no MOH supported staff in the national coordinators office. This scenario poses a challenge to the sustainability of the program. We are encouraging districts to include PMTCT in their annual work plans and budgets.

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3834.09	<b>Mechanism:</b> Refugee HIV/AIDS services in Kyaka II Settlement
<b>Prime Partner:</b> International Medical Corps	<b>USG Agency:</b> Department of State / Population, Refugees, and Migration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 4795.25175.09	<b>Planned Funds:</b> \$60,000
<b>Activity System ID:</b> 25175	



**Activity Narrative:** The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12,115 however there are a group of refugees known as "population on Hold" who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel. In the FY 2009 FY, IMC will provide HIV counseling and testing services to 1,500 pregnant women through its single service outlet. Community mobilization and awareness through use of information campaigns, dramas & door to door visits etc to increase PMTCT uptake will be done including encouragement of spouses to attend PMTCT services.

One service outlet at the Bujubuli Health Center was active and operational in providing a full package of PMTCT services. In all over 1,538 pregnant women were counseled, tested and given the results during the period. Of this amount 48 tested positive. In an effort to involve men, IMC undertook a campaign to raise the awareness of men towards PMTCT and they were also tested in addition to their spouses. 307 men were tested and 12 were found to be positive. It was not possible to match these positive men to their wives as the testing was done individually. 13 mothers were provided with Niveprine medication as 28 weeks of pregnancy and above and 4 mothers were enrolled in the HAART program. Due to migrations, some of the mothers were not served with the Niveprine medications.

In FY 2009, IMC plans to expand PMTCT services to one other health center II in Mukondo as well as improve the quality of PMTCT services outlined below. Antenatal care will continue to provide an entry into the PMCT program. On antenatal clinic day, all expectant mothers will be sensitized on the benefits of taking HIV test, mother to child HIV transmission, general HIV/AIDS prevention information, infant feeding practices, and family planning. Group HIV pre-test counseling will be conducted and consenting mothers will be provided with an HIV test and given results. 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. Couples will also be encouraged to attend on special antenatal days. Pregnant mothers will be routinely tested and those found to be HIV positive will be informed about the PMTCT services available in addition to other HIV care and support services. Expectant mothers will be given specific services which 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, postnatal care etc 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 PMTCT campaigns using films, IEC material and other methods of community sensitization. The campaigns will highlight the benefits of PMTCT and help remove the stigma associated with the disease. As some mothers visit Traditional Birth Attendants (TBAs) to deliver these health care workers will also be the target for awareness training and the need to counsel mothers who are positive to attend a well equipped health care facility for safer deliveries. TBAs will also ensure that ARV prophylaxis is administered for both the baby and the mother since many women opt to deliver outside the health centers because of the distances involved. The program will also establish home-based PMTCT program to follow up on expectant mothers who do not attend ANC clinics due to distance with related information and drugs. These programs will also be linked to the Basic Care Package Program currently being implemented by PSI. IMC will also link newly born babies who have been exposed to HIV to other prevention, care and treatment services. This will be done through the establishment of an early infant diagnosis (EID) and pediatric care program. IMC will also promote counseling of mothers on specific infant feeding soon after delivery and at 5-6 months when babies are expected to be weaned. HIV positive babies will be enrolled in the ART program. Awareness of the need for early cessation of breast feeding and rapid weaning will be provided during home visits. Related supplies and recruitment of relevant staff will also be undertaken to improve the services offered

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16078

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16078	4795.08	Department of State / Population, Refugees, and Migration	International Medical Corps	7337	3834.08	Refugee HIV/AIDS services in Kyaka II Settlement	\$60,000
8298	4795.07	Department of State / Population, Refugees, and Migration	International Medical Corps	4801	3834.07	Refugee HIV/AIDS services in Kyaka II Settlement	\$51,514
4795	4795.06	Department of State / Population, Refugees, and Migration	International Medical Corps	3834	3834.06	Refugee HIV/AIDS services in Kyaka II Settlement	\$44,531

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

#### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

#### Refugees/Internally Displaced Persons

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$30,386

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

Estimated amount of funding that is planned for Education \$4,200

### Water

Table 3.3.01: Activities by Funding Mechanism

---

**Mechanism ID:** 1290.09

**Prime Partner:** Catholic Relief Services

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 8584.20736.09

**Activity System ID:** 20736

**Mechanism:** AIDSRelief

**USG Agency:** HHS/Health Resources  
Services Administration

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** \$550,000

**Activity Narrative:** AIDSRelief (AR) provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AR is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology, Constella Futures Group (CF), Catholic Medical Mission Board and Interchurch Medical Assistance World Health; AR services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AR supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AR and manages a number of the LPTFs.

As of July 31st, 2008, AR in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. In addition it was providing care and support to 5,144 infected children under the age of 18, and antiretroviral treatment to 1726 children under the age of 15.

In FY 2008, AR promoted a comprehensive package of PMTCT services at 9 LPTFs. This included provider-initiated HIV testing in ANC, encouraging mothers to deliver in a health facility (the program also encourage linkages with Traditional Birth Attendants), CD4 testing of all pregnant HIV+ mothers, DBS for babies, the provision of ARV prophylaxis to mother and infant and referral for HAART as required. The program additionally encouraged comprehensive PMTCT services at all 18 AR supported LPTFs through internal and external linkages. A total of about 30,000 pregnant mothers have been counseled, tested and have received results in FY 2008. Of those tested, about 8% were HIV positive and of these, 2,400 HIV+ mothers and infants received full course of ARV prophylaxis.

AR increased accessibility and utilization of PMTCT services by increasing the skills of staff working in ANC and by providing access to rapid HIV testing in ANC. HIV positive pregnant women were referred from satellite clinics to antenatal care providing sites. Laboratory links were developed to increase access to earlier infant diagnosis using PCR testing. As part of the essential components of a PMTCT program, all HIV positive mothers were provided with nutritional information as regards to exclusive breastfeeding and alternative feeding options.

Training including and update on the new MOH adopted PMTCT guidelines, was provided to 290 health workers including midwives in ANC clinics providing PMTCT services. Additional training was conducted in PMTCT and malaria prevention for 720 community volunteers enabling them to carry out community mobilization and early referral to facilities for suspected malaria in pregnant women. Linkages were created between PMTCT and the ART clinics at all LPTFs, and also between other health facility services (e.g: MCH). Long lasting insecticide treated nets were provided to the mothers through linkages with PSI/CDC. There was also increased sensitization of care providers to provide Cotrimaxazole to infected pregnant women in care.

Coordinated by CF, 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. AR has built and maintained a strong PMM system using in-country networks and available technology at 18 LPTFs in FY 2008. CF 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.

AR will continue to encourage increased uptake of PMTCT services at 18 LPTFs. The program will promote a comprehensive package of PMTCT services, as occurred in FY 2008. In FY2009, with access to additional funding, AR proposes to reach 25,000 pregnant women with HIV counseling and testing for PMTCT and about 2,400 HIV positive pregnant women and their exposed infants with antiretroviral prophylaxis in accordance with Uganda National Guidelines, supported by treatment preparation and adherence support.

The PMTCT program will continue to be underpinned by strong community outreach and follow-up of all HIV positive women during pregnancy and after delivery.

This community linkage will ensure reduced losses to follow-up of both mothers and their babies. The program will also focus on the coordination and integration of services provided at the HIV clinic, ANC, delivery and MCH clinic within the facilities it supports. Provision of nutritional information and education will continue and HIV + mothers will also be linked to access to nutritional programs during pregnancy and breastfeeding as part of a commitment to promoting better maternal and infant health. Long lasting insecticide treated nets will be provided to the mothers through linkages with PSI/CDC and 720 additional community volunteers trained to reinforce malaria prevention messages during their outreach activities and given skills to identify the symptoms of suspected malaria and refer to a health institution. There will be increased sensitization of care providers to provide intermittent Cotrimaxazole to infected pregnant women in care.

Training, including updates on the new MOH adopted PMTCT guidelines as well as blood collection for CD4 screening and dry blood spots, and on HIV rapid tests will be provided to 290 health workers including midwives in ANC clinics providing PMTCT services, counselors, and laboratory staff.

Coordinated by CF, 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, CF 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

**Activity Narrative:** 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 donors. 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 AR and LPTFs to improve service delivery, provide forecasting for drugs and testing kits, and gauge the need for human resource planning. Using available data, AR 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.

To support provision of PMTCT services, AR will identify all females of reproductive age attending the ART and care clinics and refer them for pregnancy tests. The program will refer and document referrals from PMTCT to ART services within LPTFs. A system that supports EID will be strengthened and infant-mother pairs referred to the ART clinic for care and treatment follow-up. Sustainability lies at the heart of the AR program and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions. AR will particularly focus on its relationship with indigenous organizations such as the Uganda Catholic Medical Bureau and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13261

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13261	8584.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$687,500
8584	8584.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$703,667

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* Safe Motherhood

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$206,250

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 17090.20792.09

**Activity System ID:** 20792

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** \$150,000

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and care givers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

RO in partnership with MU has implemented PMTCT programme since 2004 using a peer model of mother-to-mother supporters, this is aimed at reducing HIV transmission to the unborn baby to 3%. RO PMTCT programme has been improving since its inception with HIV transmission of 33% in 2005 reducing to 7% in 2006. By July 2008, 461 mothers had been enrolled with 307 deliveries, 219 babies tested for HIV DNA PCR with peri natal HIV transmission reduced to 3% 24/219, in these infants. The baby-mother pairs are offered a comprehensive PMTCT package according to national and international standards. In addition MU has been and will, in FY 2009, continue training nursing assistants, a key cadre involved in managing pregnancy and childbirth in addition to nurses and midwives, to further strengthen PMTCT activities. Specific activities include face-to-face training, field practicum and supervisory visits. Within the Mildmay regional approach where the courses are run in the targeted rural districts. . MU PMTCT training has been carried out with emphasis on nurses and midwives who are the direct implementers. 122 health workers have been trained. Through the short courses; as an intensive two-week programme. 21 participants have been reached through this program area. Participants are exposed to the National Hospital Referral PMTCT site. 101 participants have been reached through the work based programmes where PMTCT is done as a component within the larger HIV clinical care module.

For FY 2009 RO is targeting to enroll 220 pregnant mothers onto comprehensive PMTCT package, provide nutrition supplementation to 300 pregnant women, lactating mothers, and their babies up to 18 months of age .We are targeting to train 32 health workers in the provision of PMTCT at RO and 100 at MU. The capacity of the community health workers (68) and staff (32) will be built to provide PMTCT services, and the referral systems will be strengthened. We are targeting to train 35 health workers in the provision of PMTCT.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17090

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17090	17090.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$150,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Safe Motherhood

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 629.09

**Mechanism:** Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services

**Prime Partner:** National Medical Stores

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: PMTCT

**Budget Code:** MTCT

**Program Budget Code:** 01

**Activity ID:** 12377.20816.09

**Planned Funds:** \$753,936

**Activity System ID:** 20816



**Activity 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 health 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 (HCT), can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. Following the national credit line for essential medicines, the Ministry of Health (MOH) provides a 20% contribution to JMS for faith-based and mission health facilities and NMS allocates the same 20% of PEPFAR funding for JMS to procure and store HIV/AIDS-related laboratory commodities.

The Ministry of Health (MOH) has accredited 580 health center laboratories to perform PMTCT HIV testing and other associated laboratory tests including: urinalysis examinations; stool examinations; blood hemoglobin concentration; and syphilis tests for antenatal services. In the updated National HIV/AIDS Strategic Plan 2007/08-2011/12, an increased emphasis has been placed on expanding HCT for pregnant mothers and their partners. This HTC expansion mechanism will contribute to reducing mother to child transmission, by identifying and providing treatment to HIV + woman during pregnancy and in addition their partners. To support this effort, in FY 2007 NMS procured an additional 300,000 HIV test kits to contribute to Health Center IIIs and IVs for distribution to the PMTCT program.

NMS will continue to utilize FY 2008 funds, for the procurement of additional test kits to support PMTCT activities. NMS will also 'pilot' having PMTCT HIV test kit orders prepared by individual PMTCT testing sites; the orders will be submitted to NMS using the laboratory commodity order form, ensuring prompt delivery of test kits to the District Stores. The JMS PMTCT test supplies for FBO/NGO health facilities will be collected directly from the JMS warehouse. Bimonthly credit utilization, distribution reports and trucking reports will be prepared on monthly basis. The reports will be shared with all relevant stakeholders, starting in the first quarter of FY 2009. In FY 2009, NMS and JMS will continue to supply additional HIV test kits for PMTCT activities and expand the coverage to 780 PMTCT testing sites. In addition, both NMS and JMS will support training their management and support staff in order to build internal human resource capacity to improve the supply chain system. NMS has also received support from DANIDA in several areas, most recently for the construction of a 20,000 m3 volume extension to the main warehouse in Entebbe. This additional space will eliminate the need for rented warehousing. The World Health Organization (WHO) is also supporting NMS by conducting a business process and information systems assessment review. This WHO technical assistance will also identify gaps, outline strategies, and improve NMS management capacity to fully implement the national supply chain system. Finally, JMS had recently been supported by the PEPFAR funded Supply Chain Management System (SCMS) project to conduct a business process review, and assist JMS with the acquisition of a new logistics management information system.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13302

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13302	12377.08	HHS/Centers for Disease Control & Prevention	National Medical Stores	6435	629.08	Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services	\$753,936
12377	12377.07	HHS/Centers for Disease Control & Prevention	National Medical Stores	4810	629.07		\$300,000

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 679.09 **Mechanism:** Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)

**Prime Partner:** Protecting Families Against AIDS **USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State) **Program Area:** Prevention: PMTCT

**Budget Code:** MTCT **Program Budget Code:** 01

---

**Activity ID:** 4047.20862.09

**Planned Funds:** \$5,346,650

**Activity System ID:** 20862

**Activity Narrative:** Protecting Families Against HIV/AIDS (PREFA) is a Non-Governmental Organization that has been actively promoting comprehensive PMTCT activities in Uganda since 2004. With initial PEPFAR funds, PREFA was only able to operate PMTCT in 4 districts namely; Kampala, Wakiso, Kayunga and Tororo. In late 2007, PEPFAR funds were modestly increased, and the Ministry of Health (MOH) in collaboration with key PMTCT stakeholders mandated PREFA to expand to 22 additional districts. The expansion of PREFA's services would address the low PMTCT coverage in Uganda; with a specific focus on implementing PMTCT in eastern and central districts of the country (Eastern region-17; Central region-9). The organization successfully allocated conditional grants to support the 22 new districts; enabling the project to offer PMTCT services up to all new Health Center IIIs (HCIIIs) in their coverage areas. Consequently, PREFA developed a new plan to implement PMTCT services. PREFA utilized a district wide approach, where the District health officers (DHOs) developed their own PMTCT plans. A MOH technical panel assisted the DHOs in prioritizing their PMTCT activities according to district coverage and uptake needs. With PEPFAR funds, PREFA currently supports 26 districts for PMTCT service provision and technical assistance, namely: Amuria, Budaka, Bududa, Bukedea, Bukwo, Busia, Butaleja, Kaberamaido, Kalangala, Kampala, Kapchorwa, Katakwi, Kiboga, Kumi, Luweero, Manafwa, Mbale, Mityana, Mubende, Nakaseke, Nakasongola, Pallisa, Sironko, Soroti, Tororo and Wakiso and 2 sub-partners Tororo District Hospital (TDH) and Islamic Medical Association of Uganda (IMAU).

In FY 2008, PREFA and their sub-partners are expected to support PMTCT implementation to approximately 70% of their target population, including 303 health care outlets: 31 hospitals, 48 health centers (HC) IVs, and 224 HC IIIs, out of a potential 400 outlets within the 26 districts. The program is expected to provide HIV counseling and testing [HCT] to 274,697 pregnant women (out of an expected 413,078 pregnant women), and identify 20,504 (out of 29,292) HIV+ women. All identified HIV positive pregnant women will receive ARV prophylaxis (12,303 combined ARVs, 2,050 on HAART at 10% eligibility, and 6,151 to receive NVP only). A total of 16,403 HIV positive women (80%) will be expected to give birth at health facilities, and all of their newborns will receive ARV prophylaxis.

The DHOs, with technical support from MOH and PREFA, have finished preparing the Maternal/Child Health (MCH) units for PMTCT implementation and are working hard to meet their annual target. The new program is in major transition, since it provides PMTCT services within a large 26 district coverage area. The FY2008 semi-annual MEEPP report (October 2007-March 2008), most of the new districts had not started implementing PMTCT, thus only 30,442 women had received antenatal care (ANC)/PMTCT services via 25 health care outlets in PREFA's original 4 districts. Of the 30,442 women seen, 2,485 were identified to be HIV positive and 2,210 of them received ARV prophylaxis. Results from the new districts will be included in the FY2008 Annual report.

Furthermore, PREFA is supporting the MOH to hire two new staff members, in order to strengthen the logistics and community services departments of the National PMTCT program. The extra staff support will assist MOH with the monitoring and supervision of PMTCT activities nation-wide.

In FY 2009, PREFA and its sub-partners will further strengthen and expand intra-district support of comprehensive PMTCT services including: providing routine HCT to 302,167 pregnant women (projected at 10% increment and at 7% HIV prevalence), in the on-going 26 districts (Eastern region-17; Central region-9) and an additional new 7 West-Nile districts (Adjumani, Moyo, Yumbe, Koboko, Nyadri, Arua, and Nebbi), through 419 outlets (31 hospitals, 48HCIVs, 31HCIIIs, and outreaches to 29HCIIIs). PREFA has estimated to reach 21,152 HIV+ pregnant women with PMTCT services. Providing comprehensive PMTCT services will follow the four pillar approach: primary prevention; family planning; provision of ARV prophylaxis; and care and support.

PREFA's core targets in FY 2009, (not including TDH and IMAU) will be 276,167 pregnant women, and their families. The PREFA supported districts will continue intra-district scale up with outreaches to some HC-IIIs. Clients will receive a comprehensive PMTCT package including opt-out routine HCT and hemoglobin (Hb) estimation at all MCH units. An estimated 20,242 HIV+ pregnant women will receive a basic care package (BCP), their blood samples be referred for CD4 testing after WHO clinical assessment. ARV prophylaxis and treatment for HIV+ mothers and their babies will be provided according to national revised PMTCT policy including: approximately 4,048 (20%) women who present for ANC and are eligible for ART (CD4<350) will receive HAART; 14,170 (70%) will receive combined ARV prophylaxis and those who present late estimated at 10% (2,024), will receive SD-NVP. Given the availability of pre-packaged take home NVP syrup for infants, majority of infants (> 20,000) born to HIV positive women will receive NVP or AZT syrup as recommended in the policy guidelines. Midwives in MCH units will receive training in PMTCT/RH issues under the comprehensive IMAI/IMPAC course. The acquired skills from the training will enable them to provide appropriate ARV prophylaxis or actively manage clients with the nearest ART clinic, provide infant feeding counseling and conduct early infant diagnosis. All ART clinics will prioritize HIV+ pregnant women for screening and ART provision. In addition, HIV+ mothers will receive quality obstetric care (focused antenatal, maternity, and post-natal care).

In order to strengthen links between existing ART implementing partners (IPs) and PMTCT sites, PREFA will facilitate the development of district work groups; will include members from both programs. These district work groups will assist in developing a district wide system, to better manage all referred HIV+ positive women and their babies. Family planning (FP) will be provider-initiated for all adults presenting at all health facilities up to HC-II. FP will be strengthened in ANC and postnatal services, through districts providing personnel close supervision, and emphasizing HIV+ women attending postnatal clinics. All mothers of babies accessing postnatal and young child clinics will be counseled to test for HIV (if not done and documented before delivery), to know their status and assess if their babies are exposed to HIV. Early infant HIV testing with appropriate counseling will be integrated according to policy guidelines. Blood specimens (DBS) will be taken from all HIV exposed infants and tested using DNA-PCR at the nearest diagnostic centers. All tested infants will be linked to care and support services including infant feeding services.

To ensure quality PMTCT services, PREFA will assist district health teams to strengthen their reproductive

**Activity Narrative:** health systems (RHS) through collaboration with relevant stakeholders in each district. The RHS collaborative activities will include: strengthening human resource capacity by training more service providers in PMTCT, infant feeding counseling, PMTCT policy updates for 260 health workers (10 per district), and training/mentoring 130 counselor supervisors (5 per district) in all 26 districts. All trainees will receive post-training follow-up after 3 months. Furthermore, PREFA will support districts by hiring 130 additional staff members (5 per district, with a plan to eventually add them to the district pay role), in specialty areas where qualified staff are vital to a comprehensive PMTCT program. Districts' critical staffing needs are in pediatric care and counseling, Early Infant Diagnosis (EID) with linkage to pediatric care, FP, community awareness and mobilization. District health teams will support improvement of facilities to accommodate such additional services as routine HCT. PREFA will also provide technical support for implementation of PMTCT activities, procurement of limited essential maternity equipment, as well as funds for activities agreed upon at district level. The organization will support mechanisms for enhancing PMTCT service delivery through private and government health units (public-private partnership) collaboration, including sensitization of traditional birth attendants (TBAs), private midwives, and other relevant professional associations in PMTCT, to enable them identify and refer HIV+ women to deliver in health facilities. PREFA will facilitate the Districts improvement of monitoring and evaluation capacity through training in data management processes. The organization will provide computers (as needed), other forms of data processing and storage, data quality assessment; ensuring timely reporting from health facilities to district health offices, MOH and PREFA. District health teams will conduct regular monthly supervision of health facilities, MOH will host quarterly supervision visits through regional supervisors. Quality assurance for HIV tests will be conducted in collaboration with the MOH central laboratory.

PMTCT service provision will be further strengthened through performance monitoring, and link referrals within and between facilities located in communities around the country. Districts will strengthen their community PMTCT activities by utilizing existing workforce structures, including: health workers, PHA, community post test clubs, Community Based Organizations (CBOs), and community resource persons (VHTs, CCAs and TBAs). A total of 6,240 PMTCT mobilizers (240 per district) will receive relevant training in PMTCT enabling them to mobilize, sensitize, counsel, refer and set up follow-up visits appropriately for clients and their families. During the FY 2009 intra-district scale up of the PMTCT services, PREFA plans to support and target at least 1000 moderate to severely malnourished HIV+ positive pregnant women with nutrition supplements. PREFA will also liaise with the MOH and other stakeholders to print and disseminate updated training materials, policy guidelines, related registers, and appropriate community PMTCT IEC materials. Furthermore, PREFA will scale up to other districts, the Family Care Consortium approach (FCCA) for families. Over the years, the FCCA has successfully improved access and uptake of quality comprehensive HIV/AIDS services, including PMTCT, pediatric and adult ART in lower health facilities in Kampala.

In addition to the activities above, sub-partner TDH will support provision of PMTCT services to 21,000 women in ANC and 4,300 of their male partners; provide ARV prophylaxis to 600 HIV+ pregnant women and EID for HIV exposed children at 9 more health facilities. Health teams will conduct home visits to 600 HIV+ pregnant/nursing mothers (2 visits each), conduct 600 home based HCT to increase access to HIV services by family members, provide the Basic Care Package (BCP), and refer clients and family members for further care/treatment to TASO – Tororo and TDH ART clinics. Funding will also support training 45 health workers in pediatric care, rapid HCT, procuring test kits, lab equipment, reagents and supplies, therapeutic feeding of 480 infants, and nutrition classes for all enrolled HIV+ mothers. Approximately 480 HIV+ pregnant women and breastfeeding mothers will be supported with nutrition supplements. The program will also facilitate community support teams to mobilize the community for PMTCT and monitor its contribution to service delivery. Community sensitization will continue through monthly radio talk shows, drama by HIV/AIDS support groups, and community video shows. During FY 2009, most of the TDH activities will be merged into those of Tororo district; TDH will be phased out as a sub-partner organization. At the next planning phase, the district health team will meet with TDH to discuss the phase-out strategy.

Similarly, in FY 2009, IMAU, another sub-partner, will continue to provide comprehensive PMTCT services at Saidina Abubakar Islamic Hospital (SAIH) and in collaboration with the DHO Wakiso district, support provision of PMTCT services at 10 HCIIIs: Namulonge, Manze, Kalibbala, Bulondo, Tikkalu, Kira, Kakiri, Wakiso Epicentre, Nsangi and Kiziba. IMAU is planning to add on other 5 health centre IIIs in the FY 2009, these include: Nabweru, Mende, Kasozi, Namalire and Gombe (please note that these facilities are subject to final confirmation from IMAU and Wakiso district). SAIH will provide PMTCT services to 5,000 pregnant women and 1,200 of their male partners. The program will also offer treatment options of combined ARV drugs for PMTCT to 310 HIV+ mothers and their infants, CD4 tests for all HIV+ women, and ART to eligible women and their partners. PCR tests will be done for 180 HIV-exposed infants. IMAU will also conduct community education and mobilization through religious leaders, local council leaders, and PHAs, who will target 30,000 adult men and women, using health fairs, outreaches, sermons, group talks, mini lectures and home visits. The project will support the community educators to conduct home visits and referral of 4,500 pregnant women and their families. This project will also support IMAU's faith based network model for improving HIV/ AIDS services, which has a health facility component and a community component with linkages between the two. The funding will also support purchase of HIV test kits, PMTCT ARVs, equipment, logistics and supplies, and training of 30 service providers in PMTCT counseling.

Overall, PREFA contributes greatly to PEPFAR due to its vision of improving access and uptake of high quality HIV/AIDS services, and the utilization of the family approach to provide comprehensive PMTCT services. In FY 2009, this program will reach an estimated 302,167 pregnant women (out of an expected 413,078 pregnancies). HCT service and ARV prophylaxis will be provided to an estimated 21,152 HIV+ women (out of an expected 29,292 HIV+ women) and their infants, as well as appropriate referral for treatment, care and support services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13310

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13310	4047.08	HHS/Centers for Disease Control & Prevention	Protecting Families Against AIDS	6438	679.08	Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)	\$5,000,000
8356	4047.07	HHS/Centers for Disease Control & Prevention	Protecting Families Against AIDS	4813	679.07		\$4,847,705
4047	4047.06	HHS/Centers for Disease Control & Prevention	Protecting Families Against AIDS	3186	679.06		\$1,130,076

#### Emphasis Areas

##### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

##### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$15,000

#### Economic Strengthening

#### Education

#### Water

Table 3.3.01: Activities by Funding Mechanism

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 17058.20874.09

**Activity System ID:** 20874

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** \$450,000

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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. Over 67% of the 100,000 active TASO clients are females and over 60% are in the reproductive age bracket of 15 to 49 years. One of the effects due to improved health resulting from ART is rebuilding broken relationships and families; and resuming 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. Mother to Child transmission (MTCT) is the second most common mode of HIV transmission accounting for up to 20% of new infections and 25,000 pediatric infections each year in Uganda. In FY 2008, the TASO priorities for PMTCT were: providing health education on PMTCT; identifying HIV positive, pregnant clients; counseling identified HIV positive, pregnant clients and their sexual partners; providing ARV prophylaxis for mothers and their new born babies; prioritizing and providing ART to eligible pregnant women; conducting supportive home visits; linking pregnant clients to antenatal services as part of a two-way referral mechanism; active follow up of pregnant clients to support delivery in health facilities; facilitating access to early infant HIV diagnosis at 6 weeks postnatal; engaging in partnership with other PMTCT stakeholders to promote key activities (including 2 way referral, male involvement, infant feeding and essential postnatal care for HIV exposed infants); providing family planning information and commodities to all sexually active clients; providing couple counseling and supported disclosure for both HIV concordant and HIV discordant couples; supporting concordant positive and discordant couple peer clubs. Key outputs up to July 31, 2008 were: finalizing and roll-out of the TASO PMTCT Strategy and Guidelines document; provision of the minimum package of PMTCT services at all 11 TASO service outlets; 100 eligible pregnant women (both TASO clients and referrals in) accessed HAART as priority clients from the 200 ART slots reserved for the PMTCT program; 50 pregnant women ineligible for HAART received ART prophylaxis; a functional two-way referral mechanism was established between TASO and other partners; and 70 service providers were trained to provide PMTCT services. During FY 2009, TASO will provide PMTCT services using the 4-pronged approach for PMTCT at the 11 Centres (in Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso). Each of the Centres directly serves clients from the host district and 6 neighboring districts. PMTCT mobilization and sensitization activities will target all the 80,000 TASO adult clients; provision of PMTCT services will target sexually active clients and their partners. TASO will target 400 pregnant women with PMTCT interventions; 200 to be enrolled on HAART and 200 on ART prophylaxis. Key activities for the PMTCT Program Area will include: integrating family planning into PMTCT program; provision of the minimum package of PMTCT services by the 11 TASO Centres; clinical and immunologic staging of all pregnant women; provision of combination ARV prophylaxis for all pregnant clients not eligible for ART; and prioritizing eligible pregnant clients for ART; pregnant clients already on ART will receive support to adhere to treatment in addition to appropriate PMTCT support; health workers will be trained/retrained to provide PMTCT services in accordance with national guidelines and standards; all pregnant and lactating mothers

**Activity Narrative:** will be provided with multivitamin supplements. TASO will also invest in laboratory infrastructure enhancements and establish DNA PCR sample transport systems to reference laboratories. TASO aims at achieving universal access to HIV prevention, treatment, care and support for infants and children. The activities under this Program Area are also linked to other USG funding through USAID focusing on Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other development partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17058

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17058	17058.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$450,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 9212.09

**Mechanism:** Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies



**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: PMTCT

**Budget Code:** MTCT

**Program Budget Code:** 01

**Activity ID:** 21112.21177.09

**Planned Funds:** \$750,000

**Activity System ID:** 21177

**Activity Narrative:** Integrated Community based Initiatives (ICOB), is an indigenous NGO formed in 1994 with a mission to improve the quality of life of people living in rural communities. Its headquarters are located in Kabwohe-Itendero Town Council, Bushenyi District with a liaison office in Kampala. ICOBI has been involved in implementation of Health programs with community bias since its inception. Programs which ICOBI has implemented include: World Bank supported STI project (1995-2000), MAP Project (2001-2006) and Nutritional and Early Childhood Development Project (1999-2003); EGPAF supported facility based PMTCT in 15 health units in Bushenyi District (2002-2005); and CDC supported Full-access Door-to door Home based VCT in Bushenyi District (2004-2007). In April 2008, ICOBI started implementing the three year NPI supported OVC project in Bushenyi and Mbarara districts and in July 2008 it received two five year awards from CDC to implement a Home Based VCT project in 6 districts in Central Uganda and a national level Community PMTCT project with a special focus on 6 districts in South Western Uganda. The Community PMTCT project is entitled: Expanding Uptake For Interventions To Prevent The Transmission of HIV From Mothers To Their Children (PMTCT) In The Republic of Uganda by using Community Based Strategies Under The President's Emergency Plan For AIDS Relief. The overarching goal of the project is to contribute towards the improvement of child survival through increasing the uptake of prevention of mother to child HIV transmission services and providing care & support to HIV infected parents and children using home/community based approaches. The project intends to achieve the following strategic objectives;

- 1.To promote innovative community based primary prevention of HIV through community mobilization and sensitization of pregnant women and their spouses for HIV counseling and testing at health facilities.
- 2.To prevent un-intended pregnancies among women living with HIV by promoting use of modern contraceptives and other family planning strategies.
- 3.To reduce HIV transmission from pregnant or lactating women living with HIV to their babies by referring them to health facilities for appropriate ART for PMTCT as well as other strategies.
- 4.To enhance advocacy, capacity building and behavior change communication for community PMTCT interventions.

In the Community PMTCT program, ICOBI intends to work with the community and health facility based structures and various partners including civil society organizations, faith based organizations, the district directorates of health services and EGPAF, the major partner in PMTCT in South Western Uganda. This project will be implemented at two levels: 1) in collaboration with the MOH, will conduct some national aspects of community involvement in general, 2) with a special focus on 6 districts in South Western Uganda. The districts are Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhura; with a total population of 2,446,600 people. The expected pregnancies are 122,330 and the expected HIV pregnant women are 7,360. There are 183 health facilities in this region which are disproportionately distributed within the districts. There are 94 sub-counties and 512 parishes in this region. The geographic coverage of PMTCT services varies from district to district; with Ntungamo being the most under served with 4 health facilities providing PMTCT services and yet has the highest HIV prevalence among pregnant women attending the antenatal clinics of 9.3% compared to 6.7% in Bushenyi district with 41 health facilities providing PMTCT services. The project will take advantage of the expansion of PMTCT services by EGPAF in this region and mobilise the community to utilise the available PMTCT services. Implementation of the project will be phased, beginning with Bushenyi and Ntungamo in the first year, Mbarara and Ibanda districts in the second year, Isingiro and Kiruhura districts in the third year. The final two years of the project will experience a consolidation of community PMTCT services across the Ankole region and the nation at large. The project will be implemented under the auspices of the national PMTCT strategy with a regional character as well as national outlook whereby this project will contribute to awareness creation through well designed and targeted strategies including, among others, promotional and motivational activities for PMTCT through mass media, local language information, education and communication (IEC) campaigns including using music and drama, interpersonal channels and community dialogue. In addition, professional linkages and family based (Home-based) out-reaches will support community based PMTCT with referrals and counter referrals between the community based structures and the health facilities. The sub-county based counselors (CPO) and the resident parish mobilisers (RPM)/mentor mothers working together with other community based groups like Village health teams and other community owned resource persons, will link the pregnant women in the community with the health facilities where PMTCT services will be offered and vice-versa for follow up of the PMTCT women in the community. Some of the trained CPOs and RPMs will augment the health unit staff in provision of PMTCT services on busy days. The project will be launched at the national level and in the districts to create a forum for key stakeholders. The project will concurrently implement other HIV preventive programs including abstinence and being faithful (AB); and other prevention. During the first year of the project, a total of 44 sub-counties and 258 parishes of Bushenyi and Ntungamo will be covered; with a total population of 1,210,400 with 60,520 expected pregnancies and 3,632 expected HIV positive pregnant women in the two districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21112

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21112	21112.08	HHS/Centers for Disease Control & Prevention	Integrated Community Based Initiatives	9212	9212.08	Integrated Community-based Initiatives	\$750,000

#### Emphasis Areas

##### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

##### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9211.09	<b>Mechanism:</b> Traditional & Modern Health Practitioners
<b>Prime Partner:</b> Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 11313.21192.09	<b>Planned Funds:</b> \$750,000
<b>Activity System ID:</b> 21192	

**Activity 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 15 years of experience implementing community-based health activities for underserved populations in both urban and rural areas of Uganda. THETA has built health and social services community delivery systems that comprises community lay providers (CLPs), community support teams and district-based trainers in each of the districts where it has operated. THETA's call has been in the area of HIV prevention and care for those infected and affected with HIV/AIDS. THETA received a notice of grant award in July 2008 from CDC to implement a program entitled "Community-based strategies to expand uptake of Prevention of mother-to-child transmission of HIV (PMTCT) interventions" (cooperative Agreement Grant Number: 1U2GPS001088-01, Program period: 07/01/2008-06/30/2013). The primary goal of this project is to develop and implement a model of community support for PMTCT based on an active network of CLPs working in close collaboration with facility-based health workers. The project is in line with the Uganda National policy for reduction of Mother-To-Child HIV transmission and will work with all the PMTCT implementing partners and districts to identify gaps that could be addressed through community strategies.

To date, THETA is in the preparatory stage for the implementation of this project; recruiting project staffs and setting up systems and structures. A planning meeting is scheduled for the first week of September to map out clearly the implementation of the project. Full implementation of activities is pending CDC approval of the program application work plan and budget. The program will cover the districts Amolatar, Oyam, Lira, Rakai and Tororo in FY 2009. In all districts, the target groups will include pregnant women and their spouses, women of reproductive age and local communities. Specific emphasis will be on increasing ANC attendance, HCT, health facility deliveries, referral of mothers for PMTCT, follow-up of PMTCT mothers children and community mobilization.

THETA will conduct initial visits to districts to introduce the project together with PMTCT implementing partners in the selected districts. During this visit, THETA will mobilize the different PMTCT stakeholders and local leaders conduct a partnership meeting with district officials, community leaders and PMTCT partners in the districts to identify PMTCT service delivery gaps, clarify roles and responsibilities and create common understanding of the programme among community support team members.

Community Lay Providers (CLPs) will be identified and trained at Parish level. They will mobilize mothers legible for the PMTCT program by reinforcing community knowledge and promote behavioral change towards improved uptake PMTCT services. Trainings for CLPs will be conducted using the adopted National PMTCT community training manual. The training of CLPs especially the TBAs will improve the quality of services provided by them.

In addition, 5,000 posters, 1,000 THETA today magazines, 2,000 calenders, 1,500 copies of the THETA annual reports, 4,000 brochures, 1,500 best practices booklets, 1,000 T-shirts and caps, one CD documentary and 1,000 referral booklets will be produced and distributed.

THETA will facilitate community radio announcements with regard to outreach days and venues for the different PMTCT services. 3 radio announcements will be aired in each of the 10 districts per month aimed at reinforce community knowledge and promoting behavioral change towards improved uptake PMTCT. THETA will host 48 radio talk shows on 4 radios with special focus on the regions. These will be on thematic areas highlighting key barriers to PMTCT uptake and are intended to have positive influence behavior change.

Community dialogues will be conducted to raise awareness and educate communities about PMTCT. These will involve informing the general population 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 community dialogues in each districts at village level.

30 Biomedical Health Workers per district will be targeted for a one day orientation workshop in each district in the THETA PMTCT community model. The rationale is to make them familiar with socio-cultural issues that influence uptake of PMTCT.

THETA will collaborate with HCT partners in the districts to provide HCT services for those who want to know their HIV status during community dialogues. CLPs working in pairs with 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 5 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. The aim of this approach will be to ensure contact is made between the CLP and the midwife in the presence of the referred client so that they are attended to as well as possible.

Male peers will play a role in mobilizing male partners to go for HIV testing with their spouses during ANC through use of male peer approaches at relevant community venues and events preferred by men. 42 male peer group members will be trained 2 times in each of the 5 districts. Male peers will be asked to identify and map couples in their respective parish of operation and to discuss with them PMTCT and HIV testing in relation to their plans for raising a family.

Mother 2 mother (m2m) strategy will be supported in each of the 5 districts. A total of 60 groups of HIV positive mothers (volunteers) operating at parish levels will be supported to identify mothers and couples for the PMTCT programme and ensure follow up of cases after their training is completed. 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. In addition, 42 male peer groups will be supported in the districts to visit their peers, provide psychosocial counselling, provide family planning information among others.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13253

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13253	11313.08	HHS/Centers for Disease Control & Prevention	Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	9211	9211.08	Traditional & Modern Health Practitioners	\$750,000
11313	11313.07	HHS/Centers for Disease Control & Prevention	To Be Determined	5759	5759.07	Support Strategies to increase PMTCT uptake at community level	■

**Emphasis Areas**

Gender

- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Safe Motherhood

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$375,670

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: PMTCT

**Budget Code:** MTCT

**Program Budget Code:** 01

**Activity ID:** 4022.21213.09

**Planned Funds:** \$40,000



**Activity Narrative:** 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 Program (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 Lyantonde districts. A few of the patients served come from districts neighboring Rakai, like Masaka and Mbarara). This is a five year grant that carries forward lessons learnt in phase 1. The grant has two major programming components.

1) 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. MUSPH also recently received additional funds from CDC to establish an internet based distance learning program in collaboration with Johns Hopkins University. This program targets staff at various PEPFAR supported partner organisations.

2) The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention.

The PMTCT program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis.

During the FY 2008, the program has continued to implement the new WHO PMTCT guidelines, where

- All pregnant women eligible for ART are given AZT+3TC+NVP as the first line regimen.
- Women for whom ART is not yet indicated, AZT is provided at 28 weeks of pregnancy plus single dose NVP and 3TC at onset of labour, with a 7-day tail of AZT plus 3TC in order to reduce the risk of NVP resistance;
- Alternatively, prophylactic AZT from 28 weeks plus single dose NVP for woman or single dose NVP and AZT+3TC during labour and 7 days postpartum for woman, or single dose NVP to woman and infant
- The program has adopted the modified infant ARV prophylaxis recommended by a randomized clinical trial conducted in Malawi, to provide where infants born to HIV positive mothers are offered single dose NVP soon after birth plus AZT for 7 days, then the extended prophylaxis with nevirapine and AZT (zidovudine, Retrovir), after completion of the 7 days of AZT for fourteen weeks of life.
- Approximately, 100 HIV positive persons become pregnant in Rakai each year. In FY 2008, a total of 26 mothers were enrolled into the PMTCT program and 20 babies were delivered live for the PMTCT mothers during the first quarter (January-March 2008) while in the second quarter, 35 mothers and 12 babies received PMTCT services from the program.
- Health education for the pregnant mothers: All HIV positive mothers receive targeted education to address issues like antenatal care attendance, delivery under the care of a trained mid wife, contraception and infant feeding.
- Infant feeding: Following results that revealed a higher mortality among formula-fed infants as compared to the breastfed infants born to HIV-positive mothers, we ceased provision of infant formula. We currently recommend exclusive breast feeding as the safest infant feeding option for these babies.

HIV counseling will be provided for pregnant women residing in Rakai, Lyantonde and the neighboring districts of Masaka and Mbarara. These will include mothers participating in the Rakai cohort studies as well as HIV positive women enrolled in the HIV clinics.

- PMTCT counseling services shall be provided to all the HIV positive women identified through the above sources. ARV prophylaxis, infant feeding counseling shall be provided for the HIV-positive women identified. These women shall be encouraged to attend regular antenatal care clinics at their nearest health centers.
- On-going health education to all pregnant HIV positive mothers shall be given during pregnancy and the post partum period, emphasizing the importance of delivery in a health center, post-partum hygiene, infant feeding and adherence to ARV prophylaxis for the mother and baby.
- Reproductive health services will particularly be provided to these women.

ARV prophylaxis - The program shall provide counseling and testing for pregnant mothers. This will help identify HIV positive mothers so that they are provided with the available PMTCT care.

- RHSP shall provide PMTCT services via 17 clinics spread out in communities in Rakai and Lyantonde districts. ARV prophylaxis shall be provided to all HIV positive pregnant women registered with the program clinics according to WHO guidelines i.e.
- All pregnant women eligible for ART shall be given AZT+3TC+NVP as the first line regimen.
- For Women for whom ART is not yet indicated, AZT will be provided from 28 weeks of pregnancy plus single dose NVP and 3TC at onset of labour, with a 7-day tail of AZT plus 3TC in order to reduce the risk of NVP resistance;
- Alternatively, prophylactic AZT from 28 weeks plus single dose NVP for woman and single dose NVP and 7 days of AZT for infant or single dose NVP and AZT+3TC during labour and 7 days postpartum for woman, and single dose NVP for infant; or single dose NVP to woman and infant
- The program will continue to offer the modified infant ARV prophylaxis to infants born to HIV positive mothers where the infant is offered single dose NVP soon after birth plus AZT for 7 days, then the extended prophylaxis with nevirapine and AZT (zidovudine, Retrovir), after completion of the 7 days of AZT for

**Activity Narrative:** fourteen weeks of life.

Training - In this budget period, two permanent district health center staff in each of the 17 clinics at which we conduct our outreaches will receive training and refresher courses in referral and screening of HIV+ patients, HIV care and PMTCT care services.

- These health units will be provided with materials and services such as PMTCT drugs if needed, Information Education and Communication (IEC) materials, and access to consultation to enable them actively participate in provision of quality PMTCT services. We shall provide structured continuing medical education sessions (CME) for various district health staff participating in PMTCT.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13231

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13231	4022.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV/AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$40,000
8327	4022.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV/AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$36,670
4022	4022.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$35,250

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Safe Motherhood

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$24,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.01: Activities by Funding Mechanism****Mechanism ID:** 1259.09**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development**Prime Partner:** Ministry of Health, Uganda**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Prevention: PMTCT**Budget Code:** MTCT**Program Budget Code:** 01**Activity ID:** 4402.21228.09**Planned Funds:** \$250,000**Activity System ID:** 21228



**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Program (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, aimed at expanding access to quality HIV prevention, care, and treatment services to HIV infected/affected persons and their families. PEPFAR is currently supporting MOH to undertake the following five initiatives: 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, 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 HIV counseling and testing 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 HIV testing 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 central public health laboratory 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 programs and population-based studies.

The PMTCT program area of the MOH includes central level activities of the national PMTCT program. The current PMTCT policy (2006-2010) focuses on supporting the holistic implementation of the four-pronged PMTCT strategy (primary prevention; family planning; provision of ARV prophylaxis; care and support) and includes the consolidation of services to increase uptake, male involvement, strengthening of family planning services, improvement of comprehensive care for HIV positive women, their spouses and their exposed children through early HIV diagnosis and linkages to care. The program coordination and scale up is guided by a National Advisory Committee (formerly National PMTCT Technical committee), which meets quarterly to oversee, discuss and advise on the roll out of the program in the country. This advisory committee has 5 sub committees (Capacity building, IEC/BCC, Community mobilization, M & E and logistics and laboratory sub committees) with clear terms of reference related to the various technical issues pertaining to each sub-committee. All the major donors supporting the PMTCT program such as PEPFAR, UNICEF, WHO, USAID, UAC, UGFATM and major implementing partners (EGPAF, PREFA and JSI/SCMS) are represented in the National advisory committee and its subcommittees. Other implementing partners on subcommittees include IRC, AVSI, GTZ, MSF-France, AMREF, ISS-ROME and PLAN-Uganda. The research partners include MU-JHU and MRC that conduct informative research to guide policy formulation and review as well as program implementation. MOH/ACP performs the overall function of ensuring coordination of the many partners, equitable distribution of PMTCT services in the country, ensuring the implementation of the decisions taken by the National Advisory Committee, reviews and updates the policy, implementation guidelines and training package as need arises. MOH also supports capacity building at national and regional level and supports the districts in development of their work plans to priorities HIV/AIDS activities. Regarding the logistics and supplies for the PMTCT program, the STD/ACP with technical support from JSI/SCMS/DELIVER handles the Procurement Supply chain Management (PSM) plan that includes product selection, forecasting, procurement, planning, inventory management and rational use of medicines. MOH is also mandated to ensuring quality of the PMTCT services provided and this is usually achieved through technical support supervision to the districts as well as through inter-district coordination meetings. The MOH is also supposed to conduct operations research to inform program implementation, monitoring and evaluation.

During FY2008, MOH PMTCT program was involved in the dissemination of the revised PMTCT policy guidelines and provision of technical support supervision to the districts and together with the implementing partners provided oversight during the intra-district scale up of PMTCT services. By June 2008 a total of 596(51%) of health facilities up to HC III were providing PMTCT services (99% of Hosp, 94% of HC IV, 31% of HC III and 3.2% of HC II) with support from USG and other partners. The National Program now prioritizes scaling the services to all HC III by 2010 and to improve the quality of PMTCT data being collected. The PMTCT program was also evaluated this year and the report is available. The program intends to implement most of the recommendations from this report as well as the recommendations from The joint review of the PMTCT and Pediatric HIV/AIDS program in the FY2009 and FY2010.

During FY 2009, MOH aims at strengthening capacity for delivery of PMTCT services in line with the HSSP II and revised PMTCT policy guidelines 2006-2010. Overall national targets are to reach 80% of HC III in financial year 2009/2010; provide counseling and testing to 80% of pregnant women through routine opt out approach; reach 100% prophylaxis coverage for mothers and 60% for babies; improve uptake of combination regimens from 20% to 50%; increase HAART coverage for eligible pregnant women from the current 7% to 15% by 2010. Intra-partum single-dose Nevirapine (SD-NVP) prophylaxis will also be implemented as stipulated in the revised PMTCT policy. The specific activities for FY 2009 are: i) continue to disseminate the current revised PMTCT policy guidelines as well as the revised implementation guidelines to the district health workers at the PMTCT sites. ii) Initiate the process of revising the current PMTCT policy guidelines to incorporate new developments including new CD-4 T cell counts cut off points for ART initiation among pregnant women and Pediatric ART treatment guidelines. iii) In 2007, UNICEF supported revision of infant feeding policy guidelines and their dissemination will continue this year. iv) strengthen the Monitoring and Evaluation components of the program by reviewing/updating, printing and dissemination of M & E tools, protocols and job aids for overall PMTCT implementation. This includes the integrated RH/PMTCT registers and program monitoring and reporting tools. Data management, reporting and utilization at sub national levels will be strengthened and supported, v) strengthen regional and district supervision teams through regular or targeted technical supervisions to the districts as well as through revision, updating and dissemination of the integrated RH/HIV/AIDS supervision tool. vi) WHO supported the program to update the PMTCT Training package in line IMAI/IMPAC WHO training curriculum. The latest version is ready for field testing and finalization and in FY 2009 we shall conduct refresher training for trainers on the revised materials as part of the expansion of services to HC IIIs. vii) The early infant diagnosis program (EID) which began in FY 2006 will be strengthened and expanded with the goal to reach 80% of the HIV exposed infants in 2009/2010. The MOH will provide supervision and monitoring to ensure

**Activity Narrative:** that HIV infected children are linked to Pediatric AIDS care, treatment and support services within the health facilities. viii) Strengthen integration of PMTCT into care and treatment programs through harmonization and collaboration with RH and ART programs to support linkages, ix) strengthen supply chain management for PMTCT commodities through supporting PSM plan including support for the storage and distribution of donated products, ix) Hold regular coordination and collaborative meetings with the donors and implementing partners. x) Print and disseminate the revised and updated Family/Psychosocial support strategy as part of innovations to improve male involvement and uptake of PMTCT services in general. xi) review, update, print and disseminate the communication strategy for PMTCT. xii) Review and update the existing VHT guidelines to include PMTCT. xii) Peer support groups for PMTCT clients will be established through the involvement of NGOs, CBOs, FBOs and the private sector. This will also include support to HIV negative pregnant women and their spouses to remain HIV negative. MOH will provide overall programmatic oversight on these activities xiii) Strengthening the linkage between health facilities and communities including streamlining referrals and guideline for linkage. xv) Support the national officers to participate in conferences and short courses to update their skills.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13293

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13293	4402.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$350,000
8341	4402.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$299,897
4402	4402.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$94,914

---

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$120,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 15894.21544.09

**Activity System ID:** 21544

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** ██████████

**Activity Narrative:** The USG has been supporting provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships, which demonstrate competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so, USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive, and on the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. USAID will award the new agreement by March 2009. This will ensure smooth transition between the current JCRC program and the TBD mechanism.

In FY 2009 the major focus of the activity will be to ensure the continuity of life saving services, a smooth transition and capacity building of 11 regional referral hospitals and expansion of district wide HIV/AIDS care and treatment services in 40 facilities located in the 11 districts hosting the regional referral hospitals.

Specific activities will include: training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis (TB) and HIV. The program will train physicians and non-physicians to provide ART services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, ART literacy, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for prevention with positives and linkages to basic preventive package and wrap-around services.

In an effort to integrate delivery of interventions for Prevention of Mother to child Transmission (PMTCT) within maternal and child health services (MCH), the TREAT program will scale-up the use of highly active anti-retroviral (ARVs) for treating pregnant women and preventing HIV-infection in infants in 55 supported sites. The program will provide HIV/AIDS Counseling and Testing (HCT) and CD4+ cell measurement services to at least 10,000 HIV-positive pregnant women in 55 sites to determine anti-retroviral therapy (ART) eligibility and provide ART to those eligible. It is estimated that 30 percent of these women will receive ART services.

The program will provide support and training to other USG-supported program to integrate CD4+ cell measurement and Early Infant Diagnosis using DNA-PCR in the essential package for pregnant women and setup referral networks to ensure that health facilities without CD4+ cell measurement facilities send samples to referral laboratories.

In addition to training staff in MCH services to provide ART, the program will procure and provide ARVs to antenatal clinics in 55 sites. The program will also ensure that AZT and Nevirapine for infants is available in the 55 MCH sites.

It is estimated that 400 HIV-positive pregnant women with CD4 cell count below 350 cells/mm<sup>3</sup> will receive ART while 700 not yet eligible for ART will receive a course of highly effective ARVs for prevention of HIV infection in infants. All the 400 HIV-exposed infants will receive a seven-day course of Zidovudine (AZT) and Nevirapine. The program will follow the revised Ministry of Health protocol for PMTCT and the WHO recommendations for ARV drugs for treating pregnant women and preventing HIV-infection in infants in Resource-limited setting. It is anticipated that through this activity, PMTCT using single dose Nevirapine will be reduced to an absolute minimum in the supported sites.

The program will link with the President's Malaria Initiative (PMI) to provide Intermittent Preventive Therapy for malaria in pregnancy using either daily Cotrimoxazole or three-doses of sulfadoxine-pyrimethamine and the distribution of Insecticide Treated Mosquito nets to pregnant mothers. All women diagnosed to be HIV-positive will be screened for tuberculosis (TB) and receive nutritional counseling and education including support for infant feeding. All women eligible will receive Cotrimoxazole prophylaxis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15894

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15894	15894.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$300,000

**Emphasis Areas**

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9221.09	<b>Mechanism:</b> STAR-EC
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 21145.21573.09	<b>Planned Funds:</b> \$851,000
<b>Activity System ID:</b> 21573	

**Activity Narrative:** Activity Narrative:

This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity will focus on increasing access to PMTCT services through support to six districts in the East Central region of Uganda including Bugiri, Iganga, Kairi, Kamuli, Mayuge and Namutumba at both facility and community settings. Whereas these districts are estimated to have more than 74,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners providing HIV/AIDS care and treatment services. This program will expand delivery of PMTCT services in districts without a PEPFAR implementing partner 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 in districts without a PEPFAR PMTCT partner will be to directly support PMTCT programs 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 in Districts that have PEPFAR PMTCT implementing partners depending on the prevailing need.

The program will also 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, coverage of and utilization of care and treatment services. Community programs will strengthen social mobilization in order to enhance demand for PMTCT services. Involvement of the Private Sector and TBAs in the provision of Comprehensive PMTCT services and strengthening of follow-up mechanisms for the Mother-baby pair will be strengthened.

During FY 2009, objectives for the PMTCT services will focus on:

1. Support the scale up of PMTCT services to reach 85% of the expected population of pregnant women in the six districts.
2. Promote the use of more efficacious ARV regimens for PMTCT through strengthening capacity building and logistics management.

**Key Activities**

The district based program will aim at contributing to the national PMTCT strategy(2006 – 2010) whose focus is to roll out the revised PMTCT policy, 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:

- Increasing program coverage for PMTCT: Focus will be placed on the scaling up PMTCT services up to Health Center IIIs in all districts without a USG PMTCT Implementing Partner. Outreach services will be extended to H/C II or lower level health facilities that do not have the capacity to offer maternity services. Strengthening quality improvement interventions at health district and health facility levels will increase program coverage. Strengthened 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.
- 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. Significant improvement in access to combined regimens for PMTCT will be through improvement of quantification of ARV requirements and use of innovative approaches to increase access to HIV positive pregnant women. Logistical support for the procurement and distribution of ARVs, drugs for opportunistic infections and HIV test kits will continue to be major activity. All of eligible HIV positive pregnant women (CD4+ > 350/ml) will be started on HAART and 50% of pregnant women (CD4+ <350) will receive Combined ARV regimens.
- Continuum of care and treatment of the HIV positive mothers and their families: The provision 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 program will further support to HIV infected families to adopt safe infant feeding practices in relation to the revised infant feeding materials.
- 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

**Activity Narrative:** 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.

- In collaboration with other stakeholders, the district based program 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.
- Integration of family planning services into HIV/AIDS/MCH/Treatment services.
- 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

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.

This activity will also endeavor to scale up adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	██████████

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Military Populations

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 690.09	<b>Mechanism:</b> N/A
<b>Prime Partner:</b> US Department of Defense	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 4551.21593.09	<b>Planned Funds:</b> \$100,000
<b>Activity System ID:</b> 21593	



**Activity Narrative:** As commander in chief of the armed forces, the President of Uganda mandated the UPDF's AIDS Control Program to oversee and manage prevention, care, and treatment programs throughout the forces and their families. Although the exact prevalence rates of the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated with the military, with up to 50% of patient visits being non-military. The UPDF HIV/AIDS Control program is comprehensive, although the PEPFAR support for PMTCT was added more recently in the past few years. The initial thrust has been to augment PMTCT services at 5 of the military bases with ART clinics. The activities include sensitization and increased awareness for pregnant women to access services. Midwives and nurses are being trained in these PMTCT centers according to Uganda MOH guidelines. PMTCT is also used as an entry point to ART services and an avenue to identify discordant couples and emphasize the linkage to clinical services. For those bases without military PMTCT services, pregnant service women and spouses are referred to civilian sites.

2. Progress to-date

With PEPFAR funding PMTCT is offered at 5 of the UPDF bases, and limited training of health care providers has been offered. An assessment is underway to estimate the coverage of Counseling and Testing of pregnant women, the linkages of PMTCT services to ART and follow-up procedures of the mother infant pair. One notable observation is the very low level of access to PMTCT services by pregnant women (less than 40%)—and an even lower level for their families.

3. Activities for FY 2009.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: During FY 2009, the program will focus on increasing the coverage of women receiving PMTCT services in the supported UPDF facilities. The target for this performance period is to reach 75% of pregnant women and 25% of spouses and partners of the targeted pregnant women with PMTCT services. To do so, the program will strengthen the capacity of health workers to provide quality PMTCT services including FP and HCT; augment efforts to reach male partners and enhance their level of involvement in pregnancy and childbirth issues, and; provide easily accessible education on ways to reduce risk of HIV infection from mother to child before and during pregnancy, at delivery and during infant feeding. More than 100 service providers will undergo training on MTCT with a goal of using them to scale PMTCT services for military families. Pregnant women and their spouses who are found to be HIV-positive will be linked to other services for continued care and support and where necessary antiretroviral treatment.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16065

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16065	4551.08	Department of Defense	US Department of Defense	7336	690.08		\$100,000
8390	4551.07	Department of Defense	US Department of Defense	4821	690.07		\$100,000
4551	4551.06	Department of Defense	US Department of Defense	3156	690.06		\$50,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 15889.21710.09

**Activity System ID:** 21710

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** [REDACTED]

**Activity Narrative:** Faith-based organizations (FBOs) have been strong partners in the delivery of health services in Uganda. Through their established and extensive network of health units, they support 47% of the country's health care services. Besides the wide coverage, FBO health services are targeted and reach the most remote areas of the country. FBOs have also been incredible partners in the national response to the HIV and AIDS epidemic.

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 HIV care and treatment services. As at March 2008, it had enrolled 23,746 individuals (8,787 males and 14,959 females) into care and 2,605 (964 males and 1,641 females) on treatment through its twenty-two partner sites. 362 of these were pregnant women received HIV counseling and testing. Thirteen of these sites jointly deliver care and treatment, an approach that has been proved to alleviate pressure on the already overstretched capacity of the partner health units, particularly personnel.

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.

Poor access to health services remains one of the major bottlenecks to uptake of PMTCT services. In addition, psycho-socio and cultural factors also constitute major barriers to women's utilization of MCH/PMTCT services in health facilities. These include limited male partner involvement in PMTCT programs, high levels of HIV stigma, low levels of community HIV awareness and mobilization as well as high community attachment to, and preferential use of Traditional Birth Attendants (TBAs) and home deliveries by close relatives. Other factors include poor quality of services provided by government facilities, poor linkages to HIV care and treatment services for HIV positive mothers, weak procurement and distribution systems leading to frequent stock out of essential PMTCT commodities and inadequate staffing levels at the health facilities.

Over the last three years, IRCU has been supporting the Ministry of Health (MOH) PMTCT program with special focus on intensifying primary prevention of HIV/AIDS, prevention of unintended pregnancies among HIV positive women and comprehensive care to the mothers and family. The IRCU follow-on program will continue to provide comprehensive PMTCT services in line with the new MOH guidelines. It will support community advocacy programs, which include encouraging mothers to attend antenatal care (ANC), male involvement during PMTCT activities, and training of midwives and TBAs to distribute mother-baby ARV packs to mothers prior to delivery in case delivery takes place at home. This program will also facilitate the supplies management at the units to increase the uptake of HIV counseling and testing at ANC and provision of HAART and complex ARV regimens for prophylaxis by providing a steady supply of HIV testing kits and more efficacious ARV regimens as stated in the revised PMTCT guidelines.

This program will further support the formation of PMTCT clubs consisting of HIV positive mothers, community volunteers and counselors. These clubs then carry out extensive health education and sensitization in the community, work with newly diagnosed mothers encouraging them to bring their spouses or partners for testing and track mothers and infants after delivery to assess their health care seeking habits. This follow-on program will work with MOH and EGPAF (located in 8 IRCU supported sites) to train the implementing sites set up systems for PMTCT follow-up and male involvement. The sites will set up PMTCT-support clubs to work with the newly diagnosed mothers and help them to cope with their new health status, encourage them to test their other children and spouses and follow up on the male involvement and testing. These clubs will also teach mothers about nutrition, infant feeding options and other care. The sites will also set tracking teams to identify all diagnosed mothers, open a clinical record for each mother, follow up each mother till time of delivery and during the postnatal period after which both the mother and infant will be transferred to the HIV clinic on site for regular care. The program will train religious leaders to mobilize couples especially the male partners of expecting mothers through their routine pastoral work and home visitations to access PMTCT and related services. Individuals who test positive will be assisted to receive care and treatment.

The program will further strengthen the PMTCT community follow up program by tracking HIV positive mothers to assess their health seeking behaviors for themselves and their infants and at the same time promote early initiation of cotrimoxazole prophylaxis and ART for the infants. Mothers will be encouraged to deliver in health units.

This program will initiate links with the District Health Services Commissions and will collaborate with existing PEPFAR PMTCT partners to streamline PMTCT services according to the district health sector plan. This will involve holding coordination meetings with district leaders and partners and other stake holders. Through partnerships, this program will build the capacity of key groups in the community such as community leaders, and PHA networks so that they are an indigenous source of knowledge within their communities and can be utilized to refer mothers or couples for HIV testing and PMTCT services.

The IRCU follow-on will prioritize CD4 testing for both the mothers and infants. The exposed infants will be tested for HIV infection using RNA-PCR from the nearest Joint Clinical Research Center (JCRC) Regional Labs of Excellence. 600 infants will receive HIV testing by the end of 2009. These children will be enrolled into care and given the required basic HIV care including Cotrimoxazole prophylaxis and also assessed for eligibility for ART.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15889	15889.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$250,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7156.09	<b>Mechanism:</b> NUMAT
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 4696.21723.09	<b>Planned Funds:</b> \$838,000
<b>Activity System ID:</b> 21723	

## Activity Narrative: Activity Narrative

This activity also relates to other NUMAT activities which include, Prevention /Abstinence and Being Faithful, Prevention Other, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning. The FY2009 activities are a continuation from FY2008.

In FY2008, NUMAT focused on improving and strengthening existing PMTCT services, especially in hospitals, HC IVs and HC IIIs. Emphasis was also placed on scaling up services to more HC IIIs and selected HC IIs with MCH facilities in order to increase access to services by the target populations. A total of 80 sites were supported. NUMAT input was in the form of technical assistance (TA) through support supervision and mentoring of PMTCT service providers; establishing and strengthening of the already existing Family support groups (FSGs); distribution of IEC/BCC materials; delivery of data and Logistics Management Information System (LMIS) tools; provision of buffer stocks of HIV test kits to sites experiencing shortages; supporting the supply chain management with emphasis to PMTCT supplies (HIV test kits, ARVs). NUMAT conducted trainings in the areas of new PMTCT policy guidelines giving prominence to the combined ARV regimens and HAART for eligible HIV+ mothers; Integrated Infant and Young Child feeding counselling; PMTCT counselling training; Early Infant HIV Diagnosis; and implementation of FSGs. NUMAT strengthened PMTCT-ART collaboration activities in 10 PMTCT/ART sites with specific attention to CD4 testing (while working with a contracted partner-Cnapsis), WHO clinical staging, HAART initiation for eligible mothers and Opportunistic infections management / prophylaxis. In Kitgum and Pader districts, the PMTCT activities were supported through AVSI as a grantee.

NUMAT continued to support the established FSGs at the health units and these helped mothers, their partners and infants to access and adhere to ARV regimens and infant feeding options, and were able to receive psychosocial support for their families. The members were also linked to 'wrap-around' services such as home based care, family planning, food and nutrition support. NUMAT also supported Rwoth Ogwok Ayaru Foundation (ROAF), a local CBO in Lamwo County in Kitgum, to conduct community based FSGs in PMTCT sites of Padibe HC IV, St Peter and Paul Padibe HC III, and Madi Opei HC IV. A total of 202 HIV positive mothers and their partners to benefit from these meetings that are conducted twice a month by ROAF in addition to over 350 mothers and partners who benefit from facility based FSGs. Over 60 mother-baby pairs have been followed up through home visits and FSG meetings.

NUMAT teamed up with the Ministry of Health and district partners to provide regular integrated PMTCT and HCT technical support supervision to all sites in the 9 districts. During supervision visits, revised PMTCT and HCT policy guidelines; Integrated MCH registers; LMIS and reporting tools; as well as IEC materials on infant feeding were distributed to the sites. In addition, health workers were oriented on the revised PMTCT and HCT policy guidelines (including HAART and use of combination regimens for PMTCT as well as early infant HIV diagnosis) and how to use MCH registers and LMIS and reporting tools. The supervision teams provided HIV test kits, Nevirapine tablets and suspension to facilities that lacked them. NUMAT also supported formation of supervision teams in the districts of Gulu and Amuru and these were able to carry out quarterly supervision visits.

A total of 116 health workers were trained as PMTCT and infant feeding counselors. The training helped to prepare an additional 20 sites that will be fully supported in FY2009. NUMAT also conducted EID trainings in the districts of Amuru and Apac in addition to Lira and Gulu regional referral hospitals where 203 health workers from 32 PMTCT sites were trained. The health facilities were also supplied with EID materials. Thirty six health workers were also trained in FSG implementation.

Because of the NUMAT support, over 56,000 pregnant women benefited from PMTCT services in form of counseling, testing and receiving test results.

In FY 2009, NUMAT will continue to provide technical assistance to the existing 80 PMTCT sites and 20 new sites in the 9 districts of Gulu, Amuru, Kitgum, Pader, Oyam, Lira, Apac, Dokolo and Amolatar. The scale up of PMTCT services to more sites will enable NUMAT to reach more pregnant women with the services. The technical assistance will take the form of support supervision and mentoring of PMTCT service providers; orientation of health workers in new PMTCT advances/policies as per MOH guidelines; provision of buffer stocks of HIV test kits and ARVs for PMTCT; strengthen the supply chain management with emphasis to PMTCT supplies. Support supervision will involve partners at 3 levels: 1) MOH led supervision- to be conducted bi-annually will involve all the partners in the region, 2) District led supervision- to be carried out quarterly in order to follow up recommendations by MOH teams, and 3) HSD led supervision – to be done monthly in order to deal with all the site specific issues.

NUMAT will support the districts of Kitgum, Pader, Oyam, Lira, Apac, Dokolo and Amolatar to form PMTCT support supervision teams both at district and HSD levels. The teams will be established according to the MOH guidelines.

NUMAT will support integrated outreach services from health units to IDP camps. This will be done while putting into consideration of the fact that IDP population is currently returning to their homes and that there has been formation of satellite camps which are near to their homes in view of the human resource challenges in the region. NUMAT will support NGOS and local CBOs especially in the areas of mobilization for the outreach activities. Again, emphasis will be placed on areas with limited access to services. To promote behavioural change and as part of health education, NUMAT will procure and distribute more IEC/BCC materials and equipment to all the 100 PMTCT sites. The materials will focus on male partner

**Activity Narrative:** involvement, early infant HIV diagnosis, ARV adherence, ANC attendance and hospital delivery. Radio talk shows on local radio stations will be strengthened. Drama activities will also be conducted, by locally based CBOs, like ROAF, focusing on all PMTCT interventions.

A total of 72 health workers will be trained in PMTCT counseling, another 180 (20 per district) will be trained in family planning counseling within the context of HIV/AIDS. NUMAT will partner with Engender Health and Family Planning Association of Uganda to support Family planning services with emphasis to dual protection.

PMTCT orientation trainings mainly targeting the newly recruited health workers will be supported. This will be supplemented by attachment of health workers, especially from peripheral/lower health facilities to HC IV and hospitals to acquire the necessary "hands-on" skills. More health workers in the districts of Pader, Kitgum, Gulu, Lira, Oyam, Dokolo and Amolatar will be trained in DBS collection and supplies will be provided. Districts will also be supported to transport blood samples (DBS) for DNA-PCR testing to the JCRC laboratory center of excellence in Gulu at least twice a month, so that tested children can be linked to care and support. NUMAT will also support more training in integrated infant and young child feeding counseling where 72 health workers will be trained.

NUMAT will support regional PMTCT bi-annual coordination meetings in each of the sub-regions for purposes of sharing experiences, challenges upholding best practices, and addressing site/district specific PMTCT related issues/challenges. This will bring together all PMTCT stakeholders and partners in each of the regions. The existing Family support groups will be strengthened and 12 more will be established. In order to strengthen the community component of PMTCT, peer mothers and fathers, community counseling aides and other community owned resource persons will be provided with skills to provide support to HIV positive mothers and their families. Sexual and gender based violence (SGBV) activities will be incorporated within the PMTCT services. Safe motherhood, including post-natal services and follow up of babies with emphasis on immunization, growth monitoring and infant feeding will be given priority in PY3.

PMTCT-ART linkages will be strengthened in all ART sites to enable health workers to offer care and support to HIV positive women and their HIV+ family members/partners - including co-trimoxazole prophylaxis and CD4+ services - and enable eligible individuals to access ARVs. Coordination meetings and CME sessions between ART and PMTCT/MCH departments will be supported in order to strengthen the linkages. This will mainly target large facilities like hospitals where departments tend to exist/operate independently and or in isolation. This will be in addition to already supported CME monthly sessions for the regional hospitals.

NUMAT will continue to partner with AVSI in the districts of Pader and Kitgum in the delivery of PMTCT services. Emphasis will be placed on scaling up PMTCT services to more sites. Additionally, under the AVSI grant, NUMAT will provide food/nutrition support to 60 HIV+ pregnant/ lactating women.

Apart from supporting established channels of follow up like immunization clinics, Post-Natal Clinics, FGSs, NUMAT will support local CBOs to follow up mothers and their babies. Additionally, realizing that only 38% of mothers deliver in health units, NUMAT will support the training of Traditional Birth Attendants, Village Health Teams, Community Drug Distributors and CBOs to help the referral for accessing PMTCT interventions and also the follow up of mother-baby pairs in the communities.

In FY 2009, NUMAT targets to have 122,295 pregnant women counselled, tested and receive results from the 100 NUMAT supported PMTCT sites. This translates into 7,949 HIV+ mothers (6.5% of those tested) and of these NUMAT targets to have 7,429 (80%) HIV+ pregnant women receive ARV for PMTCT prophylaxis and a similar number of infants (100%) born to HIV + mothers to receive ARVs for prophylaxis. This is possible since Nevirapine suspension can now be repackaged and given to pregnant women. It is also expected that 50% (2,475) of all HIV + pregnant women will have their CD4+ counts done to assess their eligibility for HAART in addition to WHO clinical staging. The PMTCT\_ART collaborative activities will be strengthened in mainly the 23 NUMAT supported ART sites and approximately 1,120 (20% of HIV + pregnant women) are expected to be eligible for HAART.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15467

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15467	4696.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$850,000
8466	4696.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$761,542
4696	4696.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$250,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$120,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$4,000

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 12367.21809.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21809	

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to ARV drugs, Adult Care and Treatment, Pediatric Care and Treatment, CT, TB/HIV, and Laboratory Infrastructure.

The Ministry of Health, with support from the Abbott and Boehringer donation program, has expanded PMTCT coverage to all districts in Uganda currently reaching 90 percent of health center IVs and 20 percent of health center III's, with a plan to reach 100 percent and 35 percent respectively by the end of 2008. Regarding support to PEPFAR partners, SCMS provided technical assistance to NUMAT in forecasting and quantifying program needs and procurement of PMTCT commodities for NUMAT-supported sites. During a recent field visit health workers from a sample of NUMAT districts reported no problems with ARV supplies. At the national level, SCMS supported the MOH in providing capacity building in logistics data capture and management, forecasting, procurement planning, and coordination of emergency responses to product shortfall in PMTCT and other HIV/AIDS commodities. In FY 2008, SCMS provided support to revise the logistics system to incorporate new treatment policies and the additional commodities required to implement the current scale-up of PMTCT services. Training of new staff in the logistics management system of PMTCT commodities continued. A proposal to integrate PMTCT into the essential drugs system was proposed in January 2008, but has not been approved. SCMS worked with MOH to submit a final procurement and supply management (known formally by the GFATM as the PSM) plan for Global Fund Round 7, Phase 1 ARV procurement. SCMS worked with the quantification review committee to review the assumptions used in the quantification. Submission of the plan is a GFATM requirement for signing of the grant agreement and having funds released for ARV procurement. SCMS provided regular status updates on HIV test procurement in light of the almost six 6 month stock out of the screening test.

In FY 2009, SCMS will continue to provide procurement services to USAID-supported partners to buy ARVs and other commodities as appropriate for PMTCT and other HIV/AIDS services. The new procurement mechanism will provide technical assistance to national and district-level PEPFAR partners on commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submitting timely reports to keep the supplies flowing. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution from district stores to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14230



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14230	12367.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$350,000
12367	12367.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$91,796

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 9832.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 12375.22929.09

**Activity System ID:** 22929

**Mechanism:** Western Region / PMTCT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** ██████████

## Activity Narrative: Introduction

This narrative is a component of other EGPAF activities that include HIV care and treatment supported through USG funding. EGPAF also supports treatment services at 5 sites using private funds donated through the Abbott Fund.

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. The Foundation directly supports programs in 27 districts to provide HIV counseling and testing, ARV prophylaxis, HAART, psychosocial support, community mobilization, training, adequate counselor and laboratory technician staff, upgraded laboratory facilities and counseling rooms, management information systems and strengthened MCH/FP services. The Foundation's staff provides technical support to the district programs and by participating in MOH technical committees such as pediatric ART and PMTCT. 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. The Joint Clinical Research Centre provides laboratory services for CD4 cell counts to HIV positive pregnant women as well as providing ARVs for PMTCT and ART. ICOBI is a recent recipient of funding to carry out community PMTCT we hope to develop joint programming with an aim of ensuring the seamless delivery of PMTCT services within participating districts. Other collaborating partners are Uganda Cares that provides CD4 cell testing in the districts of Masaka, Sembabule and Rakai; WHO and UNICEF for the development and distribution of job aides, advocacy. EGPAF Uganda participates in the various technical working groups at AIDS Control Program /Ministry of Health and works with other USG PMTCT implementing partners including PREFA, Mild May, TASO, AIDS Information Centre, Baylor Children's Foundation Uganda, CRS/AIDS Relief collaborate in the sharing of best practices and the coordination of district activities.

## 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. Since the start of USAID funding in late 2003 the number of service outlets have increased from 37 to 363 in 27 districts (Bundibugyo, Bushenyi, Iganga, Namutumba, Hoima, Ibanda, Iganga, Kasese, Masaka, Sembabule, Isingiro, Kiruhura, Mbarara, Kabale, Mayuge, Mukono, Kampala, Mpigi, Lyantonde, Kamwenge, Kibaale, Kabarole, Rukungiri, Ntungamo, Kisoro, Kanungu and Rakai). During SAPR08 156,159, women were tested for HIV, 11,410 HIV positive women received ARV prophylaxis respectively. 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. This has strengthened linkages between the community and the health facility by involving peer educators selected from among HIV positive parents (mothers and their male partners) identified during PMTCT and trained and assigned roles alongside professional health workers at the care and treatment sites.

## FY 2009 Activities

EGPAF will focus on three activity Objectives: 1) Support the scale up of PMTCT services to reach 85% of the expected population of pregnant women in the districts where the Foundation works. 2) Promote the use of more efficacious ARV regimens for PMTCT through strengthening capacity building and logistics management. 3) Scale up Family focused HIV Care Clinics within MOH Health Centers and directly enroll HIV-positive mothers and family members in HIV comprehensive care including treatment. 1) Increasing program coverage for PMTCT. Current population coverage (Proportion of the expected number of pregnant women [corrected for 2008] reached with HIV counseling) within the 27 districts stands at approximately 60%. The EGPAF Uganda program plans to broaden PMTCT coverage from 64% to an average of 85%. Focus will be placed on the newest 7 district programs to reduce on missed opportunities and on the remaining Health Center IIIs in all districts. In spite of the widespread human resource challenges EGPAF will scale up the integration of PMTCT services within maternity, post natal services including Family Planning, and in the well child clinics where efforts to identify HIV exposed infants to offer nutritional counseling and initiate OI prophylaxis with cotrimoxazole. Outreach services will be extended to lower level health facilities that do not have the capacity to offer maternity services. Strengthening quality improvement interventions at health district and health facility levels will increase program coverage: HIV counseling, testing and logistic services will be targeted. Support for general reproductive health services will continue in the form of supplies for infection control including plastic sheeting, gloves, disinfectants, disinfection bins, aprons and gumboots for labor and delivery rooms. EGPAF will also replenish used up stationery including integrated RH registers and job aides. Equipment like delivery kits will be procured on a case-by-case basis.

2) Increase the uptake of combination ARV regimen for the maternal/infant pair. The Foundation will aim to increase the uptake of combination PMTCT regimen (AZT and SD NVP, or AZT/3TC and Sd NVP) from the current approximately 20% to 50% (semiannual 2291 out of 11,831), and to increase the uptake of HAART from 5% to 10% (semiannual 560 out of 11,831) of eligible HIV positive pregnant women accessing PMTCT services. The latter target will however be limited by the capacity of health facilities to offer ART services. 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. By improving quantification of ARV requirements, providing repackaging material for both nevirapine (aluminum foil pouches) and AZT (syrup bottles of a more appropriate/ smaller volume) oral solutions and improving coordination at national level the Foundation hopes to realize a significant improvement in access to AZT, and AZT+3TC for PMTCT. Successful training approaches on the use of the combination regimen will be rolled out to more PMTCT sites. The Uganda program will continue to supporting the sites to improve the collection of data related to these ARV regimens. Logistical support for the procurement and distribution of ARVs, drugs for opportunistic infections and HIV test kits will continue to be major activity. EGPAF has

**Activity Narrative:** developed a system of transporting blood samples for CD4 test from health facilities to regional laboratories run by JCRC (Kabale, Fort Portal, Mbarara, Mengo, Kakira and Mbale) and returning results to PMTCT sites. In coordination with JCRC, this critical referral service will be scaled up to include more sites. This same facility is used for DNA PCR testing for HIV exposed infants. 3) Longitudinal follow-up of HIV-positive mothers within MCH including during well-child visits. HIV care and treatment services will be strengthened through the development of mechanisms to offer continuum of care to HIV-positive mothers and their families. The provision of care and support services to eligible individuals has been shown to improve the uptake of all other PMTCT services. Capacity will be built to support the scale up of the program for early infant diagnosis of HIV. Focus will be directed at strengthening the enrollment of identified HIV-exposed and infected infants into continuum of care programs. Standardized operating protocols and job aides will be developed as part of this effort. Following the successful involvement, PLWHA networks in the provision of HIV care at five-health center IVs the Foundation rolled out this initiative to 41 sites. The integration of peer mothers and fathers (drawn from the Family Support Groups) into the regular HIV/AIDS services at health facilities will be expanded to support the follow up of the mother-baby pair in the community. The provision of peer counseling to parents of HIV exposed infants and guiding them through the various services on offer at the health facility has reduced loss to follow up of identified HIV exposed infants. HIV infected families will roll out use of revised infant feeding materials to support the adoption of safe infant feeding practices. Postnatal registers have been introduced at PMTCT sites and will enable the recording of specific data for HIV services offered during this period. HCT has been introduced within Family Planning at regional and some district hospitals and this will be scaled up during FY09. In a bid to reach those women and men who do not, come to health facilities EGPAF intends to work with the new Community PMTCT partners to develop effective linkages with the community. Joint programming will be developed to improve the delivery of ARVs for PMTCT within the community, follow up of mother-baby pairs from PMTCT and to support community/home-based counseling and testing for male partners. There is need to include how EGPAF will collaborate with ICOBI and/or THETA in relation to the community PMTCT services. 4) Human resource capacity building: The Foundation will continue to conduct IMAI/IMPAC training activities, Continuing Medical Education (CME) approach and using the mentoring approach in order to reinforce skills development among health facility staff with the goal of improving program uptake. The technical development of MOH staff in the supported districts will ensure sustainable capacity for program implementation. The Foundation will train up to 600 health workers during FY09 with the focus primarily targeting health workers in the Maternal and Child Health departments in the remaining Health Center IIIs in supported districts. Clinicians, nursing/midwifery and laboratory staff will be trained as integrated teams for HIV/AIDS patient care. Training activities will reflect the expanded nature of the PMTCT program with a strong bias towards integrating preventive and treatment aspects of HIV/AIDS. Special emphasis will be made towards increasing the use of more efficacious (combination) regimen for PMTCT and the repackaging of oral ARV medications for HIV exposed infants. This opportunity will be used to introduce and disseminate any new changes to national policies and implementing guidelines. Through sub grants to the supported districts EGPAF will continue to support full time positions for urgently needed health facility staff. In all situations, district health services will be encouraged to absorb these individuals onto permanent payrolls as soon as local government budgetary allocations allow. 5) Monitoring and Evaluation Plan: The Foundation will continue to support the MOH's M&E network through the provision of evaluation reports on key PMTCT and HIV care and treatment indicators. Field support 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. 6) Nutrition Support: The Foundation will in collaboration with the NuLife Project initiate a therapeutic feeding program in 9 EGPAF supported districts. This will also involve the development of resource materials like job aides, pamphlets for infant feeding (IYCF) and nutrition of pregnant women.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14190

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14190	12375.08	U.S. Agency for International Development	Elizabeth Glaser Pediatric AIDS Foundation	6734	6159.08	EGPAF	\$3,000,000
12375	12375.07	U.S. Agency for International Development	Elizabeth Glaser Pediatric AIDS Foundation	6159	6159.07	Plus up EGPAF	\$0

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development



## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 21110.24010.09

**Activity System ID:** 24010

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** \$552,000

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity will focus on increasing access to PMTCT services through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. Whereas these districts are estimated to have more than 42,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners providing HIV/AIDS care and treatment services. This will expand delivery of PMTCT 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 in districts without a PEPFAR PMTCT partner will be to directly support PMTCT programs 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 in Districts that have PEPFAR PMTCT implementing partners depending on the prevailing need.

The program will also 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, coverage of and utilization of care and treatment services. Community programs will strengthen social mobilization in order to enhance demand for PMTCT services. Involvement of the Private Sector and TBAs in the provision of Comprehensive PMTCT services and strengthening of follow-up mechanisms for the Mother-baby pair will be strengthened.

During FY 2009, objectives for the PMTCT services will focus on:

1. Support the scale up of PMTCT services from 16% to reach 85% of the expected population of pregnant women in the eight districts.
2. Promote the use of more efficacious ARV regimens for PMTCT through strengthening capacity building and logistics management.

#### Key Activities

The district based program will aim at contributing to the national PMTCT strategy(2006 – 2010) whose focus is to roll out the revised PMTCT policy, 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:

- Increasing program coverage for PMTCT: Focus will be placed on the scaling up PMTCT services up to Health Center IIIs in all districts without a USG PMTCT Implementing Partner. Outreach services will be extended to H/C II or lower level health facilities that do not have the capacity to offer maternity services. Strengthening quality improvement interventions at health district and health facility levels will increase program coverage. Strengthened 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.
- 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. Significant improvement in access to combined regimens for PMTCT will be through improvement of quantification of ARV requirements and use of innovative approaches to increase access to HIV positive pregnant women. Logistical support for the procurement and distribution of ARVs, drugs for opportunistic infections and HIV test kits will continue to be major activity. All of eligible HIV positive pregnant women (CD4+ > 350/ml) will be started on HAART and 50% of pregnant women (CD4+ <350) will receive Combined ARV regimens.
- 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 program will further support to HIV infected families to adopt safe infant feeding practices in relation to the revised infant feeding materials.
- 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

**Activity Narrative:** 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.

- In collaboration with other stakeholders, the district based program 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.
- Integration of family planning services into HIV/AIDS/MCH/Treatment services.
- 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

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 HCl or HIVQUAL; support accreditation of new ART sites, mapping community resources; and create community and facility networks.

This activity will also endeavor to scale up adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21110

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21110	21110.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	████████

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Military Populations

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 15899.24020.09

**Activity System ID:** 24020

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** ██████████

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity will focus on increasing access to PMTCT services through support to nine districts in the Western and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo 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. This will expand delivery of PMTCT 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 in districts without a PEPFAR PMTCT partner will be to directly support PMTCT programs 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 in Districts that have PEPFAR PMTCT implementing partners depending on the prevailing need.

The program will also 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, coverage of and utilization of care and treatment services. Community programs will strengthen social mobilization in order to enhance demand for PMTCT services. Involvement of the Private Sector and TBAs in the provision of Comprehensive PMTCT services and strengthening of follow-up mechanisms for the Mother-baby pair will be strengthened.

During FY 2009, objectives for the PMTCT services will focus on:

1. Support the scale up of PMTCT services to reach 85% of the expected population of pregnant women in the nine districts.
2. Promote the use of more efficacious ARV regimens for PMTCT through strengthening capacity building and logistics management.

#### Key Activities

The district based program will aim at contributing to the national PMTCT strategy(2006 – 2010) whose focus is to roll out the revised PMTCT policy, 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:

- Increasing program coverage for PMTCT: Focus will be placed on the scaling up PMTCT services up to Health Center IIIs in all districts without a USG PMTCT Implementing Partner. Outreach services will be extended to H/C II or lower level health facilities that do not have the capacity to offer maternity services. Strengthening quality improvement interventions at health district and health facility levels will increase program coverage. Strengthened 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.
- 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. Significant improvement in access to combined regimens for PMTCT will be through improvement of quantification of ARV requirements and use of innovative approaches to increase access to HIV positive pregnant women. Logistical support for the procurement and distribution of ARVs, drugs for opportunistic infections and HIV test kits will continue to be major activity. All of eligible HIV positive pregnant women (CD4+ > 350/ml) will be started on HAART and 50% of pregnant women (CD4+ <350) will receive Combined ARV regimens.
- 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 program will further support to HIV infected families to adopt safe infant feeding practices in relation to the revised infant feeding materials.
- 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



**Activity Narrative:** 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.

- In collaboration with other stakeholders, the district based program 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.
- Integration of family planning services into HIV/AIDS/MCH/Treatment services.
- 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

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.

This activity will also endeavor to scale up adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15899

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15899	15899.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development ██████████

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.01: Activities by Funding Mechanism**

**Mechanism ID:** 11125.09

**Prime Partner:** Inter-Religious Council of  
Uganda

**Funding Source:** GHCS (State)

**Budget Code:** MTCT

**Activity ID:** 15889.26779.09

**Activity System ID:** 26779

**Mechanism:** IRCU

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Prevention: PMTCT

**Program Budget Code:** 01

**Planned Funds:** \$0

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to address mutually identified development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. IRCU coordinates the largest network of faith-based health units in Uganda, which together deliver close to 50% of the health care services in Uganda. In June 2006, IRCU initiated a program to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR).

Mother to child transmission is the second most common means of transmission of HIV in Uganda. In Uganda, about 1 million women get pregnant yearly. With an estimated HIV prevalence of 6.5%, about 65,000 HIV-infected women get pregnant yearly and will transmit HIV to about 20,000 infants if there is no intervention. Using either Nevirapine at the onset of labour and Nevirapine syrup to the baby within 72 hours of birth or Zidovudine from 36 weeks of gestation until one week after delivery and syrup to the baby for the first week after birth minimizes the risk of mother to child transmission (MTCT) by 50%. In 2001 the Ministry of Health (MOH) started implementing a robust national PMTCT program, focusing in integrating it into existing antenatal services. Currently, there are 405 PMTCT sites in Uganda with each of the 80 districts having at least one site. The Ministry of Health, in partnership with its partners (donors, NGOs, FBOs and the private for profit organizations) have developed a national PMTCT policy which aims to provide universal access to PMTCT services by 2010.

Despite these landmark achievements, access and utilization of PMTCT services remains dismal. Poor access to health services remains one of the major bottlenecks to uptake of PMTCT services. In addition, Psycho-socio and cultural factors also constitute major barriers to women's utilization of MCH/PMTCT services in health facilities. These include limited male partner involvement in PMTCT programs, high levels of HIV stigma, low levels of community HIV awareness and mobilization as well as high community attachment to, and preferential use of Traditional Birth Attendants (TBAs) and home deliveries by close relatives. Other factors include poor quality of services provided by government facilities, poor linkages to HIV care and treatment services for HIV positive mothers, weak procurement and distribution systems leading to frequent stock out of essential PMTCT commodities and inadequate staffing levels at the health facilities.

In FY 2006 IRCU began the PMTCT program to support the MOH plan of intensifying primary prevention of HIV/AIDS, prevention of unintended pregnancies among HIV positive women and comprehensive care to the mothers and family. IRCU undertook an assessment of the existing PMTCT program at 18 hospital based sites in order to establish the gaps within existing services as well as the demand for PMTCT in health units where these services were not yet initiated. Of these 18 hospital based unit, eight are currently carrying out PMTCT services supported by their individual districts through Elizabeth Glazer Foundation for Pediatric HIV care (EGPAF). The rest are lower health centers which have not been accredited to provide PMTCT services. For these sites, IRCU is working with MOH to accredit these sites to provide PMTCT services by the end of FY 2007.

Using FY 2007 funds, IRCU will implement joint facility and community based PMTCT services. Currently, there are estimated 5-25 mothers who test HIV positive each month at the implementing sites. In FY 2008, IRCU will continue to provide comprehensive PMTCT services in line with the new MOH guidelines as well as support community advocacy programs which include encouraging mothers to attend antenatal care (ANC), male involvement during PMTCT activities, and training of midwives and TBAs to distribute mother-baby ARV packs to mothers prior to delivery in case delivery takes place at home. IRCU will also facilitate the supplies management at the units to increase the uptake of HIV counseling and testing at ANC and provision of ARVs for prophylaxis by providing a steady supply of HIV testing kits and more efficacious ARV regimens as stated in the revised PMTCT guidelines.

In this program, IRCU will encourage the formation of PMTCT clubs consisting of HIV positive mothers, community volunteers and counselors. These clubs then carry out extensive health education and sensitization in the community, work with newly diagnosed mothers encouraging them to bring their spouses or partners for testing and track mothers and infants after delivery to assess their health care seeking habits. IRCU will work with MOH and EGPAF to train the implementing sites set up systems for PMTCT follow-up and male involvement. With IRCU help, the sites will set up PMTCT-support clubs to work with the newly diagnosed mothers cope with their new health status, encourage them to test their other children and spouses and follow up on the male involvement and testing. These clubs will also teach mothers about nutrition, the hazards of breast feeding, alternative feeding for the infants and other care. The sites will also set tracking teams to identify all diagnosed mothers, open a clinical record for each mother, follow up each mother till time of delivery and during the postnatal period after which both the mother and infant will be transferred to the HIV clinic on site for regular care.

With the FY 2008 funds, IRCU will specifically strengthen the PMTCT community follow up program by tracking HIV positive mothers to assess their health seeking behaviors for both them and exposed infants and at the same time promote early initiation of Cotrimoxazole prophylaxis and ART. IRCU will also continue to educate mothers and encourage them to deliver in health centers. The team will then counsel the mother and either refer to the nearest center or encourage them to continue seeking care at that particular health unit.

IRCU will initiate links with the district health Services Commissions especially the department of PMTCT, and EGPAF to work as partners to streamline PMTCT services according to the district health sector plan. This will involve holding coordination meetings with district leaders and partners and other stake holders. This will be incorporated in the IRCU quality assurance plan for provision of PMTCT services according to

**Activity Narrative:** national standards.

As part of the gender equality strategy for the HIV/AIDS care provision, IRCU will prioritize promotion of male involvement in the PMTCT program. This will be done by encouraging wives to disclose their HIV status to their spouses and encourage them to enroll in the program. Once the male partners have enrolled in the program, they too will be counseled and encouraged to go for HIV/AIDS testing so that they know their status. They will be encouraged to escort their wives during required PMTCT visits to health facilities for sessions. Religious leaders will be trained to mobilize couples especially the male partners of expecting mothers through their routine pastoral work and home visitations to access PMTCT and related services. Individuals who test positive will be assisted to receive care and treatment.

The implementing sites will be required to follow up all the children born to Mother infected with HIV through the PMTCT program. IRCU will prioritize CD4 testing for both the mothers and infants. The exposed infants will be tested for HIV infection using RNA-PCR from the nearest Joint Clinical Research Center (JCRC) Regional Labs of Excellence. IRCU signed a Memorandum of Understanding with JCRC which institution has agreed to provide this lab service. By the end of FY 2008, IRCU is targeting to test over 600 infants through the various sites. These children will be enrolled into care and given the required basic HIV care including Cotrimoxazole prophylaxis and also assessed for eligibility for ART.

Through partnerships, IRCU will build the capacity of key groups in the community such as community leaders, PHA networks and traditional birth attendants so that they are an indigenous source of knowledge within their communities and can be utilized to refer mothers or couples for HIV testing and PMTCT services at the IRCU related health units.

PMTCT will also be strengthened by promoting linkages and inter departmental referral between HIV counseling and testing (HCT), Tuberculosis (TB) as well as referral to other health units, in particular ART, at all its implementing sites. IRCU will specifically ensure that PMTCT services are linked to the onsite HIV clinic and mothers will be assessed for eligibility of ART and those eligible will be fast tracked to receive ART.

By the end of FY 2008, IRCU will have supported community mobilization around the 18 sites delivering PMTCT services, enrolled 500 mothers in the program and strengthened male involvement by encouraging 300 couples to test for HIV infection.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15889

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15889	15889.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$250,000

**Table 3.3.01: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11126.09	<b>Mechanism:</b> TREAT (Timetable for Regional Expansion of ART)
<b>Prime Partner:</b> Joint Clinical Research Center, Uganda	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: PMTCT
<b>Budget Code:</b> MTCT	<b>Program Budget Code:</b> 01
<b>Activity ID:</b> 15894.26788.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26788	

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY2008, this activity will focus on training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis(TB) and HIV

In an effort to integrate delivery of interventions for Prevention of Mother to child Transmission (PMTCT) within maternal and child health services(MCH), the TREAT program will scale-up the use of highly active anti-retroviral (ARVs) for treating pregnant women and preventing HIV-infection in infants in 60 supported sites. The program will provide HIV/AIDS Counseling and Testing (HCT) and CD4+ cell measurement services to at least 10, 000 HIV-positive pregnant women in 60 sites to determine anti-retroviral therapy (ART) eligibility and provide ART to those eligible. It is estimated that 30 percent of these women will receive ART services.

The program will provide support and training to other USG-supported program to integrate CD4+ cell measurement in the essential package for pregnant women and setup referral networks to ensure that health facilities without CD4+ cell measurement facilities send samples to referral laboratories.

In addition to training staff in MCH services to provide ART, the program will procure and provide ARVs to antenatal clinics in 60 sites. The program will also ensure that AZT and Nevirapine for infants is available in the 60 MCH sites.

It is estimated that 3,000 HIV-positive pregnant women with CD4 cell count below 350cells/mm<sup>3</sup> will receive ART while 7,000 not yet eligible for ART will receive a course of highly effective ARVs for prevention of HIV infection in infants. All the 10,000 HIV-exposed infants will receive a 7-day course of zidovudine (AZT) and nevirapine. The program will follow the revised Ministry of Health protocol for PMTCT and the WHO recommendations for ARV drugs for treating pregnant women and preventing HIV-infection in infants in Resource-limited setting.

It is anticipated that through this activity, PMTCT using single dose Nevirapine will be reduced to an absolute minimum in the supported sites.

The program will link with the President's Malaria Initiative (PMI) to provide Intermittent Preventive Therapy for malaria in pregnancy using either daily cotrimoxazole or 3-doses of sulfadoxine-pyrimethamine and the distribution of Insecticide Treated Mosquito nets to pregnant mothers. All women diagnosed to be HIV-positive will be screened for tuberculosis (TB) and receive nutritional counseling and education including support for infant feeding. All women eligible will receive cotrimoxazole prophylaxis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15894

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15894	15894.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$300,000

**Table 3.3.01: Activities by Funding Mechansim**

**Mechanism ID:** 12193.09

**Mechanism:** TBD - HOPE

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: PMTCT

**Budget Code:** MTCT

**Program Budget Code:** 01

**Activity ID:** 29692.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 29692

**Activity Narrative:** FY08 Collaborative Ugandan PHE- UG.08.0203: Multi-country PMTCT How to Optimize PMTCT Effectiveness (HOPE) Project

The FY08 - 09 Collaborative Multi-Country Public Health Evaluation for PMTCT, HOPE (How to Optimize PMTCT Effectiveness), will be implemented in Uganda through CDC This PHE will be conducted in two phases. First, a line list of all PMTCT sites in the country will be created, along with key variables, such as patient volume, HIV prevalence, and PMTCT coverage. Second, from this list, PMTCT sites will be randomly selected for inclusion. From selected sites, more detailed data will be collected, including site characteristics, PMTCT program implementation, data collection and data quality, and PMTCT indicators and infant outcomes. Associations identified through bivariate and multivariate analyses will be used to improve PMTCT programs. As part of this PHE, PMTCT Monitoring and Evaluation and local capacity for PMTCT M&E and PMTCT implementation, will be improved.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 02 - HVAB Sexual Prevention: AB

**Total Planned Funding for Program Budget Code: \$17,887,816**

**Program Area Narrative:**

The Government of Uganda (GOU) finalized its 2007-2012 National Strategic Plan (NSP) for HIV/AIDS. The plan is grounded in epidemiological data from the 2004/5 Ugandan HIV/AIDS Sero-Behavioral Survey (UHSBS), cross-sectional and longitudinal studies identifying drivers of the epidemic, and surveillance trends. The NSP emphasizes the stark realization that the steady decline in HIV prevalence (from 20% to 6.4% during the first 20 years of the epidemic) attributed to early prevention efforts has reached a plateau, and that HIV incidence is back on the rise (an estimated 126,100 new infections and 70,300 deaths in 2007). The NSP therefore highlights HIV prevention as a cornerstone of HIV/AIDS programming to alter the course of Uganda's mature generalized epidemic.

UHSBS and other studies suggest that sexual transmission accounts for over three-fourths of all new infections (marital sex 42%, commercial sex work 21%, and casual sex 14%). Mother-to-child HIV transmission (MTCT) is the second largest source accounting for over one-fifth (22%) of new infections. Fuller analysis of the UHSBS data also suggests that the epidemic has shifted into the general population and the older age groups, for which there has been little prevention programming in recent years, since the Zero Grazing campaign waned. The UHSBS data highlight that whereas knowledge of HIV is high, comprehensive knowledge (knowledge of transmission and rejection of misconceptions), which may influence behavior change and risk perception, is still below 50% for both men and women. Based on these findings, the MOH has developed Policy Recommendations that complement the NSP to guide implementation of prevention priorities. Recommendations particularly relevant to HIV prevention stress the need to increase comprehensive knowledge and risk perception through use of communication channels, particularly radio; to strengthen behavior change for risk reduction and risk avoidance among young people; and to promote protective social norms. The USG Prevention Working Group is well represented on the National HIV Prevention Committee, which provides a channel for coordination of prevention programming across GOU agencies, NGOs and the AIDS development partners. Since FY07, the USG Prevention Working Group has thus supported a prevention program and strategies that are in line with epidemiological findings and national priorities.

**USG Prevention Programming**

The USG portfolio includes comprehensive ABC programming approaches that are balanced differently as they are applied and tailored to specific groups, behaviors, and underlying factors, in line with OGAC's ABC guidance and principles, and the NSP's ABC+ approach.

**Comprehensive Prevention Programming**

In FY09, USG will continue to devote priority attention to prevention programming which is comprehensive, and includes appropriate emphasis on adults, youth, at risk groups, risky behaviors and norms. USG partners will strengthen behavior change approaches among youth, including educational counseling and communication efforts, to reflect results of ongoing evaluations (e.g., AB/Y; PIASCY; Be a Man) and incorporate state of the art practices. 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. Correct and consistent condom use will be promoted among sexually active populations and social marketing programs will ensure distribution and availability. In FY09, behavior change efforts will likely be bolstered by two national crosscutting communication campaigns. One will deal with issues of stigma and discrimination, as they underlie prevention, care and treatment practices. The other, "Know your status" will promote counseling, testing and disclosing. It is expected that such intensified efforts will create more of an enabling environment for positive behavior change that increases self-perception of risk and promotes protective behaviors.

**Personalized Risk**

---

In FY08 a particular effort was made across all USG partners to focus messages and activities on heightened risk perception, which seems to have waned across all population segments and all age groups. 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 (s)he will contract HIV, with variations by age, gender, and residence. With the strong feeling in GOU circles that there is increased disinhibition among population groups, it is important that USG and its partners refocus messages explicitly on personalized risk. Approaches to heighten personalized risk will be linked to HIV counseling and testing initiatives, and the Know Your Status campaign.

#### Programming for Youth

USG partners will build on the positive trends and behavior change noted among youth. Young women for example, are increasingly delaying the age at first sex. This trend is not as clear among young men, however. Data also show that 50 percent of never married men and 64 percent of never married women aged 15-24 have never had sex. In view of these positive trends and the reality that young people will always need information and motivation as new cohorts enter the 10-20 age groups, USG partners will continue to consolidate and strengthen their youth programming toward the goal of ensuring an "HIV-free generation". A particular effort will be made to ensure the soundness of existing abstinence programs among young people 10-14 years old, through a combination of school-based and out of school programs, media, and community approaches. Programs will continue to support the Ministry of Education and Sports to reach more students in primary and post primary schools, through President Museveni's PIASCY initiative with a strong teacher training component, and age appropriate comprehensive prevention messages, skills, and activities. In addition to this curriculum-based approach, USG will continue to support a large number of civil society and faith-based organizations working at community level to reach out of school youth through peer education, information, education, and communication approaches, drama, and local radio programming. Initiatives such as "Young Empowered and Healthy (YEAH)", the "Something for Something Love" campaign, the radio series "Rockpoint 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. In FY09, USG will continue to support such efforts and encourage those that are innovative and appealing to young people. USG will also support implementing partners and counterpart organizations to improve programming and linkages across prevention for youth and OVC prevention needs. The prevention needs of young positives are being addressed with a combination of general and tailored communication and education efforts both at facility and community level.

#### High Risk Sex

High risk sex, defined as having multiple concurrent partners and unprotected sex, is the main driver of the generalized Ugandan epidemic. Analysis of sexual behavior 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. Sex among discordant couples seems to account for the largest number of new infections. USHBS found that among cohabitating (married or living together) couples, 91% of partners were both HIV negative; 3% were both HIV positive, and 5% were discordant. The fact that there were more cohabitating couples discordant for HIV than cohabitating couples that were both infected represents a critical unmet prevention need. The vast majority of cohabitating couples do not mutually know their HIV status, and are therefore not empowered to take action to prevent transmission. It is, however, unknown what proportion of infections that arise among discordant couples are due to transmission between these couples. Transmission may also arise from concurrent sexual relations that the couple may be engaging in outside their primary relationship. Prevention counseling and messages targeting discordant couples therefore need to stress faithfulness as well as correct and consistent condom use within discordant relationships. Knowing HIV status and disclosing it within couples is also critical. At least two key factors contribute to low non-disclosure rates among discordant couples: stigma, and fear of violence, particularly by men against women. Therefore, USG will expand FY09 support for these themes as part of overall programming, and also as part of the Stigma and Know Your Status campaigns. USG has increased its procurement of condoms, in response to the data on high risk sex.

#### High Risk Groups

In addition to focusing on decreasing risk behaviors in the general population, USG partners have targeted high risk, vulnerable and mobile populations with renewed interest, as they remain sources of new infections within Uganda's "mixed" epidemic. These populations include commercial sex workers, 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. A USG supported HIV prevalence and risk behavior survey is underway to identify modifiable risk factors among most at-risk populations, including fishermen, prisoners, men who have sex with men, and commercial sex workers.

#### Sex Work

USG will continue to support innovative work targeting low-income women, who often supplement their income through commercial sex with "boda boda" (motorcycle) drivers, long distance truck drivers, and the communities they serve. Commercial outlets existing within a specified radius of lodges, nightclubs and bars will be targeted for condom distribution and risk behavior avoidance messages. Partner activities that focus on sex workers include providing access to drop-in centers where they can receive peer education targeting HIV prevention and sexual violence mitigation, counseling and testing services, and income-generation activities.

#### Herpes Simplex Virus Type 2 (HSV-2)

UHSBS found that genital herpes is a strong driver of the HIV epidemic, with close to 50% of Ugandans being infected (49% of women; 38% of men aged 15-49). Among HIV-infected UHSBS participants, 85% were co-infected with HSV-2; among HIV-negative participants, 44% were infected with HSV-2. To better understand risk factors for recently acquired (within 150 days) HIV infection, USG conducted a secondary UHSBS analysis that included testing of all HIV positive participants using the serology-based HIV incidence (BED) assay. The BED analysis found that compared to persons sero-negative for HSV-2 infection, persons sero-positive for HSV-2 had four times the risk of acquiring recent HIV infection. In FY08, USG supported the MOH to develop a public health prevention campaign emphasizing education, targeted prevention, promotion of HIV and HSV-2 testing prior to marriage, and promotion of condom use among HIV and HSV-2 discordant couples these efforts may help prevent new infections. In addition, the STD clinic in Mulago was upgraded to provide diagnostic services for selected STIs and staff were trained. The STD clinic is mandated with the provision of diagnostic, care, and treatment services for selected sexually transmitted infections, including HIV.

#### Focus on High Prevalence Areas

In FY09, USG will target high prevalence regions identified by UHSBS for integrated support in HIV programming, including prevention. Support to IDPs in Northern Uganda will continue, and USG support to prevention programming among members of the Uganda People's Defense Force (UPDF) will be increased. USG will strengthen prevention programs for service members and their families through behavioral change and communication interventions, counseling and post-test clubs. Private security companies, police and prison staff will be new populations for targeted prevention programming.

#### Substance Abuse

Alcohol consumption is associated with an increase in high-risk sexual behavior, and with violence, particularly by men against women. Excessive alcohol consumption and its link to HIV will be addressed by further strengthening projects and alliances with Ugandan breweries initiated in FY06 and FY08. In addition, alcohol messages will be fully integrated into media programs targeting men, and outreach programs with vulnerable youth.

#### Gender Norms

The recently conducted trend analysis (1985-2005) shows that certain positive behaviors are sliding backward from the late 1980s. In particular, there is an increase in casual sex, an increase in multiple partners, and a recent decrease in men's condom use with casual partners. Clear gender disparities emerge from these analyses and cut across risky behaviors: men more commonly engage in sex earlier and with more partners than women do. USG objectives within prevention programming to reduce sexual transmission include a strong focus on the critical role of partner reduction, faithfulness, and the underlying gender inequalities that sanction this behavior. Recognizing the importance of the data on male behavior, particularly multiple partners, several of the USG partners have coordinated with the 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.

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11128.09	<b>Mechanism:</b> TASO
<b>Prime Partner:</b> The AIDS Support Organization	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 24543.26795.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26795	
<b>Activity Narrative:</b> ACTIVITY UNCHANGED AND ENDING IN DECEMBER 2008. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.	
<p>This activity will focus on community mobilization activities to promote positive behaviors such as: gender equity; couple dialogue; partner counseling and testing; disclosure; and accessing treatment together. Community mobilization activities will also be directed towards elimination of negative behaviors that bring about stigma and discrimination associated with HIV/AIDS. TASO will support to strengthening/setting up of PLHA networks through training and logistics support in 28 districts of Uganda. PLHA networks will increase community mobilization, address stigma, denial and discrimination among PLHAs and their communities, and facilitate referral for treatment. This support is expected to increase the overall capacity of PLHA networks to access additional funding opportunities.</p>	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 24543	



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
24543	24543.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$221,660

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11125.09	<b>Mechanism:</b> IRCU
<b>Prime Partner:</b> Inter-Religious Council of Uganda	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 4685.26780.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26780	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

Currently, Uganda is experiencing a mature and generalized HIV/AIDS epidemic with a high prevalence rate of 6.4%. Despite high levels of knowledge on HIV/AIDS, high risk sex is still the main driver of the epidemic in Uganda. The main factor that influences the continuation of high risk sex is attributed to lack of personalization and internalization of HIV risk. Extra marital sex, mother to child transmission have also continued to drive the epidemic. Data from the Rakai Health Sciences Program also shows that HIV sero discordance among couples is high. Most of these couples are not aware of their HIV Status and therefore not motivated to take action towards prevention. Other factors such as poverty that influences people and especially girls to engage in commercial sex and other social cultural factors such as the position of women in society have also continued to increase the transmission of HIV in our country. In November, 2006 IRCU joined other major HIV/AIDS partners in launching of the Road map towards Universal Access to HIV prevention in Uganda. The road map sets out key actions that need to be taken to arrest the spread of new infections and turn the tide against HIV/AIDS. They include bridging the HIV prevention gap, building of synergies between HIV prevention and care and ensuring the sustainability of HIV treatment scale up.

In FY 2006 IRCU initiated a robust prevention program to promote the country's vision on prevention as outlined in the Road map. Several initiatives in the area of primary HIV prevention were undertaken, particularly activities that promoted abstinence and mutual fidelity among married couples using both mass media and our religious structures. Working through the heads of the main religious institutions in Uganda, HIV/AIDS prevention messages were integrated into sermons and other religious teachings across the country. In addition, IRCU implemented a mass media campaign where religious leaders spearheaded HIV/AIDS advocacy, particularly appealing for abstinence and mutual fidelity. IRCU also rented billboards in strategic sites across the country to disseminate HIV/AIDS prevention messages. IRCU has also developed a comprehensive curriculum to train religious leaders, pastoral agents and volunteers in HIV/AIDS. The curriculum aims to build the capacity of religious leaders and equip them with easy facts and skills in HIV/AIDS prevention. Using FY 2007 funds, an initial 25 senior religious leaders were trained as trainers and these will in turn train other high quality trainers in our communities. This will create a source of knowledge in our communities as we continue to roll out our HIV prevention program.

In the same year, we expanded our HIV prevention approaches to ensure that as many people as possible benefit from our prevention activities. Using our faith based tenets; we emphasized primary prevention approaches as a corner stone of our program. This was undertaken through public dialogues on radio and TV that we organized during the world AIDS day campaigns. We also emphasized primary prevention to all our partners by organizing workshops on the importance of prevention as the most effective means against contracting HIV/AIDS. We emphasized abstinence for the youth and other unmarried persons and mutual faithfulness among those who are married by printing flyers, posters and by encouraging the partners whom we fund to focus on these areas. By doing what? During this year, IRCU PEPFAR supported activities were crucial in expanding the scale and coverage of our prevention programs. We enrolled 16 faith based organizations across the country to implement HIV prevention. To date at least 600 couples and more than 10,000 youth have benefited from our prevention activities.

Using FY 08 funds, we shall put emphasis on couple counselling and testing. By knowing their sero status, couples will be able to make informed choices those who test negative will be encouraged to stay negative and those that test positive will be enrolled in our other HIV/AIDS services or referred to seek other preventive measures. This program will entail supporting religious leaders with more HIV/AIDS skills to offer HIV prevention knowledge during pre-marital counselling. We shall also expand our community and facility based testing This will ensure that people access services and in particular pregnant mothers in PMTCT. We shall strengthen linkages between our HIV/AIDS services within facilities so that clients who come for HIV/AIDS services will be able to receive information on prevention And other available services either in our facilities or beyond.

Through the program, we will use information, education and communication materials to promote prevention activities. We shall use radio and drama in our communities to pass on information in local languages concerning HIV prevention. In this way even the uneducated will benefit. Based on the current studies that indicates that HIV prevalence has shifted from the young people (15-24) to adults (30-34), we shall particularly try as much as possible to concentrate on reducing HIV infection among couples. We shall use abstinence seminars for youth, conduct parental workshops for parents and guardians towards helping them to acquire skills for responsible behaviour. We shall also use person to person interaction by encouraging peer to peer dialogues, distribution of pledge cards towards abstinence and holding of public rallies on HIV/AIDS in tertiary institutions.

Using our Curriculum, we shall strengthen the role of volunteers and religious by equipping them with skills in referral so that they are able to be a source of HIV prevention knowledge within communities. Finally we shall support health facilities supported will continue to carry out their routine infection measures such as blood safety and STI treatment.

During the year we shall support institutional and community AIDs clubs to deliver HIV information. The institutional based clubs such as those in schools will be supported to deliver prevention activities for children in upper primary while community clubs will be supported to give information to youth out of school. Twenty (20) organisations will implement these activities reaching up to 400,000 couples, 800,000 youths in school and out of school. We shall support 500 religious leaders including lay readers to deliver our prevention activities during the year.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14206	4685.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$500,000
8426	4685.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$500,000
4685	4685.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$500,000

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 5740.09

**Mechanism:** Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 16731.26504.09

**Planned Funds:** \$100,000

**Activity System ID:** 26504

**Activity Narrative:** This is a newly funded activity and it is a component of Counseling and Testing and Adult Care and Treatment activities. Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a Liaison office in Kampala. ICOBI's vision is a healthy and prosperous rural population and its mission is to improve the quality of lives of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely: Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple-S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project (NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing (HBCT) in Bushenyi district (October 2004-June 2007) with funding from CDC/PEPFAR. The home based counseling and testing program was able to offer HBCT services to about 270,000 adults and children, identified about 12,000 HIV+ clients and provide them with basic care package with collaboration of Bushenyi district health system. The current ongoing programs include Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID in Bushenyi district and OVC Care & support with funding from NPI/USAID for Mbarara and Bushenyi district.

Recently (June 2008), ICOBI received a notice of award from CDC to implement a program entitled "Provision of Full Access Home based confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda" (ICOBI HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013). The program will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda but will be implemented using a phased approach beginning with Mubende and Mityana districts. The goal of the program is to provide 100% access to HIV confidential Counseling and Testing services to all adults and children at risk of HIV infection residing in the six districts in five years. In addition, the program is to provide basic HIV/AIDS care and support, strengthen TB/HIV integration services to all identified HIV infected individuals and their families. The program will also support primary prevention of HIV and prevention with positives activities. The program will be implemented by outreach counseling and testing teams who will be based at the Sub-counties and the resident community mobilizers who will be based at the Parishes. In addition, the village health teams and local councils will also be engaged during community mobilization and sensitization. Under sexual prevention, ICOBI will implement activities related to meeting the program specific objective of reducing new HIV infection in the population especially among the youth out of school, adults in marriage and or long term relationships and high risk populations. The people tested as HIV negative will be supported to remain HIV negative by encouraging adoption of appropriate prevention behaviors. HIV positive individuals will be encouraged not to spread the infection by adoption of safer practices. The prevention messages will be strengthened within the general population including those not tested and age appropriate information and messages will be communicated to targeted population groups throughout program implementation in the four districts. Ongoing supportive counseling will mainly target HIV infected individuals eg 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 partners at risk. Additionally ICOBI will target at high risk populations groups with relevant messages and other behavioral change prevention options. The groups of population to be targeted will include about 60,000 men and women in Mubende and Luwero districts respectively. Vendors, Motorcycle cyclists, long distance drivers, sex workers in urban centers, discordant couples, out of school youth, widows and divorcees. Strategies and activities to be implemented will reach about 20,000 young people out of school aged 10-19 years with messages on abstinence and behavioral change and about 80,000 adults in marriage and or long-term relationships /partnerships reached through activities targeting faithfulness, fidelity and HBCT, and about 200 discordant couples recruited as condom distributors. About 40,000 high risk individuals will be reached with safer sex messages and interventions during the program period from 1st October 2009 to 30th September 2010.

**Sexual prevention - Youth and Couples Peer enrollment, orientation & training:**  
ICOBI will work with community volunteers (Resident Parish mobilizers/RPMs) and village health teams to map out high risk groups and their strategic sites in the program districts (where the high-risk groups and the youth people congregate for leisure and targeted employment). 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 other support to their groups. They will encourage their peers through 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. This strategy and related activities will be supported by the radio program, one hour each week. We hope to identify, enroll and train 295 youth as peer-educator and 46 model couples (1 per each sub county). We hope the 295 peer educators should be able to identify and induct others 2,405 based a village level who will be able to interact on one to one in one year at about 100 individuals thus reaching about 250,000 with abstinence and be faithful messages and behavioral change information.

**Strengthening Abstinence/Being Faithful:**  
Through peer education and interpersonal communication, community mobilization and provider education, AB messages to young people and Be-faithful messages, and or consistent and effective condom use will be strengthened. In addition AB messages will be communicated through home-based HIV counseling and testing (C&T) activities conducted in homes by CT teams in 46 sub counties. Other strategies and activities of communicating AB messages will include Film shows targeting young people, dance & drama shows by community groups trained to incorporate AB messages in their shows, Football and Netball competitions gatherings, community meetings where the community members will converge and the facilitator communicates relevant and age appropriate information related to AB. Specifically for be faithful message, Model couples will be identified and oriented in couple counseling and will hold community meetings and hold family dialogue sessions among couples so as to increase HBCT

**Activity Narrative:** uptake and to sustain B message communication in the program areas. Similarly all parishes will be mobilized to identify one person to be trained in peer education and communication of AB messages. The funds for this activity will be spent on community mobilization and Education (IEC), identification and training of peer educators, facilitating peer educators to carry out peer education sessions for commercial sex workers, PLHA in post test clubs, out of school youth (who include motorcycle cyclists) and military populations through drama at parish levels and communication of messages to targeted audiences.

Other sexual prevention: Community Mobilization for project activities and Condom Distribution - Community mobilization will be done 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 and form post test clubs or expand and join the existing post test clubs in each parish. The referred clients who will get the starter kits already will have received and had demonstration on condom use by the health worker and will 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 295 parishes in the program four districts. The funds for this activity will be spent mainly on paying staff salaries, setting up of condom outlets in locations of populations at risk eg urban centers like bars, disco halls, hotels etc, training of community condom distributors (295), 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16731

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16731	16731.08	HHS/Centers for Disease Control & Prevention	To Be Determined	6423	5740.08	Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts	■

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$30,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.02: Activities by Funding Mechanism

**Mechanism ID:** 11121.09

**Mechanism:** The Core Initiative

**Prime Partner:** CARE International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 3198.26761.09

**Planned Funds:** \$0

**Activity System ID:** 26761

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In FY 2009, CARE/CORE will continue to strengthen the capacity of Ministry of Gender and social Development (MGLSD) to increasingly build the capacity of districts through the established Technical Service Organizations in management, planning and coordination; monitoring and evaluation; and advocacy and communication of OVC response. CARE/CORE support will focus on improving the quality of OVC services and HIV prevention in order to strengthen district and civil society capacity to provide integrated and comprehensive services. Also, CARE/CORE will serve as the interim Technical Management Agent of the Civil Society Fund (CSF), helping in consolidating the established granting mechanism, provide operational and administrative support to the steering committee, and ensure the technical quality of the civil society OVC and HIV prevention portfolio. Key deliverables of CARE/CORE in FY09 include a) Strengthening district capacity to plan, manage, coordinate, monitor and evaluate their OVC programs, b) Supporting all districts in Uganda to roll out the OVC M&E framework and OVC MIS, and c) all civil society organizations in districts supported to implement OVC Quality Standards.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14183

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14183	3198.08	U.S. Agency for International Development	CARE International	6729	1030.08	The Core Initiative	\$495,000
8409	3198.07	U.S. Agency for International Development	CARE International	4827	1030.07	The Core Initiative	\$170,000
3198	3198.06	U.S. Agency for International Development	CARE International	2760	1030.06	The Core Initiative	\$2,020,000

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 15982.24021.09

**Activity System ID:** 24021

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** [REDACTED]

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – South – South Western will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project in South – South Western will cover nine districts of Bulisa, Kibaale, Kamwenge, Kyenjojo, Isingiro, Kanungu, Ibanda, Kisoro and Kiruhura.

AB

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiplicity of partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity, reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Other Sexual Prevention:

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly referred to as 'Boda boda in Uganda), discordant couples, fishermen and the communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions

Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'

- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.



- Activity Narrative:**
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.
  - Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).
  - Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.
  - Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15982

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15982	15982.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 7204.09	<b>Mechanism:</b> Eastern Region - HIV/AIDS & TB Program
<b>Prime Partner:</b> Management Sciences for Health	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02

---

**Activity ID: 21454.24011.09**

**Planned Funds: \$183,333**

**Activity System ID: 24011**

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – Eastern will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project will cover eight districts Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko.

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiple partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity; reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly refereed to as 'Boda boda in Uganda), discordant couples, fishermen and the Communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions
- Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'
- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.

**Activity Narrative:** • Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).

• Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.

• Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21454

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21454	21454.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechansim**

**Mechanism ID:** 5033.09

**Mechanism:** Contraceptive and Reproductive Health Technologies and Utilization (CRTU)

**Prime Partner:** Family Health International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

Activity System ID: 24381

Activity Narrative: Activity Narrative

Progress to-date, activities and achievements:

In COP 2008, FHI is receiving funding to generate strategic information on the extent and pattern of concurrency in sexual partnerships, and factors that may contribute to each. Specifically, the FY 2008 assessment will improve knowledge of partnership dynamics, their relationship to sexually transmitted infection (STI), including HIV, risk and the factors that assist individuals in choosing and navigating relationships in ways that reduce risk.

FY 2009 Activity: Assessment to Improve Understanding of Multiple Concurrent Sexual Partnerships and Identify Potential Behavior Change Communication Strategies for Reducing Concurrency

In FY 2009, Family Health International (FHI) will build on the FY 2008 formative assessment to better understand and describe multiple concurrent partnerships and identify potential behavior change communication strategies for reducing concurrent partnerships. Additionally, FHI will focus on understanding patterns of concurrency among populations identified as most at risk for HIV in the Ugandan context.

Background

Multiple sexual relationships, outside of established couples, increase the risk of exposure to disease, including HIV. In the last 10 years, concurrency of sexual partnerships has been proposed by several authors as playing the more critical role in the dynamics of HIV epidemics. For the same number of sexual partners, overlapping partnerships would be associated with a more rapid spread of HIV than serial partnerships. Results from modeling exercises suggest that sexual concurrency increases both the intensity and the variability of the intensity of an HIV epidemic and that the final size of the epidemic increases exponentially as concurrency increases.

Concurrency in sexual networks has been proposed as a factor associated with the spread of HIV infection in Uganda. For example, sexual networking data from rural Uganda suggests that sexual concurrency is common among rural Ugandan adolescents, with males reporting higher rates of concurrent sexual relationships than females. There is little information, however, to help us understand these patterns and behavior change programs to prevent HIV have mainly promoted condom use or abstinence, while partner reduction remains a largely neglected component of ABC.

In FY 2009, FHI will continue to improve knowledge about the type and extent of multiple concurrent partnerships in Uganda and the underlying and contributing factors to these relationships. In FY 2009, FHI will collect additional qualitative information to understand concurrency among most-at-risk populations (MARPs), such as market vendors, truckers, commercial sex workers and fishing communities. Members of these professions interact with each other, with their own spouses/partners, and with members of the general population. This makes for situation in which risk of transmitting and acquiring HIV is heightened. The aim of this mainly qualitative assessment will be to identify networks of sexual activity, risky behaviors the different categories of MARPS commonly engage in; reasons why those risky behaviors are prevalent; and to suggest possible BCC interventions that could be implemented to address these behaviors. Cluster sampling will be applied to facilitate analysis by category of MARP. However, correlates of risk-behavior patterns that cut across all categories of MARP will be highlighted. This exercise will generate valuable qualitative data to complement the bio-behavioral surveillance USG has been conducting to measure HIV risk behaviors, and determine prevention, care and treatment needs among MARPS in Uganda.

Additionally, in-depth analysis of sexual concurrence data generated through FY 2008 and 2009 will be undertaken in order to identify behavioral patterns that could be addressed through behavior change communication (BCC) interventions. Findings of this analysis and suggestions for potential BCC strategies for reducing multiple concurrent partnerships will be disseminated widely to inform HIV prevention programs in Uganda.

Expected Results

The assessment will provide strategic information to inform the implementation of sexual prevention programs that focus upon high risk populations, including development of behavioral change interventions targeting MARPs and other sexually active individuals in Uganda and the region.

New/Continuing Activity: Continuing Activity

Continuing Activity: 19069

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
19069	19069.08	U.S. Agency for International Development	Family Health International	6735	5033.08	Contraceptive and Reproductive Health Technologies and Utilization (CRTU)	\$247,815

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 10934.09

**Mechanism:** New Partners Initiative: Traditional & Modern Health Practitioners

**Prime Partner:** Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 26097.09

**Planned Funds:** \$0

**Activity System ID:** 26097

**Activity 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 15 years of experience implementing community-based health activities for underserved populations in both urban and rural areas of Uganda. In each district of operation, THETA has built a health and social services community delivery system that comprises of community lay providers (CLPs), a community support team, and district-based trainers. THETA's call has been in the area of HIV prevention and care for those infected and affected by HIV/AIDS. THETA received a notice of grant award on June 2008 from NPI to implement a program entitled "Building Referral Networks to reach the underserved communities with comprehensive HIV prevention services and to improve the livelihood of orphans and vulnerable in Uganda". The goal of this program is to scale up access to comprehensive HIV/AIDS prevention services and improve the livelihoods of orphans and vulnerable children through building and strengthening community support structures and referral networks between the biomedical and traditional health care system in Luwero, Mukono, Kiboga, Apac and Hoima districts for three years. The program will use traditional systems in HIV prevention and strengthen community initiatives in the care for OVC. Currently THETA is strengthening the structures to enable proper implementation of the program. So far the process of recruiting staff to beef up the human resources is underway as well as the procurement of equipment.

In this program, THETA will recruit "Sengas" (paternal aunts) and male peer promoters who will be equipped with basic HIV/AIDS information and send them out to facilitate HIV education and awareness events in communities following the ABC strategy. They will organize age and gender appropriate community groups targeting the youth, couples and other interest groups to discuss HIV/AIDS prevention concerns at individual, family and community levels. Some of the program implementers will receive basic HIV counseling training to enable them provide psychosocial support at community level and provide appropriate referrals. Sengas and male peer promoter's activities will be linked with the bio-medical health practitioners to ensure successful referral for HIV testing as well as treatment, care and support. Community behavioral Change Communication will be further be reinforced by community sensitization and counseling support. In addition, there will be radio programs by the Sengas and male peer promoters to reach more people in the community with HIV prevention information. These programs will also promote cultural values like virginity, faithfulness in marriage, abstinence and increase couple communication. The Sengas and male peer promoters will also distribute condoms at the community level.

There will be continuous interaction between the biomedical health practitioners and the Sengas/male peer promoters. They will together meet and share challenges and successes on the program. There will be four-day training where both the community lay providers and the biomedical practitioners at the new sub-counties will undergo training about the program. The Sengas/male peer promoters from the other sub-counties where the program has been operating in FY 2008 will join the new recruits on the last day of the training to share experiences. Also there will be stakeholder meetings held annually at the district level where all players will come together and share lessons as well as map out implementation of the next period.

In addition to that there will be community dialogues. They will aim at educating communities with their full participation. Members will be given an opportunity to share their personal experiences, cultural practices related to HIV transmission in the presence of the health providers, local and cultural leaders. Myths and misconceptions will be addressed and at the end of each dialogue members will be informed about community based HCT and other HIV services. During the dialogues health services in the perspective of traditional and modern health care will be discussed. This will give opportunity for the providers to get a feed back to improve their services and make them more culturally sensitive.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.02: Activities by Funding Mechanism****Mechanism ID:** 9212.09**Mechanism:** Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies**Prime Partner:** Integrated Community Based Initiatives**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Sexual Prevention: AB**Budget Code:** HVAB**Program Budget Code:** 02**Activity ID:** 26498.09**Planned Funds:** \$45,062**Activity System ID:** 26498



**Activity Narrative:** Integrated Community based Initiatives (ICOBI), is an indigenous NGO formed in 1994 with a mission to improve the quality of life of people living in rural communities. Its headquarters are located in Kabwohe-Itendero Town Council, Bushenyi district with a liaison office in Kampala. ICOBI has been involved in implementation of Health programs with community bias since its inception. Programs which ICOBI has implemented include: World Bank supported STI project (1995-2000), MAP Project (2001-2006) and Nutritional and Early Childhood Development Project (1999-2003); EGPAF supported facility based PMTCT in 15 health units in Bushenyi District (2002-2005); and CDC supported Full-access Door-to door Home based VCT in Bushenyi District (2004-2007). In April 2008, ICOBI started implementing the three year NPI supported OVC project in Bushenyi and Mbarara districts and in July 2008 it received two five year awards from CDC to implement a Home Based VCT project in 6 districts in Central Uganda and a national level Community PMTCT project with a special focus on 6 districts in South Western Uganda. The Community PMTCT project is entitled: Expanding Uptake For Interventions To Prevent The Transmission Of HIV From Mothers To Their Children (PMTCT) In The Republic Of Uganda By Using Community Based Strategies Under The President's Emergency Plan For AIDS Relief. The overarching goal of the project is to contribute towards the improvement of child survival through increasing the uptake of prevention of mother to child HIV transmission services and providing care & support to HIV infected parents and children using home/community based approaches. The project intends to achieve the following strategic objectives;

1. To promote innovative community based primary prevention of HIV through community mobilization and sensitization of pregnant women and their spouses for HIV counseling and testing at health facilities
2. To prevent un-intended pregnancies among women living with HIV by promoting use of modern contraceptives and other family planning strategies
3. To reduce HIV transmission from pregnant or lactating women living with HIV to their babies by referring them to health facilities for appropriate ART for PMTCT as well as other strategies
4. To enhance advocacy, capacity building and behavior change communication for community PMTCT interventions

In the Community PMTCT program, ICOBI intends to work with the community and health facility based structures and various partners including civil society organizations, faith based organizations, the district directorates of health services and EGPAF, the major partner in PMTCT in South Western Uganda. This project will be implemented at two levels: 1) in collaboration with the MOH, will conduct some national aspects of community involvement in general, 2) with a special focus on 6 districts in South Western Uganda. The districts are Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhura; with a total population of 2,446,600 people. The expected pregnancies are 122,330 and the expected HIV pregnant women are 7,360. There are 183 health facilities in this region which are disproportionately distributed within the districts. There are 94 sub-counties and 512 parishes in this region. The geographic coverage of PMTCT services varies from district to district; with Ntungamo being the most under served with 4 health facilities providing PMTCT services and yet has the highest HIV prevalence among pregnant women attending the antenatal clinics of 9.3% compared to 6.7% in Bushenyi district with 41 health facilities providing PMTCT services. The project will take advantage of the expansion of PMTCT services by EGPAF in this region and mobilise the community to utilise the available PMTCT services. Implementation of the project will be phased, beginning with Bushenyi and Ntungamo in the first year, Mbarara and Ibanda districts in the second year, Isingiro and Kiruhura districts in the third year. The final two years of the project will experience a consolidation of community PMTCT services across the Ankole region and the nation at large. The project will be implemented under the auspices of the national PMTCT strategy with a regional character as well as national outlook whereby this project will contribute to awareness creation through well designed and targeted strategies including, among others, promotional and motivational activities for PMTCT through mass media, local language information, education and communication (IEC) campaigns including using music and drama, interpersonal channels and community dialogue. In addition, professional linkages and family based (Home-based) out-reaches will support community based PMTCT with referrals and counter referrals between the community based structures and the health facilities. The sub-county based counselors (CPO) and the resident parish mobilisers (RPM)/mentor mothers working together with other community based groups like Village health teams and other community owned resource persons, will link the pregnant women in the community with the health facilities where PMTCT services will be offered and vice-versa for follow up of the PMTCT women in the community. Some of the trained CPOs and RPMs will augment the health unit staff in provision of PMTCT services on busy days. The project will be launched at the national level and in the districts to create a forum for key stakeholders. The project will concurrently implement other HIV preventive programs including abstinence and being faithful (AB); and other prevention. During the first year of the project, a total of 44 sub-counties and 258 parishes of Bushenyi and Ntungamo will be covered; with a total population of 1,210,400 with 60,520 expected pregnancies and 3,632 expected HIV positive pregnant women in the two districts.

Objective 1. To accelerate the prevention of sexual transmission of HIV through behavioural change communication

Activity 1.1. Provide HIV/AIDS education with emphasis on Abstinence and Being faithful (AB) to persons aged 15-49 in the project area through radio programs and drama and Production of IEC materials targeting 60% of 15-49 year olds in 258 parishes of Bushenyi and Ntungamo.

In Uganda, radio is a strong medium of communication. The talk is mainly targeting to educate listeners on prevention of sexually transmitted diseases, HIV, condom use, hygiene etc. We intend to use this platform to pass on tailored community PMTCT and AB messages as well as mobilize communities to access and own these services. Weekly hourly live-phone-in programs will be held in Runyakitara on a local FM station based in Mbarara and provide radio spots in different languages and occasional talk shows at a radio station with national coverage based in Kampala. Radio talk shows will last thirty weeks in this budget period.

Activity 1.2. Promoting behavioural change through staging drama  
Drama shows are one of the most cost-effective ways of community mobilization and information dissemination. ICOBI will train and support drama groups to stage drama shows in each of the 258 parishes in the two districts of Bushenyi and Ntungamo with key messages on PMTCT and AB.

ICOBI is in the initial stages of project implementation. The organization has responded to the issues raise

**Activity Narrative:** in the technical review of the application including revising the project narrative, budget and work-plan. Meetings have been held with CDC staff and there are ongoing consultations with key stakeholders including Ministry of Health STD/AIDS Control Program. Offices have been established and some key project staff recruited. The staff has embarked on the harmonization of the organization's communication strategy with the national HIV communication strategy. Everything is being set for full scale project implementation as soon as project funds are disbursed.

ICOB I will design and produce information, education, and communication (IEC) tool kit specially packaged to reach all leaders. The tool kit will include a PMTCT and AB information booklet (in different major languages) giving key information on how to increase PMTCT uptake including need for antenatal care, HIV testing & disclosure, delivery in health units, male involvement and above all how to achieve an HIV free generation. It will emphasize the role of abstinence and being faithful as primary prevention strategies. The tool kit will also include a T-Shirt because it has been shown that a T-shirt is one of the best IEC material as many people will wear and go with them at parties, funerals, markets, churches, drinking places etc and people will be reading and internalizing the message written on. Sometimes what is written attracts debate. Where possible, we might add re-prints of other available AB leaflets/posters.

ICOB I will increase awareness on all elements indispensable for the attainment of all the objectives of this program. ICOB I will develop and implement a systematic approach of local language community education and participation that will ensure information about AB 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, among others, promotional and motivational activities for AB 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. As part of mass media, ICOB I will use radio stations to disseminate information and allow for community participation through calling in or writing. ICOB I has experience using radio as a means of information sharing. There will be two approaches, one will be a radio talk show to be held once every week for 30 weeks in the first year; and the other being using various radio spots promoting AB. 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. ICOB I in collaboration with its sister organizations has been having reserved radio air time (Sunday 4.00-5.00PM) since November 1999 on the Radio West FM station based in Mbarara and intends to use this time for this program. The listenership is over 10 million and it can be heard in ¾ of the country. We used the same radio station during the implementation of the HBVCT program and it helped to significantly increase uptake of VCT to over 95%. For national coverage, ICOB I will produce radio spots in different languages and air them on various radios in different parts of the country or use one or two radio stations that cover the entire country as will be advised by the stakeholders. The general prevention messages will include: remaining faithful to your partner and endeavor to know each other's HIV status; practice safer sex within a discordant couple, young people remain abstaining sex before marriage, etc.

In year one, ICOB I will build capacity of the community resource persons through training of 258 RPMs and 44 Community PMTCT Officers from Bushenyi and Ntungamo and another 119 RPMs and 25 CPOs from Mbarara and Ibanda in year two; in sexual prevention using Abstinence and being faithful (AB). The training will be organized in 5 groups/sessions. Each training workshop will last for 7 days. The project will identify and recruit sub-county based counselors and the resident parish mobilisers/mentor mothers who will provide preventive counseling to the PMTCT pregnant women and their spouses for long term risk reduction of HIV transmission; promotion and facilitation of disclosure of HIV status to their male partners; promotion of faithfulness in marriage (zero grazing); promotion of correct and consistent use of condoms; promote ongoing follow-up counseling and education through established community and peer psycho-social support groups such as post test clubs (Family support groups), mothers' union and various assorted women groups. A strategy to use couples to reach other couples with behavior change communication will be explored (The model of 'Couple-Couple influence in HIV prevention).

Targeted health education will be given to the community on condom use. The RPM will supply condoms in the community to ease the access in order to reduce the risks of persons engaged in risk behaviours 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. ICOB I will out source for 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 subsidized price. The COPs will conduct on-going counseling on issues like avoidance of Home violence, alcohol consumption and its risks and other gender norms that need modification.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$15,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1107.09	<b>Mechanism:</b> Mulago-Mbarara Teaching Hospitals - MJAP
<b>Prime Partner:</b> Makerere University Faculty of Medicine	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 26300.09	<b>Planned Funds:</b> \$460,000
<b>Activity System ID:</b> 26300	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008.

Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council - KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP has been providing prevention counseling including Abstain "A" and Be faithful "B" counseling through the HIV testing programs. Prevention counseling has also been integrated into the care and treatment programs and OVC interventions (counseling and life skills training). In the Routine HIV testing and Counseling (RTC) program, couple testing is encouraged thus promoting HIV status disclosure and strengthening the B messages for couples. 'A' messages are encouraged for single youth below 18 years, among other interventions. Family members who are tested through the HBHCT program also receive prevention counseling. Since November 2004, more than 5,000 children and youth have been served through the MJAP Counseling and testing, care and treatment programs. We have provided HIV testing to over 3,000 couples, 19% of who were sero-discordant and 60% concordant negative. Since 2007, MJAP has been supporting the STD Unit of Mulago hospital to carry out facility based RTC and prevention counseling with a community component of targeted interventions towards Commercial Sex Workers (CSW) in selected communities around Kampala City whose HIV prevalence is as high as 40%, according to sentinel STI surveillance data. These interventions include HIV testing, STI screening and treatment, partner/contact tracing, community sensitization, training of CSWs peer leaders, and establishing condom outlets within these high-risk communities. In February 2008, MARPI (Most At Risk Population Initiative) project was started with an aim of i) providing HCT services to MARPs especially Commercial Sex Workers (CSWs), ii) increasing the level of comprehensive HIV/STD knowledge among MARPs, iii) providing effective STD services to CSWs and iv) promoting safer sexual practices and early STD care seeking behavior among the MARPs. A number of areas in Kampala district with high risk populations including Kisenyi, Kinawataka/Mbuya, Bwaise, Kagoma, Ndeeba, Kasubi and Ntinda were identified. A total of 9 additional staff was recruited. A total of 161 individuals were trained. Of these, 43 are peer leaders of CSWs while 118 are from the different sub-categories identified to be clients to CSWs. A total of 2,334 individuals have been tested for HIV. Of these, 637 individuals were tested through community VCT, 672 through facility based VCT, 975 through facility based RTC and 50 individuals through Sex workers clinic. Sero-prevalence among individuals tested through community VCT was 8.5% whereas that among individuals tested through the facility was 18.9%. Sero-prevalence among individuals tested through the sex workers clinic was 32%. Laboratory investigations were also carried out. These included 526 RPR tests for syphilis, 62 wet preparations and gram stains for STIs and 16 blood slide tests for malaria. In addition to the above services, MARPI promotes 100% condom use among sex workers and their clients through education and sensitization and also ensures that condoms are available and accessible through establishment of acceptable condom outlets. The Ministry of Health supplies the condoms. A total of 23 condom outlets have been established by far and 424,800 condoms have been distributed.

In FY 2009, MJAP will strengthen the integration of AB activities into the existing programs. Through FBC, the community outreach program that promotes HIV/AIDS through abstinence and/or being faithful, we will provide home based counseling and testing to family members of 2,500 households of index patients in care. Within these households we plan to reach 10,000 youth both male and female with interventions that emphasize health education, counseling support and life skills training to enable them make informed choices. The "A" activities will primarily target children and single youth below 18 years and the adults who are sexually active and/or married will also receive "B" messages and other prevention support including condom use, as appropriate. The "B" activities will also be integrated with couples counseling (in RTC and HBHCT) to encourage couples' HIV testing, disclosure of results and mutual faithfulness. We will also integrate the entire spectrum of prevention activities within the care and treatment sites through the positive prevention and family planning interventions. Through collaboration with the Mulago STD clinic, we will provide STI diagnosis and treatment to 4000 individuals referred from the community. Within the community

**Activity Narrative:** we will provide outreach voluntary HIV counseling and testing (VCT). The high-risk and commercial sex worker (CSW) communities have organized networks with peer leaders (queen mothers). We will train 400 such peer leaders whom we will use to distribute coupons for facility based VCT for individuals who do not wish to test within the community. These coupons will be numbered and tracked to evaluate the response rate of these referrals. HIV infected individuals identified through the community-based and facility-based HIV testing activities will be referred to the MJAP supported clinics and others facilities within Kampala. Education within the community will address STI and HIV prevention, and will address the entire spectrum of prevention (AB and condom use) as appropriate. We will identify and train peer leaders to mobilize the high-risk communities, provide education and support for distribution of condoms. We will also work with bar owners and attendants to distribute condoms through the 30 established outlets for high-risk groups. Through these activities we will reach over 5,500 individuals in the high-risk communities. Overall, 60,000 individuals will be supported in FY 2009 (includes HIV positive patients in the clinics, discordant couples, and high-risk groups in the selected communities in Kampala). We will provide condoms through 101 condom distribution outlets (all the 16 HIV clinics, 30 community outlets for high-risk groups, Mulago and Mbarara, and seven regional referral hospitals). The 'other sexual prevention' budget will cover training, IEC materials, health education and support for the PHAs who will be involved in the prevention interventions. We will strengthen the prevention with positives and family planning activities in all clinics, and will involve People living with HIV/AIDS (PHA) in prevention education and Counseling for patients. We will also strengthen the support for discordant couples identified through the HIV testing programs. All HIV testing facilities and care and treatment sites will provide condoms to support the discordant couples, in addition to the prevention Counseling. We will also improve on the data management, reporting and M&E for 'other prevention' programs. The capacity of the STD laboratory will be reinforced through purchase of additional laboratory supplies. We will also procure some additional drugs for treatment of STIs in order to supplement the MOH drugs, and support additional staff to improve the clinical management at the unit.

MJAP will support Post Sexual Exposure Prophylaxis beginning with the Mulago Hospital 5A Annex which is the reception ward for patients presenting with sexual assault among other obstetrics and gynecological emergencies. In this centrally initiated pilot program, MJAP intends to offer a comprehensive package of medical services for survivors of Sexual Gender based Violence (SGBV). This package will include emergency contraception, HCT, ART for the infected (post sexual exposure prophylaxis (PSEP); STI diagnosis and treatment, psychosocial support. Funding will go towards training in PEP for Health care providers, production and distribution of IEC materials, establishing linkages to Police and organizations offering psychosocial support through referrals and networking, recruitment of additional staff (counselors, social workers ), training of all the staff (midwives, laboratory staff, interns, medical officers, senior doctors) in PEP, RTC, and SGBV; procurement and infrastructure refurbishments ( Drugs, laboratory reagents and testing kits) treatment of STIs and soft tissue injuries. The results of this pilot will be used for a nation wide scale up of provision of PSEP services for survivors of SGBV with the ultimate aim of reducing HIV transmission and improving care and support as well as early linkage of those infected by HIV/AIDS virus to care.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$202,731

## Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

## Economic Strengthening

## Education

Estimated amount of funding that is planned for Education      \$16,000

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 26478.09

**Planned Funds:** \$370,000

**Activity System ID:** 26478

## Activity Narrative: ACTIVITIES UNCHANGED FROM FY 2008

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 paediatric & family-centered 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/ Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and is due to open in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/ Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum). Other collaborating partners include Feed the Children-Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kirudu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala. In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

Baylor-Uganda took a leadership role in the development of the a national 'Positive Prevention' Curriculum, especially in the area of adolescent care and prevention of HIV transmission, e.g. disclosure of HIV status, sex and sexuality, sexual and reproductive health (including family planning) counseling and services provision. Over the period, more than 45,000 people have participated in our sexual prevention messages. Implementation of sexual prevention interventions is aimed at increasing the proportion of target audience adopting safer sex practices to reduce the risk of new HIV (re)infection.

Family Planning (FP) and STD/cervical cancer screening services have been introduced as part of the prevention services on Tuesdays during Adolescent Clinic and on Thursdays during Family-Clinic at PIDC since June 2007; with 57 women & adolescents receiving pap smear and 495 put on family planning methods. About 600 children in our HIV/AIDS care and treatment program are adolescents who have grown through the program, and who are likely to express their natural sexual, fertility and/or reproductive desires. Already 40 out of a probable 420 female HIV positive adolescents in our care and treatment program have become pregnant. This implies; they have had unprotected sex with likely risk of (re)infection to themselves and their partners and future risk of transmission to unborn babies. Untreated STIs increase the risk of HIV acquisition and transmission. Similarly, there are care givers who are also diagnosed with HIV at PMTCT, from other referral points or during care to their children. All these categories of people need HIV prevention services to avoid HIV (re)infection. Therefore, treating STIs and addressing their sexual & reproductive health needs in a manner that reduces the risk of HIV (re)infection with their partners is vital in our sexual prevention program. Our interventions include: health education talks, individual and group counseling, positive prevention, training for adolescent peer educators & counselors, peer support groups, condom promotion, STI management, development of IEC materials, etc. Baylor – Uganda has partnered with Population Services International to provide Basic Care Package (which includes condoms), SCOT for

**Activity Narrative:** development and implementation of adolescent and youth positive prevention programming, and with Ministry of Health for other contraceptive supplies.

The Baylor-Uganda sexual prevention interventions target HIV infected & affected adolescents and family members of HIV infected children (siblings, care givers, etc) utilizing HIV/AIDS care and treatment programs from our services delivery points. In UNICEF (NON-PEPFAR) supported Regional Centres of Excellence in Eastern (Soroti) & Western (Kasese) regions and other rural areas where Baylor- Uganda works indirectly through government facilities, support will be provided to community groups to provide similar messages during home visits, health education and counseling sessions, as well as over radio programs in the local languages.

oConduct of health education and counseling sessions at COE and Satellites on clinic days on AB and other prevention options (Target: 20,050 unique individuals/year).

oOrganize annual adolescent (9 - 11 years) meeting at Sanyuka Camp & children (12 - 18 years) Hope camp; with 80 children participating in both camps.

oPurchase and equip home health workers/community volunteers with Home Based Care kits.

oSupport related staff positions from this program area (counselors, social worker, etc.)

oSupport radio programs that disseminate messages on sexual prevention (AB and others).

#### ACTIVITIES MODIFIED FROM FY 2008

oWe have modified our Home Health Program. Instead of our staff doing community level mobilization and health educations sessions, we will work with and support 7 community based groups (one group of 30 participants in each of the 7 Divisions of Kampala) to make the necessary community link: home visits, community sensitization. Each Volunteer visits 2 homes/week, making 20,160 visits/year .

#### NEW ACTIVITIES

oDevelopment of a standard communication strategy covering HIV/AIDS prevention, treatment & care in children, which will be used as a guide for all health education messages across the program.

oTrain health care providers (integrated with other trainings) in addressing sexual and reproductive health needs of PHAs (Target: 300)

oConduct 'teen' mothers support group meetings quarterly with about 50 adolescents participating in each meeting (200 participants).

oCommunity mobilization and sensitization at parish level within the Home Health Program of Baylor – Uganda, with about 20 people/quarter/person/division (16,800)

oTrain adolescents and members of community groups in Home Based Care, including sexual prevention of HIV transmission.

oCommunity mobilization and sensitization in partnership with groups supported by Christian Children's Fund, Save the Children in Uganda, Plan International as part of strengthening community link component of the program and leveraging resources

**New/Continuing Activity:** New Activity

**Continuing Activity:**



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9211.09

**Mechanism:** Traditional & Modern Health Practitioners

**Prime Partner:** Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 22503.26439.09

**Planned Funds:** \$45,063

**Activity System ID:** 26439

**Activity 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 15 years of experience implementing community-based health activities for underserved populations in both urban and rural areas of Uganda. In each district of operation, THETA has built a health and social services community delivery system that comprises of community lay providers (CLPs), a community support team, and district-based trainers. THETA's call has been in the area of HIV prevention and care for those infected and affected with HIV/AIDS. THETA received a notice of grant award in July 2008 from CDC to implement a program entitled "Community-based strategies to expand uptake of Prevention of mother-to-child transmission of HIV (PMTCT) interventions" (cooperative Agreement Grant Number: 1U2GPS001088-01, Program period: 07/01/2008-06/30/2013). This project will develop and implement a model of community support for PMTCT based on an active network of CLPs working in close collaboration with facility-based health workers. The project is in line with the Uganda National policy for reduction of Mother-To-Child HIV transmission. The goal of the project is to increase uptake of Uganda national PMTCT programme through strengthening/building community-based support models that can be replicated nationwide.

To date, THETA is in the preparatory stage for the implementation of this program by recruiting project staffs and setting up systems and structures A planning meeting is scheduled for the first week of September to map out clearly the implementation of the project. Full implementation of activities is pending approval of the FY 2008 work plan and budget. The program will cover the districts Amolatar, Oyam, Mbale, Sironko and Masaka in FY 2009 but also continue with implementation in Lira, Apac, Kumi, Tororo and Rakai districts.

The activity under this program area will focus on supporting the reduction of HIV transmission among married couples, individuals including girls and women by providing them with culturally sensitive and comprehensive HIV/AIDS prevention information aimed at promoting abstinence, faithfulness; reducing the number of sexual partners and supporting discordant couples not to transmit HIV to the negative pregnant women identified through the PMTCT program. In most communities in Uganda, women and girls are not empowered to make decisions or even allowed to get involved in activities without the consent of their male partners. This makes them vulnerable to the sexual demands of men. THETA will work with Community Lay Providers and peer educator to in the communities to enhance preventive counseling for long term risk reduction of HIV transmission; promote HIV testing among the male partners of HIV negative pregnant women through appropriate linkages with the general HCT services and promote correct and consistent use of condoms. In addition, this program will also promote Sexual HIV prevention targeting women of reproductive age groups and their partners to be though the general PMTCT community works. Adults of reproductive age groups will be targeted through community dialogues to ensure that when they decide to have children, they are not infected with HIV. Community dialogue is a process that fosters dialogue and collaboration within the community by assisting community members in identifying the positive aspects of their community and existing successful mechanisms, while at the same time encouraging lessons learnt on how existing social problems have been successfully dealt with. There is ample opportunity during the process for community participants to gain clearer, correct understanding of basic HIV/AIDS and PMTCT issues; and there is time for reflection and planning so that communities can begin to create more caring and supportive environments for HIV-affected families, using community-available resources. In FY 2009 it is anticipated that about 60,000 people within the target groups (couples, single women and girls) will be reached with sexual prevention interventions and over 380 CLPs will be trained.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 22503

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
22503	22503.08	HHS/Centers for Disease Control & Prevention	Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	9211	9211.08	Traditional & Modern Health Practitioners	\$45,062

---

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$20,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.02: Activities by Funding Mechanism****Mechanism ID:** 9836.09**Prime Partner:** Natural Family Planning  
Center**Funding Source:** GHCS (State)**Budget Code:** HVAB**Activity ID:** 23781.09**Activity System ID:** 23781**Mechanism:** National Family Planning  
Center/NPI**USG Agency:** U.S. Agency for International  
Development**Program Area:** Sexual Prevention: AB**Program Budget Code:** 02**Planned Funds:** \$0

**Activity Narrative:** TSU is a sub-partner of the Natural Family Planning Center of Wash. D.C.'s Teen STAR Program. Teen STAR is a dedicated educational program which seeks to prevent the transmission of HIV/AIDS via primary and secondary sexual abstinence. It teaches the physiological, emotional, social, cognitive and spiritual aspects of human sexuality in developmentally appropriate curricula. In addition, individual meetings are held between students and teachers to ensure adequate understanding and integration of the material. The program is taught at the junior high and high school level once per week over a period of 8 months. Females and Males are separated for the first half of the program to address the specialized individual needs of both genders. The program has been used in 35 countries around the globe. Evaluation since 1980 has demonstrated that students successfully maintain primary or return to secondary abstinence. Parental permission and involvement are entrance requirements for minors. Informational meetings and materials serve to educate parents as well on the transmission of HIV/AIDS. A series of three parent meetings are held during the project year. Teachers undergo a five day training session on the curriculum and must complete a one year practicum in which they teach 2 classes of 25 students with intense supervision. TSU and NFPC monitor the quality of curriculum delivery, program data collection, and the administration of the program.

Progress to date: since program start-up in December 2006 (fiscal years 2007-8) 1863 female and 842 male youths have been "reached" with the intensive abstinence message. The curriculum stresses mutual respect between genders serving the goal of supporting female equality. Parents and members of the general community received information about HIV/AIDS. A total of 175 (74F and 101M) teachers were trained to deliver the Teen STAR program. 60 couples received the Be Faithful message in marriage preparation programs for young single adults, underscoring the need for zero grazing. Animators are used to provide information to community groups about the program. Community acceptance has been excellent. All current sites are eager to continue the program and new sites are recruited continuously based on word of mouth. New teachers are generally easily identified and will be trained to handle the demand.

Work begun in the districts of Wakiso, Kampala, Mbarara, Bushenyi, Isingiro and Kasese reaching the next classes of students.

In 2009, TSU will expand to the districts of Kabalere (Fortportal Diocese) Kabale, Rukungiri and Kisoro (Kabale Diocese) and the Hoima (Hoima diocese). TSU will reach 6,000F and 4,000 M through community outreach that promotes HIV/AIDS prevention through abstinence and being faithful; and a total of 5,000 F and 4,000 M will be reached with abstinence only messages. TSU is planning to train 300 new teachers (100 in each of the three new dioceses in 2009). The new teachers will be available to teach 5000 students per diocese. Programs are held in schools and in community centers with teachers recruited from existing faculties or communities. The program also reaches young adults in marriage preparation programs and marriage programs focusing on marital fidelity and the transmission of HIV/AIDS

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

---

**Mechanism ID:** 9858.09

**Prime Partner:** American Refugee Committee

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 23782.09

**Activity System ID:** 23782

**Mechanism:** NU APPROACH/NPI

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$0

**Activity Narrative:** The American Refugee Committee (ARC) is a non-profit, non-sectarian humanitarian relief organization working for the survival, health, and well being of refugees, displaced persons and those at risk caught in the crossfire of civil violence, warfare and other disasters. Founded in 1979, ARC has grown to over 1,800 employees and has received recognition for its efficient and effective delivery of humanitarian assistance. Today, ARC operates in Guinea, Liberia, Pakistan, Rwanda, Sierra Leone, Sri Lanka, Sudan (Darfur and Southern Sudan), Thailand, and Uganda.

ARC has provided life-saving assistance to refugees, displaced persons, and other war-affected populations in post-conflict settings around the world and brings accumulated technical capability and experience in emergency relief, transitional relief, and post-conflict stabilization from 25 years of experience in Asia, Africa and Eastern Europe. ARC's sectors of expertise include HIV/AIDS awareness and prevention, primary and curative health care, community health education and awareness, vocational health training, water and sanitation, gender-based violence prevention and counseling, emergency shelter assistance and transition services, and microcredit/income generation. ARC strives not merely to provide emergency aid to those in need but also to enable them to achieve self-sufficiency; ARC's "refugee to return" model sees relief assistance not as an end to itself but rather as part of a process whose eventual goal is a population's durable return to their homes. ARC takes a community-based approach to developing and implementing all programs and encourages beneficiaries to take as much ownership and responsibility as possible.

ARC's PEPFAR project, NU APPROACH (Northern Uganda Access, Prevention, Referrals, and Organizational Assistance to Combat HIV/AIDS) focuses on three mutually supportive objectives focused on prevention, care and support, and organizational development/capacity building. These complementary components all link into the needs of the larger Ugandan health context. ARC is proposing to work with national community based partners in its response to HIV/AIDS, as community-level outreach and capacity-building, and support to the lower level Health Centers (Health Center level 2), remain serious gaps in Northern Uganda.

ARC's strategy will include a combination of increasing knowledge and facilitating behavior change, supporting key service provision, and capacity building of local systems and organizations to better respond to the situation. ARC's first objective will address the lack of basic HIV knowledge among the population. ARC and its partners will design and execute, based on best practices in Uganda, a Behavior Change Communication (BCC) strategy to educate high-risk groups about basic HIV facts, including the nature of the disease, modes of transmission, and prevention. These activities will target married couples, pregnant mothers, youth, members of the security forces, ex-combatants and ex-abductees, and women who engage in transactional sex. To implement the BCC strategy, ARC and its partner HIDO will establish peer education structures throughout IDP and returnee communities.

ARC's second objective will support the quality and accessibility of HIV-related services. Given the low availability of HIV Counseling and Testing (HCT) in the North, ARC will operate mobile HCT teams to bring HCT services closer to the people as they continue to leave the main camps and return to their original homes. ARC will also promote PMTCT access by training midwives and TBAs as sensitization and referral agents, creating a link between HIV+ mothers and PMTCT services. In the Home-Based Care sector, ARC will work with the wide range of existing HBC actors to better coordinate, standardize, and upgrade the services they offer. ARC will address the issue of treatment of STIs and opportunistic infections (OIs) by providing training to MOH health workers on syndromic management of STIs and on referral procedures for relevant cases. Lastly, ARC has secured an agreement from a major HIV service provider in Uganda, The AIDS Support Organization (TASO), to receive referrals of PLWHA from ARC and its partners; this will link TASO with the IDP population and thus expand treatment and service options for the displaced. Although ART treatment is not a direct component of this project ARC will prioritize referral of PLWHA to ART providers, including TASO and appropriate health facilities.

Finally, ARC's third objective will focus on improving the capacity of Ugandan actors operating in the North. ARC will work with local NGOs and CBOs to improve their technical and operational capacity. The capacity building will focus on upgrading the technical capacity of partners in areas such as BCC/IEC, peer education, HCT, HBC, and referral. It will also focus on improving those organizations' ability to manage and implement activities, and so will cover project planning, operational support, finance and administration, staff management, and fundraising. ARC has already identified its first principal partner, HIDO, and will also identify between 3- 5 other partners via a competitive process. Tailored capacity-building plans for those agencies will be elaborated by ARC in collaboration with the partners to establish a continuous capacity building process for them. Gradually, as the partners' capacities are strengthened, ARC will begin handing over responsibility of project implementation to them, via sub-grants.

Since the grant became operational in the beginning of June 2008, ARC has now reached the final stages of project start up and preparation. ARC has been dialoguing with USAID CTO to finalize all necessary revisions of the workplan and the supporting documentation and to formalize any modifications to the Cooperative Agreement.

Some of the main activities to date include:

- \* Logistical and administrative set up
- \* Liaising with key HIV stakeholders (District authorities and key partners)
- \* Staff recruitment initiated
- \* Elaboration of ToR for KAP Baseline Assessment Consultancy; discussions with CDC on development of survey tool and methodology; call for proposals for consultancy.
- \* Technical support to sub-grantee, HIDO, in development of their first year workplan, corresponding budget, budget narrative, timeline, and logframe; technical support in development of job descriptions and recruitment.
- \* Modification of JSI template sub-grant agreement for one year sub-grant with HIDO
- \* Elaboration of ARC "small grants package" for use with future partners (ongoing)
- \* HIDO has begun identification of available IEC materials for use in its BCC campaign
- \* Identification and consultative meetings held with key HBC actors

**Activity Narrative:** \* Gap analysis initiated

During this period, ARC sub-grantee, HIDO, will finalize the elaboration of their BCC strategy and initiate prevention activities, including: 1) Establishing a peer education network and sensitizing key community actors in HIV issues 2) facilitating radio listening clubs with peer education groups 3) development and distribution of relevant IEC materials 4) initiating participatory video project and talk-back sessions 5) establishing condom distribution mechanism through fixed sites and supported by trained peer educators. ARC will target groups engaging in high-risk behaviors including those below, taking into account the draft Uganda National Strategic Plan (NSP) for HIV/AIDS, which identifies discordant couples and pregnant mothers as primary focus groups.

- Members of married/partnered couples
- Pregnant mothers (assuming that this group will significantly overlap with the married couples group)
- Youth
- Drivers
- Members of the security forces
- Women engaging in transactional sex

**Peer education Network:**

ARC and HIDO will select and train peer educators, utilizing the YPEER methodology. HIDO will initiate its behavioral change and prevention activities through inter-personal communication (IPC) peer education sessions. HIDO will assist each of the PEs in forming 3 groups of 10 members. Once peer groups are formed, Peer Educators will be supported to carry out weekly meetings and appropriate educational activities; the peer groups will be involved in the radio listening discussion clubs and video awareness outreaches described below. In lines with the YPEER methodology, Lead Peer educators and Master Trainers will be identified based on their high performance and serve as supervisors and quality control agents. Following completion of both rounds of trainings, it is expected that about 90 Peer Educators will have been trained; and through them, a total of approximately 4,050 community members will have been reached in FY 2009.

In this period, HIDO will assess available IEC materials and develop any additional IEC resources required for the BCC campaign, such as educational videos, posters, pamphlets, fact sheets, radio broadcasts, and dramas. Subsequently, HIDO will produce, and disseminate these IEC materials to specified target audiences.

**Radio Listening Clubs:**

Development of radio messaging will be completed jointly by ARC-HIDO within the third quarter, focusing on prevention of HIV/AIDS, where to go for testing, the importance of testing pregnant women, discordancy and prevention for positives. In the fourth quarter, the radio show will be broadcast and peer education groups will be initiated into radio listening clubs. Using discussion guides elaborated by ARC-HIDO, the peer educators will direct the peer groups discussions to cover the key HIV messages for each radio episode; PEs will use interactive interpersonal communication (IPC) methods during the discussion sessions to engage members and increase internalization of knowledge. Pre- and post-tests will be administered to estimate levels of understanding and retention among the peer group members. As each peer educator group will double as a radio listening club, it is expected that in this period between 50 and 80 listening clubs will be formed.

**Participatory Video Project:**

Use of the participatory communications video methodology will increase HIDO's tool-kit of culturally appropriate methodologies to discuss difficult topics and to encourage prevention behaviors among men, women and youth. ARC, in collaboration with Communication for Change (C4C), plans to work with HIDO and provide an intensive 2-week training in proper video production including a strong focus on playback sessions, which is a key factor in monitoring behavior change. As the peer groups HIDO has identified will have received sufficient basic information on HIV through the radio listening clubs, it is expected that they would be able to produce culturally relevant and language appropriate dramas/skits that raise prominent issues on HIV in their communities, which would be video-taped and played back to the communities for discussion.

**Condom Distribution:**

The 5 identified condom distribution points will be managed through the Lead Peer educators. They will oversee the functioning of the condom distribution points, providing direct information sessions to community members selected to distribute condoms at the various fixed locations, such as bars, restaurants, kiosks, lodges, etc. In addition, these Lead PEs will themselves serve as condom focal persons in the communities, referring their peers to free condom access points and providing any counseling and information on correct use of condoms.

Additionally, throughout this period, ARC will be providing its sub-grantee, HIDO, with technical support and capacity building in terms of developing its BCC strategy, establishing and managing peer educator networks effectively

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.02: Activities by Funding Mechanism**

---

**Mechanism ID:** 9833.09

**Prime Partner:** Johns Hopkins University  
Center for Communication  
Programs

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 23923.09

**Activity System ID:** 23923

**Mechanism:** Health Communication  
Partnership

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$800,000



## Activity Narrative: Activity Narrative

### ACTIVITY UNCHANGED FROM FY 2008:

Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health's Center for Communication Programs that was awarded in July, 2007. 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 two multi-channel communication campaigns for young people—one discouraging transactional and cross-generational sex, and the other—the Be a Man campaign—promoting more gender equitable attitudes and behaviour among men. Both 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. expects to reach 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 2007, HCP assisted Y.E.A.H. to design a second phase “Be a Man” campaign, which will focus on alcohol, violence against women, multiple concurrent partners, and transactional sex. During FY 2008, Y.E.A.H. will have launched the second phase umbrella campaign, and rolled out two sequential focused campaigns on alcohol and violence against women as they relate to HIV. HCP will work with Y.E.A.H. and other partners to launch a hotline with telephone counselors prepared to answer callers' questions about these issues, as well as medical male circumcision, HIV counseling and testing, ARV treatment, family planning.

### ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

FY 2009 activities are a continuation of FY 2008 work and will have four components. The first component is to execute two more focused campaigns under the Be a Man umbrella—the first on transactional sex and the second on concurrent partners. 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 will be established during FY 2008 with a Ugandan non-governmental partner for personalized information and counseling.

The second component involves a continuation of training facilitators among men's groups and youth groups at community level, and vocational training institutions 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, and more compassionate attitudes toward people living with HIV and AIDS. 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. HCP will assist Y.E.A.H. to train 1,200 peer educators and community resource persons, and 50 police community welfare officers to facilitate group discussions and education sessions about alcohol abuse, concurrent partners, violence against women, transactional sex, and HIV/AIDS related violence. These peer educators and community resource persons will each counsel and facilitate discussions among 40 young people, for a total of 50,000 young men and women reached through community outreach with alcohol and HIV prevention information.

The third component is to assist Y.E.A.H. to mobilize resources to support future communication initiatives for young people. During FY 2008, Y.E.A.H. prepared three proposals for funding from non-USG sources, and received some supplemental financial and in-kind support for the Be a Man campaign from Save the Children and the British Council, and promises of funding through the Global Fund. Also during FY 2007, HCP assisted Y.E.A.H. to finalize a resource mobilization and advocacy strategy, which will be fully implemented during FY 2008 and FY 2009. The strategy focuses on leveraging private commercial sponsorship for Rock Point 256 comic books and radio programs; raising institutional support through private foundation funding; and applying for bilateral or multi-lateral donor funds to support future campaign activities. During FY 2009, HCP will hire a consultant to assist Y.E.A.H. to prepare and submit at least four proposals to private foundations and bilateral or multi-lateral donors, with the aim of obtaining funding from at least two non-USG sources.

The fourth component is to evaluate the reach and impact of Y.E.A.H. communication through a second household survey in the same 14 districts as were surveyed in FY 2007. Data from the 2009/10 survey will

**Activity Narrative:** be compared with data from the FY 2007 Y.E.A.H. survey, and will provide information about the reach and effectiveness of various communication messages and approaches which can be used to inform the design of future HIV/AIDS communication for young people, and particularly for young men.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$75,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9462.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 21858.09

**Activity System ID:** 21858

**Mechanism:** Technical Management Agent/Civil Society Fund

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** ██████████

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities, with another 90 expected to be awarded at the end of FY 2008. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community.

Resources for the Technical Management Agent (TMA) will primarily be used to provide technical support and capacity building to CSOs competitively selected to receive grants. The TMA will identify, obtain and adapt technical resources with the aim of producing a comprehensive and standard package of resources to be used by all grantees working in prevention and OVC service delivery. Through a variety of strategies, small workshops, one-on-one training, site visits and cross-visits among grantees, the TMA will provide necessary and critical support to ensure that grantees are implementing their programs with the most up-to-date technical information and best-practices available. The TMA will also support the CSF Secretariat at the Uganda AIDS Commission, supporting the operational functions of the Steering Committee and the institutionalization of transparent and competitive granting mechanisms used by the CSF to solicit, review and award civil society grants. These resources will be used to support a portion of the management fees (along with funding from other key program areas such as OVC) for the TMA, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Financial Management and Monitoring and Evaluation Agents. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the TMA component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 21888.09

**Activity System ID:** 21888

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** [REDACTED]

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 3340.09

**Prime Partner:** Johns Hopkins University  
Center for Communication  
Programs

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 22305.09

**Activity System ID:** 22305

**Mechanism:** AFFORD

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$800,000

## Activity Narrative: INTRODUCTION

Since its inception in November 2005, the AFFORD Health Marketing Initiative has primarily worked to increase accessibility to condoms through several channels, with special emphasis on high risk locations. The project has used innovative communication approaches and channels to reach specific populations with HIV and STI prevention messages and products. Condoms and direct counseling have been promoted aggressively to most at risk groups (MARPS) across the country. The general public has also been exposed to a wide range of communication messages promoting fidelity, reduction in sexual partners and correct and consistent use of condoms for sexually active adults. The project has also addressed gender norms related to increasing the risk of HIV infection.

### PROGRESS TO DATE

#### Increased condom outlets and product distribution

In a bid to make condoms even more readily accessible at high risk locations, AFFORD stocked condoms in as many bars as possible in all the regions of the country and carried out direct condom promotion at these locations. This together with getting more corner shops (dukas) to stock condoms resulted in an increase of condom outlets from 29,000 in 2007 to 32,000 in 2008. This benefited both the project and suppliers of other brands of condoms. Socially marketed condoms in Uganda increased from 22 million in 2005 to 30 million in 2006, 34 million in 2007 and we are expecting about 38 million in 2008. Protector, the AFFORD promoted condom brand and the oldest on the market, appeared to be a tired brand. In 2008, AFFORD repackaged Protector in an attempt to make the brand more attractive to consumers.

#### Targeting Most At Risk Populations (MARPS)

AFFORD has continuously identified locations of high risk behaviors targeting most at risk populations with HIV and STI prevention. Using community outreach and interpersonal communication, the project has directly reached fishermen in several fishing communities, commercial sex workers in four major locations in the country, the military, police and other private security agencies. Working through six partners, a total of 29,671 MARPS were reached in 2008. The MARPS program included 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. Through subcontractors, AFFORD trained 607 peer educators in FY 2008 among commercial sex workers, police, UPDF and fishermen. They were trained to address gender and social norms and practices that increase men's risk of HIV infection using the "Be a Man" training manual and tools. These interpersonal approaches reached 28,378 people in 21 districts.

In an effort to facilitate sustainable programming for MARPS, AFFORD supported the establishment of the MARPS network, a national network that brings together all organizations working with MARPS. The MARPS network's main function is to facilitate information sharing and dissemination of best practices, provide strategic direction in MARPS programming and advocate for resource allocation to MARPS interventions. To date the MARPS network has a membership of 20 organizations, a three year strategic plan and a functional secretariat

#### 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.

The Good Life campaign launched with The Good Life! Show, a highly popular TV, radio and experiential game show that uses edutainment to increase knowledge, facilitate couple communication, promote healthy behaviors, and increase demand for products and services. Areas of HIV focus include risk perception, condom use, HIV testing, disclosure, PMTCT, adherence, and positive living. In FY 2008, 24 episodes were broadcast on 3 TV stations, 20 radio stations in 5 languages and appeared in 120 locations countywide through the experiential road shows.

The experiential road shows were further refined to enhance interpersonal communication and resulted in the development of the "four tent" model. Using this approach, fewer people gather under a tent to learn about HIV prevention and engage in meaningful exchange with the moderators. The four tent approach went to 120 communities in 2008 reaching 300,000 people.

In partnership with the HIPS project, AFFORD implemented a number of workplace programs targeting major companies and sugar and tea plantation workers. A total of 32,000 people in 16 workplaces were reached through this intervention with HIV prevention messages and products including condoms.

#### Interpersonal communication at the village level – Popular Opinion Leaders

AFFORD created the Popular Opinion Leader model in 2006 to complement its efforts at reaching Ugandans at the grassroots. Popular Opinion Leaders are volunteers recruited at the village level and trained to offer education on basic health issues including HIV/AIDS. To date over 700 POLs are operating in 18 districts. In FY 2008, 736 new POLs were trained in 23 districts. POLs use interpersonal approaches to raise awareness on condom use, HIV testing, discordance, and benefits of early treatments of STIs.

#### Addressing Alcohol and Sexual Violence

In FY 2008, AFFORD and its partner PULSE reached over 100,000 people in high risk locations in Uganda. AFFORD trained over 190 bar and lodge owners in condom use at the work place, STI and HIV referral, and sexual violence to staff and patrons. Working in collaboration with UPHOLD, AFFORD also oriented 231 bar and lodge owners in 12 districts on HIV in the workplace. The objective was to enhance bar and lodge owners' knowledge on 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 work place policies in their establishments.

### FY 2009 ACTIVITIES

In FY 2009 AFFORD will consolidate its gains by maintaining all its existing activities as mentioned above. The project will strengthen the quality of programming with the aim of reaching more under-served areas

**Activity Narrative:** and people with HIV prevention messages. AFFORD will use local languages and approaches that the intended population can appreciate and effectively participate in promoting the reduction of sexual partners and consistent and correct condom use. AFFORD expects to reach approximately 390,000 people directly through HIV prevention messages.

C

#### Condom Distribution

AFFORD will work on increasing its distribution by increasing the number of outlets stocking condoms. The following strategies will be adopted:

Increasing number of wholesale outlets with our products. The number of outlets is expected to increase to 50,000.

Recruit Fast Moving Consumer Goods (FMCG) distributor: AFFORD will recruit 3 FMCG distributors as means of reaching existing high risk locations (bars, lodges, hotels, etc). FMCG distributors (especially beer distributors) target the same locations as those for condom distribution. AFFORD piggybacks on distribution mechanisms of FMCG products like laundry soaps, toothpaste (Unilever products) and beers to increase availability and accessibility of condoms in high risk locations and outlets. Distributing condoms through HIV prevention stakeholders/organizations: Through the HIPS project, AFFORD will sell condoms to companies that employ large numbers of staff. This will be extended further to reach other NGO's working in the areas of HIV prevention, for example, MAVAP, AIC, IRC, and MSF, among others.

#### Condom promotion

AFFORD will concentrate on improving acceptability of condoms at MARPS locations and general retail outlets using the medium of karaoke in bars. The bars will also serve as channels for condom sales.

In order to encourage condom stocking by traders, AFFORD will carry out trade promotion, providing attractive incentives for traders that buy and restock condoms in good purchase quantities.

AFFORD will liaise with beer companies to hold joint promotions. This will cut costs of promotions and at the same time highlight responsible drinking, coupled with correct and consistent condom use.

AFFORD will also roll out a merchandising campaign to ensure condom visibility, emphasizing the affordability of the condoms. This campaign will ensure that point of sale materials are properly displayed and that condom stocks are available at these outlets.

The field teams (PMOs) will work together with night club management countrywide to organize condom promotions. Night clubs have proven to be locations for high risk behavior.

#### Targeting Most At Risk Populations

In FY 2009 AFFORD will continue MARPS interventions in its current districts, and work with the MARPS network and organizations to scale up interventions for fishermen, truckers and CSWs in 8 new districts. AFFORD will also expand the number of MARPS organizations it is working with from 8 to 10.

Peer Educators (PE) program: Through sub grants to MARPS organizations, AFFORD will conduct refresher training for the 607 previously trained PEs and train 500 new PEs for all four categories of MARPS (CSW, military, police and fishermen). AFFORD will support PEs to reach 100,000 people through interpersonal communication and community mobilization with HIV/AIDS messages and link them to needed products and services for reproductive health. AFFORD will reproduce and distribute support materials, job aids and tools needed by PEs to do their work. Support materials will focus on HIV prevention approaches and gender norms that increase the risk of HIV transmission, and address alcohol consumption and sexual violence. AFFORD will continue to target men with gender positive messages from the male perspective.

Access to friendly service outlets: AFFORD will continue to support MARPS to access friendly services for HCT, STI and family planning. Special and convenient places like previously supported drop-in centers for CSW will be supported and equipped to make them fully functional. AFFORD will support establishment of 2 additional drop in centers for CSW. Similarly 2 additional safe sailing boats manned by PEs to deliver services and products to fishermen and fishing communities in remote fish landing sites will be procured and equipped. Static condom outlets in military and police barracks and parking yards for long distance truck drivers will be procured for 10 new locations each.

Internally displaced persons (IDPs): Of the 31 priority districts supported by AFFORD, 4 have been under conflict, still have high populations of IDPs and have high HIV prevalence. In 2009 AFFORD, will extend HIV prevention interventions through our innovative communication campaign and use the product distribution mechanisms to step up condom promotion and addressing gender norms that increase the risk of HIV transmission. In addition, through sub grants, AFFORD will identify and support organizations providing tailored HIV prevention programs using community mobilization and interpersonal communication.

#### Good Life Campaign

In FY 2009 AFFORD will continue to use the Good Life campaign to address critical issues that drive the epidemic in Uganda. Mass media will reinforce community interventions, positive behaviors, risk perception and gender issues influencing people's behaviors. The Good Life Essence campaign will be launched, which will include better linkages to the AFFORD health messages and products through mass media, a loyalty scheme and rewards to consumers who recall, purchase and use the AFFORD products and messages. It will culminate into the Good Life awards rewarding households, communities, distributors and POLs who emulate the Good Life. The Good Life Show will also be shown in more community video halls and generate discussions thereafter while also scaling up the 4 tent model, which will cover the whole country.

#### Interpersonal communication at the village level – Popular Opinion Leaders

In FY 2009 AFFORD will continue to work with CDFU to consolidate gains registered in the 23 districts. Refresher training for POLs to enhance their skills in interpersonal communication and community mobilization will be held. AFFORD will continue to strengthen this interventions aimed at preventing sexual



**Activity Narrative:** transmission of HIV to reach 100,000 people. Through this intervention AFFORD and CDFU will intensify activities in the 23 districts with more in depth activities for condom promotion, prevention among discordant couples and raise awareness on gender issues that increase the risk of HIV transmission. AFFORD will also intensify interventions for gender using the Be a Man campaign and the African Transformation Model, a skill building model to analyze gender stereotypes. Special attention will be given to strengthening interventions for fidelity and partner reduction by working with religious leaders and other community self help groups. Through this intervention AFFORD will reach 500 couples and 20,000 men with gender and HIV /AIDS prevention messages.

**Addressing Alcohol and Sexual Violence**

In FY 2009 bar and lodge owners, small local brewers, brothel owners and pimps who link sex workers to their clients and engage in alcohol and substance abuse will be sensitized through interpersonal activities. AFFORD will collaborate with organization like Serenity Center and Indigenous Knowledge Resource Center to mainstream alcohol and sexual violence training in all our prevention programs. AFFORD will train 50 peer educators and reach 60,000 people with alcohol and sexual violence messages.

AFFORD will also promote responsible drinking using consumer promotions, community activities and mass media. Mass media and community activities will target men using male dominated activities like soccer and drama. At these activities gender based violence and alcohol will be discussed and men's responsibility promoted. Direct condom promotion and sales events will take place.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

Refugees/Internally Displaced Persons

Workplace Programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$250,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9713.09

**Mechanism:** Preserving the African Family in the face of HIV/AIDS (CAF ABY Track 1)

---

**Prime Partner:** Children's AIDS Fund

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** Central GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 8583.22540.09

**Planned Funds:** \$1,724,870

**Activity System ID:** 22540

**Activity Narrative:** The Children's AIDS Fund (CAF) is a non-profit, non-partisan organization working to mitigate the impact of HIV/AIDS on children and their families. CAF works with families, communities, charitable organizations, policy makers, and advocates in the areas of HIV prevention, treatment, care and support in several countries of Africa and in the United States. Preserving the African Family in the Face of HIV/AIDS Through Prevention is funded by the United States Agency for International Development (USAID), with funds from the President's Emergency Plan for AIDS Relief (PEPFAR), under cooperative agreement GPO-A-00-05-00042-00 with CAF. The project aims to increase the adoption of risk avoidance strategies for the prevention of sexual transmission of HIV/AIDS among youth ages 10 – 24, through interpersonal communications, community mobilization strategies, and the promotion of institutional involvement. The project intends to reach 350,000 individuals with HIV prevention activities that promote abstinence and faithfulness, by the end of 2010. CAF's program complements its Preserving the African Family in the face of HIV/AIDS through Treatment and Care (PAFTC) clinic programs providing HIV testing /diagnosis and treatment for HIV positive clients and HIV affected families in Uganda.

Since activities commenced in FY 2005, the project has reached 82,332 individuals with HIV prevention activities that emphasize abstinence and faithfulness as HIV prevention strategies, and trained 160 individuals to promote risk avoidance through abstinence and faithfulness. In the first two years of program implementation, the project mechanism underperformed relative to targets. Radical restructuring of the peer education system, initiated in FY 2007, has offset earlier challenges. As a result, the project has already surpassed its targets for FY 2008 by almost 10%, reaching 59,811 youth by the end of July 2008. With the insight gained from past experience, the project is placed on sounding footing to significantly broaden and deepen its youth outreach in the areas of operation.

In FY 2006, the project adopted the Choose Life curricula (age-segmented for youth 10-14 and 15+), which was developed by World Relief International for use in Africa. Eighty five (85) individuals were equipped to implement this curriculum by trainers from World Relief Kenya. The trained peer facilitators have initiated peer education activities in over 400 sites, primarily schools and religious and social institutions, to date. Technical support from the implementation unit of Young Empowered and Healthy (YEAH), a flagship health communication project of Uganda AIDS Commission (UAC) enabled the project to integrate gender-transformative messages and approaches into its community-based and peer education efforts. Ten (10) Training Of Trainers (TOT) were trained directly by a national training team from YEAH. In turn, seventy three (73) implementers were equipped in gender transformative approaches based on the content of two key YEAH communication packages: Something for Something Love and Be a Man. Twenty-five (25) adult facilitators have also been trained to facilitate community dialogues that critically examine the role of adults in youth sexual risk-taking, and the importance of partner reduction among adult males. In addition to the peer education activities, youth clubs, sports leagues, and other outreach modalities have been utilized to sustain youth exposure to critical messages, and have mobilized traditionally hard-to-reach out-of-school youth. Institutional commitment to youth prevention programming and support has been solicited through presentations to local councils, district leaders, CBO/FBO executives, religious leaders, caregivers, Parent-teacher associations (PTAs), head-teachers associations, and other influential adults.

The evidence base suggests that the Ugandan epidemic, which is largely fueled by heterosexual contact and mother-to-child transmission of HIV/AIDS, is in a period of stabilization, after a decade of decline. Transmission within the context of couples' sero-discordance appears to be a significant contributor to the epidemic, with risk of acquiring HIV increasing exponentially between the ages of 20 and 30 for both sexes. As a result, there is a strong need for HIV prevention interventions focused on partner reduction/faithfulness among young married couples. The evidence also indicates that early marriages amongst females in rural areas, and limited access to health services may contribute to general vulnerability in late-youth (between ages of 20 and 29).

Expanding target audience categories: For the reasons listed above, in FY 2009 and FY 2010, the project will expand its focus to include young individuals who are currently married, in long-term relationships, and/or are previously married (ages 15-29); and will strengthen its outreach among youth who have aged out of the primary and secondary educational system (out-of-school youth aged 15-24). These two audiences, along with in-school youth between ages of 10 and 24 who have been the project's core audience, will be targeted with activities to strengthen life-skills and comprehensive knowledge about HIV/AIDS. To reach the young married couples, CAF will leverage existing communication materials to promote faithfulness messages, including Catholic Relief Service's "Faithful House" curriculum, and "Faithfulness in Marriage", a curriculum developed jointly by AERDO and Food for the Hungry

Expanding geographic coverage: Both CAF and its implementing partner, Uganda Youth Forum (UYF), will slightly expand the areas of operation, in response to community demands. While both entities will continue activities in the five districts of Kampala, Mpigi, Luweero, Wakiso and Mukono, CAF will operate in thirteen (13) additional sub-counties, increasing the number of sub-counties in which it works to 35 sub-counties. UYF will expand its activities, and will cover five (5) additional parishes within the five (5) divisions of Kampala, increasing its presence to 20 parishes.

Strengthening Program Quality: The project will focus on broadening the quality and intensity of HIV prevention activities, by: i) Increasing the exposure of youth participants from approximately 6 hours to 8-12 hours of curriculum-guided activity; ii) increasing support/follow-up activities through the scaling up of youth clubs; iii) Increasing the utilization of creative approaches such as peer-to-peer outreach, edutainment/entertainment activities, community dialogues, and youth competitions, to cater for youths who are less amenable to the traditional curriculum-based outreach; (iv) Support materials that reinforce core project messages and enhance comprehensive knowledge will be reproduced to support interpersonal communication strategies, including the one-on-one outreach and curriculum-based small-group activities; (v) Translating communication materials into the local language (Luganda) to ensure that non-English speaking audiences are reached

Consolidating Peer Education and Peer Outreach efforts: The peer education aspect of the project will be expanded to enable greater institutional buy-in, and actualize the goal of community-driven programming. In FY 2009 and FY 2010, 370 individuals will be selected and trained to support school- and community-

**Activity Narrative:** based peer education activities. We intend to maintain a volunteer group of 320 individuals with training of 50 individuals to compensate for attrition after the first year. In FY 2009 the project will deepen its relationships with private schools which are not full participants in the current PIASCY (school-based HIV prevention) effort. This will be accomplished by investing in training, staff sensitization and material support to ensure that schools buy into curriculum-based activities, youth support activities, and improved institutional policies to reduce youth risk. Youth clubs and groups supported by the project will be equipped to reach their peers with prevention messages through creative avenues such as youth corners, forum theatre, the performing arts, and sports outreach.

Capitalize on peer affiliations in outreach to out-of-school youth: The project will capitalize on the strong peer affiliations of out-of-school youth and married youths. These two audiences will be targeted through community structures that are naturally youth-centric, and will be reached by peer facilitators who are selected from the established peer structures and social networks. Among this group, project approaches will also be strengthened to effectively address the practice of multiple, concurrent sexual partners, transactional, and coercive sex. The project will continue to pursue its technical partnership with YEAH, and will continue to use its acclaimed communication packages as a foundation for gender-transformative programming.

Intensify involvement of parents and other custodians of youth: . Available information sources confirm the centrality of parents to youth decision-making.

The project will continue its work with adults who play a crucial role in the process of youth development and sexuality, specifically parents, caregivers, and teachers. Community structures such as mothers unions, fathers unions, boda boda cyclist associations, and church-based "marrieds" groups, will be co-opted into the project's community outreach, by training facilitators from these groups, and equipping them with materials to support their activities. Outreach activities will focus on improving their skills in parent-to-child dialogue, and will address behavioral practices that directly and indirectly affect youth behaviors, particularly harmful gender stereotypes and practices, and multiple concurrent sexual partnerships. Parents and other custodians will be encouraged to participate in existing local committees and district-based peer education teams, which will be further strengthened to ensure that community-level planning, implementation, and oversight can occur at an increased level of activity.

Incorporate referral elements at all intervention levels: The project will further expand on work initiated in FY 2008, to link community-level volunteers with service providers to ensure that youth are referred for health and relevant psychosocial services including referrals for HCT, HIV Treatment, drug and alcohol abuse, OVC support, livelihood skills, and other services in the areas, using existing service provision mapping resources from UNASO, Save the Children, and PEPFAR. Especially in the areas of OVC support, HCT and treatment special effort will be made to assist youth with accessing services currently provided by USG funded projects. In response to community, parental, and youth feedback, the project will engage community-level artisans and artisan groups to provide modest livelihood skills training to 400 highly vulnerable girls and young women, with the aim of reducing their economic vulnerability.

Institutional and Community Capacity Building: During FY 2009 and FY 2010, the project will endeavor to ensure the sustainability of all activities, by increasing its capacity building efforts at community-level. In FY 2009, peer educators will be selected from institutions which indicate a commitment to incorporating youth prevention activities and adult outreach strategies into their institutional approaches. In the last year of the project cycle, the project aims to fully transfer the support supervision and oversight function to community level, by training and equipping social, cultural, educational, and political institutions that indicate a desire to collaborate with the project mechanism. Selected institutions will be equipped to leverage additional resources (both USG and non-USG) to support on-going activities. Finally, the project will develop relationships with USG-supported institutions for the purposes of capacity building of project staff, both at the implementing partner-level, and at CAF, to achieve and sustain all activities listed above. These arrangements will provide staff with enhanced skills in project planning and management, health communication programming, leadership and team work, resource mobilization, finance management, monitoring and evaluation, and strategic planning, amongst other skills.

Augment existing monitoring and evaluation efforts: Staff capacity, systems and procedures, will be strengthened to improve the collection and utilization of qualitative information. Information dissemination channels will be developed to improve feedback at the district and community levels. Data collection tools will be adapted to facilitate reporting on referral activities and secondary contacts reached by youth participants in project activities. The M&E function will be developed to contribute more strongly to the project learning agenda, through operations research and process evaluation efforts which will be built into training, support supervision, youth outreach, and community capacity building.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15980

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15980	8583.08	U.S. Agency for International Development	Children's AIDS Fund	7307	4887.08	Preserving the African Family in the face of HIV/AIDS (CAF ABY Track 1)	\$224,870
8583	8583.07	U.S. Agency for International Development	Children's AIDS Fund	4887	4887.07	Preserving the African Family in the face of HIV/AIDS Through Prevention	\$131,666

#### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1060.09	<b>Mechanism:</b> Empowering Africa's Young People Initiative (EAYPI) (IYF ABY Track 1)
<b>Prime Partner:</b> International Youth Foundation	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 4384.22551.09	<b>Planned Funds:</b> \$622,444
<b>Activity System ID:</b> 22551	

**Activity Narrative:** International Youth Foundation (IYF) is an international organization dedicated to supporting programs that improve the conditions and prospects for young people where they live, learn, work, and play. Established in 1990, IYF works with many companies, foundations and NGOs to strengthen and 'scale up' proven programs that are making a positive and lasting difference in young lives. Since its founding, IYF and its partners have helped equip millions of young people with the life skills, education, job training, values and opportunities so critical to their success. The IYF's Empowering Africa's Young people Initiative (EAYPI) project covers three countries- Uganda, Tanzania and Zambia and supports the four strategic objectives indicated below.

This activity is a continuation from FY 2008 and has been updated for targets and budgets only. IYF is implementing the empowering Africa's young people initiative project whose goal is to scale up evidence-based programs that promote healthy behaviors to prevent the spread of HIV/AIDS among youth, aged 10 to 24 years in Uganda. Activities comprise training of trainers, and peer educators to promote abstinence, fidelity and address issues such as partner reduction, stigma, and discrimination while simultaneously engaging parents, communities and trusted adults in supporting individual behavior change among the youth. The project is implemented through five youth-serving sub-grantee organizations namely: The Uganda Red Cross Society; Uganda Scouts Association; Uganda Girl Guides Association; Young Women's Christian Association, and the Source of the Nile Award. The five organizations formed an Alliance (Uganda Youth Empowerment Alliance, UYEA); where the Alliance Secretariat serves as the coordination office. In FY2008, 2,642 unique individuals were trained and 135,881 people were reached with AB messages. During the FY2009 period, 3,139 new unique individuals (2,584 youth and 555 adults) will be trained to promote AB and 1,047 individuals (814 youth and 233 adults) will be refreshed with AB messages. A total of 134,307 people (116,824 young people and 17,483 adults) will be reached with AB messages through four integrated and reinforcing strategic objectives in the 10 districts of Kampala, Iganga, Kabale, Hoima, Lira, Kayunga, Kamuli, Budaka, Tororo, and Wakiso. Lira district has a number of Internally Displaced People s who are a major target for this program.

i) Scaling up skills based HIV prevention education, especially for younger youth and girls: At least 2,620 peer educators will be trained using the cascade peer training model and workshop training setting. The purpose of the training is to equip peer educators with facilitation and communication skills for disseminating accurate and correct AB messages, and to provide life skills necessary for practicing AB. The training will also equip peer educators with skills to pass on to the peers on how to deal with peer pressure, and to refer young people that need other services like VCT, STD management, correct and consistent condom use, and social services that address issues of sexual violence. The trained peer educators will reach a total of 116,824 young people, in and out of school, through a series of one-to-one contacts, guided group peer education interactions, community outreaches and enter-education youth activities, all focused on abstinence and behavior change for the youth.. Other topics to be covered will include VCT, increased risk among people with multiple concurrent partners, vulnerability of girls to sexual exploitation and coercion as well as male norms and behavior. The young people will be reached through existing sub-grantee youth forums like youth clubs, school debates, sports activities, blood donor clubs, jamborees and expeditions. Resource materials will be identified from other partners and distributed to the peer educators to help them carry out their work satisfactorily. These will include activity kits containing games, pamphlets, posters material.

ii) Stimulating broad based community discourse on health norms and risky behavior: In FY 2009, a total of 1,822 adults and other community members will be reached through district and sub-county meetings. Working through established sub-grantee adult and community networks, community participatory dialogue and action planning outreaches will be conducted with a focus on identifying and recognizing prevailing youth health norms, gender issues, youth risky behaviors, advocacy issues related to stigma and discrimination, and ways that communities can use the information to address the identified risk behaviors predisposing young people to HIV. Target audience includes adult members and volunteers of the sub-grantees, parents, teachers, cultural leaders, scouts and girl guides masters in schools, civic leaders, politicians, women and youth leaders, community resource persons, and other volunteer groups. The target audience will be reached through forums such as, the YWCA adult clubs that comprise parents, influential leaders, and community members; Red Cross community blood donor clubs; Scouts and girl guides open troops in the communities. These will be provided with accurate information and AB Behavior Change Communication (BCC) materials to dispel misinformation, and they will draw up action plans to address the identified issues. A cadre of community facilitators will be recruited from existing sub-grantee volunteer staff and equipped with facilitation skills to conduct adult and community meetings.

iii) Re-enforcing the role of parents and other influential adults: A core team of 345 new community facilitators will be trained in parent to child communication (PTC). The new and the existing parent to child communication facilitators will in turn reach 16,700 parents and other influential adults through some of the existing forums described above. They will mainly focus on PTC, and the role of the family. The training of trainers and facilitators in PTC and interpersonal communication skills will be done using the materials adopted from Safe from Harm curriculum developed by Population Services International's (PSI) AIDS Mark program. Other PSI reference materials will also be used. The trainers and community facilitators will in turn reach other parents and responsible adults to mitigate the difficulty many parents, teachers, leaders and other key gatekeepers face in communicating with teens and young people regarding sexuality and the role of the family in providing an enabling environment for young people to delay sexual debut or be faithful. The existing sub-grantees structures such as teacher guiders, scout rangers, YWCA adult clubs, youth mentor, role models and other parent-elder programs will be utilized as forums to strengthen communication skills, mentoring and role modeling. Furthermore, the adults and the influential people will be provided with knowledge and skills that will increase their self-esteem and capacity to talk about youth sexuality, abstinence, fidelity and monogamy, partner reduction and define parental responsibilities to help young people practice AB behaviors.

iv) Reducing the incidence of sexual coercion and exploitation for younger people: A total of 1,822 adults and other community members targeted to be reached with outreaches in ii) above will also be reached with interventions under this objective by the trained community facilitators and older peer educators. This will build on activities already implemented in FY2008 that included identification of key influential leaders within

**Activity Narrative:** the communities, and risky behaviors and areas for young people. Community advocacy and sensitization meetings will be conducted for younger and older males. For younger males, the focus will be on challenging gender norms about masculinity, the acceptance of early sexual activity, multiple sexual partners and transactional sex, which are among the drivers of the epidemic in Uganda. These interactions will be a deliberate effort to impart positive gender sensitive attitudes, practices and behaviors in young males at an early age as a long term strategy to address sexual violence and exploitation of their female counterparts. For older males, the focus will be to support counseling, peer education, and community interventions. These two reinforcing objectives are aimed at addressing equitable gender norms in ABY HIV/AIDS prevention and addressing high risk sexual behaviors such as multiple concurrent partnerships, transactional and cross-generational sex, and alcohol and drug abuse. This will help to address the current major drivers of the epidemic and decreasing on the number of new infections.

Contribution to overall AB program area:

EAYPI has produced a synergistic alliance of organizations that possess a combined HIV/AIDS prevention expertise, life skills and peer-to-peer education programming as well as expertise in youth development, and capacity building. This combination of expertise has enabled EAYPI to scale –up culturally appropriate and technically sound behavior change programs that are contributing to a reduction in HIV prevalence among the youth in Uganda. The added value of the alliance lies in its ability to support the scale-up of program activities, to generate program results through the provision and coordination of technical assistance, leveraging resources and ensuring quality of A and B approaches and messages in the communities where the affiliates work. EAYPI supports USAID/Uganda strategic objective (SO) #8: Improved human capacity, the Uganda HIV/AIDS National Strategic Plan 2007/08- 2011/2012, and the Health Sector Strategic Plan 2005/6-2009/10, through prevention of HIV infection among the youth by influencing sexual behavior to postpone first sex among young people who have not yet initiated sexual activity, promoting partner reduction strategies and fidelity in youth who are sexually active and to encourage secondary abstinence. EAYPI plans to reach 300,000 youth with AB messages by the end of the five year period, thus contributing significantly to the PEPFAR's five year target.

Links to other activities:

EAYPI will continue to collaborate with the other track 1 ABY partners, the YEAH campaign, students partnership worldwide (SPW), Walter Reed project, sectoral ministries especially the ministry of gender, labor and social development, and the Uganda AIDS Commission. These linkages together with district and community linkages with the district health office and the health services outlets will ensure that young people reached by the ABY programme can be referred for specialized services like VCT.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14205

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14205	4384.08	U.S. Agency for International Development	International Youth Foundation	6739	1060.08	Empowering Africa's Young People Initiative (EAYPI) (IYF ABY Track 1)	\$837,500
8421	4384.07	U.S. Agency for International Development	International Youth Foundation	4835	1060.07	AB Track 1/ Round 2	\$939,803
4384	4384.06	U.S. Agency for International Development	International Youth Foundation	3333	1060.06	AB Track 1/ Round 2	\$759,792

## Emphasis Areas

Gender

\* Addressing male norms and behaviors

\* Reducing violence and coercion

Refugees/Internally Displaced Persons

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 1061.09

**Prime Partner:** Program for Appropriate  
Technology in Health

**Funding Source:** Central GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 4388.22552.09

**Activity System ID:** 22552

**Mechanism:** Scouting for Solutions (PATH  
ABY Track 1)

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$653,613



**Activity Narrative:** INTRODUCTION AND OVERVIEW - Through the Scouting for Solutions (SfS) project, PATH is working with Uganda Scout Association (USA) to reach an estimated 150,000 young people aged 12-15 years with HIV prevention messages through various activities. These activities are built around three strategic objectives namely: reaching young people with information and skills for HIV prevention; engaging parents/guardians and other protective adults in creating a supportive environment for behavior change; and building capacity of scout associations to develop, implement, and monitor large-scale HIV prevention programs. Working with USA, PATH is providing information and skills to promote abstinence until marriage, fidelity and monogamous relationships, avoidance of unhealthy sexual behaviors and gender equality among scouts in Uganda.

**HIGHLIGHTS AND ACHIEVEMENTS OF YEAR 4:** During Year 4, the activities implemented included information and skills building for scouts through two issues of the Scout Voice newsletters (80,000 copies), and camporee edition (1500 copies produced during the annual National camp), development of 4 new activity packs and training of 13 scouts in pilot amateur photography (Shootback) to document scouting and community level activities with cameras they had won in national scout competitions where HIV prevention messages were included. National capacity for training was built through training of 43 national scout trainers in SPLASH! (this is none cascade training methodology that involves practical experiential knowledge and skills), held jointly for Uganda and Kenya; training of 800 scout leaders on additional modules on Management and Supervision, Little Magnet Theatre, Activity Pack 3 (on HIV and AIDS) and 4 (Care and Support and Stigma Reduction) and Counseling. These scout leaders were able to reach 64,000 boys and girls aged 12-15 years. A joint creative workshop was held to develop a comic book to add to the repertoire of information materials available for young people. 163 rover scouts were trained on supervision to assist the District Executive Commissioners (DECs) who have limited time to carry out effective support supervision to schools due to heavy workplan since most of them are head teachers or self-employed. An experience sharing meeting was held with 48 ABY partners in Kampala to share lessons regarding implementation of PEPFAR activities in Uganda. Parents and guardians were involved in creative workshops to develop activity packs and in school committees. Although the transfer of teachers has been a challenge, the project continues to train new scout leaders to ensure continuity of scouting activities in project schools.

**DETAILS OF YEAR 2009 ACTIVITIES:** During this final year of the SfS project, PATH will identify lessons learnt as well as challenges for reaching even more young people. This project will focus on issues of cross-generational and transactional sex between young people and adults as well as behavior change for HIV prevention. The scouting principle of respect for self and others is the basis for young people to help protect themselves and others from HIV infection. To provide information and skills to the scouts, Activity Packs 5-8 which have already been developed and pretested, will be finalized and distributed to schools during training of scout leaders. Activity Packs 5 and 6 address issues of ASRH, healthy relationships, cross generational and transactional sex, gender-based violence including sexual abuse and its implications. Packs 7 and 8 focus on abstinence, negotiation for safe sex and life skills. Three new editions of the Scouts Voice newsletter will be produced (two regular editions plus a camporee edition during the national competitions). Themes for the newsletters will be developed by the scouts during creative/editorial workshops. However, one edition will be dedicated to discussing male circumcision which is increasingly being seen as a way to reduce HIV infection among men. In Year 5, rover scout will assist the scouts to use Little Magnet Theatre (LMT), a theatrical approach to share critical HIV prevention information and messages on promotion of gender in scouting to the school and outside communities including their parents. The scout leaders have already been trained to develop stories and generate discussions on topical issues such as abstinence, faithfulness and partner reduction and condom use for those who are sexually active. Scouts who participate in 3 LMT performances will be given a badge while certificates will be awarded to the troops with exemplary performances. The project will continue to award the Red Ribbon HIV and AIDS badge. Those scouts who complete activity packs 1-4 will be awarded the Red Ribbon badges with the stars in Year 5. Completion of activity packs 5-8 will see a scout earn all the three stars. The Merit and proficiency badges to promote gender equity which were to be produced in Year 4 will be produced this year. These will feature cookery, housekeeping, baby care and handiwork. The objective of these badges is to expose boys and girls to activities that are traditionally reserved for the other gender. In Year 4, 13 scouts were trained on Shootback on a pilot basis and given cameras to go and take photos. These scouts will start a pilot program on amateur photography that includes provision of films and notebooks to record interesting activities for scouts and communities. The films will be sent back to USA for development and the best photos will be used for making a scouts calendar for Year 2009. The photos are also used to trigger discussions on HIV prevention, gender issues and care for environment among other scouting activities. Through Shootback, the scouts will record and share their stories on HIV prevention and also take the skills they learned through the newsletter editorial to another level. The best photos will earn a photography badge.

In 2009, SfS will continue to strengthen the capacity of USA to provide HIV prevention information to the scouts through the following activities: A refresher training will be held for all the 2,500 scout leaders to update them on the Activity Packs 5-8. This will be done with support from the national trainers who were trained in Year 4. Even with free primary and secondary education, there are still young people out of school and this leaves them out of the mainstream HIV prevention messages. In Year 5, 300 Rover Scouts will be given orientation on how to reach the out-of-school youth who constitute one of the most vulnerable youth due to the ever-increasing number of AIDS orphans. They will be expected to recruit one female and male patrol each who will be provided with skills and information for HIV prevention. Each trained rover will recruit and manage at least two patrols – one of boys and the other for girls. A module for HIV prevention and other topics such as drug and substance abuse will be developed for use by rover scouts to assist them in working with out-of-school youth. The project will deliberately target schools among the Internally Displaced Persons (IDPs) populations in the north which are accommodating children from displaced families. The teachers from these schools will be trained on counseling, HIV prevention, the negative impact of teenage pregnancy. Advocacy activities will include working with parents and guardians and provision of orientation workshops for head teachers and education officers to be more supportive of project activities and also support policies that allow teenage mothers to go back to school. The Parliamentary Scouts Committee will also be used as advocates to facilitate SfS in achieving its objectives. Sexual violence and

**Activity Narrative:** abuse against women and girls have been shown to be a major driver of the epidemic so the project will continue to promote of gender in scouting as a way of making men and boys more gender sensitive and also recruit more female scout leaders and girl scouts. The policy on prevention of Sexual Harassment and Abuse among scouts will be disseminated together with the gender advocacy toolkit to all stakeholders to support protection of the girl-child. Sharing of information and lessons learnt with other ABY partners will be done by sharing meetings which will be held bi-annually. Project Leadership Group comprising of PATH country Director, SfS project director, National Executive Commissioners of KSA and USA and the Chief Commissioners of Kenya and Uganda will meet twice in the year to ensure adherence to project goals and objectives. 2. CONTRIBUTIONS TO OVERALL PROGRAM AREA: During this final year of the project, SfS will continue to put emphasis on providing information and building life skills for scouts to enable them to avoid HIV infection. PATH and its partners consider this an important contribution to HIV prevention in both Uganda and Kenya as experiences have shown prevention is best strategy to beat the HIV epidemic. As scouts move towards adolescence, they are faced with peer pressure and choices of whether to get involved in relationships that might encourage them to be sexually active. The project is equipping them with information and skills which will help them to make healthy choices including whether or not to use a condom. This approach is in line with the PEPFAR program of comprehensive ABC approach to HIV prevention. The project will continue to address gender issues, especially gender-based violence, because of its proven contribution to the spread of HIV among communities in Africa including the two project countries. It is important that scouts are grounded in scouts' principles of respect for self and others so they can start to learn treating women with respect. By working with parents and policy makers, the project will ensure that both boys and girls are in an environment that supports them to make healthy choices without undue pressure. Building the capacity of Scout Associations' to implement and institutionalize HIV prevention in their day-to-day activities is the best strategy towards sustainability of HIV prevention since the epidemic will be with us for a long time while prevention resources cannot be guaranteed. 2. GEOGRAPHICAL COVERAGE: The project is working in 812 sub-counties and 117 counties in 59 districts which are spread in all the four regions of the country. 3. LINKS TO OTHER RESOURCES: The work that PATH is doing through the Scouting for Solutions project has attracted the attention of policy makers such as Members of Parliament. With support from USA, the MPs are setting up a caucus of Scout Members of Parliament who will constitute an important avenue for lobbying resources from the government to support HIV prevention in schools. In some districts, the visibility given to scouting through the SfS project has generated support to scouting activities from Chief Administrative Officers and Education Officers. In some districts, local councils have given scouts land for camping or office space in government offices. These efforts to leverage other resources will continue in Year 5. 4. POPULATIONS BEING TARGETED The primary target of SfS project is male and female adolescents aged 12 to 15 who are involved in the scouting movement, their teachers in primary and secondary schools, and community leaders and volunteers in the rural and urban areas. Other target audiences include parents, guardians, and policy makers 5. KEY LEGISLATIVE ISSUES ADDRESSED The Sexual Harassment and Abuse prevention policy will contribute to the work going on under the domestic violence bill by localizing efforts to operationalise the bill. The project will also contribute towards effort to allow teenage mothers to return to school. 6. STAFF SUPPORTED BY PEPFAR: To strengthen institutional capacity of USA, the project supports keys personnel responsible for project implementation. These include a BCC Officer, the M&E Officer and the Data Management Officer, the driver for the project vehicle and the security guard. In addition, the project supports part of the National Executive Commissioner's time (30%), accountant (40%) and Admin Officer's time (40%) to ensure projects reports are maintained according to donor requirements. In addition, the SfS project support office running costs as part of institutional support (\$1,136 per month).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14238

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14238	4388.08	U.S. Agency for International Development	Program for Appropriate Technology in Health	6748	1061.08	Scouting for Solutions (PATH ABY Track 1)	\$705,000
8448	4388.07	U.S. Agency for International Development	Program for Appropriate Technology in Health	4845	1061.07	AB Track 1/ Round 2	\$1,071,918
4388	4388.06	U.S. Agency for International Development	Program for Appropriate Technology in Health	3336	1061.06	AB Track 1/ Round 2	\$900,806

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7287.09

**Mechanism:** SPEAR

---

**Prime Partner:** World Vision International

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 16271.21805.09

**Planned Funds:** \$100,000

**Activity System ID:** 21805

**Activity Narrative:** Activity Narrative

This activity relates to Palliative care - home-based and Counseling and testing.

Building on the USG public sector programs, this activity is a follow-on to the Education Sector Workplace AIDS Policy Implementation (ESWAPI) that provided support to the education sector that ended in July 2008. The new follow-on program called Supporting Public sector workplaces to Expand Action and Responses against HIV/AIDS (SPEAR) is the USG prime mechanism for leveraging public sector support to increase access to and utilization of HIV/AIDS treatment, prevention and care services to selected sectors that include: ministries of Internal Affairs (MoIA); Local Government (MoLG); and Education and Sports (MoES). The SPEAR program is supporting 3 sectors that have worked with the National HIV/AIDS Program to develop and integrate HIV/AIDS into their work place through operationalization of the new National HIV/AIDS workplace policy. World Vision is the lead implementing agency for the USAID funded-five year program. The SPEAR initiative, which begun in June 2008 aims to achieve three key results:

1. Supporting public sectors have policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees
2. Increasing 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
3. Improving 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

On the overall, ESWAPI which ended in July 2008 trained 630 Behavior Change Agents (BCAs) and reached over 50,000 MoES employees and their dependants with prevention programs over a period of 3 years.

In FY 2009, SPEAR project activities under this program area (Sexual Prevention) will be geared towards increasing personal perception of risk of HIV infection/transmission and utilization of prevention services through aggressive targeted behavior change programs. Activities will include: Conducting sectoral assessments: in the MoIA and MoLG to ascertain the variations in KAP, the variations in risk factors (both behavior and socio-economic), and the most effective channels through which each population segment can be effectively reached. This assessment will be combined with the policy assessment planned for the Ministries of internal Affairs and Ministry of Local Government. The KAP survey will include the communities where some of the target audiences leave e.g. police/prisons barracks and boarder post custom quarters. Developing/adopting targeted behavior change messages: This activity focuses on tapping into locally and internationally available behavior change communication expertise and the using the power of peer influence to change and model public sector employees' behaviors for HIV/AIDS prevention. Led by an international BCC consultant, SPEAR will review ongoing behavior change programs in Uganda and beyond; assess their appropriateness for prevention among adult public sector workers; identify the gaps in terms of messages, dissemination channels; and develop an initial strategy for adopting/adapting/developing targeted behavior change programs (messages, a mix of dissemination channels and performance indicators) for the target ministries/departments. Behavior change messages will seek to increase perception of benefits of safer behaviors compared to the costs of risky behavior. Specifically, messages will target reducing those behaviors that increase risk for HIV transmission such as engaging in casual sex encounters, transactional sex and sex with an HIV-positive partner or whose status is unknown + dealing with concurrent multiple sexual partners. To ensure that target public sectors identify with the behavior change messages communicated, SPEAR will involve the relevant ministries/workplaces in adapting the messages. Facilitating creative communication for behavior change: The project will involve employees and utilize the existing structures in the target line ministries as agents for passing on BCC messages to their colleagues and peers. Specific messages and modes of delivery will be adopted to ensure that the hard to reach and underserved areas are not left out or underserved. Additional messages will be developed for dissemination to police, prisons, schools and guards during their routine parades. Training behavior change agents: SPEAR will work with the respective workplaces to identify and train about 2,500 workers and their families in influencing their peers' self-efficacy and promoting positive behavior change. Developing and executing a multi-dimensional BCC program: Depending on evidence gathered regarding effective BCC channels, SPEAR will develop a BCC campaign that may integrate the use of "affinity groups," small groups discussions, public talks by PHA and experts on HIV/AIDS, public relations (such as radio talk shows and TV panels), posters, media advocacy, and educative entertainment tailored to meet the needs of public sector workplaces. The activities will cover employees in MoIA, MoLG and MoES in all the 81 districts of Uganda. The project will liaise with other ongoing behavior change programs such as by MoH, UAC and AFFORD. About 150,000 public sector workers and their families are targeted for behavior change drive in FY 2009.

Also, 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. Activities will include training 20 individuals in workplace HIV-related policy; and 100 workplace AIDS policy implementation champions to operationalize policy and plans. About, 30 points of operation will be supported with institutional capacity building for workplace HIV/AIDS policy implementation including having costed workplace HIV/AIDS related work plans. About, 50 individuals will be trained in workplace HIV-related community mobilization for prevention, care and/or treatment; and 500 will be trained in HIV-related stigma and discrimination reduction. SPEAR project will support 10 stigma and discrimination (S&D) campaigns/events, to reach / benefit 1,000 people.

These activities will be conducted in the workplaces of the three target ministries i.e. MoES, MoIA and MoLG countrywide, starting from headquarter employees through the districts to the lower levels. SPEAR will support human resource departments and PHA support groups to organize creative events (such as debates, radio seminars, video shows, concerts, testimonies, etc) and Anti- S&D campaigns to highlight dangers of S&D and raise awareness in the respective communities. SPEAR will build the capacity of the three target line ministries to fight workplace related stigma and discrimination engage in policy reforms, financial and program planning for HIV/AIDS interventions in their respective workplaces. Capacity building is essential for enhancing sustainability of HIV/AIDS interventions in the workplaces.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16271

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16271	16271.08	U.S. Agency for International Development	World Vision Uganda	12196	12196.08	Public Sector Work Place Program (ESWAPI)	\$50,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$20,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7274.09

**Mechanism:** SPRING (Stability, Peace and Reconciliation In Northern Uganda)

**Prime Partner:** Emerging Markets

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 15979.21802.09

**Planned Funds:** \$350,000

**Activity System ID:** 21802

**Activity Narrative:** The U.S. Government (USG) and Uganda government are working together to ensure peace and security, good governance, access to social services, economic growth, and humanitarian assistance in northern Uganda. The United States Agency for International Development (USAID) Mission in Uganda intends to support an integrated program to promote peace and stability in northern Uganda. The program will be entitled Stability, Peace and Reconciliation In Northern Uganda (SPRING). In light of recent developments in northern Uganda, including the ongoing peace talks between the Government of Uganda (GoU) and the Lord's Resistance Army (LRA), improved security and the return home of large numbers of internally displaced populations, the new program will contribute to the transition from relief to recovery and development. SPRING will support a core set of activities in three component areas: (1) Peace-building and reconciliation, (2) Economic security and social inclusion, and (3) Access to justice. The PEPFAR AB activity in FY08 promotes the third component – access to justice. This activity leverages USAID/Uganda's Democracy and Governance activities.

As people return to their homes after years of displacement in northern Uganda, vulnerable populations (including women, youth, children and child-headed households) will be most impacted; access to land and resources are key to ensuring economic security. When vulnerable groups have no access to land and other resources, there is an increased likelihood of HIV infection as they become reliant on males for survival and are therefore more vulnerable to high-risk activity such as transactional sex, and sexual violence.

According to recent studies, 56% of Uganda's population is under the age of 15. By 2050 the population is expected to quadruple to 93 million. Northern Uganda's children (age 0-17) and youth (age 18-24) constitute a significant group which is in need of education, economic opportunities and social services to prevent their having to resort to high-risk sex or other risky coping mechanisms. Without these support systems in place and other positive motivation, restless and war-affected young people will become a major source of instability and vulnerability to HIV/AIDS in Uganda. Conversely, this youth cohort can become a powerful force for stability and peace if they are supported and their energies are channeled constructively. It is critical that young people living in and returning from IDP camps are integrated socially and economically into their host communities and are given opportunities to become productive members of society with a stake in the future.

SPRING will support activities that promote non-violent decision-making and constructive social and economic participation. SPRING will work with young people most at-risk for marginalization, HIV/AIDS or recruitment into destructive activities and through proactive outreach, will engage people constructively. This project will link with and complement the SPRING OVC and Policy activities. SPRING will include HIV/AIDS components (prevention, education, OVC, and advocacy support for HIV/AIDS-affected families and individuals) as part of its overall strategy to promote equity and economic growth for HIV vulnerable women and youth. Specifically for HIV prevention, SPRING will target young people aged 10 -24, both in school and out of school. Broadly Sexual Prevention AB related activities will include : Support to youth centers that provide multiple services to communities such as education and training opportunities, and social services; Provision of abstinence, faithfulness and behavior change information and services for youth, including linkages with HIV/AIDS voluntary counseling and testing; Interventions to specifically address the vulnerability factors of specific categories of youth such as young people involved in transactional or cross-generational sexual relationships, and young people living with HIV; Interventions to address social norms among youth, including harmful gender norms and practices.

SPRING is in the process of identifying a sub partner to roll out the sexual prevention related activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15979

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15979	15979.08	U.S. Agency for International Development	Emerging Markets	7274	7274.08	SPRING (Stability, Peace and Reconciliation In Northern Uganda)	\$350,000

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Refugees/Internally Displaced Persons

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 8775.21724.09

**Activity System ID:** 21724

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$500,000

**Activity Narrative:** This activity also relates to Counseling and Testing, Prevention Of Mother To Child Transmission, Adult Care and Treatment, Strategic Information and Health Policy Analysis Systems and Strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning. This activity is a continuation from FY 2008.

In FY 2008 NUMAT reached an estimated 198,497 people with HIV prevention messages through promoting positive social norms and healthy sexual behaviors such as abstaining from sex till marriage and being faithful to one faithful partner, correct and consistent condom use, as well as issues related to stigma and discrimination, and sexual and gender based violence. Approximately 68,185 youth were reached with abstinence only messages, 136,345 were reached with AB messages and 62,150 were reached with other prevention messages. NUMAT strengthened the capacity of the 9 Youth Advisory Groups. A total of 87 master trainers were trained to facilitate the roll-out of HIV prevention activities among the youth both in and out of school. These master trainers trained 728 peer educators and provided them with monthly supportive supervision which included discussions on their experiences, lessons learnt and data collection on the number of people reached by prevention messages. Using a variety of tested approaches, messages on abstinence, delayed sexual debut, faithfulness and condom use were relayed to and promoted among both in school and out of school youth by the peer educators. NUMAT trained 480 religious and cultural leaders on issues of HIV/AIDS response and on Stigma and discrimination reduction. These leaders reached an estimated 37,000 people with AB messages as well as issues related to stigma and discrimination of People living with HIV. NUMAT trained and provided follow up support to over 690 community resource persons (animators) on SGBV and its link to HIV transmission. The animators in turn sensitized the community in camps and in the return sites on gender, sexual and reproductive health rights. They also helped in reporting and referring SGBV cases for immediate medical and legal support. Over 35,984 people were reached by NUMAT's supported SGBV activities.

Working with local CSOs, women's groups and the uniformed forces including the UPDF, Prisons and Police, behaviour change agents trained the previous financial year increased the demand of condoms and reduced high risk behaviors among an estimated 1,826 adults and most at risk populations. The BCAs sensitized their peers and community members and referred them to other HIV services like HCT, PMTCT ART, HBC and other economic empowerment activities (including Village Saving and Loans Associations).

In FY 2009, NUMAT will support activities that build on those achieved from FY 2008. These will include the following:

#### ACTIVITY UNCHANGED FROM FY 2008

- Facilitating the establishment of youth and parental committees that will strengthen community dialogues between the youth and adults about issues affecting young people such as improving parent-child communication on HIV and sexuality.
- Supporting families and communities to build skills that promote sexual norms and behaviors, working on issues related to Stigma and discrimination and Gender Based Violence by promoting family life education and addressing other gender issues;
- Engaging community leaders, uniformed services and the police including community security guards in programs to reduce SGBV; prevent HIV and empower communities to promote societal norms that reduce the risk of HIV transmission and promote the use and access to condoms and HIV counseling and testing services.
- NUMAT will work with the district GBV working group and other stakeholders to map SGBV services and actors, and also to undertake a Community KAP assessment which will help inform the IEC SGBV strategy.
- Supporting media campaigns that reinforce and make abstinence, fidelity, partner reduction, HIV counseling and testing, and other safer behaviors legitimate options and standards of behavior for both youth and adults; For example, Supporting IEC/BCC activities that promote positive behaviors for the prevention of HIV infection, TB and malaria. Of particular interest will be messages regarding alcohol consumption and risk taking behaviors.
- Carrying out campaigns to sensitize the community about HIV prevention, stigma and discrimination as well as sexual and gender based violence
- With the mobilization of FBOs for prevention (primarily abstinence/faithfulness) activities using the Channels of Hope methodology, NUMAT will support activities that emphasis reduction of stigma and discrimination among PHAs, abstinence, fidelity, partner reduction, HIV counseling and testing, and other positive social norms for both youth and adults
- NUMAT will continue supporting youth-led community programs to help youth, their parents, and the broader community, personalize the risk associated with early sexual activity, sex outside of marriage, multiple partnerships, and cross-generational and transactional sex.
- NUMAT will also continue supporting the review, revision and adaptation of other curricula, interactive materials, radio programmes and toolkits available in the country to make them suitable for the districts in Acholi and Lango regions. HIV prevention messages will be linked to health centers and CSO that provide HCT, reproductive health and condom services in addition to vocational training and economic empowerment activities.
- NUMAT will continue working with NGOs and CSO, as well as the UPDF to increase demand for condoms. Targeted messages for most at risk groups will be developed, as well as determining best locations and distribution points for condoms. The project will also continue working with PHA groups to integrate condom messages and distribution into ongoing service provision activities.
- NUMAT will also support other prevention efforts like syndromic management of STIs which will be integrated in all other areas. This will include integrated training of health workers in management of STI and HIV/AIDS, supporting logistics for STI drugs including procurement of STI drugs should situations of stock outs occur. Supporting integrated support supervision of STI with HIV/AIDS activities as well as linking



**Activity Narrative:** STI clients to HCT within their treatment areas and through referral from lower units.  
 • Instead of rolling out PIASCY as initially planned in FY 2008 this ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:  
 • NUMAT will use the Adventures Unlimited, Choose Freedom and YEAH Campaign Curricula to compliment the PIASCY program that will be rolled out by the UNITY project in the region. NUMAT will train teachers, youth leaders, peer educators and mentors identified through the community, schools and youth groups. These curricula will equip youth with “value-based life skills” to enable them make informed choices and avoid risky behaviour.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15468

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15468	8775.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$800,000
8775	8775.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASCY Primary; TASO; AIC; Conflict	\$550,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$60,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

---

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 4685.21711.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21711

**Activity Narrative:** Currently, Uganda is experiencing a mature and generalized HIV/AIDS epidemic with a high prevalence rate of 6.4%. The 2006 National Sero-Behavioral Survey showed an increase in multiple concurrent partnerships and a close relationship between the number of sexual partners and the risk to HIV infection. In addition, the survey also showed a rise in the age of initiation of sex. The survey further indicates that 42% of the new infections occurred among individuals who were either married or co-habiting. These findings signal and further reaffirm the need to intensify abstinence and being faithful programs within the overall national HIV prevention agenda.

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 two years, IRCU has implemented a variety of HIV prevention interventions focusing on promotion of abstinence and faithfulness through sixteen community based faith-based organizations. Working through the heads of the main religious institutions in Uganda, HIV/AIDS prevention messages have been integrated into sermons and other religious teachings across the country. As of March 2008, prevention activities had covered 47,794 adults (17,684 males and 30,110 females) with interventions focusing on faithfulness, and 87,632 youth (32,424 males and 55,208 females) with abstinence only interventions. Pre-marital counselling has also been revamped and religious leaders have been trained and equipped with more HIV/AIDS skills to offer HIV prevention counselling. A total of 3,124 individuals were trained in activities that promote abstinence and/or being faithful.

USAID/Uganda's partnership with IRCU ends in June 2009. USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU. Using context appropriate and innovative strategies, the follow-on program will aim to further expand prevention activities among the youth. Special focus will also be put on reaching the adult population with the ultimate aim of promoting mutual faithfulness and reducing concurrent sexual partnerships.

Youth in school shall be reached through their school environments by working through the school administration including head teachers, teachers, School Management Committees (SMC) and Parents Teachers Associations (PTA). The aim will be to create a supportive environment in the schools that allows children to access age appropriate information on health, HIV/AIDS and sexuality. The program will train senior male/female teachers and school nurses in basic HIV and AIDS communication and encouraged pupils to seek support/advice from them. The program will further empower schools 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.

The program will facilitate schools to encourage pupils and students to identify role models either from their community or from elsewhere who they adore and along whose life they would like to model their own. The proposed models shall then be discussed with pupils to ensure that their life history, regardless of their current economic status, is consistent with the aim of promoting a healthy and responsible life. Where possible, the chosen models shall be invited to talk to pupils about the need to protect themselves against HIV/AIDS, as well as the importance of goal and vision setting. Where possible, the program will facilitate schools to identify an adolescent mother/father or a young positive, willing to share their experience to come and talk to the pupils.

The program will also facilitate health workers within the vicinity of the schools to come and give health education to the pupils/students. Besides giving them an opportunity to ask questions on HIV/AIDS or any other health related issues, the rapport created with health workers will create confidence that will enable pupils/students to continually seek information from the health units at individual levels.

The follow-on program will be required to use innovative strategies to reach youth out of school, predominantly absorbed into the informal sector. Targeted messages and segregation of target audiences will be required since the target group consists of a mixture of those sexually active but not yet married, those not yet sexually active as well as those married and/or cohabiting in long term relationships.

The IRCU follow on program will be required to harness the existing religious structures and institutions that have historically been forums for discussing and addressing marital and other social development issues. Examples include Mothers/Fathers Union, Women Catholic Guild, and the Muslim Women League. Weekly meetings are held by these institutions throughout the religious structures and various topics are discussed. Individuals with problems are 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. Where necessary, the structures will be facilitated to mobilize more members in the community in order to expand attendance and hence coverage. Similar structures exist for the youth and they include the Young Christian Society (YCS), Legion of Mary, Military Chaplains, Girl and Boy Scouts, Girls and Boys Brigade, all providing avenues for reaching the youth.

The follow on program will continue to build the capacity of religious leaders at community level to enable them deliver accurate HIV/AIDS information and integrate HIV preventions in their routine clerical duties.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14206

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14206	4685.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$500,000
8426	4685.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$500,000
4685	4685.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$500,000

### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development ██████████

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 690.09	<b>Mechanism:</b> N/A
<b>Prime Partner:</b> US Department of Defense	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 18548.21594.09	<b>Planned Funds:</b> \$50,000
<b>Activity System ID:</b> 21594	

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members.

The UPDF Prevention program utilizes the post test clubs as one of the cornerstones for prevention strategies. Formed mainly from persons who have tested positive, the clubs are open to all military personnel, their families, and the people from the surrounding community who has tested for HIV. The clubs are also seen as an important link for care and treatment services and for follow-up for psychosocial support. Another common practice which has been highly effective for the commanders to reach through to the troops, has been the use of military parades, to pass on information using open discussions with disclosure by the PTC members. Activities include training of trainers to have 'focal points' of peer educators within these PTCs, expanding the peer education program to include an emphasis on gender issues, family planning, challenging male norms, and addressing stigma and discrimination and ARV adherence. Distribution of condoms from the Ministry of Health has been extended to 12 centers, which will continue to be a focus of prevention activities.

Progress to Date - During FY 08, the cadre of peer educators within the PTCs associated with each of the 13 VCTs was expanded, with a concomitant increase in the HIV Prevention activities of awareness, abstinence and being faithful, and delaying of sexual debut, and pre and post test counseling. An area of emphasis with VCT counselors has been to encourage disclosure to the spouses of HIV positive soldiers. Outreach has been extended through a mobile film van which travels to the UPDF units around the country and incorporates peer education, C & T, sensitization, and condom distribution.

Planned Activities for FY09 - ACTIVITY UNCHANGED FROM FY2008. There will be linkages between the other Prevention activities of Counseling and Testing and Male Circumcision.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18548

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18548	18548.08	Department of Defense	US Department of Defense	7336	690.08		\$50,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9326.09

**Mechanism:** Monitoring and Evaluation Agent/Civil Society Fund

**Prime Partner:** Chemonics International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 21478.21584.09

**Planned Funds:** \$225,000

**Activity System ID:** 21584

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities; with another 90 expected to be awarded at the end of FY 2008 in both the areas of prevention and OVC service delivery. The monitoring and evaluation component of the CSF will function similar to the MEEPP project for the USG PEPFAR program in Uganda and will help the CSF grantees to set reasonable targets and report on their progress. The participating development partners, UNAIDS and the Uganda AIDS Commission are currently mapping out the best way to manage and support this M&E function under the new national M&E plan but it is anticipated that these results will feed into the larger information system at the Uganda AIDS Commission. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Tracking the impact of HIV programs remains a challenge within civil society and resources will continue to be used to provide capacity building support to CSOs competitively selected to receive grants. Upon award in FY08, the Monitoring and Evaluation Agent will immediately be responsible for measuring the impact of the CSF through monitoring the 200+ grantees performances, and improving the capacity of these grantees to collect better data and use such data for future decision-making. These activities will not change in FY09. The requested resources will be used to support a portion of the management fees (along with funding from other key program areas such as Sexual Prevention and OVC) for the Monitoring and Evaluation Agent, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Technical and Financial Management Agents, in addition to providing technical support to the Steering Committee. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the M&E component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21478

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21478	21478.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$600,000

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9221.09	<b>Mechanism:</b> STAR-EC
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 21145.21574.09	<b>Planned Funds:</b> \$183,333
<b>Activity System ID:</b> 21574	

**Activity Narrative:** This activity relates to PMTCT, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – East - Central will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project will cover six districts of Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba.

AB

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiplicity of partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity, reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Other Sexual Prevention:

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly refereed to as 'Boda boda in Uganda), discordant couples, fishermen and the communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions
- Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'
- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.



- Activity Narrative:**
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.
  - Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).
  - Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.
  - Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechansim**

**Mechanism ID:** 6181.09

**Mechanism:** Financial Management Agent/  
Civil Society Fund (FMA/CSF)

**Prime Partner:** Deloitte Touche Tohmatsu

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

Activity System ID: 21745

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities, with another 90 expected to be awarded at the end of FY 2008. The target of this granting mechanism is to ensure that Uganda's youth have access to age and risk appropriate abstinence, faithfulness and behavior change information and services. Prevention resources also assist the national response in appropriately addressing the shifting nature of the epidemic, expanding attention to faithfulness and partner reduction initiatives among married and cohabitating couples. In addition, resources specifically address the vulnerability factors of key categories of youth such as young people involved in transactional or cross-generational sexual relationships, young people living with HIV and address 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, poverty and economic security vulnerabilities, and gender discrimination issues that make youth, and in particular young girls, at increased risk of exposure will be highlighted.

Further solicitations are to be issued in FY 2009 to ensure a wide geographical reach, especially targeting mutually identified underserved areas such as districts in the West Nile and Karamojong regions. It is anticipated that a total of 168,750 men and 206,250 women will be reached with prevention messages and activities by the end of FY 2009. Grants will also be given to NGOs serving as lead agencies to ensure that smaller, local grantees have access to CSF funding. Further support will be provided through Chief Administrative Officers in the district local governments who will be engaged in ensuring that effective mapping and support to the grantees is provided.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15991

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15991	15991.08	U.S. Agency for International Development	Deloitte Touche Tohmatsu	6733	6181.08	Financial Management Agent/ Civil Society Fund (FMA/CSF)	\$1,027,466

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9220.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 21143.21568.09

**Activity System ID:** 21568

**Mechanism:** TBD - HCT/AIC Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** ██████████

**Activity Narrative:** This activity is an on-going program related to the CSF/Deloitte and Touche Sexual Prevention AB and OP program that was approved in COP 08 that is to be implemented by a national indigenous organization contributing towards the national goal of scaling up HIV counselling and testing services in Uganda. The goal of this program is to support the MOH, districts, private sector; and Community based Organizations (CBOs)/ Non-governmental organizations (NGOs) by enabling young people and adult's access appropriate information and services. The HIV sexual prevention services will be provided as an integral component of HCT services at the Regional HCT Centers of Excellence, public, private, and CBO/NGO/FBO HCT sites. This program will cover all Regional referral hospitals, all District hospitals, all private hospitals, and all health centers up to H/C II sites that are not covered by the USAID funded District based program and other PEPFRAR HCT implementing partners. In addition, 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 Regional HCT Centers of Excellence will be a focus 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 10-14); those aged 15+ should get comprehensive HIV/AIDS information including information regarding condoms) and OP will focus on n 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.

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.

Linkages to care, treatment and support services for HIV-infected clients and their families will be strengthened at all levels of the health system. Persons living with HIV/AIDS (PHA) networks, youth friendly services, couple HCT services and post-test clubs will be enhanced to strengthen referral linkages to care, treatment, and support. Activities supporting couple clubs will include providing training in key communication skills, prevention of gender-based violence among couples and promotion of disclosure. These couple clubs will continue to be a vessel in mobilization and promotion of HCT uptake by their fellow couples and promotion of faithfulness.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21143

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21143	21143.08	U.S. Agency for International Development	To Be Determined	9220	9220.08	TBD/HCT	

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Military Populations

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 1222.09

**Prime Partner:** US Peace Corps

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 3999.21609.09

**Activity System ID:** 21609

**Mechanism:** Peace Corps

**USG Agency:** Peace Corps

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$321,600

**Activity Narrative:** The Peace Corps Uganda Emergency Plan program supports the USG Strategy of the Emergency Plan (the EP) for Uganda. By supporting the EP Strategy Peace Corps Uganda contributes to the Uganda National Strategic Plan (NSP) for HIV/AIDS, and, in turn, to the goals and objectives of our partner organizations which are hosting Volunteers. The program is designed so that Volunteers are closely engaged with a community through one or more hosting organizations, providing technical assistance for capacity building, and developing close personal relationships necessary for effective innovation in underserved areas. The EP allows Peace Corps Uganda to strengthen community and Volunteer HIV/AIDS expertise and service delivery, and to support highly focused community organizations in a variety of HIV/AIDS functions.

Peace Corps Uganda has been involved with PEPFAR activities since its inception in Uganda in FY04. From FY 2006 to date, 55 PEPFAR-funded two year Volunteers, have been added to Peace Corps Uganda's portfolio and placed with prevention and care programs. Through these Volunteers and ongoing training and small project support activities, Peace Corps was able to strengthen community and Volunteer HIV/AIDS expertise and support HIV/AIDS-focused community organizations to enhance their organizational capacity and implement a variety of HIV/AIDS prevention and care interventions. From FY 2007 to date, Peace Corps Volunteers have reached 10605 with Abstinence Only messages, 56655 individuals with sexual prevention AB and other prevention messages, trained 1582 service providers and assisted 171 services outlets through organizational development support and training. Currently, a group of 25 PEPFAR- funded two year community health trainees are undergoing pre-service training and will be deployed at the end of October. In all assignments, Volunteers are prepared through pre-service training to encourage their partner organizations to either; 1) incorporate a full range of prevention, care, and treatment services, or 2) to actively seek out and use local referral opportunities to ensure all individuals and families receive necessary services. This commitment reflects and supports the emphasis on the Ugandan Network Model, described in the USG 5-Year Strategy

In FY 2009, Peace Corps will continue to support and strengthen abstinence and being faithful activities to reach a total of 6500 individuals (3000 males and 3500 females) targeting in-school and out-of-school youth, along with highly targeted "being faithful" messages for married individuals designed in collaboration with FBO partners in particular. This target includes a total of 2800 individuals (1200 Males & 1600 Females) that will be reached with Abstinence Only messages mainly through our school based abstinence program. Under this program area, 16 two year and 12 short term (Peace Corps Response) Volunteers will be recruited and placed with organizations focusing on prevention for youth and adults. Volunteers and their counterparts will carry out campaigns to sensitize the general population about HIV prevention using information, education and communication messages that aim at creating an enabling environment for married partners to reduce sexual partners and remain faithful to each other. In FY 2010, we propose to reach 4200 individuals with AB programming with special emphasis on the drivers of the epidemic identified in the 2005/2006 Uganda National Sero- Behavioral survey. Peace Corps Volunteers will work with other USG partners to continue the roll-out of the PIASCY program to post primary level. Peace Corps Volunteers will continue to promote and support the establishment of school-based health/ant-HIV/AIDS clubs aimed at creating a friendly and safe environment for students to discuss myth and facts about HIV/AIDS with guidance from their teachers and school counselors. Volunteers will disseminate age appropriate information and activities for this target population – beginning with life skills and self-esteem development for younger age groups and moving to more specific HIV/AIDS messages and youth empowerment for older youth from 15 to 24 years of age. Volunteers and their Counterparts will continue to support the roll-out of PIASCY activities to schools in their work areas and through their affiliation with primary teacher colleges and coordinating centers and the work these institutions do to provide in-service teacher training, promote school clubs, support educational materials development and advance linkages with other community organizations.

In FY 2009, Peace Corps will scale up sexual prevention OP activities by placing more Volunteers with prevention focused organizations to reach many most-at risk populations in hard to reach and under served areas. In FY 2009, 25000 (12000 males & 13000 females) individuals will be reached and 36000 (22000 males & 14000 females) in 2010 with HVOP programming. The activities will include information dissemination through various channels; education and appropriate communication on reproductive health issues; sexually transmitted infections management; information about dangers of multiple relationships especially among the married couples, education about condoms and usage; and other related areas that support HIV prevention. These activities will target vulnerable groups, specific at-risk populations, and community members at large through activities implemented by Volunteers and their Counterparts. Promotion of Counseling and Testing and Prevention of Mother to Child Transmission (PMTCT) for prevention purposes will also be encouraged. Community members will be encouraged to be tested for HIV, hence further preventing transmission. HIV-positive pregnant mothers will be better equipped to prevent transmission of HIV to their babies. In addition, Volunteers and Counterparts will be supported to develop various behavior change promotion materials to support this program area. At post primary level, Peace Corps secondary school based Volunteers will play a major in rolling out the PIASCY program to ensure that students have access to information about comprehensive HIV/AIDS prevention.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15231

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15231	3999.08	Peace Corps	US Peace Corps	7091	1222.08	Peace Corps	\$221,600
8398	3999.07	Peace Corps	US Peace Corps	4823	1222.07	Peace Corps	\$84,300
3999	3999.06	Peace Corps	US Peace Corps	3162	1222.06	Peace Corps	\$114,900

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1059.09	<b>Mechanism:</b> Affirming Life, Avoiding Risk (CRS ABY Track 1)
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 4029.21751.09	<b>Planned Funds:</b> \$295,406
<b>Activity System ID:</b> 21751	

**Activity Narrative:** Catholic Relief Services' (CRS') "Avoiding Risk, Affirming Life" is a five year PEPFAR funded program working with a broad range of faith- and community-based partners that share CRS' commitment to equip youth and young adults with the values, attitudes, skills, and support to abstain from sex prior to marriage, adopt secondary abstinence, and remain faithful in marriage. The goal of this project is to reduce the HIV/AIDS prevalence among youth and young adults in Uganda, Ethiopia and Rwanda. Through partnership with faith- and other community-based organizations, this program will continue to mobilize the Catholic Church at all levels, as well as community-based organizations such as local anti-AIDS clubs, Mothers and Fathers' union groups and small Christian communities. The multilevel mobilization within the Catholic Church structure will allow for a national scale-up of effective, local responses to the challenge of HIV/AIDS prevention. In Uganda the program is implemented primarily in partnership with 6 catholic Dioceses namely: Gulu, Kampala, and Fort portal, Masaka, Mbarara and Kasana Luwero. The co-coordinating body in all the 6 dioceses is the HIV Focal Point Office, an establishment of the Uganda Catholic Secretariat.

In the previous reporting period (Semi annual report FY 08), activities included HIV/AIDS awareness and education( Music, dance and drama, dissemination of IEC materials, Retreats and sensitization talks): Life skills workshops using Education for Life and Faithful house curricula ; debates using In charge methodology; support to youth clubs ; community group discussions using PAPAS methodology; promotion and referrals for VCT and finally capacity building through trainings to increase skills and knowledge for those involved in mobilization of communities. The breakdown of key outputs was as follows; Music, dance and Drama (4,637 Youth reached directly and 46,370 secondary contacts compared to a set target of 4000 direct and 40,000 indirect) Information, Education and Communication materials mainly from Straight Talk foundation and Youth Empowered And Healthy (YEAH ) campaign were disseminated to 10,772 youth directly while 107,720 were reached indirectly compared to a target of 30,000 direct and 300,000 indirect individuals. Retreats were also organized for Anti AIDS club members especially youth reaching out to a total of 730 individuals directly and 3650 indirectly compared to a set target of 600 direct and 3000 indirect individuals. Last, were sensitization and awareness talks with Parish priests, pastoral co-coordinators and other influential members of the church about the Faithful House program with a view of integrating it into the church structures. A total of 370 people were directly reached with this program as compared to 300 planned. Under Life skills building, Faithful house workshops reached 616 people directly and 3080 indirectly compared to a target of 600 people directly and 3000 indirectly; Education for Life for Youth activities reached 534 directly and 2670 indirectly compared to a target of 360 people directly and 1800 indirectly; Education for Life adults activity reached 320 directly and 960 indirectly compared to a target of 288 people directly and 864 indirectly. In charge debating sessions for in-school youth reached 1240 directly and 3720 indirectly compared to a target of 750 directly and 2250 indirectly. Finally PAPAS group discussions for adults reached 744 people directly and 3720 indirectly compared to the target of 300 people directly and 1500 indirectly.

During FY 2009, the program will continue to build life skills for the youth and adults around HIV prevention following the key PEPFAR indicators and the 3 key program strategic objectives as will be elaborated below. The program will reach out to a total of 59220 youth and adults (26,649 males, 32,571 females) with community outreach prevention activities that promote HIV prevention through Abstinence and Be faithful behaviors. The program will also reach out to a total of 58,860 youth alone (32,373 females, 26,487males) with community outreach prevention programs that promote Abstinence alone and finally train a total of 75 people to promote Abstinence and Be faithful behaviors. Looking at a more detailed description following the program strategic objectives;

Strategic objective 1: The objective aims at reducing the risk of HIV infection among youth and adults through the practice of Abstinence, secondary Abstinence and fidelity. The key activity under this object will include promotion of be Faithful behaviors through the Faithful House curriculum for married and cohabiting couples. A total 12 workshops will be organized targeting 360 people directly and 1800 indirectly. Please note that beginning FY 2009 all faithful house activities will be funded using CRS private funds. To increase knowledge and awareness level, the program will continue to disseminate information and educational materials during all outreach activities such as posters and brochures, all focusing on AB . The IEC dissemination activity will reach 58,500 youth in schools and out of school both irrespective of whether they belong to the anti AIDS clubs or not. The youth both in school and those out of school will also be encouraged to join the already existing 15 Anti-AIDS clubs where they can share, learn and support each other to practice abstinence and fidelity. In addition to encouraging youth to join clubs, the program will conduct training in club management for 75 club members. This will ensure effective and efficient running of anti-AIDS clubs thus contributing to program sustainability at grass root level.

Strategic objective 2: To reduce unhealthy sexual behaviors that increase vulnerability to HIV /AIDS such as cross generational sex and sexual exploitation of the high risk groups, the program will continue to build individual life skills for youth especially those in school using In-charge manual.12 In-charge sessions will reach out to a total of 360 youth through out the year.

Strategic objective 3: Indigenous Faith and Community based organizations effectively lead and participate in community discourse, challenge social norms, attitudes, values and behaviors contributing towards HIV/AIDS and implement AB programs. During FY 09, the program will aim at building the capacities of implementing partners to be able to effectively mobilize communities to implement AB activities which skills acquired will be carried on even after program completion. This is going to be implemented first through a series of planning meetings that will involve the following

- Development of the draft sustainability framework defining the functions and roles of the different stakeholders, the necessary skills that need to be enhanced, the different capacities that need to be developed and how they are to be developed at the different stages i.e. Program activity level, organization level, funding level, policy and advocacy level and lastly fundamental competences required. This is an ongoing activity that commenced in FY 2008 and is to be carried on through FY 2009. Organize a meeting with the Head of Programming and Country Representative to share and discuss the draft sustainability framework. This is to be accomplished by October 30th 2008



- Activity Narrative:**
- Organize meeting with the AB diocese partners and representatives from the focal point of the Uganda Catholic Secretariat to discuss the sustainability plan and how best the focal point can come in to fully support the partners to continue with the program implementation including putting together a proposal for joint funding in PEPFAR 2 and other available funding mechanisms. Finally come up with a draft work plan and budget to role out the capacity building plan within the sustainability framework. This is to be held from on the Sept 5th, 2008 during the annual diocesan exposure visit.
  - Develop a Monitoring and Evaluation plan for monitoring progress on achieving the plan's set objectives. This is to be accomplished by October 20th 2008

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14186

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14186	4029.08	U.S. Agency for International Development	Catholic Relief Services	6730	1059.08	Affirming Life, Avoiding Risk (CRS ABY Track 1)	\$299,000
8411	4029.07	U.S. Agency for International Development	Catholic Relief Services	4828	1059.07	AB Track 1/ Round 2	\$220,740
4029	4029.06	U.S. Agency for International Development	Catholic Relief Services	3180	1059.06	AB Track 1/ Round 2	\$245,599

**Emphasis Areas**

- Gender
  - \* Addressing male norms and behaviors
- Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$67,020

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5028.09	<b>Mechanism:</b> HIPS (Health Initiatives in the Private Sector)
<b>Prime Partner:</b> Emerging Markets	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02

**Activity System ID:** 21752

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

In partnership with the private sector, HIPS implements activities to improve accessibility to information and messages on HIV/AIDS at the work place. HIPS has adopted the Uganda Health Marketing Group (UHMG) '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 and STIs at work place settings and in surrounding communities. Messages also target the reduction of high risk behaviors especially among 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 nearly half of those reached are men. At least 1500 male and female peer educators have so far been trained; over 20 health fairs have been held. Through these and other mechanisms, over 100,000 persons have been reached with other sexual prevention messages. Condoms have also been sold to partner companies who distribute these to the company workers, out-growers and surrounding communities.

The activities for FY 2009 include but are not limited to the following:

1. Peer educator training; in FY 2009, HIPS will conduct training of 2000 peer educators to disseminate messages and information aimed at reducing risky behavior and preventing HIV transmission among company workers, out growers, migrant workers and surrounding communities. Participants for these trainings will be company workers, out growers (where they exist) and surrounding community members so as to effectively reach the target population. These peer educators will also act as condom distribution agents to their peers at the work place and in the community. They will also be trained to disseminate information on STI management and prevention. This is anticipated to result in sexual prevention through condom use. This activity will be conducted among all HIPS partner companies across the country. Focus will also be placed on fighting stigma and discrimination, promotion of messages on positive prevention, promotion of adherence to ART, home-based care and VCT. HIPS will employ a training of trainers (TOT) model to increase the number of peer educator trainers, to include members of Straight Talk Foundation, Living Goods, UHMG, and company employees who will add to the HIPS network of trainers, extending HIPS reach.
2. Provide relevant information to both stationary and highly mobile worker populations (migrant workers) such as seasonal workers from sugar and tea estates. Through various health fairs organized in partnership with companies, and with the aid of peer educators, HIPS will provide relevant information to company workers and the neighboring community with health information relating to sexual prevention.
3. Promote consistent use of condoms to avoid the increasing risk of transmitting sexually transmitted diseases. This will involve the purchase and distribution of condoms, and educating target audiences in correct and consistent condom use and other means of HIV prevention. HIPS will support a marketing officer at UHMG to focus on the promotion and sales of health products at HIPS partner companies.
4. Support to private companies to provide prevention programs that benefit employees, dependants and surrounding community. The prevention programs will include focus on problems related to alcohol abuse/consumption and substance abuse.
5. Promotion of responsible behaviors that reduce risks of transmission such as couple counseling and testing, mutual disclosure within established couples, correct and consistent condom use for both the work place setting populations and discordant couples

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14169

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14169	9086.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$200,000
9086	9086.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$150,000

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

#### Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1062.09	<b>Mechanism:</b> Mobilizing, Equipping and Training (MET) (SP ABY Track 1)
<b>Prime Partner:</b> Samaritan's Purse	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 4813.21741.09	<b>Planned Funds:</b> \$1,182,748
<b>Activity System ID:</b> 21741	

**Activity Narrative:** Samaritan's purse is an international faith based organization implementing an ABY program called MET (Mobilizing, Equipping and Training) in Kamwenge district. The Program trains community leaders to influence youth to make healthy life choices that prevent the spread of HIV, with a focus on abstaining from sex outside marriage and faithfulness in marriage. The training involves two workshops and intense follow-up that develops the leaders as they implement abstinence and behavior change focused educational programs for youth, and other interpersonal outreaches that promote positive behavior change. In planning for FY 2009, the Samaritan's purse will focus on increasing accepting attitudes among unmarried youth towards people living with HIV/AIDS (PLHIV) and increasing the practice of secondary abstinence among the never married youth. In FY 2009, Samaritan's purse will expand to Ibanda and Kyenjojo districts.

Since inception, the MET program has reached 87,800 individuals through 3,956 trained community leaders. This is 59% of the 5 year program 147,705 target of individuals reached and 66% of the 6,014 target of trained individuals. The MET program has 10 standard activities which include; 1) Community mobilization, 2) Staff Development, 2.2) Media Promotion, 3) Monitoring and Evaluation, 4) Initial 5-day workshop, 5) Commitment to the initial 5 day work shop, 6.1) Advanced 5-day workshop, 6.2) Community meetings 7) Formation of community based volunteer teams 8) Commitment to the advanced 5 day workshops 10) Final networking meeting

**Activity 1: Community Mobilization (ACTIVITY UNCHANGED FROM FY 2008)**

There are three approaches to community mobilization which will be conducted in FY 2009. These include 15 stakeholders meetings at sub county level, 36 community sensitizations meetings and 36 volunteer selection meetings. The aim of the meetings is to soliciting the stakeholders' support and stake in the program.

**Activity 2:1 Development of the Samaritan's purse MET Program Staff (ACTIVITY UNCHANGED FROM FY 2008)**

In FY 2009, under staff development Samaritan's purse will hold 2 trainings, attend a MET annual meeting and hold monthly staff meetings and two staff retreats.

**Activity 2.2: Media Promotion (ACTIVITY UNCHANGED FROM FY 2008)**

In FY 2009, media promotion will be a major strategy in promoting secondary abstinence and for promoting accepting attitudes. Eighteen radio talk shows on 2 radio stations will be held, 12 shows will be shown in different communities about the effects Sexually transmitted diseases to increase the fear fact for effective behavioral change and Billboard messages will be posted in 10 locations of Kamwenge district.

**Activity 3: Monitoring and Evaluation (ACTIVITY UNCHANGED FROM FY 2008)**

Samaritan's purse will continue to monitor the quality and number of people trained in field to ensure fidelity to activity design. Twice a month, Area Program Supervisors will participate in volunteer selection and training activities. The supervisors will also, 3 times a month, work with mobilizers to ensure fidelity to MET program activities. The MET program mobilizers will also ensure a quality message by following up each youth educator at least 3 times before they complete their commitment. Two Knowledge attitude and practices (KAP) surveys will be carried out in all the six supervisory areas of Kamwenge district using Lot quality assurance sampling techniques. Three focus group discussions and 1 key informant interview will be carried out. These will be used to probe underlying factors of high stigma levels and low practice of secondary abstinence among never married youth.

**Activity 4: Initial Five-Day Workshops: (ACTIVITY UNCHANGED FROM FY 2008)**

Having outreached all the communities of the program target population, trainings will be carried out in districts of Ibanda and Kyenjojo. In FY 2009, MET trainers will spend more time discussing with youth educators the myths and misconception that are exasperating stigma among the unmarried youth.

Basic HIV prevention –sexual, blood, and Mother-to-Child

a. Interactive lessons

b. Emphasis on abstinence, secondary abstinence and faithfulness.

On abstinence,

- Why do never married youth have sex before marriage?
- How can those who have never started be helped to remain abstinent?
- On secondary abstinence
- Why do youth who have ever had sex continue in the practice?
- What risks do they stand?
- How can they be helped to stop and practice secondary abstinence?
- On faithfulness
- Why do married people have extra- marital sex?
- What risks do they stand?
- How can these people be helped to stop and be faithful to their partners?

MET Uganda will conduct 36 trainings teaching a target number 1,332 youth educators in FY 2009. Youth educators who do score less than 80% will be given coaching to improve their knowledge before they outreach youth.

**Activity 5: Commitment from the Initial Five-Day Workshops (ACTIVITY UNCHANGED FROM FY 2008)**

Each participant in the workshops must commit to minimum specific action as part of the selection process. This action includes two interventions: 1) Outreach target of 26,240 youth across Kamwenge district with HIV/AIDS awareness and Abstinence and be faithful messages by 1,360 youth educators. 2) Provide two households with basic care and involve youth in giving this care.

These interventions take place in the three months following the initial workshop. Participants will record the names, ages, genders and marital status of the youth taught, the two youth who accompany them to two vulnerable households, and the ages and genders of the persons receiving home-based care for their reports to the MET staff mentors. The MET staff mentors will perform quality checks by meeting one-on-one

**Activity Narrative:** with each youth educator.

In FY 2009, MET- U will continue to train and give footballs and netballs to sports team leaders. These will continue to attract the >15 youth who do not like attending outreaches with younger youth.

In order to reach more youth in each community where the MET program will be implemented, experience sharing meetings. Youth educators will be supported to implement strategies that maximize youth outreaches and ensure quality programming. These meetings will be held half way the 3 months of fulfillment of the youth educators' commitment. In FY 2009 36 experience sharing meetings will be carried out for the commitment to the initial 5 day work shop.

**Activity 6.1.1 Advanced Five-Day Workshops(ACTIVITY UNCHANGED FROM FY 2008)**

The advanced workshop includes all participants from the first workshop who have completed the first workshop and the commitment to reaching youth with education and involving youth in visiting vulnerable households. The workshops will continue to use the It Takes Courage! a youth character and life skills curriculum with a one-day session on mentoring at risk youth.

36 advanced 5 day workshops will be carried out in FY 2009 by MET-U and 960 youth educators (80 percent of youth educators trained at the initial 5 day work shop) are expected to attend.

**Activity 6.1.2 Advanced 5 day be faithful workshop (ACTIVITY UNCHANGED FROM FY 2008)**

In FY 2009 MET-U will use the One Love faithfulness curriculum to offer specific messages, skill-based lessons and strategies on mutual fidelity and partner reduction for married youth. MET staff will train all youth educators who received It takes courage curriculum training in FY 08. These youth educators will outreach the married youth in their communities with the One Love curriculum.

MET-U trainers will carry out 36 be faithful 5 day workshops targeting 1,080 participants.

**Activity 6.2: Community Meetings (ACTIVITY HAS BEEN MODIFIED BY FACILITATING SCHOOL DEBATES)**

**School debates**

To reach school going youth with secondary abstinence messages, debates will be held in 24 schools. These debates will be held in schools that have active anti-AIDS clubs. SAMARITAN'S PURSE- Mobilizers, CBVT leaders together with anti-AIDS school club leaders will organize school debates where youth can discuss the possibility of practicing primary or secondary abstinence. Because these clubs already exist, they will supplement CBVTs on the sustainability of the program in areas where they exist.

**Conversations on Sexual Abuse and Exploitation with Leaders**

In each community where Samaritan's purse MET staff teams conduct an advanced 5-day workshop, the area program supervisor will host a two to three hour meeting on sexual abuse and exploitation for about 3,600 village leaders including headmasters, elders, church and other religious leaders as well as traditional leaders. The meeting's purpose is to open a dialogue on the sexual abuse and exploitation of children and youth in the community, and identifying other traditions that are harmful to youth and place them at risk for HIV infection. 36 conversations on abuse and exploitation will be conducted in FY 2009

**Community Parents Day Ceremonies**

Being primarily responsible for children's wellbeing, SP-U will continue to partner with parents in FY 2009 to encourage behavioral change among their youth. In 36 communities where Community based volunteer teams will be formed, the members of these teams will host 5,400 parents to a one day conversation on parent-child communication for behavioral change. The implementation of these parents meetings will equip parents with HIV/AIDS and AB knowledge and help them to communicate sexual issues with their children. In FY 2009, Samaritan's purse-U will continue to hold 36 parents' day meetings to boost the program.

**Abstinence Campaigns**

In FY09, Samaritan's purse-U will continue to mobilize youth who have been outreached by MET program educators to initiate community dialogue about secondary abstinence and accepting attitudes towards PHAs.

The youth will march through villages with banners and other items that have secondary abstinence messages. After the marches, youth will gather in public ground to open discussion on primary abstinence and secondary abstinence through debates.

MET- U will organize 12 A campaigns in Kamwenge district and 3000 youth and program volunteers will participate.

**Faithfulness Campaign**

Having discovered that it is effective in increasing risk perception, MET-U will continue hosting married men for 2-3 hour discussion on faithfulness. The discussion will focus on dispelling, respectfully, cultural norms that undermine faithfulness in Kamwenge district. SP-U will use the 'Be a man campaign' curriculum developed by an ABY partner called Young Empowered and Healthy (YEAH) partner.

In FY 2009, 36 faithfulness campaigns will be held targeting 4,320 participants.

**Activity 7: Establishment of Community Based Volunteer Teams (CBVT) (ACTIVITY UNCHANGED FROM FY 2008)**

Youth Educators who would have completed the two trainings, will be encouraged to form a team promoting their work and for the sustainability of ABY programming in their communities. CBVT leaders will assist fellow participants in fulfilling these commitments, and will compile information about the youth reached into reports. A toolkit for CBVT that includes training in administration for civil society organizations and specific help for developing AB focused activities in has been developed by Samaritan's purse-USA. All formed teams will be trained.

They will have the continued opportunity to receive additional training opportunities, including, but not limited to, participation in other workshops and any other MOH or NGO trainings in the area.

In FY 2009, 36 new CBVTs will be formed and 108 leaders will be selected to lead them.

**Activity 8: Commitment from the Advanced Workshop (ACTIVITY UNCHANGED FROM FY 2008)**

**Activity Narrative:** Participants in the advanced workshop will teach a total of 26,240 youth in Kamwenge district with the 16 character and life-skill lessons from It Takes Courage! Youth educators will teach this curriculum to the same youth groups they reached with the initial training curriculum.

The youth educators outreaching married youth will commit themselves to teaching the complete One Love curriculum.

Activity 9: Networking and follow up meetings with the trainees and community based volunteer teams (ACTIVITY UNCHANGED FROM FY 2008)

Six months following the advanced workshop, CBVT will host a meeting in the village of their trainee peers, bringing together some district level leaders to recognize their volunteerism, as well as Samaritan's purse senior staff. In this meeting, CBVTs and other participants will share success stories, identify obstacles to reaching the goals of their commitments, and discuss ways to link interventions with existing or future HIV/AIDS programs, give feedback, and find ways for sustainability of behavior change programs for youth at the village level. It is expected in FY2009 that 36 networking meetings will be held in all the supervisory areas of Kamwenge with 2,160 people attending.

Activity 10: Final Meeting with Participants, CBVTs, and District Level Leaders (ACTIVITY UNCHANGED FROM FY 2008)

Approximately nine months after the advanced workshop, a second meeting between CBVTs, participants, district level church, and government leaders will be held. Community based volunteer team members will be rewarded for their service and charged to continue their efforts to abstinence and faithfulness and other healthy behavior change among youth in their community. Forty two final meetings will be held in FY2009 with an attendance of 4,200 participants.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14241

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14241	4813.08	U.S. Agency for International Development	Samaritan's Purse	6751	1062.08	Mobilizing, Equipping and Training (MET) (SP ABY Track 1)	\$824,107
8450	4813.07	U.S. Agency for International Development	Samaritan's Purse	4847	1062.07	Track 1, Round 2 AB	\$588,833
4813	4813.06	U.S. Agency for International Development	Samaritan's Purse	3480	1062.06	Track 1, Round 2 AB	\$527,037

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$38,200

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 1258.09

**Prime Partner:** Family Health International

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 9169.21759.09

**Activity System ID:** 21759

**Mechanism:** Roads to a Healthy Future/ROADS II-SafeTStop Project

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$300,000

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these three sites, Busia, Malaba and Katuna truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. HIV services in the sites have historically been underdeveloped. While sexual prevention programming has had significant impact, it can still be scaled up to reach more truck drivers, community men and women, and out-of-school youth. Programming through ROADS is addressing critical drivers of the HIV epidemic in Busia, Malaba and Katuna, including joblessness and the absence of recreation beyond drinking. Yet there is still a high level of hazardous alcohol consumption in the community and alarming levels of gender-based exploitation and violence against women, young girls and boys.

Since launching SafeTStop in Busia, Malaba and Katuna, ROADS has reached more than 206,000 people with sexual prevention programming (January 2006-March 2008). This has been accomplished in partnership with more than 70 community-based organizations, which were organized into "clusters" for joint program planning, training/capacity building and implementation. Through June 2008, ROADS has trained 2,743 individuals in the three sites. Activities have included peer education and counseling, magnet theatre, and condom promotion and distribution. Target audiences have included truck drivers, community men and women, in- and out-of-school youth, and commercial sex workers. Venues have included SafeTStop Resource Centers, private drug shops/pharmacies, health facilities, faith-base organizations, and private businesses, including lodges, guesthouses and petrol stations (through the Energy Institute of Uganda). ROADS distributed more than 110,000 condoms through 50 outlets during October 1, 2007-March 31, 2008 alone.

In FY 2009, ROADS will strengthen ongoing sexual prevention programming in the three existing sites to reach 130,000 individuals (66,300 females and 63,700 males) with HVAB programming and 130,000 (66,300 females and 63,700 males) with HVOP, training 3,000 people to deliver HVAB and HVOP messages. In FY 2010, we propose to reach 149,500 (76,245 females and 73,255 males) with HVAB programming and 149,500 (76,245 females and 73,255 males) with HVOP, training 3,000 (refresher and replacement) to deliver HVAB and HVOP messages. There will be special emphasis on prevention among discordant couples. ROADS will integrate with existing services, where possible, as a priority. This will include linking HVAB and HVOP activities with such services as C&T, ART, PMTCT and existing efforts to promote and distribute condoms. Importantly, we will harness our community structures to promote messages relating to FP/RH, malaria (barriers to use of ITNs), and child survival (promotion of immunization, etc). In Busia, Malaba and Katuna, ROADS will mobilize the private sector, especially brothel/bar/guest house owners, and promote joint action to reduce risk for bargirls and patrons. This will include work with the AFFORD Project and other PEPFAR partners to provide condoms through 110 outlets in FY 2009 and 135 outlets in FY 2010. To enhance the community education effort, local pharmacists/drug shop providers will receive expanded training in managing STIs, condom promotion and referral for C&T. ROADS will continue to utilize the SafeTStop resource centers as a central focus for community outreach, offering C&T at regular times convenient for MARPs, 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. The project will continue strengthening linkages with local health facilities, including pharmacy/drug shop providers to promote expanded C&T and other services for truck drivers, sex workers, other community men and women, and sexually active youth. With FY 2009 funds, we will continue to address joblessness among women and youth (through the LifeWorks Partnership), alcohol abuse, and gender-based violence as key HIV prevention and care strategies. This will include addressing male norms that impact women's access to services, legal protection for women and youth, post-rape services, and legal and law enforcement services. The project will also expand food/nutrition support to enhance HIV prevention, care and treatment. With FY 2009 funds, ROADS will introduce an innovative MP4 device with HVAB and HVOP content for use by drivers on the road and discussion groups where they stop. SUSTAINABILITY: Almost all partners on the project are local entities that exist without external funding. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project were established without outside assistance and will continue functioning over the long term. Local businesses, traders, market sellers, etc. are also part of the fabric of community life and will be present over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

EXPANSION SITES: Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DRC; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. Because Kasese and Koboko are growing rapidly it would be most cost-effective to intervene early with prevention programming. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.



**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14192

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14192	9169.08	U.S. Agency for International Development	Family Health International	6736	1258.08	ROADS - SafeTstop Project	\$300,000
9169	9169.07	U.S. Agency for International Development	Family Health International	4833	1258.07	Northern Corridor Program/Uganda Section	\$250,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$25,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$110,000

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 9320.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Mechanism:** Community-based Care and Support/TASO Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: AB

Budget Code: HVAB

Program Budget Code: 02

Activity ID: 21457.21767.09

Planned Funds: [REDACTED]

Activity System ID: 21767

**Activity Narrative:** This is follow-on to USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to the Government of Uganda (GOU) and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated capacity to manage USAID programs as prime partners.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from the sole sourcing or subgrant approach to direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs

The activity will support expansion of epidemiologically-appropriate, context specific, best-practice HIV prevention interventions that apply the "ABC" approach to preventing sexual transmission across different groups including community engagement and dialogue to address coercive, transactional or cross-generational sex in communities.

Through this mechanism, USG intends to conduct prevention activities in line with the Uganda National Road-Map for HIV Prevention which aims to accelerate HIV prevention activities including reduction of sexual transmission of HIV, PMTCT, post-exposure prophylaxis, promotion of counseling and testing, disclosure, protection of vulnerable populations, integration of HIV prevention into treatment and prevention of sexually transmitted infections.

Prevention AB messages will be tailored to address the HIV/AIDS challenges of specific target groups. Abstinence-tailored prevention messages will target children, adolescents, students, out-of-school youth and HIV-infected children. The Be-Faithful-tailored messages will target sections of the general adult population deemed to be sexually active and so vulnerable to HIV infection e.g. married or cohabiting couples, men and women.

This activity will also support targeted HIV/AIDS prevention activities within HIV/AIDS care and support settings by targeting PHAs, couples, their families and community members. The messages will focus on abstinence, fidelity, partner reduction and consistent condom use. This activity will also advocate for national level policy and strategy formulation for promoting and implementing other evidence based HIV/AIDS prevention activities including medical circumcision for HIV negative male partners, and concurrent partner reduction. Support scaling-up of approaches for HIV secondary prevention counseling to individuals and couples of persons living with HIV/AIDS.

USG intends to reach the target groups through different approaches including: live radio talk shows, school focused prevention activities in coordination with PIASCY, HIV/AIDS prevention communication and campaign through community venues and networks, integration of HIV/AIDS prevention activities within HIV/AIDS care and treatment services. Moreover, USG will support local and national leaders, volunteers, and other influential community members to respond to the epidemic and to reinvigorate national HIV/AIDS prevention campaign.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21457

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21457	21457.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$407,340

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Family Planning

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7306.09

**Prime Partner:** Creative Associates  
International Inc

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 15983.21743.09

**Activity System ID:** 21743

**Mechanism:** UNITY

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$3,914,357

## Activity Narrative: Activity Narrative

One of the objectives of the three-year Ugandan Initiative for Teacher Development and Management System (TDMS) and PIASCY (UNITY) Project is to expand implementation of the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), and strengthen Guidance & Counseling (G&C).

PRIMARY PIASCY: Between 2003 – 2005, the USAID-funded BEPS/SUPER Project supported the development and piloting of PIASCY Primary; its launch, development and printing of Teachers' and pupils' handbooks for Lower Primary P3-P4 and Upper Primary P5-P7, Log book and Posters. All these materials were distributed to 15,000 public schools and 23 Core Primary Teachers' Colleges (PTCs). 45,000 teachers from 15,000 public schools were trained in the use of the materials. PIASCY Primary has since been the mandate of UPHOLD. UNITY project was responsible for the production of HIV Readers.

UPHOLD's PIASCY Achievements:

UPHOLD printed and distributed 100,643 PIASCY G&C materials to all primary schools, trained 17,305 primary, teachers and Supported school based activities in 2,156 primary schools and their Coordinating Centers. The effort led to the institutionalizing of PIASCY HIV Education in schools and PTC's, regular passing on HIV related information through talks, music, dance, skits/drama, testimonies, and other innovative student-led activities. It resulted into the strengthening of MOES systems through provision of support supervision and monitoring of 80 districts and approximately 3,500 model schools each term. UPHOLD has ended and UNITY Project is continuing implementation of Primary PIASCY and G&C.

PROGRESS TO DATE:

PRIMARY – HIV READERS: UNITY Project developed and delivered a kit of 12 books as reading materials to support the PIASCY initiative. The 12 themes are HIV related and relevant to the challenges and situations that prevail in the community. They are aimed at improving HIV literacy and impacting behavior change for upper primary pupils, their parents and the community around their school. The project distributed 60,343 kits and 30,758 teachers' manuals to 9,980 primary schools in 64 districts, 47 Primary Teachers' Colleges, MOES departments and partners. It trained 7,714 primary teachers, Tutors and MOES Officials in the effective integration of the content into the school curriculum, co-curricular activities and community outreach programs.

POST PRIMARY EDUCATION and TRAINING (PPET): PIASCY - The major thrust of PPET PIASCY is the enhancement of abstinence among learners and faithfulness among the teachers and other members of institutional staff. The project has so far printed 21,500 Teachers Resource books, 72,500 students' hand books for lower secondary and 13,500 for upper secondary, 60,000 G&C Guidelines; and 22,500 G&C Teachers Resource books. The materials were distributed during teacher training workshops. 40 Master trainers and 3,654 Teachers in 688 schools from four regions: West Nile, northern, north eastern and eastern regions were trained. As follow up of PIASCY implementation, UNITY has conducted support supervision and monitoring of 75 institutions in Acholi and Lango sub regions.

SPECIAL NEEDS EDUCATION (SNE): - UNITY project has supported SNE Department to braille PIASCY, G&C and HIV Readers materials to benefit pupils, students and teachers with visual impairment. This support covers all the SNE institutions nationwide.

FY 2009 – FY 2010 ACTIVITIES:

With new pupils and students entering school every year, as others leave, the PIASCY program should be a continuous program as it is always reaching out to new populations.

PRIMARY PIASCY - In order to consolidate gains made under BEPS and UPHOLD, the UNITY Project will strengthen the Whole School Approach to include all stakeholders in addressing factors that influence behavior and increase community support and involvement in HIV mitigation. In collaboration with the MoES, UNITY will develop comprehensive guidelines and orient teachers on how to embrace and effectively adapt the Whole School Approach to the PIASCY strategy. The community engagement aspect will be enhanced by initiating the "Stakeholder Champions of Behavior Change" in which community leaders, Members of Parliament, and other concerned citizens will serve as models and advocates of behavior change. The project will adopt an in-depth approach to G&C in order to equip teachers with skills to address HIV related trauma. The activities will primarily be school based, involving teachers, Center Coordinating Tutors (CCTs), parents, opinion and community leaders, as well as district officials. The UNITY proposed activities will focus on promoting a risk free school environment for pupils– supporting schools to put in place advocacy and action oriented interventions to curb sexual abuse, harassment, defilement, negative peer pressure and corporal punishment. This will promote the safety friends network, a peer support mechanism that supports children to become proactive with skills and strategies for their collective safety. To ensure school based implementation of these strategies, UNITY will collaborate with MoES to orient teachers, tutors and district officials on the basics of ensuring a safe school environment, and use music, dance and drama as a tool to educate while at the same time promote a safe environment for pupils at school and in the community.

UNITY's key approaches will include enhancing the capacity of teachers to identify vulnerable children in order to provide initial Psychosocial Support to the affected pupils. It will support the mapping of local and regional service providers for the teachers, to enable appropriate referrals, the initiation of a Networking Model to enable schools to form viable partnerships with organizations that provide specialized counseling, (specifically The AIDS Support Organization (TASO) and Supporting Public Sector Workplaces to Expand Action and Responses (SPEAR) against HIV and AIDS.

UNITY will promote Peer to Peer Education and the inculcation of Life skills (with a focus on Assertiveness, Effective Communication, Decision Making, Self Esteem and Peer Pressure Resistance) that are key to HIV mitigation and personal Stigma and Discrimination. Working closely with the MOES/G&C department, UNITY will

**Activity Narrative:** review the G&C intervention to strengthen it and focus it on addressing Stigma and Discrimination.

UNITY will develop a motivating scheme to acknowledge Schools of Distinction for their innovations. Adapt and disseminate low cost incentives to complement the process that had been initiated by UPHOLD. The project will document the good practices for replication and this will be further incentive to schools, CCs, PTCs and districts to improve their performance and sustain the initiatives.

PPET – In FY 2009 UNITY will roll out the PPET PIASCY Program to the regions of western, central and the remaining parts of eastern sub-region. The roll out will include printing of materials; teachers' resource books, students' hand books for lower and upper institutions, training manuals and posters). To be followed by the training of teachers, distribution of materials, and support supervision of institutions to ensure proper implementation of program activities.

In addition to the above, there will be in-depth orientation of teachers to psychosocial issues, in order to strengthen school-based implementation. The project will support G&C and club activities that create a conducive learning environment at school level and the development of 'Talking' and interactive environments; this is the display of key messages in the compound and classrooms, also using school assemblies to impart PIASCY targeted knowledge and education on HIV on a regular basis. Emphasis will be on student centered initiatives to facilitate learners' internalization of information and action for behavior change. The project will encourage voluntary testing for HIV while creating necessary referral systems for young positives and HIV positive teachers to access services. All the above activities will mainstream gender and disability.

UNITY's priority will be targeted support to the north and eastern regions. Under PPET PIASCY, UNITY will address G&C as well as set up referral mechanisms to address the issues of psychosocial care and support for those learners who face post-conflict trauma.

The strategy will be to identify institutions that have good practices, support them to document them and share them with other institutions in the region and beyond. These will become PIASCY epicenters where high levels of support will be given to work as satellite institutions to provide leadership to other institutions in terms of program implementation, by developing and perfecting good practices, documenting and modeling them for replication.

SPECIAL NEEDS EDUCATION (SNE): - UNITY Project supported the brailing of PIASCY materials, HIV Readers, and guidelines for mainstreaming disability to benefit pupils, students and staff with visual impairment. In FY 2009, UNITY will expand on its SNE activities by brailing more materials to cover schools outside the Phase 1 coverage, brailing new materials and providing orientation for teachers and instructors to effectively utilize the braille materials. All Special Needs Institutions will be supported with materials and teacher training.

UNITY will adapt the PIASCY Intervention (Primary and PPET) for the Hearing Impaired to ensure that learners with special needs benefit from HIV mitigation interventions; a mini-pilot in one Northern Uganda district will be carried out to provide a viable model for replication. The project will support the review and adaptation of the G&C component for further inclusion of persons with disability.

During FY 2009, UNITY will expand the distribution of HIV Readers to 16 districts, thereby ensuring national coverage. The HIV Readers are child friendly booklets meant to increase children's knowledge of HIV/AIDS transmission and mitigation. These readers have been carefully developed to be age appropriate, with linkages to the PIASCY manuals to reinforce content and to encourage critical thinking about behavior change. The readers encourage children to read, increase HIV knowledge, and help pupils to internalize the issues and analyse their personal behavior, thanks to exercises and homework included in the various chapters. UNITY also ensures that teachers are oriented in the use and purpose of the readers.

CHALLENGES: Now that the software has been developed and used as well as refined, the challenge for PIASCY is to improve the environment into which PIASCY is rolled out, to better ensure that the program is successful and sustainable.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15983

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15983	15983.08	U.S. Agency for International Development	Creative Associates International Inc	7306	7306.08	UNITY	\$3,614,357

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Refugees/Internally Displaced Persons

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

Estimated amount of funding that is planned for Education \$3,614,357

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 4019.21214.09

**Planned Funds:** \$44,823

**Activity System ID:** 21214

**Activity 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 phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a smaller extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP medical male circumcision program: Three trials of male medical circumcision (MMC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MMC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MMC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. As part of the MMC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus.

Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics.

In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as a regional MC training center.

Community based health education is being provided in an effort to continuously inform communities about HIV/AIDS and STD prevention. Over 4700 individuals attended the general community health meetings, with an almost equal distribution by gender i.e. ~ 52% females. Two community health mobilisers (CHMs) meetings and 3 Community advisory board (CAB) meetings have been held so far (2 of which were quarterly meetings and 1 an executive meeting). During these meetings the role of CAB in community based ART program as well as the role of abstinence and faithfulness (AB) were discussed.

Over 182 clinics on site health education sessions have so far been conducted. Each clinic day starts with a one hour health education/ question and answer session to address general patient concerns as well as general topics like HIV/STD prevention, including ABC, positive living, drug adherence, sanitation/hygiene, family planning, nutrition, and disclosure. Other harmful behaviors like alcohol abuse, smoking and drug use are discussed on a rotational basis. Each session is attended by 60-80 patients.

Rakai HSP has successfully reviewed and approved message to be included in the drama scripts. The drama messages address AB among other things. So far 9 drama sessions have been conducted attracting a total attendance of 1245 people (704 females and 541 males).

Under the circumcision service program, 25 community meetings have taken place with an attendance of

**Activity Narrative:** 1620 people (854 females and 766 men). Six sensitization meetings have so far been conducted with 226 men and women.

In 2009, community based health education and AB promotion will be maintained in an effort to continuously inform communities about HIV/AIDS and STD prevention. Through the VCT program HIV prevention counseling including AB messages will be provided. The program will continue to integrate prevention counseling into the care and treatment programs. Couples testing will be encouraged thus promoting mutual disclosure of results and strengthening the B messages. 'A' messages will be encouraged for single adolescents in and out of schools. Efforts will be made to integrate other prevention interventions at the following levels; 1) prevention counseling and couples counseling and testing in the VCT program; 2) prevention with positives counseling and support for all patients in the HIV/AIDS clinics and PMTCT program; 3) integration of prevention counseling in the MMC program; 4) Post-exposure prophylaxis for health care providers and post- sexual exposure (rape and defilement). Other prevention activities will include prevention counseling, condom education and distribution, STI diagnosis and treatment. The Program will continue to educate communities about the entire spectrum of prevention interventions; abstinence, faithfulness and other prevention including MMC, as appropriate. We will also continue to implement gender based violence (GBV) activities. The education activities will be conducted in Rakai and neighboring districts through the following fora;

- Community advisory board meetings will be held quarterly. The CAB, who are community representatives, will continue to advise the program on best ways of packaging the AB messages in an appropriate community sensitive manner, and on how to reach potential program beneficiaries. The CAB will also be part of the team that will promote AB and other prevention in their communities.
- CHM meetings will be held annually. The CHMs reside in communities within the program operational areas, they, like the CAB members will play advisory as well as dissemination roles in the promotion of AB and other prevention in the communities.
- Health education sessions will be used to actively promote AB and other prevention. The program has a well trained, qualified, and experience team of health educators which works in collaboration with the district health education team. Education sessions will be held in phases including sensitization meetings that will target community opinion leaders, village/town meetings to target whole communities, HIV satellite clinics sessions to target people enrolled in ART care programs, at circumcision centers to target people enrolling into the circumcision program. Attempts will also be made to reach out of school adolescents.
- Drama shows will continue to be used in promoting AB and other prevention. We have two experienced drama groups that do the shows. Drama scripts will be modified to add more messages to promote AB and other prevention.

Additional information will be given during the education sessions which will include educating communities about the locations of satellite clinics within their communities, the kind of services they should expect to receive at the facilities, the clinic days, and also discuss a range of other issues including PMTCT, reproductive health, pediatric HIV care, feeding for infants living with HIV, adherence, stigma, community engagement/role into successful HIV care provision and access, and challenges/ opportunities especially during the discussion component of the meetings. Similar education avenues will be used to educate communities about availability of male circumcision services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13232



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13232	4019.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$44,823
8324	4019.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$24,823
4019	4019.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$23,860

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$34,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 7624.09

**Mechanism:** New Partners Initiative:Visions in Action

**Prime Partner:** Visions in Action

**USG Agency:** HHS/Health Resources Services Administration

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 17152.20851.09

**Planned Funds:** \$0

**Activity System ID:** 20851

**Activity Narrative:** Visions-in-Action is a non profit organization committed to achieving social and economic justice in the developing world through grassroots programs and communities of self-reliant volunteers. VIA aims to combat the spread of HIV/AIDS by expanding its volunteer model to include local Ugandan volunteers as peer HIV counselors and is currently implementing a large VCT program targeting the war-affected youth of Northern Uganda. This is a 3 year program that began in June 2007, the first VCT services commenced on 31st July 2007 and the program is due to end November 2009. The goal of this program is to decrease the HIV/AIDS incidence and prevalence rates amongst youth in Northern Uganda. Counselors provide free counseling and testing services so that the target beneficiaries can voluntarily become aware of their HIV status, receive information on keeping safe, be referred for medical care and support and participate in ongoing support groups.

During FY08 Visions in Action planned to reach a total of 100,000 youth through an extensive IEC outreach campaign through the media, in schools and through community organized events. One of the major logistical challenges we face is the increased efforts in the transition of the internally displaced persons back to their homes of origin, thus dispersing people over a wider geographical area. Some 3,000 youth were expected directly participate in the AB workshops, 3,000 to attend Anti-stigma workshops and 3,000 on Living Positively conducted by VIA's local NGO partners. The IEC campaign seeks to promote youth awareness of the importance of VCT, and also provide logistical information on where and when to get tested. IEC is specifically conducted through radio spots, posters, billboards, banners, newsletters and stickers distributed throughout the region, in both English and Acholi. The ABC approach will be emphasized, especially a women's right to say no to sex before marriage. For young men, the focus will be on not giving in to peer pressure from other men to have sex with their partners before marriage. School and community theatre productions dramatizing the need to be tested, and actions taken afterward, will be performed by youth in the IDP camps. An annual VCT drama competition among secondary schools will be organized. Billboards will be placed in strategic locations on the main roads in Gulu and Kitgum, and near the testing centers lasting at least three years in both Acholi and English. To date VIA is conducting community mobilization and awareness sessions at least twice per week and providing information on AB, Anti-Stigma and Living Positively almost 19,000 people have attended the workshops and community mobilization sessions in the past year. The IEC team has designed and distributed an array of IEC materials, including posters, brochures, newsletters to schools, health clinics, bars, restaurants and other public places. Radio advertisements are being continually run promoting the "Know Your HIV Status" campaign. Two billboards have been erected on the main roads leading to and from both Gulu and Kitgum. The materials have been designed to reinforce the importance of knowing your HIV status, that you can go to a Visions in Action VCT Center and get confidentially tested, and that there is hope and treatment for those testing positive. The radio ads have had the widest circulation, and impact being played on the two major FM stations with an active listener base of 300,000+ persons covering the entire Acholi region.

In FY 2009, VIA will continue to run the same activities: IEC campaign will reach 100,000 youth covering 2 Districts, Gulu and Kitgum, in 9 sub-counties (Gulu: Palaro, Awach, Paicho, Odek and Patiko. Kitgum: Lagoro, Paloga, Palabek Ogili and Palabek Gem). Over 9,000 youth participants will attend intensive workshops on abstinence, anti-discrimination and HIV+ care & support through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful. Posters, brochures and newsletters will continue to be distributed. VIA will continue to strengthen relationships and work in collaboration with the local community leaders, district government officials, government health institutions, NGOs and other HIV agencies working in the area.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17152

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17152	17152.08	HHS/Health Resources Services Administration	Visions in Action	7624	7624.08	New Partners Initiative:Visions in Action	\$0

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 1255.09

**Prime Partner:** Research Triangle International

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 8540.20867.09

**Activity System ID:** 20867

**Mechanism:** Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$180,000

**Activity 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.

During FY 2008, RTI initiated AB interventions as a new program area. The program is aimed at combating HIV infections among specific target populations which include: patients, youth (in-school and out of school) and adults in the supported districts. These target populations receive AB needs assessments and community education through outreaches and drama activities. RTI scaled-up AB activities by partnering with health facilities and community based organizations (CBOs) through sub-grants. However, due to the delay in the release of funds, this activity reached a much lower number of people, compared to the original anticipated figures.

During FY 2009, RTI proposes to reach 75,000 individuals with AB prevention messages. AB activities will be conducted in a two pronged approach. First, RTI will offer small grants to health workers at supported facilities, local community based organizations (CBOs), and PHA networks; the CBOs and PHA networks will implement project activities that include outreaches and prevention education activities in their catchment areas. Second, in selected communities, a team of health educators partnered with the district health education (DHE) offices will be deployed within their catchment areas. The health educators will conduct health talks which emphasize HIV prevention using the AB methods. All grantees and health educators will be selected in a competitive and transparent manner and their activities will be rigorously evaluated on a regular basis to ensure quality.

RTI will also assess the readiness of supported health facilities to roll out AB programs given their staffing levels. RTI project staff will perform routine monitoring and provide supervision of activities including, sitting in on a sampling of outreach sessions conducted by the partners. To further verify the number of persons reached in the outreach sessions, grantees will take pictures at community meetings, per attaining the permission of participants. Each health educator and grantee will be expected to submit detailed activity reports covering accomplished work and the corresponding funds utilized for outreaches. Disbursement of funds will be made in quarterly installments; subsequent releases will be tied to grantee performance and their timely submission of the detailed activity reports, from their work in the previous quarter. All reports will be done according to guidelines provided by RTI project staff. A partner with unsatisfactory performance or issues with fiscal irresponsibility will be disqualified from obtaining further support.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13312

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13312	8540.08	HHS/Centers for Disease Control & Prevention	Research Triangle International	6439	1255.08	Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals	\$180,000
8540	8540.07	HHS/Centers for Disease Control & Prevention	Research Triangle International	4872	1255.07	Routine Counseling and Testing in Two District Hospitals	\$82,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$5,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 699.09	<b>Mechanism:</b> Basic Care Package Procurement/Dissemination
<b>Prime Partner:</b> Population Services International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 17091.20857.09	<b>Planned Funds:</b> \$60,000
<b>Activity System ID:</b> 20857	

**Activity Narrative:** 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 is an affiliate of PSI with operations in Uganda since 1998. The organization aims to measurably improve the health of vulnerable Ugandans, with added emphasis on rural populations. PSI utilizes evidence based social marketing and other proven techniques to educate and promote sustained behavior change. PSI is committed to an effective partnership with the Ministry of Health (MOH) and supports various priority areas including, but not limited to, HIV/AIDS, malaria, child health and reproductive health. There are approximately 1.2 million Ugandans are living with HIV. Young women in Uganda, (not unlike prevalence statistics in most of Sub-Saharan countries) have much higher rates of HIV prevalence than their male peers. Several research studies have linked this disparity in prevalence, to sexual relationships with older men a practice known as cross generational sex (CGS). CGS is defined as a sexual relationship between a young girl and an older man 10 or more years her senior, in exchange for material gains. Of girls aged 15 – 19 years, 10% report having had sex with men 10 or more years their senior in the past 12 months (National Survey of Adolescents – Uganda 2006). The PSI Uganda 2005 Tracking Survey revealed that among university-going sexually active girls 19 – 24 years, 20% had been in a cross generational relationship, and 36% believe it is normal to engage in such relationships. Since September 2004, PSI has received PEPFAR funding through CDC. PSI Uganda has been implementing an HIV Basic Preventive Care Program (BCP) which is focused on reducing HIV-related morbidity and mortality and HIV transmission. Currently, BCP includes identification of PHA through family based counseling and testing. PSI BCP interventions are prolonging and improving the quality of their lives by preventing OIs; and prevention with positives interventions (PWP). The PWP strives 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), safer sex practices including abstinence, and fidelity with correct and consistent use of condoms. The program's implementation is supported by a multi-faceted communications campaign. Its aim is to educate PHAs on how to prevent OIs and live longer and healthier lives. This is accomplished in the following manner: utilization of cotrimoxazole prophylaxis, prevention of diarrheal diseases using household water treatment and safe storage, use of insecticide treated nets (ITN) for malaria prevention, and the prevention of HIV transmission to sexual partners and unborn children. In addition, BCP combines key informational messages, training and provision of affordable health commodities with evidence-based health benefits, which are simple for PHA and their families to implement. 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. PSI manages the procurement, packaging and distribution of all health commodities including condoms to ensure consistent supply of the basic care starter kits and refills the different commodities.

For FY 2008 PSI-Uganda received PEPFAR funds through CDC to implement a dynamic, multifaceted intervention program to address CGS. The program focuses on the reduction of CGS, alongside delay of sexual activity, secondary abstinence among girls aged 15 -24 years and fidelity among men aged 30 - 49 years. Between October 2007 and July 2008, PSI partnered with 151 HIV/AIDS care and support organizations in 54 districts including public and private hospitals, CBOs, FBOs, and NGOs to implement the BCP program. The program funding has increased tremendously over the past fiscal year, enabling the scale up of the program and enlisting of additional implementing partners. Further expansion and scale up of the program to public sites has been completed. The scale up to non CDC and government partner sites serves to increase the production, access and utilization of BCP health products and services among People Living with HIV/AIDS (PHA). The Abstinence and Being faithful activities implementation commenced in August, 2008; following the delay in receipt of funding for FY 2008. The AB interventions are in 10 universities and 50 secondary schools in the districts of Kampala, Mukono, Wakiso, Luwero, Mbarara, Gulu, Masaka, and Mpigi. The program targets 3 main audiences; young women; older men and the general population. Among the program's components is the establishment of peer and social support groups for young women dubbed the "Go-Getters." By the end of FY 2008, PSI projects they will have reached 37,500 (22,500 female, 15,000 male) individuals through community outreaches that promote HIV prevention through abstinence and or being faithful. Likewise, at the end of this fiscal year, PSI projects they will reach 12,500 more (7,500 female, 5,000 male) individuals through community outreaches that promote HIV prevention through abstinence education; and 50 individuals will have been trained to promote HIV/AIDS prevention programs through abstinence.

The Uganda HIV/AIDS Sero-Behavioural Survey 2004/05 showed that the HIV prevalence peaks and is highest among the 30 - 44 year olds. As many men in this age bracket continue to have sexual relationships with young girls aged 15-24 years; who are easily swayed with material things such as a mobile phone, it is critical to address this CGS problem, as it is increasing (PSI Tracking Survey 2005/06). In FY 2009 PSI proposes to conduct the following AB activities:

1. Expand the interpersonal communications (IPC) to the 50 secondary schools and surrounding communities, targeting the 15-19 year olds (male and female) with messages on abstinence and cross generation sex. The IPC activities will include the screening of a new cross generation video drama "the honorable" that is followed by discussions on the problem of CGS, and what young people can do to about it CGS. PSI will continue to partner with FBOs such as CHAIN Foundation and Power Fm radio station to lead the discussions after the film dramas. Through the IPC, PSI plans to reach 50,000 male and female 15 -19 year olds in schools and their surrounding communities with key messages on abstinence, and cross generational sex. Feedback from the 15- 19 year olds will be obtained from school teachers and at the community outreach events.

2. Debates and group discussions will be held in all the secondary schools to enable students to discuss key issues regarding health, abstinence, cross generational sex and other social life pressures among others. This activity addresses various misconceptions among young people have about adult who lure them into risky behaviors. Follow up discussions and meetings will be held and social support given by the Go-Getters and teachers as part of the social support team.

3. Recordings of the discussions will be aired weekly on Power Fm radio for greater reach, especially to

**Activity Narrative:** young people out of school. 200,000 male and female 15 -24 are expected to be reached through the mass media campaign. Life skills camps will be held for secondary school graduates to empower them with life planning skills and prepare them for life at the university. The rationale for this activity is to ensure that secondary school graduates have acquired knowledge by going through the first phase of the ICP project.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17091

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17091	17091.08	HHS/Centers for Disease Control & Prevention	Population Services International	6437	699.08	Basic Care Package Procurement/Dissemination	\$60,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1298.09	<b>Mechanism:</b> HIV/AIDS Project
<b>Prime Partner:</b> Mildmay International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 8641.20793.09	<b>Planned Funds:</b> \$280,000
<b>Activity System ID:</b> 20793	

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

MU and RO have been implementing the AB strategy and other prevention through a number of activities. These include HCT, (which has been provided for over 22,423 people between April 07, and March 08 at TMC and 4,391 at Mbuya RO), AB sensitization and awareness that has benefited 15,816 people in FY 2007 and through support clubs like Our Generation Mildmay Adolescent Club (OGMAC) and group of persons living in discordant relationships. Other areas of prevention included condom distribution and training. Training carried out in the AB approach targeted specific groups like religious leaders, teachers, adolescents, and the youth. 35% of TMC patients are children and they benefited from the A aspect of prevention at TMC and family members of TMC clients tested through the VCT programme, are also targeted for AB messages. Couple counselling is offered to all patients and 'B' messages are emphasized for these couples. These activities are also extended to the communities around TMC clinics and clients at the rural sites through patients' workshops. Between October 1, 2007 and March 31, 2008, there were 9 sites under MU providing CT with a total of 9,310 individuals receiving CT and 2300 at RO. Multi-disciplinary hospital and home visits continued. The community programme was introduced in February 2008. Stable children together with their carers are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The main reasons for which counselling services were sought were mainly pre-ART counselling, Adherence and positive prevention which includes prevention of sexual transmission. 386 were trained and the training in this area includes imparting communication and counselling skills where knowledge of HIV status enables the individual to access care and support. Trainees are trained at both TMC and the rural districts. Workplace sensitisation programmes have also been carried out, notably to the Parliament of Uganda, where 300 individuals were trained and encouraged to know their HIV status. Training courses are typically 5 days to three weeks in duration. Between April 2007 and March 2008, through our AB strategy RO reached 2,719 youth aged between 12-24 years, 196 couples, 1,131 women, and 32 alcohol related adults. Several clubs function and include; discordant, couples for life, operation Gideon (Males), good Samaritan (females), Saturday children's club, AA, etc.

During FY 2009 MU will continue providing services and providing training activities at 12 sites of MU and 4 sites of RO. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. MU will continue to implement the ABC (Abstinence, Be Faithful, and Condom use) strategy and Other Prevention (OP) through a number of activities, which include HIV Counselling and Testing (HCT), sensitisation and education, condom distribution, support clubs like the persons living in discordant relationships and positive prevention clubs. The prevention of sexual transmission will be done for TMC clients, their families, communities around clinics, faith based organizations and schools and during



**Activity Narrative:** the VCT activities. The targeted numbers for FY2009 are 27,500 individuals (A=1,500; AB = 2,000 while other prevention = 15,000) and 9,000 at RO. The numbers will go slightly up in FY2010 to about 30,500 at both MU and its rural sites and RO. Abstinence messages are especially emphasized for the young people. Married people and couples in discordant relationships benefit from the ABC messages so as to prevent HIV transmission to the partner. These and other patients in risky situations are targeted with prevention messages including condom use, STI prevention and treatment, and family planning. The training will cover PMTCT, family planning, management of Sexually Transmitted Infections (STI) and adolescent sexual and reproductive health. A new area of emphasis in these two years will be treatment literacy and sensitization and follow up for persons who test HIV negative at TMC. The funding in this programme area will support the integration and strengthening of existing AB and OP activities like training, community mobilisation and awareness, production of IEC materials, support clubs, and monitoring and evaluation. In FY 2009, AB activities under RO will be further strengthened targeting 5,980 youth and adolescents in the communities and schools, 268 couples, 2,700 women, 100 local leaders, 100 discordant couples and 160 people affected by alcohol through spiritual and human awareness campaigns, sensitisation and training. 300 female and 150 male clients will be reached through adult education to equip them with basic writing and reading skills that will support the positive prevention strategies. RO shall expand their sexual prevention services including "moon-light" VCT to high risk groups such as; sex workers (50) and truck drivers (30).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13283

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13283	8641.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$280,000
8641	8641.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$135,000

#### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Military Populations

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.02: Activities by Funding Mechanism**

---

**Mechanism ID:** 8670.09

**Mechanism:** Provision of Full Access Home  
-based Confidential HIV  
Counseling and Testing and  
Basic Care Services in  
Kalangala District and the  
Surrounding Fishing  
Communities

**Prime Partner:** Kalangala District Health Office

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: AB

**Budget Code:** HVAB

**Program Budget Code:** 02

**Activity ID:** 9456.20750.09

**Planned Funds:** \$80,000

**Activity System ID:** 20750

**Activity Narrative:** In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing and basic care in Kalangala district and the surrounding fishing communities. The objectives of the four 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 and 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 was specifically targeted with this program to respond to the prevailing needs of the fishing communities related to vulnerability to HIV. Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited and 8 habited due to fish migratory patterns and harsh weather conditions. Kalangala's unique geographical location has resulted in limited health and human services to this marginalized population of 36,661 (2002 Census) and projected population of 100,000 people (2008). The district is served by only eleven health units: two Health Centre (HC) IVs, six HC IIIs and three HC IIs. There is no hospital located within the district. Referrals for patients with complicated health problems are made to mainland Entebbe, Kitovu, and Masaka Regional Referral Hospitals which is 80 kilometers from the main island. Results from the 2005 Uganda National Health and Behavioral Survey (USHBS) demonstrate that the central region, in which Kalangala is located, has the highest HIV prevalence in the country, reported at 8.5%. The secondary analysis of the USHBS central region data indicate that Kalangala District, has a prevalence of 27% which is approximately five times the national average, thus this population of fishermen and their families have been identified as a very-high risk group.

By July 31 2008, the program office had been established and equipment procured; project staff including 45 full time staff and 100 mobilisers had been recruited and trained; 3,401 individuals including 155 couples had received HIV counseling and testing and 711 HIV-positive individuals had been identified and provided basic palliative care and referred for chronic care management. As part of the community education and counseling support provided to individuals who had accessed the services, messages promoting abstinence and be faithful (AB) interventions aimed at stemming HIV infections among individuals, couples, and families were developed. Community mobilisers were trained to conduct prevention education sessions for the fishermen and their families with a focus on behavior change practices that emphasize mutual fidelity among partnerships. Field teams and volunteers were trained to disseminate AB prevention messages when counseling patients. In collaboration with the District Directorate of Health Services, local fishing groups and PHA networks, this program used a variety of communication channels such as drama, community meetings, and where appropriate, radio programs at local FM stations to reach target groups such as women and adolescents to disseminate the appropriate AB HIV prevention messages in the communities. Working with local community groups and PHA networks, the program supports the set-up and/or strengthening of community-based support groups and post-test clubs to assist in providing psychosocial support to persons who test positive for HIV. The program also supports 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 radio programs, community meetings, education sessions at identified community outlets and other similar fora, the program hopes to foster a dialogue among residents, with a view towards reducing negative attitudes about PHAs.

In FY 2009, the project will continue to support the implementation of sexual prevention interventions among individuals, couples and families targeted with HCT in the district with a view to increasing the number of mobilisers trained to conduct these activities. The activities will include the continued training of mobilisers to conduct prevention education to patients, training of field teams and volunteers to disseminate prevention messages and the use of communication strategies to reach target groups to disseminate AB HIV prevention messages. This activity proposes to reach approximately 50,000 individuals with AB interventions and train 160 volunteers. Additional community-based support groups and/or post test clubs will be strengthened or established and information, education and communication activities to reduce stigma and negative attitudes regarding PHAs will also be implemented, including training volunteers to promote these activities. The number of condom distribution outlets will be expanded to 35.

In collaboration with other partners, Kalangala district local government will increase access to HIV prevention messages for the communities, beyond abstinence and Be faithful. Condom service outlets will be expanded and in addition to condoms availed free, the social marketing options through the Uganda Health Marketing Group will be made available. In addition emphasis on staff and community mobiliser 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13221

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13221	9456.08	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8670	8670.08		\$80,000
9456	9456.07	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8792	8792.07		\$40,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.02: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: AB
<b>Budget Code:</b> HVAB	<b>Program Budget Code:</b> 02
<b>Activity ID:</b> 4393.20738.09	<b>Planned Funds:</b> \$700,000
<b>Activity System ID:</b> 20738	

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

AIDSRelief supported partners (such as Comboni Samaritan in Gulu, Meeting Point and Christian HIV/AIDS Prevention and Support (CHAPS), who built their behavior change activities on their strong community networks, to provide community sensitization using other "Faithful House" curriculum for the married couples and the Value of Life curriculum for the youth and adolescents. 585 people were trained through all the LPTFs. These facilitators then work with couples and youth at community level. Prevention priorities included behavior change for risk reduction and risk avoidance, counseling and testing and emphasized the prevention of the sexual transmission of HIV, and education to patients and community health volunteers on secondary prevention. As a way of integration the AB activities were integrated with the PMTCT, OVC and Care and treatment activities at LPTFs. Pregnant women who tested negative in ANC were also encouraged to attend these trainings with their partners. The OVCs were supported to attend the Value of Life trainings and were encouraged to form support groups that help them keep positive values.

Coordinated by Constella Futures, 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. In FY 2008, AIDSRelief built a strong PMM system using in-country networks and available technology at 18 LPTFs. Constella Futures 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. Using standard data collection tools, the program tracked and reported on Sexual Prevention activities.

In FY 2009 AIDSRelief will maintain its services at the 18 LPTFs and 24 satellite sites with the goal to maintain 20,000 patients on ART, of which 2,800 will be children, and 63,620 in care and support (55,781 adults, and 7,839 children) provided additional funding is made available. The program will continue to leverage ARVs for pediatric patients from the Clinton Foundation, but will cover other ART related support such as purchase of OI drugs, laboratory supplies and technical assistance to the LPTFs.

AIDSRelief services in abstinence and being faithful in FY2009 will continue to be offered through 18 local partner treatment facilities (LPTF), 24 satellites and 3 community based programs. These facilities are located in the Northern, Western, Southern, Central and Eastern areas of Uganda. The program will support LPTFs to implement abstinence and being faithful activities that target the HIV negative and sero status naïve persons. The interventions will include behavior change for risk assessment, risk reduction and risk avoidance.

The strong community and adherence programs developed by LPTFs during FY 2008 of the AIDSRelief program will continue to serve as the foundation for outreach to communities. In FY 2009, the program will continue to ensure that all sites provide education to patients and community health volunteers on secondary prevention, in and around each sites' catchment areas. Prevention activities focusing on primary prevention and prevention for positives will include distributing patient education materials, conducting community sensitizations and trainings, promoting couple testing, encouraging LPTFs to support couple support groups, and advocating for additional preventive measures such as male circumcision.

Various forms of media will be used for patient education and community sensitization, including radio, community volunteer efforts, and the provision of Information Education and Communication (IEC) materials, translated into the local languages. Additionally, the continued use of trainings in the Faithful House curriculum will promote fidelity amongst married couples and the Value of Life curriculum will contribute to positive character formation and the delay of sexual debut in young people. Messages delivered will also address the reduction high risk behaviors such as alcohol and drug use.

Training will be an integral part of this program and will be directed at facility and community level staff. A total of 240 facility staff, 630 Community based facilitators will be trained in the Faithful House and Value of Life curriculums. In order to increase the sustainability and continued diffusion of AB messages, 72 couples will be trained as trainers in the Faithful House curriculum and 72 individuals will be trained as trainers in the Value of Life curriculum. Each LPTF will also have one staff trained in each of the curriculums for the purpose of then monitoring and evaluating the performance of the newly trained trainers.

An additional element of AIDSRelief AB programming will include a referral system for AB training participants to counseling and testing. The program will therefore establish and enhance linkages with organizations that offer counseling and testing services, such as TASO, AIC, JCRC, etc 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. 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 addition an emphasis will be put on discordant couples to adopt risk reduction strategies.

**Activity Narrative:** AIDSRelief will also link abstinence and being faithful activities to other program areas, other organizations community- and faith-based organizations that serve the same geographic areas, and programs in other, related sectors. For example, pregnant women who attend PMTCT clinics and test negative will be encouraged to bring their spouses for the Faithful House trainings, and eventually encourage the spouses to test. Orphans and vulnerable children will be identified and integrated into the Value of Life trainings. OVC support group meetings will emphasize prevention messages such as being faithful, abstinence and avoidance of high risk behaviors. AIDSRelief will collaborate with partners working in other sectors, wherever possible to synchronize efforts to address the needs of the community. The program will also liaise with other CRS programs, such as microfinance and community savings groups, which promote improved access to income and productive resources.

With respect to strategic information, in FY 2009, Constella Futures will continue to carry out site visits to all LPTFs to provide technical assistance that will ensure continued quality data collection, data entry, data validation and analysis, and dissemination of findings across a range of stakeholders. The use of the IQ Care system, employed in FY 2008 to track AB activities, will be improved upon through providing further training to LPTF staff in the areas of data collection and interpretation. An appropriate electronic database will be designed to track AB community and facility activities, which will help facilities to capture and report on individuals, reached with abstinence and being faithful prevention messages. Furthermore, AIDSRelief will continue promoting evidenced-based decision-making, and enhance LPTF staff ability to use data for informed clinical decisions and adaptive management.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13262

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13262	4393.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$744,881
8291	4393.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$744,881
4393	4393.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$744,881

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$197,392

## Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$15,000

## Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$50,000

## Education

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 3834.09

**Prime Partner:** International Medical Corps

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 4799.25176.09

**Activity System ID:** 25176

**Mechanism:** Refugee HIV/AIDS services in Kyaka II Settlement

**USG Agency:** Department of State / Population, Refugees, and Migration

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$29,949

**Activity Narrative:** The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12, 115 however there are a group of refugees known as "population on Hold" who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel. In the FY 2009 FY, under the effort to increase community awareness of HIV/AIDS prevention through promoting Abstinence and Being Faithful, IMC will target 3,500 students with AB messages through activities of community educators and peer counselors in 6 schools

In 2007 36 Community Educators and 14 peer counselors were trained on HIV/AIDS prevention through ABC; Peer Counsellors educated 629 students on HIV/AIDS prevention through AB in 6 schools, a total of 270 female and 359 male students were trained; Seminars were held in schools to promote AD involving 1221 students out of which 463 were females and 758 were males. IMC also conducted recreation activities together with Right to Play-Uganda targeting out of school youth. Football and other programs were held at Zonal levels and involved 2,309 youth

In FY 2009 similar activities will be undertaken to involve more students and members of the host communities. In the previous years some students were not targeted with education messages because they were below the ages of 10 but a large number of them will attain the age of 10 this year and will now be targeted. IMC will continue to implement the shift to translating existing HIV knowledge into the desired behavioral change using the health beliefs model within the context of HIV/AIDS which was implemented successfully last year. The model involves providing comprehensive HIV knowledge, assessing risk for HIV and consequences, 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. This model will be tailored to promote abstinence and marital fidelity. IMC will continue promoting 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. In each school, life skills clubs will be supported to set up an HIV/AIDS garage which provides information on an ongoing basis to students as well as provide an environment where students can be allowed to share experiences or ask any questions and seek answers. 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. IMC will continue to support establishment of groups of PHAs, and train them to carry out HIV/AIDS awareness as peer educators. IMC will also continue to involve faith based institutions to carry out activities aimed at creating awareness on abstinence and promoting marital fidelity. IMC will recruit and train community educator to work among the host populations as well as the refugee community. Abstinence and Be Faithful talks will be organized in schools, using guest speakers from churches, PHAs volunteers, other health officers and district and NGO staff.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16079

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16079	4799.08	Department of State / Population, Refugees, and Migration	International Medical Corps	7337	3834.08	Refugee HIV/AIDS services in Kyaka II Settlement	\$29,949
8299	4799.07	Department of State / Population, Refugees, and Migration	International Medical Corps	4801	3834.07	Refugee HIV/AIDS services in Kyaka II Settlement	\$29,949
4799	4799.06	Department of State / Population, Refugees, and Migration	International Medical Corps	3834	3834.06	Refugee HIV/AIDS services in Kyaka II Settlement	\$34,135



## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Military Populations

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$1,475

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

Estimated amount of funding that is planned for Education      \$9,839

## Water

**Table 3.3.02: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Prime Partner:** Walter Reed

**Funding Source:** GHCS (State)

**Budget Code:** HVAB

**Activity ID:** 8544.20031.09

**Activity System ID:** 20031

**Mechanism:** Makerere University Walter Reed Project (MUWRP)

**USG Agency:** Department of Defense

**Program Area:** Sexual Prevention: AB

**Program Budget Code:** 02

**Planned Funds:** \$138,000

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program, which includes expanding the number of HIV clinical sites; improving laboratory services, infrastructure, data collection, supplies, human capacity development; innovative task shifting; short-term technical staffing, OVC services, a variety of counseling and testing and prevention programs; and youth focused programs for HIV education. The Sexual Prevention program area described below is part of a comprehensive program with activities that link to other program areas, including care, treatment, strategic information, counseling and testing, laboratory, and OVC services.

Sexual Prevention: Youth and Adult programming

During FY 2008, MUWRP's Abstinence and Be Faithful program trained and supported volunteers and District lay workers including 1200 treatment club members, and 37 dedicated youth volunteers to carry out AB prevention activities. Activities included counseling, messaging campaigns, prevention with positive activities and the development and standardization of IEC materials. Messages and activities focused on fidelity, partner reduction, couples counseling, and delay of sexual activity. In addition to AB messages, these lay workers concentrated on 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. In addition, the program has been supporting 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, ensuring that they are active, engaged, and provided with an array of health related services, including HIV education, testing and counseling. Finally, during FY2008, MUWRP supported activities for and outreach to at-risk out of school youth, youth in schools, and also high-risk fishing village youth populations along the Nile and at the inlet to Lake Kioga. Specific community activities included bi-weekly mobile HIV education outreaches, youth outreaches to schools and communities, and a District-wide sports competition with a HIV education, counseling and testing component. By June 2008, more than 10,000 individuals had been reached and were provided with abstinence and be faithful services and 20 persons had been trained

During FY2008 sexual prevention activities included reducing violence and coercion throughout Kayunga District, in all 9 sub-counties. Several reinforcing approaches were used in this respect, including training the entire Kayunga District police force, District clinicians, and lay workers - as well as a billboard campaign utilizing treatment club members in the photos. The messages of the billboards focused on testing for HIV, the benefits of disclosing ones' HIV status, and a billboard series on preventing domestic violence. MUWRP partnered 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 were disseminated to the District communities through a variety of fixed and mobile venues. Moreover, MUWRP supported a District-wide HIV drama competition that focused on domestic violence and the winning group toured all 9 sub-counties performing their play deep in the communities. Dissemination of messages under this program area continues to be District wide, utilizing: radio, marketplace loud speakers, roadside billboards and (coordination of District) state-of-the-art IEC materials. During FY2008, MUWRP implemented a post-exposure prophylaxis program at each HIV clinic site in Kayunga for victims of rape, defilement, or any other person who has had immediate exposure to HIV. Finally, MUWRP supported the NGO Reproductive Health Uganda to deliver age-appropriate reproductive health training to 30 youth counselors as well as in-depth training to an additional 30 District clinicians.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

All of the above activities will continue during FY2009, however due to the start of MUWRP's house-to-house (H2H) counseling and testing program, which began in Kayunga District during FY2008, there has been a greatly increased need for AB and OP counseling, messages, and IEC materials. H2H program counselors need to be trained to deliver messages pertaining to AB, domestic violence, gender issues, and other HIV sexual prevention. These counselors need to be supplied with various IEC materials to deliver to families participating in the program. Since the goal of the H2H program is to reach all Kayunga households, these services delivered in conjunction with the program will strengthen HIV prevention for all of Kayunga District. Radio and billboard messages, encouraging families to welcome H2H program counselors into their homes will also be supported. In addition, during FY2009, MUWRP intends to enter Mukono District to support the Kojja Health Center IV. The initial aims of this support will be to promote sexual prevention, counseling and testing, and care and treatment for the entire sub-district of Mukono South; which includes supporting 3 surrounding health center III's. These services will be extended via mobile outreach programs offering sexual prevention counseling to the surrounding fishing communities along Lake Victoria. Mukono South sub-district has a population of 120,000 persons and in May 2008, the in-charge of Kojja reported that no prevention programs except PMTCT were available. Specific prevention activities planned for this area will include training the Mukono police force, clinicians and treatment club members on issues pertaining HIV sexual prevention, including: prevention with positives, living positively, condom use, cross generational sex, and domestic violence/gender issues. Building on successes in Kayunga District, MUWRP will expand drama and sports competitions to the sub-district of Mukono South as a means to promote AB and OP messages. Dissemination of messages in Mukono south will also involve utilizing: radio, marketplace loud speakers, and IEC materials.

Finally for FY2008, MUWRP has relied on research infrastructure in the past to support data entry activities for sexual prevention reporting to OGAC. The increase in data requires the hiring of a new data entry staff for recording of all sexual prevention activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15709

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15709	8544.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$138,000
8544	8544.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$138,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$50,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$1,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$1,250

**Education**

Estimated amount of funding that is planned for Education \$4,000

**Water**

Program Budget Code: 03 - HVOP Sexual Prevention: Other sexual prevention

**Total Planned Funding for Program Budget Code: \$13,311,143**

---

**Table 3.3.03: Activities by Funding Mechansim**

**Mechanism ID:** 1245.09

**Prime Partner:** Walter Reed

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 15769.20032.09

**Activity System ID:** 20032

**Mechanism:** Makerere University Walter  
Reed Project (MUWRP)

**USG Agency:** Department of Defense

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$100,000

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 care and treatment. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in the Kayunga District of eastern Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. In FY2006 and FY2007 MUWRP increased its PEPFAR support to the Kayunga District and expanded the number of HIV/ART clinical care sites from one to four. MUWRP assisted the District Health authorities by supporting HIV treatment sites in improving laboratory services, infrastructure counseling and testing, data collection, supplies, training and with provision of short-term technical staffing. Also, MUWRP has supported activities that improved the identification of and provision of services to the Districts' population of orphans and vulnerable children. These activities link to MUWRP activities under Treatment, Care, OVC, CT, and Strategic Information. The Condoms and Other Prevention program as described below is part of a comprehensive program and its execution linked to other program areas. Program activities that are included in this comprehensive approach, such as care, treatment, OVC, and CT services, will be budgeted under their respective program areas. This OP Program will focus on training and supporting District lay workers, treatment club members, youth volunteers and PLA groups to carry out most OP Program activities. An OVC MUWRP partner, Child Advocacy International, will also disseminate OP messages through their bi-monthly community sensitizations targeting OVC adult care givers and community members. A MUWRP Prevention Coordinator will ensure that three Prevention with Positive groups, located through the Districts HIV clinics, are trained and supported to play a pivotal role in OP prevention outreach, including condom education, promotion and distribution through eight sites. Condom supply through the GOU is erratic and MUWRP will serve as a back-up source for the District. MUWRP will follow GOU policy and guidelines pertaining to condoms, not distributing condoms to persons under 18 years of age.

OP Programs will disseminate information on issues concerning: male norms and behaviors, the counseling component of male circumcision, cross generational sex, gender equity through approaches such as education on women's legal rights and access to income generating programs including life skills trainings. Another primary focus will include reducing violence and coercion against women in the communities through trainings, community sensitizations and messaging. Messages will be acquired from well-known local and international sources such as the GOU MOH and from Straight Talk. Some resources and messages will be modified or developed as required based on the assessment of the specific target audience's needs, behaviors and gaps in understanding. All messages and programs will be coordinated and vetted through the local MOH representatives to concur with national policy and approaches and to ensure accuracy and relevance.

For implementation, the MUWRP prevention coordinator will partner with local groups to ensure quality trainings and consistent, effective messages are disseminated to the District communities through a variety of fixed and mobile venues and events including drama. This will include the establishment of a District-wide messaging program which will be conducted through radio broadcasts, marketplace loud speakers, and roadside billboards. MUWRP's mobile prevention program will complement district activities and will include OP components, targeting out-of-school and in-school youth exhibiting high risk behaviors, married couples (especially discordant), and high-risk fishing village youth populations along the Nile and at the inlet to Lake Kioga. Data collected during CT and AB Prevention Program outreaches during FY2007 have indicated that these District populations are at most risk for HIV infection.

As part of its youth prevention program, the Kayunga District Youth Recreational Center was founded in 2006 as a joint effort between the Kayunga District Hospital, the Kayunga District Government and MUWRP. It functions as an organization/facility to build district capacity in identifying and providing HIV prevention services to Kayunga Districts' youth population. The Center currently provides youth with counseling, care and clinical services in a manner which is specifically geared toward young persons. Center activities will include: counseling to youth, emotional support, and a variety of activities upon which they will interweave prevention messages including recreational games, sports, music, and drama. MUWRP supports this Center's activities and is leveraging resources with the District Town Council to support staffing and event planning. This Center is currently directed by a MUWRP sponsored Peace Corps Volunteer whose main focus is to integrate the local government in taking more of a stakeholder role in the Center.

In addition, during FY2008, the MUWRP Prevention Coordinator will; (1) set up the infrastructure for a circumcision program, including renovations of the District Hospital surgical theater, training of medical officers in circumcision services and counseling, (2) establish strong links between persons found to be HIV+ and HIV care and treatment centers at the District Hospital, two Health Center IV's and one Health Center III, (3) establish and support family planning services utilizing District health personnel through the District Hospital anti-natal clinic, (4) establish and support an STD clinic through the Kayunga District Youth Recreation Center, and (5) establish a Post Exposure Prophylaxis program at the District Hospital for victims of rape, defilement or other persons at immediate risk of exposure to HIV.

In FY2008 funding under this submission will support the costs of training, facilitation of volunteers, acquisition and/or production of prevention materials, family planning and STD management commodities, renovations to the District Hospital surgical theatre, community sensitizations, mobile costs, and staffing including community mobilizers. Funding will also be used for small scale renovations at the Kayunga District Youth Recreation Center.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15769

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15769	15769.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$100,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$50,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$1,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$1,250

**Education**

Estimated amount of funding that is planned for Education \$4,000

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 8670.09

**Mechanism:** Provision of Full Access Home-based Confidential HIV Counseling and Testing and Basic Care Services in Kalangala District and the Surrounding Fishing Communities

**Prime Partner:** Kalangala District Health Office

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 9458.20751.09

**Planned Funds:** \$70,000

**Activity System ID: 20751**

**Activity Narrative:** In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing and basic care in Kalangala district and the surrounding fishing communities. The objectives of the four 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 and 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 was specifically targeted with this program to respond to the prevailing needs of the fishing communities related to vulnerability to HIV. Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited and 8 habited due to fish migratory patterns and harsh weather conditions. Kalangala's unique geographical location has resulted in limited health and human services to this marginalized population of 36,661 (2002 Census) and projected population of 100,000 people(2008). The district is served by only eleven health units: two Health Centre (HC) IVs, six HC IIIs and three HC IIs. There is no hospital located within the district. Referrals for patients with complicated health problems are made to mainland Entebbe, Kitovu, and Masaka Regional Referral Hospitals which is 80 kilometers from the main island. Results from the 2005 Uganda National Health and Behavioral Survey (USHBS) demonstrate that the central region, in which Kalangala is located, has the highest HIV prevalence in the country, reported at 8.5%. The secondary analysis of the USHBS central region data indicate that Kalangala District, has a prevalence of 27% which is approximately five times the national average, thus this population of fishermen and their families have been identified as a very-high risk group.

By July 31 2008, the program office had been established and equipment procured; project staff including 45 full time staff and 100 mobilisers had been recruited and trained; 3,401 individuals including 155 couples had received HIV counseling and testing and 711 HIV-positive individuals had been identified and provided basic palliative care and referred for chronic care management. As part of the community education and counseling support provided to individuals who had accessed the services, messages promoting abstinence and be faithful (AB) interventions aimed at stemming HIV infections among individuals, couples, and families were developed. Community mobilisers were trained to conduct prevention education sessions for the fishermen and their families with a focus on behavior change practices that emphasize mutual fidelity among partnerships. Field teams and volunteers were trained to disseminate AB prevention messages when counseling patients. In collaboration with the District Directorate of Health Services, local fishing groups and PHA networks, this program used a variety of communication channels such as drama, community meetings, and where appropriate, radio programs at local FM stations to reach target groups such as women and adolescents to disseminate the appropriate AB HIV prevention messages in the communities. Working with local community groups and PHA networks, the program supports the set-up and/or strengthening of community-based support groups and post-test clubs to assist in providing psychosocial support to persons who test positive for HIV. The program also supports 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 radio programs, community meetings, education sessions at identified community outlets and other similar fora, the program hopes to foster a dialogue among residents, with a view towards reducing negative attitudes about PHAs.

In FY 2009, the project will continue to support the implementation of sexual prevention interventions among individuals, couples and families targeted with HCT in the district with a view to increasing the number of mobilisers trained to conduct these activities. The activities will include the continued training of mobilisers to conduct prevention education to patients, training of field teams and volunteers to disseminate prevention messages and the use of communication strategies to reach target groups to disseminate AB HIV prevention messages. This activity proposes to reach approximately 50,000 individuals with AB interventions and train 160 volunteers. Additional community-based support groups and/or post test clubs will be strengthened or established and information, education and communication activities to reduce stigma and negative attitudes regarding PHAs will also be implemented, including training volunteers to promote these activities. The number of condom distribution outlets will be expanded to 35.

In collaboration with other partners, Kalangala district local government will increase access to HIV prevention messages for the communities, beyond abstinence and Be faithful. Condom service outlets will be expanded and in addition to condoms availed free, the social marketing options through the Uganda Health Marketing Group will be made available. In addition emphasis on staff and community mobiliser 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13222

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13222	9458.08	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8670	8670.08		\$70,000
9458	9458.07	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8792	8792.07		\$55,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1107.09	<b>Mechanism:</b> Mulago-Mbarara Teaching Hospitals - MJAP
<b>Prime Partner:</b> Makerere University Faculty of Medicine	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 8513.20758.09	<b>Planned Funds:</b> \$540,000
<b>Activity System ID:</b> 20758	



**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008.

Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council - KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP has been providing prevention counseling including Abstain "A" and Be faithful "B" counseling through the HIV testing programs. Prevention counseling has also been integrated into the care and treatment programs and OVC interventions (counseling and life skills training). In the Routine HIV testing and Counseling (RTC) program, couple testing is encouraged thus promoting HIV status disclosure and strengthening the B messages for couples. 'A' messages are encouraged for single youth below 18 years, among other interventions. Family members who are tested through the HBHCT program also receive prevention counseling. Since November 2004, more than 5,000 children and youth have been served through the MJAP Counseling and testing, care and treatment programs. We have provided HIV testing to over 3,000 couples, 19% of who were sero-discordant and 60% concordant negative. Since 2007, MJAP has been supporting the STD Unit of Mulago hospital to carry out facility based RTC and prevention counseling with a community component of targeted interventions towards Commercial Sex Workers (CSW) in selected communities around Kampala City whose HIV prevalence is as high as 40%, according to sentinel STI surveillance data. These interventions include HIV testing, STI screening and treatment, partner/contact tracing, community sensitization, training of CSWs peer leaders, and establishing condom outlets within these high-risk communities. In February 2008, MARPI (Most At Risk Population Initiative) project was started with an aim of i) providing HCT services to MARPs especially Commercial Sex Workers (CSWs), ii) increasing the level of comprehensive HIV/STD knowledge among MARPs, iii) providing effective STD services to CSWs and iv) promoting safer sexual practices and early STD care seeking behavior among the MARPs. A number of areas in Kampala district with high risk populations including Kisenyi, Kinawataka/Mbuya, Bwaise, Kagoma, Ndeeba, Kasubi and Ntinda were identified. A total of 9 additional staff was recruited. A total of 161 individuals were trained. Of these, 43 are peer leaders of CSWs while 118 are from the different sub-categories identified to be clients to CSWs. A total of 2,334 individuals have been tested for HIV. Of these, 637 individuals were tested through community VCT, 672 through facility based VCT, 975 through facility based RTC and 50 individuals through Sex workers clinic. Sero-prevalence among individuals tested through community VCT was 8.5% whereas that among individuals tested through the facility was 18.9%. Sero-prevalence among individuals tested through the sex workers clinic was 32%. Laboratory investigations were also carried out. These included 526 RPR tests for syphilis, 62 wet preparations and gram stains for STIs and 16 blood slide tests for malaria. In addition to the above services, MARPI promotes 100% condom use among sex workers and their clients through education and sensitization and also ensures that condoms are available and accessible through establishment of acceptable condom outlets. The Ministry of Health supplies the condoms. A total of 23 condom outlets have been established by far and 424,800 condoms have been distributed.

In FY 2009, MJAP will strengthen the integration of AB activities into the existing programs. Through FBC, the community outreach program that promotes HIV/AIDS through abstinence and/or being faithful, we will provide home based counseling and testing to family members of 2,500 households of index patients in care. Within these households we plan to reach 10,000 youth both male and female with interventions that emphasize health education, counseling support and life skills training to enable them make informed choices. The "A" activities will primarily target children and single youth below 18 years and the adults who are sexually active and/or married will also receive "B" messages and other prevention support including condom use, as appropriate. The "B" activities will also be integrated with couples counseling (in RTC and HBHCT) to encourage couples' HIV testing, disclosure of results and mutual faithfulness. We will also integrate the entire spectrum of prevention activities within the care and treatment sites through the positive prevention and family planning interventions. Through collaboration with the Mulago STD clinic, we will provide STI diagnosis and treatment to 4000 individuals referred from the community. Within the community

**Activity Narrative:** we will provide outreach voluntary HIV counseling and testing (VCT). The high-risk and commercial sex worker (CSW) communities have organized networks with peer leaders (queen mothers). We will train 400 such peer leaders whom we will use to distribute coupons for facility based VCT for individuals who do not wish to test within the community. These coupons will be numbered and tracked to evaluate the response rate of these referrals. HIV infected individuals identified through the community-based and facility-based HIV testing activities will be referred to the MJAP supported clinics and others facilities within Kampala. Education within the community will address STI and HIV prevention, and will address the entire spectrum of prevention (AB and condom use) as appropriate. We will identify and train peer leaders to mobilize the high-risk communities, provide education and support for distribution of condoms. We will also work with bar owners and attendants to distribute condoms through the 30 established outlets for high-risk groups. Through these activities we will reach over 5,500 individuals in the high-risk communities. Overall, 60,000 individuals will be supported in FY 2009 (includes HIV positive patients in the clinics, discordant couples, and high-risk groups in the selected communities in Kampala). We will provide condoms through 101 condom distribution outlets (all the 16 HIV clinics, 30 community outlets for high-risk groups, Mulago and Mbarara, and seven regional referral hospitals). The 'other sexual prevention' budget will cover training, IEC materials, health education and support for the PHAs who will be involved in the prevention interventions. We will strengthen the prevention with positives and family planning activities in all clinics, and will involve People living with HIV/AIDS (PHA) in prevention education and Counseling for patients. We will also strengthen the support for discordant couples identified through the HIV testing programs. All HIV testing facilities and care and treatment sites will provide condoms to support the discordant couples, in addition to the prevention Counseling. We will also improve on the data management, reporting and M&E for 'other prevention' programs. The capacity of the STD laboratory will be reinforced through purchase of additional laboratory supplies. We will also procure some additional drugs for treatment of STIs in order to supplement the MOH drugs, and support additional staff to improve the clinical management at the unit.

MJAP will support Post Sexual Exposure Prophylaxis beginning with the Mulago Hospital 5A Annex which is the reception ward for patients presenting with sexual assault among other obstetrics and gynecological emergencies. In this centrally initiated pilot program, MJAP intends to offer a comprehensive package of medical services for survivors of Sexual Gender based Violence (SGBV). This package will include emergency contraception, HCT, ART for the infected (post sexual exposure prophylaxis (PSEP); STI diagnosis and treatment, psychosocial support. Funding will go towards training in PEP for Health care providers, production and distribution of IEC materials, establishing linkages to Police and organizations offering psychosocial support through referrals and networking, recruitment of additional staff (counselors, social workers ), training of all the staff (midwives, laboratory staff, interns, medical officers, senior doctors) in PEP, RTC, and SGBV; procurement and infrastructure refurbishments ( Drugs, laboratory reagents and testing kits) treatment of STIs and soft tissue injuries. The results of this pilot will be used for a nation wide scale up of provision of PSEP services for survivors of SGBV with the ultimate aim of reducing HIV transmission and improving care and support as well as early linkage of those infected by HIV/AIDS virus to care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13272

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13272	8513.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$560,000
8513	8513.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$390,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$202,731

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

Estimated amount of funding that is planned for Education      \$16,000

## Water

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1298.09	<b>Mechanism:</b> HIV/AIDS Project
<b>Prime Partner:</b> Mildmay International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 8643.20794.09	<b>Planned Funds:</b> \$200,000
<b>Activity System ID:</b> 20794	

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

MU and RO have been implementing the AB strategy and other prevention through a number of activities. These include HCT, (which has been provided for over 22,423 people between April 07, and March 08 at TMC and 4,391 at Mbuya RO), AB sensitization and awareness that has benefited 15,816 people in FY 2007 and through support clubs like Our Generation Mildmay Adolescent Club (OGMAC) and group of persons living in discordant relationships. Other areas of prevention included condom distribution and training. Training carried out in the AB approach targeted specific groups like religious leaders, teachers, adolescents, and the youth. 35% of TMC patients are children and they benefited from the A aspect of prevention at TMC and family members of TMC clients tested through the VCT programme, are also targeted for AB messages. Couple counselling is offered to all patients and 'B' messages are emphasized for these couples. These activities are also extended to the communities around TMC clinics and clients at the rural sites through patients' workshops. Between October 1, 2007 and March 31, 2008, there were 9 sites under MU providing CT with a total of 9,310 individuals receiving CT and 2300 at RO. Multi-disciplinary hospital and home visits continued. The community programme was introduced in February 2008. Stable children together with their carers are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The main reasons for which counselling services were sought were mainly pre-ART counselling, Adherence and positive prevention which includes prevention of sexual transmission. 386 were trained and the training in this area includes imparting communication and counselling skills where knowledge of HIV status enables the individual to access care and support. Trainees are trained at both TMC and the rural districts. Workplace sensitisation programmes have also been carried out, notably to the Parliament of Uganda, where 300 individuals were trained and encouraged to know their HIV status. Training courses are typically 5 days to three weeks in duration. Between April 2007 and March 2008, through our AB strategy RO reached 2,719 youth aged between 12-24 years, 196 couples, 1,131 women, and 32 alcohol related adults. Several clubs function and include; discordant, couples for life, operation Gideon (Males), good Samaritan (females), Saturday children's club, AA, etc.

During FY 2009 MU will continue providing services and providing training activities at 12 sites of MU and 4 sites of RO. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. MU will continue to implement the ABC (Abstinence, Be Faithful, and Condom use) strategy and Other Prevention (OP) through a number of activities, which include HIV Counselling and Testing (HCT), sensitisation and education, condom distribution, support clubs like the persons living in discordant relationships and positive prevention clubs. The prevention of sexual transmission will be done for TMC clients, their families, communities around clinics, faith based organizations and schools and during

**Activity Narrative:** the VCT activities. The targeted numbers for FY2009 are 27,500 individuals (A=1,500; AB = 2,000 while other prevention = 15,000) and 9,000 at RO. The numbers will go slightly up in FY2010 to about 30,500 at both MU and its rural sites and RO. Abstinence messages are especially emphasized for the young people. Married people and couples in discordant relationships benefit from the ABC messages so as to prevent HIV transmission to the partner. These and other patients in risky situations are targeted with prevention messages including condom use, STI prevention and treatment, and family planning. The training will cover PMTCT, family planning, management of Sexually Transmitted Infections (STI) and adolescent sexual and reproductive health. A new area of emphasis in these two years will be treatment literacy and sensitization and follow up for persons who test HIV negative at TMC. The funding in this programme area will support the integration and strengthening of existing AB and OP activities like training, community mobilisation and awareness, production of IEC materials, support clubs, and monitoring and evaluation. In FY 2009, AB activities under RO will be further strengthened targeting 5,980 youth and adolescents in the communities and schools, 268 couples, 2,700 women, 100 local leaders, 100 discordant couples and 160 people affected by alcohol through spiritual and human awareness campaigns, sensitisation and training. 300 female and 150 male clients will be reached through adult education to equip them with basic writing and reading skills that will support the positive prevention strategies. RO shall expand their sexual prevention services including "moon-light" VCT to high risk groups such as; sex workers (50) and truck drivers (30).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13284

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13284	8643.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$220,000
8643	8643.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$200,000

#### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Military Populations

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 699.09

**Mechanism:** Basic Care Package  
Procurement/Dissemination

---

**Prime Partner:** Population Services  
International

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 4410.20858.09

**Activity System ID:** 20858

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$300,000

**Activity Narrative:** 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 is an affiliate of PSI with operations in Uganda since 1998. The organization aims to measurably improve the health of vulnerable Ugandans, with added emphasis on rural populations. PSI utilizes evidence based social marketing and other proven techniques to educate and promote sustained behavior change. PSI is committed to an effective partnership with the Ministry of Health (MOH) and supports various priority areas including, but not limited to, HIV/AIDS, malaria, child health and reproductive health. There are approximately 1.2 million Ugandans are living with HIV. Young women in Uganda, (not unlike prevalence statistics in most of Sub-Saharan countries) have much higher rates of HIV prevalence than their male peers. Several research studies have linked this disparity in prevalence, to sexual relationships with older men a practice known as cross generational sex (CGS). CSG is defined as a sexual relationship between a young girl and an older man 10 or more years her senior, in exchange for material gains. Of girls aged 15 – 19 years, 10% report having had sex with men 10 or more years their senior in the past 12 months (National Survey of Adolescents – Uganda 2006). The PSI Uganda 2005 Tracking Survey revealed that among university-going sexually active girls 19 – 24 years, 20% had been in a cross generational relationship, and 36% believe it is normal to engage in such relationships. Since September 2004, PSI has received PEPFAR funding through CDC. PSI Uganda has been implementing an HIV Basic Preventive Care Program (BCP) which is focused on reducing HIV-related morbidity and mortality and HIV transmission. Currently, BCP includes identification of PHA through family based counseling and testing. PSI BCP interventions are prolonging and improving the quality of their lives by preventing OIs; and prevention with positives interventions (PWP). The PWP strives 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), safer sex practices including abstinence, and fidelity with correct and consistent use of condoms. The program's implementation is supported by a multi-faceted communications campaign. Its aim is to educate PHAs on how to prevent OIs and live longer and healthier lives. This is accomplished in the following manner: utilization of cotrimoxazole prophylaxis, prevention of diarrheal diseases using household water treatment and safe storage, use of insecticide treated nets (ITN) for malaria prevention, and the prevention of HIV transmission to sexual partners and unborn children. In addition, BCP combines key informational messages, training and provision of affordable health commodities with evidence-based health benefits, which are simple for PHA and their families to implement. 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. PSI manages the procurement, packaging and distribution of all health commodities including condoms to ensure consistent supply of the basic care starter kits and refills the different commodities.

For FY 2008 PSI/Uganda received PEPFAR funds through CDC to implement a dynamic, multifaceted intervention program to address CGS. The program focuses on the reduction of CGS, alongside delay of sexual activity, secondary abstinence among girls aged 15 -24 years and fidelity among men aged 30 - 49 years. Between October 2007 and July 2008, PSI partnered with 151 HIV/AIDS care and support organizations in 54 districts including public and private hospitals, CBOs, FBOs, and NGOs to implement the BCP program. The program funding has increased tremendously over the past fiscal year, enabling the scale up of the program and enlisting of additional implementing partners. Further expansion and scale up of the program to public sites has been completed. The scale up to non CDC and government partner sites serves to increase the production, access and utilization of BCP health products and services among People Living with HIV/AIDS (PHA).

Distribution of condoms to adult clients occurs at 99 of the partner organizations. From October 1, 2007 to July 31, 2008, PSI has distributed 65,930 starter kits, containing 3,955,800 pieces of condoms and 1,731,517 condoms re-supplied for adult PHA. MOH has sources five million free condoms from their stock for this program. 1,212 health service providers and 553 peer educators have been trained to promote HIV/AIDS prevention beyond abstinence and/or being faithful, including correct and consistent use of condoms. PHAs have been actively involved in interpersonal communication activities at partner sites, which are comprised of health talks and community sensitization on HIV/AIDS prevention. As peer educators PHAs, have conducted 13,521 peer education sessions reaching an estimated 774,187 people. 269,165 IEC materials including posters, client guides, brochures and stickers have been distributed mainly through health units to clients and providers. To support the IEC campaign, STF has developed and aired 37,198 radio messages in eight local languages on 12 radio stations countrywide. Similarly, STF has also developed 112 parent talk programs, in 8 local languages and on 8 radio stations across the regions of Uganda. The radio program provides information to the general population and PHA in particular, on the benefits of the basic and palliative care components. Since program inception in September 2004, 174,766 adult PHA have received starter kits containing 10,485,960 condom pieces and 2,855,817 condoms re-supplied. 4,768 health service providers and 1,994 peer educators have been trained to promote HIV/AIDS prevention beyond abstinence and/or being faithful including correct and consistent use of condoms. Over 1,608,150 people have been reached with the IPC (peer education) activities.

**FY 2008 Sexual Prevention Achievements (October 1, 2007 to September 31, 2008)**

Indicator	Target Achievement to date (July 31, 2008)
Number of targeted condom service outlets	83 99 (Cumulative for 3 years)
Total number of individuals trained to promote HIV/AIDS prevention through providers, 553 peer educators) behavior change other than abstinence and/or being faithful	1,170 1,765 (1212)

The supply of condoms and other prevention activities ensures a regular and constant availability of condoms to eligible PHAs in Uganda. This will be achieved through the distribution of the complete starter kit and annual replenishment of 60 condom pieces per adult client. In FY 2009, US \$240,000 will be allocated for the procurement, shipping, handling, post shipment testing and packaging of a condom buffer stock to ensure continued access to condoms by PHA. PSI will procure more condoms, because MOH

**Activity Narrative:** supplies may be unpredictable, and may fall short of the national requirements; resulting in disruption of the assembly and supply of starter kits. A total of 2,174,400 condoms will be distributed in the starter kit, and there will be 5,600,000 pieces as refills. Other planned activities in FY 2009 include;

1. It is anticipated that in FY 2009, 5 new sites will be enrolled. For the new sites, preference will be for public facilities located in hard to reach areas; such as, islands in Lake Victoria and the Karamoja region. Through existing and new sites nationwide, 36,240 starter kits containing two LLINs, a safe water vessel, filter cloth, 60 condom pieces and four bottles of water treatment solution will be distributed to new adult clients.
2. Plans for program sustainability include;
  - a. PSI in collaboration with the local manufacturers and other partners like Uganda Health Marketing Group will continue to avail BCP commodities in the commercial sector. It is intended that all these commodities will be available nationwide through sustainable channels.
  - b. BCP activities will be further scaled up through district health structures including PMTCT sites.
  - c. Trainings will be supplemented by mentorship. Added emphasis will be placed on training and mentoring all public sector trainers on BCP, in addition to the whole site trainings that are currently conducted at all BCP service outlets. Each service outlet supervisor will also be trained (or retrained) and mentored as a BCP trainer.
  - d. Refresher training and training for new health service providers and peer educators in preventive care and prevention with positives initiatives will continue in FY 2009
  - e. BCC in FY 2009 will focus on sustaining BCP-related behavior change. This will be implemented by Straight Talk Foundation through development and production of radio spots, parent talk programs and radio talk shows. This will be supplemented by garnering for political support and utilizing testimonies of well known HIV authorities. Furthermore, through aggressive inter personal communication strategies social support in the communities will be attained.
  - f. Maintaining implementing partner regional network system and facilitate study trips across partner sites targeting unit heads and staff involved in BCP activities so as to learn from each others best practices as well as improve integration of BCP activities.
3. Communicate phase out plan to partners in the second quarter of FY 2009.  
The phase out plan will focus on:
  - a. Logistics management. PSI will build capacity of partner sites to manage BCP commodity procurement and distribution at individual sites.
  - b. The peer educators will continue to participate in routine site activities.
  - c. Distribution of IEC materials.
  - d. Updating and sharing of BCP partner sites service database.
4. Monitoring activities to track program implementation will also continue in FY 2009.
5. End of project evaluation

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13307

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13307	4410.08	HHS/Centers for Disease Control & Prevention	Population Services International	6437	699.08	Basic Care Package Procurement/Dissemination	\$300,000
8354	4410.07	HHS/Centers for Disease Control & Prevention	Population Services International	4812	699.07	Basic Care Package Procurement/Dissemination	\$250,000
4410	4410.06	HHS/Centers for Disease Control & Prevention	Population Services International	3341	699.06	Basic Care Package Procurement/Dissemination	\$250,000



## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1255.09	<b>Mechanism:</b> Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals
<b>Prime Partner:</b> Research Triangle International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 9636.20868.09	<b>Planned Funds:</b> \$80,000
<b>Activity System ID:</b> 20868	

**Activity 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.

During FY 2008, RTI initiated AB interventions as a new program area. The program is aimed at combating HIV infections among specific target populations which include: patients, youth (in-school and out of school) and adults in the supported districts. These target populations receive AB needs assessments and community education through outreaches and drama activities. RTI scaled-up AB activities by partnering with health facilities and community based organizations (CBOs) through sub-grants. However, due to the delay in the release of funds, this activity reached a much lower number of people, compared to the original anticipated figures.

In FY 2008, RTI expanded OP services in health facilities. These OP services have reached 19,066 HIV-positive individuals and their community members with positive with prevention (PWP) messages (Semi Annual Report 2008). RTI continues to implement several activities aimed at increasing risk perception for HIV transmission; especially among HIV+ positive individuals and their families. Health workers at supported facilities and PHA networks provide educational activities on risk perception including: counseling of patients on disclosure of sero-status to sexual partners, partner testing, use of family planning methods to reduce vertical HIV transmission, promotion of behavior change emphasizing the correct and consistent condom use among sero-discordant couples and populations that engage in high-risk behaviors.

During FY 2009, RTI will assist health facilities with the setting up of clinic-based support groups and post-test clubs including; a discordant couple clubs, which will assist in providing post-test counseling and psychosocial support to HIV-positive individuals. RTI proposes to reach 30,000 individuals with OP messages. The project also will increase the role of PHA leaders and networks through the provision of small grants; helping to strengthening their capacity to reach members in their networks by utilizing PWP approaches.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13313	9636.08	HHS/Centers for Disease Control & Prevention	Research Triangle International	6439	1255.08	Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals	\$100,000
9636	9636.07	HHS/Centers for Disease Control & Prevention	Research Triangle International	4872	1255.07	Routine Counseling and Testing in Two District Hospitals	\$40,000

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$5,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 7624.09

**Prime Partner:** Visions in Action

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 17253.20852.09

**Activity System ID:** 20852

**Mechanism:** New Partners Initiative:Visions in Action

**USG Agency:** HHS/Health Resources Services Administration

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$0

**Activity Narrative:** Visions-in-Action is a non profit organization committed to achieving social and economic justice in the developing world through grassroots programs and communities of self-reliant volunteers. VIA aims to combat the spread of HIV/AIDS by expanding its volunteer model to include local Ugandan volunteers as peer HIV counselors and is currently implementing a large VCT program targeting the war-affected youth of Northern Uganda. This is a 3 year program that began in June 2007, the first VCT services commenced on 31st July 2007 and the program is due to end November 2009. The goal of this program is to decrease the HIV/AIDS incidence and prevalence rates amongst youth in Northern Uganda. Counselors provide free counseling and testing services so that the target beneficiaries can voluntarily become aware of their HIV status, receive information on keeping safe, be referred for medical care and support and participate in ongoing support groups.

During FY08 Visions in Action planned to reach a total of 100,000 youth through an extensive IEC outreach campaign through the media, in schools and through community organized events. One of the major logistical challenges we face is the increased efforts in the transition of the internally displaced persons back to their homes of origin, thus dispersing people over a wider geographical area. Some 3,000 youth were expected directly participate in the AB workshops, 3,000 to attend Anti-stigma workshops and 3,000 on Living Positively conducted by VIA's local NGO partners. The IEC campaign seeks to promote youth awareness of the importance of VCT, and also provide logistical information on where and when to get tested. IEC is specifically conducted through radio spots, posters, billboards, banners, newsletters and stickers distributed throughout the region, in both English and Acholi. The ABC approach will be emphasized, especially a women's right to say no to sex before marriage. For young men, the focus will be on not giving in to peer pressure from other men to have sex with their partners before marriage. School and community theatre productions dramatizing the need to be tested, and actions taken afterward, will be performed by youth in the IDP camps. An annual VCT drama competition among secondary schools will be organized. Billboards will be placed in strategic locations on the main roads in Gulu and Kitgum, and near the testing centers lasting at least three years in both Acholi and English. To date VIA is conducting community mobilization and awareness sessions at least twice per week and providing information on AB, Anti-Stigma and Living Positively almost 19,000 people have attended the workshops and community mobilization sessions in the past year. The IEC team has designed and distributed an array of IEC materials, including posters, brochures, newsletters to schools, health clinics, bars, restaurants and other public places. Radio advertisements are being continually run promoting the "Know Your HIV Status" campaign. Two billboards have been erected on the main roads leading to and from both Gulu and Kitgum. The materials have been designed to reinforce the importance of knowing your HIV status, that you can go to a Visions in Action VCT Center and get confidentially tested, and that there is hope and treatment for those testing positive. The radio ads have had the widest circulation, and impact being played on the two major FM stations with an active listener base of 300,000+ persons covering the entire Acholi region.

In FY 2009, VIA will continue to run the same activities: IEC campaign will reach 100,000 youth covering 2 Districts, Gulu and Kitgum, in 9 sub-counties (Gulu: Palaro, Awach, Paicho, Odek and Patiko. Kitgum: Lagoro, Paloga, Palabek Ogili and Palabek Gem). Over 9,000 youth participants will attend intensive workshops on abstinence, anti-discrimination and HIV+ care & support through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful. Posters, brochures and newsletters will continue to be distributed. VIA will continue to strengthen relationships and work in collaboration with the local community leaders, district government officials, government health institutions, NGOs and other HIV agencies working in the area.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17253

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17253	17253.08	HHS/Health Resources Services Administration	Visions in Action	7624	7624.08	New Partners Initiative:Visions in Action	\$0

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 12431.21215.09

**Planned Funds:** \$20,000

**Activity System ID:** 21215

## Activity Narrative: ACTIVITY UNCHANGED FROM FY 2008

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 phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a smaller extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old. The RHSP medical male circumcision program: Three trials of male medical circumcision (MMC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MMC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MMC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. As part of the MMC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstinence from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as a regional MC training center.

Community based health education is being provided in an effort to continuously inform communities about HIV/AIDS and STD prevention. Over 4700 individuals attended the general community health meetings, with an almost equal distribution by gender i.e. ~ 52% females. Two community health mobilisers (CHMS) meetings and 3 Community advisory board (CAB) meetings have been held so far (2 of which were quarterly meetings and 1 an executive meeting). During these meetings the role of CAB in community based ART program as well as the role of abstinence and faithfulness (AB) were discussed. Over 182 clinics on site health education sessions have so far been conducted. Each clinic day starts with a one hour health education/ question and answer session to address general patient concerns as well as general topics like HIV/STD prevention, including ABC, positive living, drug adherence, sanitation/hygiene, family planning, nutrition, and disclosure. Other harmful behaviors like alcohol abuse, smoking and drug use are discussed on a rotational basis. Each session is attended by 60-80 patients.

Rakai HSP has successfully reviewed and approved message to be included in the drama scripts. The drama messages address AB among other things. So far 9 drama sessions have been conducted attracting

**Activity Narrative:** a total attendance of 1245 people (704 females and 541 males).

Under the circumcision service program, 25 community meetings have taken place with an attendance of 1620 people (854 females and 766 men). Six sensitization meetings have so far been conducted with 226 men and women.

Community based health education and AB promotion will be maintained in an effort to continuously inform communities about HIV/AIDS and STD prevention. Through the VCT program HIV prevention counseling including AB messages will be provided. The program will continue to integrate prevention counseling into the care and treatment programs. Couples testing will be encouraged thus promoting mutual disclosure of results and strengthening the B messages.. 'A' messages will be encouraged for single adolescents in and out of schools. Efforts will be made to integrate other prevention interventions at the following levels 1) prevention counseling and couples counseling and testing in the VCT program, 2) prevention with positives counseling and support for all patients in the HIV/AIDS clinics and PMTCT program, 3) integration of prevention counseling in the MMC program, 4) Post-exposure prophylaxis for health care providers and post- sexual exposure (rape and defilement). Other prevention activities will include prevention counseling, condom education and distribution, STI diagnosis and treatment. The Program will continue to educate communities about the entire spectrum of prevention interventions; abstinence, faithfulness and other prevention including MMC, as appropriate. We will also continue to implement gender based violence (GBV) activities. The education activities will be conducted in Rakai and neighboring districts through the following fora;

- Community advisory board meetings will be held quarterly. The CAB, who are community representatives, will continue to advise the program on best ways of packaging the AB messages in an appropriate community sensitive manner, and on how to reach potential program beneficiaries. The CAB will also be part of the team that will promote AB and other prevention in their communities.
- CHM meetings will be held annually. The CHMs reside in communities within the program operational areas, they, like the CAB members will play advisory as well as dissemination roles in the promotion of AB and other prevention in the communities.
- Health education sessions will be used to actively promote AB and other prevention. The program has a well trained, qualified, and experience team of health educators which works in collaboration with the district health education team. Education sessions will be held in phases including sensitization meetings that will target community opinion leaders, village/town meetings to target whole communities, HIV satellite clinics sessions to target people enrolled in ART care programs, at circumcision centers to target people enrolling into the circumcision program. Attempts will also be made to reach out of school adolescents.
- Drama shows will continue to be used in promoting AB and other prevention. We have two experienced drama groups that do the shows. Drama scripts will be modified to add more messages to promote AB and other prevention.

Additional information will be given during the education sessions which will include educating communities about the locations of satellite clinics within their communities, the kind of services they should expect to receive at the facilities, the clinic days, and also discuss a range of other issues including PMTCT, reproductive health, pediatric HIV care, feeding for infants living with HIV, adherence, stigma, community engagement/role into successful HIV care provision and access, and challenges/ opportunities especially during the discussion component of the meetings. Similar education avenues will be used to educate communities about availability of male circumcision services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13233

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13233	12431.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$20,000
12431	12431.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$54,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$10,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 7306.09

**Prime Partner:** Creative Associates International Inc

**Mechanism:** UNITY

**USG Agency:** U.S. Agency for International Development

---

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 15978.21744.09

**Planned Funds:** \$450,000

**Activity System ID:** 21744



## Activity Narrative: Activity Narrative

One of the objectives of the three-year Ugandan Initiative for Teacher Development and Management System (TDMS) and PIASCY (UNITY) Project is to expand implementation of the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), and strengthen Guidance & Counseling (G&C).

PRIMARY PIASCY: Between 2003 – 2005, the USAID-funded BEPS/SUPER Project supported the development and piloting of PIASCY Primary; its launch, development and printing of Teachers' and pupils' handbooks for Lower Primary P3-P4 and Upper Primary P5-P7, Log book and Posters. All these materials were distributed to 15,000 public schools and 23 Core Primary Teachers' Colleges (PTCs). 45,000 teachers from 15,000 public schools were trained in the use of the materials. PIASCY Primary has since been the mandate of UPHOLD. UNITY project was responsible for the production of HIV Readers.

UPHOLD's PIASCY Achievements:

UPHOLD printed and distributed 100,643 PIASCY G&C materials to all primary schools, trained 17,305 primary, teachers and Supported school based activities in 2,156 primary schools and their Coordinating Centers. The effort led to the institutionalizing of PIASCY HIV Education in schools and PTC's, regular passing on HIV related information through talks, music, dance, skits/drama, testimonies, and other innovative student-led activities. It resulted into the strengthening of MOES systems through provision of support supervision and monitoring of 80 districts and approximately 3,500 model schools each term. UPHOLD has ended and UNITY Project is continuing implementation of Primary PIASCY and G&C.

PROGRESS TO DATE:

PRIMARY – HIV READERS: UNITY Project developed and delivered a kit of 12 books as reading materials to support the PIASCY initiative. The 12 themes are HIV related and relevant to the challenges and situations that prevail in the community. They are aimed at improving HIV literacy and impacting behavior change for upper primary pupils, their parents and the community around their school. The project distributed 60,343 kits and 30,758 teachers' manuals to 9,980 primary schools in 64 districts, 47 Primary Teachers' Colleges, MOES departments and partners. It trained 7,714 primary teachers, Tutors and MOES Officials in the effective integration of the content into the school curriculum, co-curricular activities and community outreach programs.

POST PRIMARY EDUCATION and TRAINING (PPET): PIASCY - The major thrust of PPET PIASCY is the enhancement of abstinence among learners and faithfulness among the teachers and other members of institutional staff. The project has so far printed 21,500 Teachers Resource books, 72,500 students' hand books for lower secondary and 13,500 for upper secondary, 60,000 G&C Guidelines; and 22,500 G&C Teachers Resource books. The materials were distributed during teacher training workshops. 40 Master trainers and 3,654 Teachers in 688 schools from four regions: West Nile, northern, north eastern and eastern regions were trained. As follow up of PIASCY implementation, UNITY has conducted support supervision and monitoring of 75 institutions in Acholi and Lango sub regions.

SPECIAL NEEDS EDUCATION (SNE): - UNITY project has supported SNE Department to braille PIASCY, G&C and HIV Readers materials to benefit pupils, students and teachers with visual impairment. This support covers all the SNE institutions nationwide.

FY 2009 – FY 2010 ACTIVITIES:

With new pupils and students entering school every year, as others leave, the PIASCY program should be a continuous program as it is always reaching out to new populations.

PRIMARY PIASCY - In order to consolidate gains made under BEPS and UPHOLD, the UNITY Project will strengthen the Whole School Approach to include all stakeholders in addressing factors that influence behavior and increase community support and involvement in HIV mitigation. In collaboration with the MoES, UNITY will develop comprehensive guidelines and orient teachers on how to embrace and effectively adapt the Whole School Approach to the PIASCY strategy. The community engagement aspect will be enhanced by initiating the "Stakeholder Champions of Behavior Change" in which community leaders, Members of Parliament, and other concerned citizens will serve as models and advocates of behavior change. The project will adopt an in-depth approach to G&C in order to equip teachers with skills to address HIV related trauma. The activities will primarily be school based, involving teachers, Center Coordinating Tutors (CCTs), parents, opinion and community leaders, as well as district officials. The UNITY proposed activities will focus on promoting a risk free school environment for pupils– supporting schools to put in place advocacy and action oriented interventions to curb sexual abuse, harassment, defilement, negative peer pressure and corporal punishment. This will promote the safety friends network, a peer support mechanism that supports children to become proactive with skills and strategies for their collective safety. To ensure school based implementation of these strategies, UNITY will collaborate with MoES to orient teachers, tutors and district officials on the basics of ensuring a safe school environment, and use music, dance and drama as a tool to educate while at the same time promote a safe environment for pupils at school and in the community.

UNITY's key approaches will include enhancing the capacity of teachers to identify vulnerable children in order to provide initial Psychosocial Support to the affected pupils. It will support the mapping of local and regional service providers for the teachers, to enable appropriate referrals, the initiation of a Networking Model to enable schools to form viable partnerships with organizations that provide specialized counseling, (specifically The AIDS Support Organization (TASO) and Supporting Public Sector Workplaces to Expand Action and Responses (SPEAR) against HIV and AIDS.

UNITY will promote Peer to Peer Education and the inculcation of Life skills (with a focus on Assertiveness, Effective Communication, Decision Making, Self Esteem and Peer Pressure Resistance) that are key to HIV mitigation and personal Stigma and Discrimination. Working closely with the MOES/G&C department, UNITY will

**Activity Narrative:** review the G&C intervention to strengthen it and focus it on addressing Stigma and Discrimination.

UNITY will develop a motivating scheme to acknowledge Schools of Distinction for their innovations. Adapt and disseminate low cost incentives to complement the process that had been initiated by UPHOLD. The project will document the good practices for replication and this will be further incentive to schools, CCs, PTCs and districts to improve their performance and sustain the initiatives.

PPET – In FY 2009 UNITY will roll out the PPET PIASCY Program to the regions of western, central and the remaining parts of eastern sub-region. The roll out will include printing of materials; teachers' resource books, students' hand books for lower and upper institutions, training manuals and posters). To be followed by the training of teachers, distribution of materials, and support supervision of institutions to ensure proper implementation of program activities.

In addition to the above, there will be in-depth orientation of teachers to psychosocial issues, in order to strengthen school-based implementation. The project will support G&C and club activities that create a conducive learning environment at school level and the development of 'Talking' and interactive environments; this is the display of key messages in the compound and classrooms, also using school assemblies to impart PIASCY targeted knowledge and education on HIV on a regular basis. Emphasis will be on student centered initiatives to facilitate learners' internalization of information and action for behavior change. The project will encourage voluntary testing for HIV while creating necessary referral systems for young positives and HIV positive teachers to access services. All the above activities will mainstream gender and disability.

UNITY's priority will be targeted support to the north and eastern regions. Under PPET PIASCY, UNITY will address G&C as well as set up referral mechanisms to address the issues of psychosocial care and support for those learners who face post-conflict trauma.

The strategy will be to identify institutions that have good practices, support them to document them and share them with other institutions in the region and beyond. These will become PIASCY epicenters where high levels of support will be given to work as satellite institutions to provide leadership to other institutions in terms of program implementation, by developing and perfecting good practices, documenting and modeling them for replication.

SPECIAL NEEDS EDUCATION (SNE): - UNITY Project supported the brailing of PIASCY materials, HIV Readers, and guidelines for mainstreaming disability to benefit pupils, students and staff with visual impairment. In FY 2009, UNITY will expand on its SNE activities by brailing more materials to cover schools outside the Phase 1 coverage, brailing new materials and providing orientation for teachers and instructors to effectively utilize the braille materials. All Special Needs Institutions will be supported with materials and teacher training.

UNITY will adapt the PIASCY Intervention (Primary and PPET) for the Hearing Impaired to ensure that learners with special needs benefit from HIV mitigation interventions; a mini-pilot in one Northern Uganda district will be carried out to provide a viable model for replication. The project will support the review and adaptation of the G&C component for further inclusion of persons with disability.

During FY 2009, UNITY will expand the distribution of HIV Readers to 16 districts, thereby ensuring national coverage. The HIV Readers are child friendly booklets meant to increase children's knowledge of HIV/AIDS transmission and mitigation. These readers have been carefully developed to be age appropriate, with linkages to the PIASCY manuals to reinforce content and to encourage critical thinking about behavior change. The readers encourage children to read, increase HIV knowledge, and help pupils to internalize the issues and analyse their personal behavior, thanks to exercises and homework included in the various chapters. UNITY also ensures that teachers are oriented in the use and purpose of the readers.

CHALLENGES: Now that the software has been developed and used as well as refined, the challenge for PIASCY is to improve the environment into which PIASCY is rolled out, to better ensure that the program is successful and sustainable.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15978

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15978	15978.08	U.S. Agency for International Development	Creative Associates International Inc	7306	7306.08	UNITY	\$400,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Refugees/Internally Displaced Persons

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education**

Estimated amount of funding that is planned for Education \$400,000

**Water****Table 3.3.03: Activities by Funding Mechanism****Mechanism ID:** 7632.09**Mechanism:** HIV/AIDS Prison Survey**Prime Partner:** Uganda Prisons Services**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Sexual Prevention: Other sexual prevention**Budget Code:** HVOP**Program Budget Code:** 03**Activity ID:** 17050.21196.09**Planned Funds:** \$320,000**Activity System ID:** 21196

**Activity Narrative:** The prevalence of HIV, hepatitis B/C, HSV2, and tuberculosis in prisons is often disproportionately high relative to the general population. Limited access to health care, unprotected sex, injection drug use, tattooing, and other behaviors facilitate the transmission of blood-borne viruses in prison. Furthermore, movement of prisoners, staff, and visitors in and out of prison increases the opportunity for transmission among prisoners, staff, and the community. Little information exists on HIV prevalence, incidence, and correlates of infection in Uganda prisons. Data collected in 1987 and 1996 found prevalence to be 15% and 26% respectively. HIV-related illnesses were the major cause of death among inmates in 2005. To develop empirically-based HIV prevention and treatment programs for staff and prisoners of the UPS, this evaluation will assess the prevalence/incidence of HIV, determine the prevalence of HBV, HCV, HSV-2, and TB, and identify the correlates of prevalent/incident HIV infection by assessing knowledge, attitudes, beliefs, and practices. The empirically-based data collected through this evaluation will provide the basic information necessary to develop, test, and implement subsequent prevention and treatment initiatives that reduce the risk of HIV transmission and provide access to and continuity of care among HIV-infected prisoners and staff of the Uganda Prisons Services.

A single eligibility funding opportunity announcement (CDC-RFA-PS08-856) was published for FY2008 and an application submitted by Uganda Prison Services. Funding allocated for FY2008 will be carried over to FY2009 and therefore this project is now proposed to start in FY 2009.

In FY 2009, the following activities will be undertaken:

1. Development of serobehavioral and protocol, project infrastructure and staffing.
2. Obtain regulatory approval of serobehavioral survey protocol and instruments.
3. Conduct sero-behavioral survey. Prisoners and staff will participate in quantitative and qualitative interviews, as well as provide blood samples for HIV, Hepatitis B/C virus, HSV2 testing. Study participants will complete an Audio Computer Assisted Self Interview (ACASI) assessing knowledge, attitudes, beliefs, and practices potentially related to HIV transmission. A HIV treatment and care needs assessment will also be incorporated into these survey activities. CDC will train prison staff and inmates to use appropriate survey-related technology. Blood will be drawn and transported to the CDC laboratory in Entebbe for testing HSV 2, Hepatitis B/C and TB.
4. Evaluation Questions will include:
  - a) What are the current HIV treatment and prevention activities and challenges in the UPS?
  - b) Does the prevalence of HIV, STIs and TB among prisoners and staff of the UPS exceed that of the general population?
  - c) What is the estimated incidence of HIV infection among prisoners and staff of the UPS as determined by the BED assay?
  - d) What are the correlates of HIV infection among prisoners and staff of the UPS?
  - e) What is the prevalence of injection drug use, non-injection drug use, and sexual risk behavior among prisoners and staff of the UPS?
5. Methods will include:
  - a) Process measures will be used to determine current treatment/prevention activities and challenges.
  - b) Cross-sectional survey design protocol will be developed and data collection will commence in FY09.
  - c) Multistage probability sampling will be used to randomly select a subset of prisons within the UPS (total institutions=224), prisoners within selected institutions (total prisoners=27,000), and staff within the selected institutions (total staff=4,171).
  - d) A 25% sample of prisoners will be randomly selected from the sampling frame composed of individuals incarcerated within the five largest prisons and those institutions that were randomly selected.
  - e) Study participants will complete an Audio Computer-Assisted Self-Interview (ACASI) assessing knowledge, attitudes, beliefs, and practices potentially related to HIV transmission/acquisition.
6. VCT:
  - a. 3375 prisoners and 521 staff in sampled prisons across the country will receive VCT in FY 09.
  - b. Ministry of Health protocols for routine HIV testing will be used to identify HIV-infected prisoners and staff and to determine HIV prevalence among UPS institutions and administrative regions.
  - c. CD4 testing and the BED serologic incidence assay will be used to determine the prevalent or incident status of HIV-positive specimens.
  - d. All testing will be conducted by the CDC laboratory in Entebbe.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17050

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17050	17050.08	HHS/Centers for Disease Control & Prevention	To Be Determined	7632	7632.08	HIV/AIDS Prison Survey	██████████

---

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Military Populations

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$105,792

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.03: Activities by Funding Mechanism****Mechanism ID:** 9320.09**Prime Partner:** To Be Determined**Funding Source:** GHCS (State)**Budget Code:** HVOP**Activity ID:** 21457.21768.09**Activity System ID:** 21768**Mechanism:** Community-based Care and Support/TASO Follow on**USG Agency:** U.S. Agency for International Development**Program Area:** Sexual Prevention: Other sexual prevention**Program Budget Code:** 03**Planned Funds:** ██████████

**Activity Narrative:** This is follow-on to USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to the Government of Uganda (GOU) and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated capacity to manage USAID programs as prime partners.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from the sole sourcing or subgrant approach to direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs

The activity will support expansion of epidemiologically-appropriate, context specific, best-practice HIV prevention interventions that apply the "ABC" approach to preventing sexual transmission across different groups including community engagement and dialogue to address coercive, transactional or cross-generational sex in communities.

Through this mechanism, USG intends to conduct prevention activities in line with the Uganda National Road-Map for HIV Prevention which aims to accelerate HIV prevention activities including reduction of sexual transmission of HIV, PMTCT, post-exposure prophylaxis, promotion of counseling and testing, disclosure, protection of vulnerable populations, integration of HIV prevention into treatment and prevention of sexually transmitted infections.

Prevention AB messages will be tailored to address the HIV/AIDS challenges of specific target groups. Abstinence-tailored prevention messages will target children, adolescents, students, out-of-school youth and HIV-infected children. The Be-Faithful-tailored messages will target sections of the general adult population deemed to be sexually active and so vulnerable to HIV infection e.g. married or cohabiting couples, men and women.

This activity will also support targeted HIV/AIDS prevention activities within HIV/AIDS care and support settings by targeting PHAs, couples, their families and community members. The messages will focus on abstinence, fidelity, partner reduction and consistent condom use. This activity will also advocate for national level policy and strategy formulation for promoting and implementing other evidence based HIV/AIDS prevention activities including medical circumcision for HIV negative male partners, and concurrent partner reduction. Support scaling-up of approaches for HIV secondary prevention counseling to individuals and couples of persons living with HIV/AIDS.

USG intends to reach the target groups through different approaches including: live radio talk shows, school focused prevention activities in coordination with PIASCY, HIV/AIDS prevention communication and campaign through community venues and networks, integration of HIV/AIDS prevention activities within HIV/AIDS care and treatment services. Moreover, USG will support local and national leaders, volunteers, and other influential community members to respond to the epidemic and to reinvigorate national HIV/AIDS prevention campaign.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21457

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21457	21457.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$407,340

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Family Planning

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 1258.09

**Prime Partner:** Family Health International

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 4508.21760.09

**Activity System ID:** 21760

**Mechanism:** Roads to a Healthy Future/ROADS II-SafeTStop Project

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$750,000

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these three sites, Busia, Malaba and Katuna truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. HIV services in the sites have historically been underdeveloped. While sexual prevention programming has had significant impact, it can still be scaled up to reach more truck drivers, community men and women, and out-of-school youth. Programming through ROADS is addressing critical drivers of the HIV epidemic in Busia, Malaba and Katuna, including joblessness and the absence of recreation beyond drinking. Yet there is still a high level of hazardous alcohol consumption in the community and alarming levels of gender-based exploitation and violence against women, young girls and boys.

Since launching SafeTStop in Busia, Malaba and Katuna, ROADS has reached more than 206,000 people with sexual prevention programming (January 2006-March 2008). This has been accomplished in partnership with more than 70 community-based organizations, which were organized into "clusters" for joint program planning, training/capacity building and implementation. Through June 2008, ROADS has trained 2,743 individuals in the three sites. Activities have included peer education and counseling, magnet theatre, and condom promotion and distribution. Target audiences have included truck drivers, community men and women, in- and out-of-school youth, and commercial sex workers. Venues have included SafeTStop Resource Centers, private drug shops/pharmacies, health facilities, faith-base organizations, and private businesses, including lodges, guesthouses and petrol stations (through the Energy Institute of Uganda). ROADS distributed more than 110,000 condoms through 50 outlets during October 1, 2007-March 31, 2008 alone.

In FY 2009, ROADS will strengthen ongoing sexual prevention programming in the three existing sites to reach 130,000 individuals (66,300 females and 63,700 males) with HVAB programming and 130,000 (66,300 females and 63,700 males) with HVOP, training 3,000 people to deliver HVAB and HVOP messages. In FY 2010, we propose to reach 149,500 (76,245 females and 73,255 males) with HVAB programming and 149,500 (76,245 females and 73,255 males) with HVOP, training 3,000 (refresher and replacement) to deliver HVAB and HVOP messages. There will be special emphasis on prevention among discordant couples. ROADS will integrate with existing services, where possible, as a priority. This will include linking HVAB and HVOP activities with such services as C&T, ART, PMTCT and existing efforts to promote and distribute condoms. Importantly, we will harness our community structures to promote messages relating to FP/RH, malaria (barriers to use of ITNs), and child survival (promotion of immunization, etc). In Busia, Malaba and Katuna, ROADS will mobilize the private sector, especially brothel/bar/guest house owners, and promote joint action to reduce risk for bargirls and patrons. This will include work with the AFFORD Project and other PEPFAR partners to provide condoms through 110 outlets in FY 2009 and 135 outlets in FY 2010. To enhance the community education effort, local pharmacists/drug shop providers will receive expanded training in managing STIs, condom promotion and referral for C&T. ROADS will continue to utilize the SafeTStop resource centers as a central focus for community outreach, offering C&T at regular times convenient for MARPs, 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. The project will continue strengthening linkages with local health facilities, including pharmacy/drug shop providers to promote expanded C&T and other services for truck drivers, sex workers, other community men and women, and sexually active youth. With FY 2009 funds, we will continue to address joblessness among women and youth (through the LifeWorks Partnership), alcohol abuse, and gender-based violence as key HIV prevention and care strategies. This will include addressing male norms that impact women's access to services, legal protection for women and youth, post-rape services, and legal and law enforcement services. The project will also expand food/nutrition support to enhance HIV prevention, care and treatment. With FY 2009 funds, ROADS will introduce an innovative MP4 device with HVAB and HVOP content for use by drivers on the road and discussion groups where they stop. SUSTAINABILITY: Almost all partners on the project are local entities that exist without external funding. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project were established without outside assistance and will continue functioning over the long term. Local businesses, traders, market sellers, etc. are also part of the fabric of community life and will be present over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

EXPANSION SITES: Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DRC; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. Because Kasese and Koboko are growing rapidly it would be most cost-effective to intervene early with prevention programming. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.



**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14193

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14193	4508.08	U.S. Agency for International Development	Family Health International	6736	1258.08	ROADS - SafeTstop Project	\$750,000
8416	4508.07	U.S. Agency for International Development	Family Health International	4833	1258.07	Northern Corridor Program/Uganda Section	\$750,000
4508	4508.06	U.S. Agency for International Development	Family Health International	3366	1258.06	Northern Corridor Program/Uganda Section	\$150,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$50,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$190,000

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 5028.09

**Mechanism:** HIPS (Health Initiatives in the Private Sector)

**Prime Partner:** Emerging Markets

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 9084.21753.09

**Planned Funds:** \$150,000

**Activity System ID:** 21753

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

In partnership with the private sector, HIPS implements activities to improve accessibility to information and messages on HIV/AIDS at the work place. HIPS has adopted the Uganda Health Marketing Group (UHMG) '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 and STIs at work place settings and in surrounding communities. Messages also target the reduction of high risk behaviors especially among 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 nearly half of those reached are men. At least 1500 male and female peer educators have so far been trained; over 20 health fairs have been held. Through these and other mechanisms, over 100,000 persons have been reached with other sexual prevention messages. Condoms have also been sold to partner companies who distribute these to the company workers, out-growers and surrounding communities.

The activities for FY 2009 include but are not limited to the following:

1. Peer educator training; in FY 2009, HIPS will conduct training of 2000 peer educators to disseminate messages and information aimed at reducing risky behavior and preventing HIV transmission among company workers, out growers, migrant workers and surrounding communities. Participants for these trainings will be company workers, out growers (where they exist) and surrounding community members so as to effectively reach the target population. These peer educators will also act as condom distribution agents to their peers at the work place and in the community. They will also be trained to disseminate information on STI management and prevention. This is anticipated to result in sexual prevention through condom use. This activity will be conducted among all HIPS partner companies across the country. Focus will also be placed on fighting stigma and discrimination, promotion of messages on positive prevention, promotion of adherence to ART, home-based care and VCT. HIPS will employ a training of trainers (TOT) model to increase the number of peer educator trainers, to include members of Straight Talk Foundation, Living Goods, UHMG, and company employees who will add to the HIPS network of trainers, extending HIPS reach.
2. Provide relevant information to both stationary and highly mobile worker populations (migrant workers) such as seasonal workers from sugar and tea estates. Through various health fairs organized in partnership with companies, and with the aid of peer educators, HIPS will provide relevant information to company workers and the neighboring community with health information relating to sexual prevention.
3. Promote consistent use of condoms to avoid the increasing risk of transmitting sexually transmitted diseases. This will involve the purchase and distribution of condoms, and educating target audiences in correct and consistent condom use and other means of HIV prevention. HIPS will support a marketing officer at UHMG to focus on the promotion and sales of health products at HIPS partner companies.
4. Support to private companies to provide prevention programs that benefit employees, dependants and surrounding community. The prevention programs will include focus on problems related to alcohol abuse/consumption and substance abuse.
5. Promotion of responsible behaviors that reduce risks of transmission such as couple counseling and testing, mutual disclosure within established couples, correct and consistent condom use for both the work place setting populations and discordant couples.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14170

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14170	9084.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$150,000
9084	9084.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$150,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$51,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1222.09	<b>Mechanism:</b> Peace Corps
<b>Prime Partner:</b> US Peace Corps	<b>USG Agency:</b> Peace Corps
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 3993.21610.09	<b>Planned Funds:</b> \$513,200
<b>Activity System ID:</b> 21610	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

The Peace Corps Uganda Emergency Plan program supports the USG Strategy of the Emergency Plan (the EP) for Uganda. By supporting the EP Strategy Peace Corps Uganda contributes to the Uganda National Strategic Plan (NSP) for HIV/AIDS, and, in turn, to the goals and objectives of our partner organizations which are hosting Volunteers. The program is designed so that Volunteers are closely engaged with a community through one or more hosting organizations, providing technical assistance for capacity building, and developing close personal relationships necessary for effective innovation in underserved areas. The EP allows Peace Corps Uganda to strengthen community and Volunteer HIV/AIDS expertise and service delivery, and to support highly focused community organizations in a variety of HIV/AIDS functions.

Peace Corps Uganda has been involved with PEPFAR activities since its inception in Uganda in FY04. From FY 2006 to date, 55 PEPFAR-funded two year Volunteers, have been added to Peace Corps Uganda's portfolio and placed with prevention and care programs. Through these Volunteers and ongoing training and small project support activities, Peace Corps was able to strengthen community and Volunteer HIV/AIDS expertise and support HIV/AIDS-focused community organizations to enhance their organizational capacity and implement a variety of HIV/AIDS prevention and care interventions. From FY 2007 to date, Peace Corps Volunteers have reached 10605 with Abstinence Only messages, 56655 individuals with sexual prevention AB and other prevention messages, trained 1582 service providers and assisted 171 services outlets through organizational development support and training. Currently, a group of 25 PEPFAR- funded two year community health trainees are undergoing pre-service training and will be deployed at the end of October. In all assignments, Volunteers are prepared through pre-service training to encourage their partner organizations to either; 1) incorporate a full range of prevention, care, and treatment services, or 2) to actively seek out and use local referral opportunities to ensure all individuals and families receive necessary services. This commitment reflects and supports the emphasis on the Ugandan Network Model, described in the USG 5-Year Strategy

In FY 2009, Peace Corps will continue to support and strengthen abstinence and being faithful activities to reach a total of 6500 individuals (3000 males and 3500 females) targeting in-school and out-of-school youth, along with highly targeted "being faithful" messages for married individuals designed in collaboration with FBO partners in particular. This target includes a total of 2800 individuals (1200 Males & 1600 Females) that will be reached with Abstinence Only messages mainly through our school based abstinence program. Under this program area, 16 two year and 12 short term (Peace Corps Response) Volunteers will be recruited and placed with organizations focusing on prevention for youth and adults. Volunteers and their counterparts will carry out campaigns to sensitize the general population about HIV prevention using information, education and communication messages that aim at creating an enabling environment for married partners to reduce sexual partners and remain faithful to each other. In FY 2010, we propose to reach 4200 individuals with AB programming with special emphasis on the drivers of the epidemic identified in the 2005/2006 Uganda National Sero- Behavioral survey. Peace Corps Volunteers will work with other USG partners to continue the roll-out of the PIASCY program to post primary level. Peace Corps Volunteers will continue to promote and support the establishment of school-based health/ant-HIV/AIDS clubs aimed at creating a friendly and safe environment for students to discuss myth and facts about HIV/AIDS with guidance from their teachers and school counselors. Volunteers will disseminate age appropriate information and activities for this target population – beginning with life skills and self-esteem development for younger age groups and moving to more specific HIV/AIDS messages and youth empowerment for older youth from 15 to 24 years of age. Volunteers and their Counterparts will continue to support the roll-out of PIASCY activities to schools in their work areas and through their affiliation with primary teacher colleges and coordinating centers and the work these institutions do to provide in-service teacher training, promote school clubs, support educational materials development and advance linkages with other community organizations.

In FY 2009, Peace Corps will scale up sexual prevention OP activities by placing more Volunteers with prevention focused organizations to reach many most-at risk populations in hard to reach and under served areas. In FY 2009, 25000 (12000 males & 13000 females) individuals will be reached and 36000 (22000 males & 14000 females) in 2010 with HVOP programming. The activities will include information dissemination through various channels; education and appropriate communication on reproductive health issues; sexually transmitted infections management; information about dangers of multiple relationships especially among the married couples, education about condoms and usage; and other related areas that support HIV prevention. These activities will target vulnerable groups, specific at-risk populations, and community members at large through activities implemented by Volunteers and their Counterparts. Promotion of Counseling and Testing and Prevention of Mother to Child Transmission (PMTCT) for prevention purposes will also be encouraged. Community members will be encouraged to be tested for HIV, hence further preventing transmission. HIV-positive pregnant mothers will be better equipped to prevent transmission of HIV to their babies. In addition, Volunteers and Counterparts will be supported to develop various behavior change promotion materials to support this program area. At post primary level, Peace Corps secondary school based Volunteers will play a major in rolling out the PIASCY program to ensure that students have access to information about comprehensive HIV/AIDS prevention.

**New/Continuing Activity:** Continuing Activity**Continuing Activity:** 15232

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15232	3993.08	Peace Corps	US Peace Corps	7091	1222.08	Peace Corps	\$413,200
8397	3993.07	Peace Corps	US Peace Corps	4823	1222.07	Peace Corps	\$313,000
3993	3993.06	Peace Corps	US Peace Corps	3162	1222.06	Peace Corps	\$150,000

### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 690.09	<b>Mechanism:</b> N/A
<b>Prime Partner:</b> US Department of Defense	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 3967.21596.09	<b>Planned Funds:</b> \$215,000
<b>Activity System ID:</b> 21596	

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. Uganda initiated programs for high-risk groups in the early phases of the epidemic and continues to promote excellent principles of nondiscrimination in its National Strategic Framework. Starting in 1987, the Minister of Defense developed an HIV/AIDS program after finding that a number of servicemen tested HIV positive. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs through out the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 12,000 military are living with HIV with up to an additional 12,000 HIV infected family members. The UPDF HIV/AIDS Control program is comprehensive and covers the critical elements of prevention, such as counseling and testing, peer education, condom distribution, and PMTCT; HIV care, such as palliative care services and ARV services; and human and infrastructure capacity building. More recently provision of ART has been initiated on a larger scale, in 8 military sites, with drug provision via JCRC and the Ministry of Health. The UPDF leadership supports this new PEPFAR supported initiative, as one that has relevance to the active duty military and dependents. Specific activities include coordination by senior medical UPDF leadership with the Uganda Country team and PEPFAR regional efforts, to include ensuring training and adopt strategies to the military

2. Progress to-date. The UPDF has had two of its staff trained on basics of sexual and gender based violence. A work plan is in process for community engagement on sexual and gender based issues and will be initiated over the next 4 – 6 months.

3. Planned activities for FY 2009. ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: With FY 2009 COP funding, we plan to establish and strengthen linkages between health, law enforcement, legal, and community services for delivery of a coordinated response to sexual violence victims and strengthen the capacity of local partners and institutions to deliver quality health care services including PEP to victims of sexual violence around and within military facilities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16067

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16067	3967.08	Department of Defense	US Department of Defense	7336	690.08		\$215,000
8385	3967.07	Department of Defense	US Department of Defense	4821	690.07		\$150,000
3967	3967.06	Department of Defense	US Department of Defense	3156	690.06		\$50,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 1311.09

**Mechanism:** State Department

**Prime Partner:** US Department of State

**USG Agency:** Department of State / African Affairs

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 19068.21604.09

**Planned Funds:** \$100,000

**Activity System ID:** 21604

**Activity 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 (OVC). 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 (Palliative Care), 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 grass root 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 significantly larger 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 for PHAs and OVC. Additionally, the Department of State Political and Economic Section will support IMC efforts to prevent HIV transmission in Pader District by addressing underlying gender norms and social factors that lead to high risk behavior through community mobilization, training and other prevention and response activities.

In FY 2008, the IMC project will tackle the neglected problem of substance abuse as one of the leading causes of the HIV epidemic and GBV in Northern Uganda. The project will be implemented in 3 sub-counties (Puranga, Atanga and Pajule) in Pader District. IMC will implement community-based education and awareness raising aimed at changing attitudes to substance abuse and reducing new cases of substance abusers through media, drama, video shows, door to door visits, impromptu discussions, and other IEC materials like booklets, playing cards and posters. BCC campaigns will be conducted, targeting specific at-risk populations, like out of school youth, single women, bar owners, and men within trading centers. IMC, in collaboration with local partners including the DDHS and CBOs, will support the return and reintegration process in Northern Uganda by training and supporting social workers to provide treatment and rehabilitation services for substance abusers and their families. IMC will also provide education to law enforcement agencies and community health workers on the appropriate management and referral of substance abusers. HIV/AIDS and GBV awareness will be integrated into substance abuse education campaigns, drama and other community outreach programs. Village health teams will be trained and supported to provide comprehensive HIV/AIDS knowledge and to carry out STI and GBV prevention activities. The PHAs will be mobilized and supported to participate in HIV/AIDS/GBV Substance Awareness activities. Condom promotion campaigns will be conducted, targeting substance abusers and other at-risk groups so that they practice safer sex. Condom dispensers will be established at trading centers, health centers and with other key players in the community, such as elders, LC leaders and youth leaders, to increase community accessibility. Existing health centers in the sub-counties of operation will integrate HIV/AIDS Counseling and Testing, STI screening and management, and GBV-related health services. This will be done through training of Health Workers, providing the drugs and related supplies or establishing mechanisms for referral to other health centers or hospitals that provide these services. The project will also support the establishment of positive means for income generation, such as agricultural activities, tailoring and grinding machines and animal rearing. This effort will target female headed houses, young single women and survivors of GBV. This effort will also indirectly benefit entire communities as alcohol will be less readily available and will therefore reduce associated social and health ailments.

Schools will also be a major target in the effort to change their attitudes against substance abuse. School programs will include seminars, debates and life skills. These will provide information on the risks associated with substance abuse, such as HIV/AIDS, STIs, GBV, poverty and other social ills. Schoolteachers will have to be trained on substance abuse/HIV/GBV/STIs in order to support the students to carry out these activities. Recreational activities will serve as the foundation for out-of-school youth programs.

In FY 2009 with \$100,000 funds, IMC will continue with the HIV/AIDS and GBV awareness activities which will be integrated into substance abuse education campaigns, drama and other community outreach programs. 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.

**New/Continuing Activity:** Continuing Activity

Continuing Activity: 19068

Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
19068	19068.08	Department of State / African Affairs	US Department of State	7426	1311.08	State Department	\$350,000

**Emphasis Areas**

Gender

\* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$30,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$20,000

**Education**

**Water**

Table 3.3.03: Activities by Funding Mechanism

<b>Mechanism ID:</b> 9220.09	<b>Mechanism:</b> TBD - HCT/AIC Follow on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 21143.21569.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21569	



**Activity Narrative:** This activity is an on-going program related to the CSF/Deloitte and Touche Sexual Prevention AB and OP program that was approved in COP 08 that is to be implemented by a national indigenous organization contributing towards the national goal of scaling up HIV counselling and testing services in Uganda. The goal of this program is to support the MOH, districts, private sector; and Community based Organizations (CBOs)/ Non-governmental organizations (NGOs) by enabling young people and adult's access appropriate information and services. The HIV sexual prevention services will be provided as an integral component of HCT services at the Regional HCT Centers of Excellence, public, private, and CBO/NGO/FBO HCT sites. This program will cover all Regional referral hospitals, all District hospitals, all private hospitals, and all health centers up to H/C II sites that are not covered by the USAID funded District based program and other PEPFRAR HCT implementing partners. In addition, 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 Regional HCT Centers of Excellence will be a focus 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 10-14); those aged 15+ should get comprehensive HIV/AIDS information including information regarding condoms) and OP will focus on n 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.

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.

Linkages to care, treatment and support services for HIV-infected clients and their families will be strengthened at all levels of the health system. Persons living with HIV/AIDS (PHA) networks, youth friendly services, couple HCT services and post-test clubs will be enhanced to strengthen referral linkages to care, treatment, and support. Activities supporting couple clubs will include providing training in key communication skills, prevention of gender-based violence among couples and promotion of disclosure. These couple clubs will continue to be a vessel in mobilization and promotion of HCT uptake by their fellow couples and promotion of faithfulness.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21143

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21143	21143.08	U.S. Agency for International Development	To Be Determined	9220	9220.08	TBD/HCT	

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Military Populations

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.03: Activities by Funding Mechanism

**Mechanism ID:** 631.09

**Mechanism:** Commodity Security Logistics (CSL)

**Prime Partner:** Commodity Security Logistics

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 3966.21742.09

**Planned Funds:** \$2,000,000

**Activity System ID:** 21742

**Activity Narrative:** Commodities Security Logistics (CSL) is a division in the Office of Population and Reproductive Health (GH/PRH) which manages the Central Contraceptive Procurement (CCP) project. USAID procures condoms directly from the CCP project for distribution through targeted promotion activities. In addition to the procurement of condoms at the lowest possible price, the project provides independent testing for quality assurance and pre-shipment testing for products compliance to the specifications in the contract. Forecasting of commodity needs is done by USAID/Uganda with assistance from the DELIVER logistics project.

The Government of Uganda estimates that 144 million condoms a year are needed in Uganda for HIV/AIDS prevention activities. Of these, 40 million are supported by PEPFAR funds through the social marketing program.

In FY 2008, CSL procured 40 million condoms for the social marketing program in Uganda. In addition, CSL, with support from the centrally funded commodity fund, procured and shipped 20.4 million condoms for the AIDS Control Program of the Ministry of Health as an emergency response.

ACTIVITY UNCHANGED FROM FY 2008

As an efficient mechanism for consolidated USAID purchases of condoms, CSL will continue procuring, pre-shipment, pre-shipment analyzing and shipment of condoms made available to high risk groups at military and refugee camps, lodges and bars, prisons, sea ports and docks, truck drivers' stop points, as well as for discordant couples. It is estimated that 338,710 individuals will be reached with condoms in FY 2009.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14188

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14188	3966.08	U.S. Agency for International Development	Commodity Security Logistics	6732	631.08	Commodity Security Logistics (CSL)	\$2,000,000
8413	3966.07	U.S. Agency for International Development	Commodity Security Logistics	4830	631.07	Commodity Security Logistics	\$1,500,000
3966	3966.06	U.S. Agency for International Development	Commodity Security Logistics	3155	631.06		\$1,500,000

**Table 3.3.03: Activities by Funding Mechansim**

**Mechanism ID:** 6181.09

**Prime Partner:** Deloitte Touche Tohmatsu

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 15993.21746.09

**Activity System ID:** 21746

**Mechanism:** Financial Management Agent/  
Civil Society Fund (FMA/CSF)

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$768,758

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities, with another 90 expected to be awarded at the end of FY 2008. The target of this granting mechanism is to ensure that Uganda's youth have access to age and risk appropriate abstinence, faithfulness and behavior change information and services. Prevention resources also assist the national response in appropriately addressing the shifting nature of the epidemic, expanding attention to faithfulness and partner reduction initiatives among married and cohabitating couples. In addition, resources specifically address the vulnerability factors of key categories of youth such as young people involved in transactional or cross-generational sexual relationships, young people living with HIV and address 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, poverty and economic security vulnerabilities, and gender discrimination issues that make youth, and in particular young girls, at increased risk of exposure will be highlighted.

Further solicitations are to be issued in FY 2009 to ensure a wide geographical reach, especially targeting mutually identified underserved areas such as districts in the West Nile and Karamojong regions. It is anticipated that a total of 168,750 men and 206,250 women will be reached with prevention messages and activities by the end of FY 2009. Grants will also be given to NGOs serving as lead agencies to ensure that smaller, local grantees have access to CSF funding. Further support will be provided through Chief Administrative Officers in the district local governments who will be engaged in ensuring that effective mapping and support to the grantees is provided.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15993

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15993	15993.08	U.S. Agency for International Development	Deloitte Touche Tohmatsu	6733	6181.08	Financial Management Agent/ Civil Society Fund (FMA/CSF)	\$575,166

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 21145.21575.09

**Activity System ID:** 21575

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$316,667

**Activity Narrative:** This activity relates to PMTCT, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – East - Central will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project will cover six districts of Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba.

AB

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiplicity of partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity, reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Other Sexual Prevention:

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly refereed to as 'Boda boda in Uganda), discordant couples, fishermen and the communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions
- Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'
- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.

- Activity Narrative:**
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.
  - Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).
  - Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.
  - Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechansim**

**Mechanism ID:** 9326.09

**Prime Partner:** Chemonics International

**Funding Source:** GHCS (State)

**Mechanism:** Monitoring and Evaluation Agent/Civil Society Fund

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: Other sexual prevention

Budget Code: HVOP

Program Budget Code: 03

Activity ID: 21478.21585.09

Planned Funds: \$75,000

Activity System ID: 21585

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities; with another 90 expected in the end of FY 2008 in both the areas of prevention and OVC service delivery. The monitoring and evaluation component of the CSF will function similar to the MEEPP project for the USG PEPFAR program in Uganda and will help the CSF grantees to set reasonable targets and report on their progress. The participating development partners, UNAIDS and the Uganda AIDS Commission are currently mapping out the best way to manage and support this M&E function under the new national M&E plan but it is anticipated that these results will feed into the larger information system at the Uganda AIDS Commission. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Tracking the impact of HIV programs remains a challenge within civil society and resources will continue to be used to provide capacity building support to CSOs competitively selected to receive grants. Upon award in FY08, the Monitoring and Evaluation Agent will immediately be responsible for measuring the impact of the CSF through monitoring the 200+ grantees performances, and improving the capacity of these grantees to collect better data and use such data for future decision-making. These activities will not change in FY09. The requested resources will be used to support a portion of the management fees (along with funding from other key program areas such as Sexual Prevention and OVC) for the Monitoring and Evaluation Agent, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Technical and Financial Management Agents, in addition to providing technical support to the Steering Committee. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the M&E component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21478

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21478	21478.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$600,000



---

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 4698.21725.09

**Activity System ID:** 21725

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$550,000

**Activity Narrative:** This activity also relates to Counseling and Testing, Prevention Of Mother To Child Transmission, Adult Care and Treatment, Strategic Information and Health Policy Analysis Systems and Strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning. This activity is a continuation from FY 2008.

In FY 2008 NUMAT reached an estimated 198,497 people with HIV prevention messages through promoting positive social norms and healthy sexual behaviors such as abstaining from sex till marriage and being faithful to one faithful partner, correct and consistent condom use, as well as issues related to stigma and discrimination, and sexual and gender based violence. Approximately 68,185 youth were reached with abstinence only messages, 136,345 were reached with AB messages and 62,150 were reached with other prevention messages. NUMAT strengthened the capacity of the 9 Youth Advisory Groups. A total of 87 master trainers were trained to facilitate the roll-out of HIV prevention activities among the youth both in and out of school. These master trainers trained 728 peer educators and provided them with monthly supportive supervision which included discussions on their experiences, lessons learnt and data collection on the number of people reached by prevention messages. Using a variety of tested approaches, messages on abstinence, delayed sexual debut, faithfulness and condom use were relayed to and promoted among both in school and out of school youth by the peer educators. NUMAT trained 480 religious and cultural leaders on issues of HIV/AIDS response and on Stigma and discrimination reduction. These leaders reached an estimated 37,000 people with AB messages as well as issues related to stigma and discrimination of People living with HIV. NUMAT trained and provided follow up support to over 690 community resource persons (animators) on SGBV and its link to HIV transmission. The animators in turn sensitized the community in camps and in the return sites on gender, sexual and reproductive health rights. They also helped in reporting and referring SGBV cases for immediate medical and legal support. Over 35,984 people were reached by NUMAT's supported SGBV activities.

Working with local CSOs, women's groups and the uniformed forces including the UPDF, Prisons and Police, behaviour change agents trained the previous financial year increased the demand of condoms and reduced high risk behaviors among an estimated 1,826 adults and most at risk populations. The BCAs sensitized their peers and community members and referred them to other HIV services like HCT, PMTCT ART, HBC and other economic empowerment activities (including Village Saving and Loans Associations).

In FY 2009, NUMAT will support activities that build on those achieved from FY 2008. These will include the following:

#### ACTIVITY UNCHANGED FROM FY 2008

- Facilitating the establishment of youth and parental committees that will strengthen community dialogues between the youth and adults about issues affecting young people such as improving parent-child communication on HIV and sexuality.
- Supporting families and communities to build skills that promote sexual norms and behaviors, working on issues related to Stigma and discrimination and Gender Based Violence by promoting family life education and addressing other gender issues;
- Engaging community leaders, uniformed services and the police including community security guards in programs to reduce SGBV; prevent HIV and empower communities to promote societal norms that reduce the risk of HIV transmission and promote the use and access to condoms and HIV counseling and testing services.
- NUMAT will work with the district GBV working group and other stakeholders to map SGBV services and actors, and also to undertake a Community KAP assessment which will help inform the IEC SGBV strategy.
- Supporting media campaigns that reinforce and make abstinence, fidelity, partner reduction, HIV counseling and testing, and other safer behaviors legitimate options and standards of behavior for both youth and adults; For example, Supporting IEC/BCC activities that promote positive behaviors for the prevention of HIV infection, TB and malaria. Of particular interest will be messages regarding alcohol consumption and risk taking behaviors.
- Carrying out campaigns to sensitize the community about HIV prevention, stigma and discrimination as well as sexual and gender based violence
- With the mobilization of FBOs for prevention (primarily abstinence/faithfulness) activities using the Channels of Hope methodology, NUMAT will support activities that emphasis reduction of stigma and discrimination among PHAs, abstinence, fidelity, partner reduction, HIV counseling and testing, and other positive social norms for both youth and adults
- NUMAT will continue supporting youth-led community programs to help youth, their parents, and the broader community, personalize the risk associated with early sexual activity, sex outside of marriage, multiple partnerships, and cross-generational and transactional sex.
- NUMAT will also continue supporting the review, revision and adaptation of other curricula, interactive materials, radio programmes and toolkits available in the country to make them suitable for the districts in Acholi and Lango regions. HIV prevention messages will be linked to health centers and CSO that provide HCT, reproductive health and condom services in addition to vocational training and economic empowerment activities.
- NUMAT will continue working with NGOs and CSO, as well as the UPDF to increase demand for condoms. Targeted messages for most at risk groups will be developed, as well as determining best locations and distribution points for condoms. The project will also continue working with PHA groups to integrate condom messages and distribution into ongoing service provision activities.
- NUMAT will also support other prevention efforts like syndromic management of STIs which will be integrated in all other areas. This will include integrated training of health workers in management of STI and HIV/AIDS, supporting logistics for STI drugs including procurement of STI drugs should situations of stock outs occur. Supporting integrated support supervision of STI with HIV/AIDS activities as well as linking

**Activity Narrative:** STI clients to HCT within their treatment areas and through referral from lower units.  
 • Instead of rolling out PIASCY as initially planned in FY 2008 this ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:  
 • NUMAT will use the Adventures Unlimited, Choose Freedom and YEAH Campaign Curricula to compliment the PIASCY program that will be rolled out by the UNITY project in the region. NUMAT will train teachers, youth leaders, peer educators and mentors identified through the community, schools and youth groups. These curricula will equip youth with “value-based life skills” to enable them make informed choices and avoid risky behaviour.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15473

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15473	4698.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$250,000
8467	4698.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASCY Primary; TASO; AIC; Conflict	\$250,000
4698	4698.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$450,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$56,425

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

---

**Mechanism ID:** 7287.09

**Prime Partner:** World Vision International

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 15917.21806.09

**Activity System ID:** 21806

**Mechanism:** SPEAR

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$600,000

**Activity Narrative:** Activity Narrative

This activity relates to Palliative care - home-based and Counseling and testing.

Building on the USG public sector programs, this activity is a follow-on to the Education Sector Workplace AIDS Policy Implementation (ESWAPI) that provided support to the education sector that ended in July 2008. The new follow-on program called Supporting Public sector workplaces to Expand Action and Responses against HIV/AIDS (SPEAR) is the USG prime mechanism for leveraging public sector support to increase access to and utilization of HIV/AIDS treatment, prevention and care services to selected sectors that include: ministries of Internal Affairs (MoIA); Local Government (MoLG); and Education and Sports (MoES). The SPEAR program is supporting 3 sectors that have worked with the National HIV/AIDS Program to develop and integrate HIV/AIDS into their work place through operationalization of the new National HIV/AIDS workplace policy. World Vision is the lead implementing agency for the USAID funded-five year program. The SPEAR initiative, which begun in June 2008 aims to achieve three key results:

1. Supporting public sectors have policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees
2. Increasing 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
3. Improving 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

On the overall, ESWAPI which ended in July 2008 trained 630 Behavior Change Agents (BCAs) and reached over 50,000 MoES employees and their dependants with prevention programs over a period of 3 years.

In FY 2009, SPEAR project activities under this program area (Sexual Prevention) will be geared towards increasing personal perception of risk of HIV infection/transmission and utilization of prevention services through aggressive targeted behavior change programs. Activities will include: Conducting sectoral assessments: in the MoIA and MoLG to ascertain the variations in KAP, the variations in risk factors (both behavior and socio-economic), and the most effective channels through which each population segment can be effectively reached. This assessment will be combined with the policy assessment planned for the Ministries of internal Affairs and Ministry of Local Government. The KAP survey will include the communities where some of the target audiences live e.g. police/prisons barracks and boarder post custom quarters. Developing/adopting targeted behavior change messages: This activity focuses on tapping into locally and internationally available behavior change communication expertise and the using the power of peer influence to change and model public sector employees' behaviors for HIV/AIDS prevention. Led by an international BCC consultant, SPEAR will review ongoing behavior change programs in Uganda and beyond; assess their appropriateness for prevention among adult public sector workers; identify the gaps in terms of messages, dissemination channels; and develop an initial strategy for adopting/adapting/developing targeted behavior change programs (messages, a mix of dissemination channels and performance indicators) for the target ministries/departments. Behavior change messages will seek to increase perception of benefits of safer behaviors compared to the costs of risky behavior. Specifically, messages will target reducing those behaviors that increase risk for HIV transmission such as engaging in casual sex encounters, transactional sex and sex with an HIV-positive partner or whose status is unknown + dealing with concurrent multiple sexual partners. To ensure that target public sectors identify with the behavior change messages communicated, SPEAR will involve the relevant ministries/workplaces in adapting the messages. Facilitating creative communication for behavior change: The project will involve employees and utilize the existing structures in the target line ministries as agents for passing on BCC messages to their colleagues and peers. Specific messages and modes of delivery will be adopted to ensure that the hard to reach and underserved areas are not left out or underserved. Additional messages will be developed for dissemination to police, prisons, schools and guards during their routine parades. Training behavior change agents: SPEAR will work with the respective workplaces to identify and train about 2,500 workers and their families in influencing their peers' self-efficacy and promoting positive behavior change. Developing and executing a multi-dimensional BCC program: Depending on evidence gathered regarding effective BCC channels, SPEAR will develop a BCC campaign that may integrate the use of "affinity groups," small groups discussions, public talks by PHA and experts on HIV/AIDS, public relations (such as radio talk shows and TV panels), posters, media advocacy, and educative entertainment tailored to meet the needs of public sector workplaces. The activities will cover employees in MoIA, MoLG and MoES in all the 81 districts of Uganda. The project will liaise with other ongoing behavior change programs such as by MoH, UAC and AFFORD. About 150,000 public sector workers and their families are targeted for behavior change drive in FY 2009.

Also, 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. Activities will include training 20 individuals in workplace HIV-related policy; and 100 workplace AIDS policy implementation champions to operationalize policy and plans. About, 30 points of operation will be supported with institutional capacity building for workplace HIV/AIDS policy implementation including having costed workplace HIV/AIDS related work plans. About, 50 individuals will be trained in workplace HIV-related community mobilization for prevention, care and/or treatment; and 500 will be trained in HIV-related stigma and discrimination reduction. SPEAR project will support 10 stigma and discrimination (S&D) campaigns/events, to reach / benefit 1,000 people.

These activities will be conducted in the workplaces of the three target ministries i.e. MoES, MoIA and MoLG countrywide, starting from headquarter employees through the districts to the lower levels. SPEAR will support human resource departments and PHA support groups to organize creative events (such as debates, radio seminars, video shows, concerts, testimonies, etc) and Anti- S&D campaigns to highlight dangers of S&D and raise awareness in the respective communities. SPEAR will build the capacity of the three target line ministries to fight workplace related stigma and discrimination engage in policy reforms, financial and program planning for HIV/AIDS interventions in their respective workplaces. Capacity building is essential for enhancing sustainability of HIV/AIDS interventions in the workplaces.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15917

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15917	15917.08	U.S. Agency for International Development	World Vision Uganda	12196	12196.08	Public Sector Work Place Program (ESWAPI)	\$650,000

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$200,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 3340.09

**Mechanism:** AFFORD

**Prime Partner:** Johns Hopkins University  
Center for Communication  
Programs

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other  
sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 4385.21735.09

**Planned Funds:** \$2,713,900

**Activity System ID:** 21735

## Activity Narrative: INTRODUCTION

Since its inception in November 2005, the AFFORD Health Marketing Initiative has primarily worked to increase accessibility to condoms through several channels, with special emphasis on high risk locations. The project has used innovative communication approaches and channels to reach specific populations with HIV and STI prevention messages and products. Condoms and direct counseling have been promoted aggressively to most at risk groups (MARPS) across the country. The general public has also been exposed to a wide range of communication messages promoting fidelity, reduction in sexual partners and correct and consistent use of condoms for sexually active adults. The project has also addressed gender norms related to increasing the risk of HIV infection.

### PROGRESS TO DATE

#### Increased condom outlets and product distribution

In a bid to make condoms even more readily accessible at high risk locations, AFFORD stocked condoms in as many bars as possible in all the regions of the country and carried out direct condom promotion at these locations. This together with getting more corner shops (dukas) to stock condoms resulted in an increase of condom outlets from 29,000 in 2007 to 32,000 in 2008. This benefited both the project and suppliers of other brands of condoms. Socially marketed condoms in Uganda increased from 22 million in 2005 to 30 million in 2006, 34 million in 2007 and we are expecting about 38 million in 2008. Protector, the AFFORD promoted condom brand and the oldest on the market, appeared to be a tired brand. In 2008, AFFORD repackaged Protector in an attempt to make the brand more attractive to consumers.

#### Targeting Most At Risk Populations (MARPS)

AFFORD has continuously identified locations of high risk behaviors targeting most at risk populations with HIV and STI prevention. Using community outreach and interpersonal communication, the project has directly reached fishermen in several fishing communities, commercial sex workers in four major locations in the country, the military, police and other private security agencies. Working through six partners, a total of 29,671 MARPS were reached in 2008. The MARPS program included 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. Through subcontractors, AFFORD trained 607 peer educators in FY 2008 among commercial sex workers, police, UPDF and fishermen. They were trained to address gender and social norms and practices that increase men's risk of HIV infection using the "Be a Man" training manual and tools. These interpersonal approaches reached 28,378 people in 21 districts.

In an effort to facilitate sustainable programming for MARPS, AFFORD supported the establishment of the MARPS network, a national network that brings together all organizations working with MARPS. The MARPS network's main function is to facilitate information sharing and dissemination of best practices, provide strategic direction in MARPS programming and advocate for resource allocation to MARPS interventions. To date the MARPS network has a membership of 20 organizations, a three year strategic plan and a functional secretariat

#### 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.

The Good Life campaign launched with The Good Life! Show, a highly popular TV, radio and experiential game show that uses edutainment to increase knowledge, facilitate couple communication, promote healthy behaviors, and increase demand for products and services. Areas of HIV focus include risk perception, condom use, HIV testing, disclosure, PMTCT, adherence, and positive living. In FY 2008, 24 episodes were broadcast on 3 TV stations, 20 radio stations in 5 languages and appeared in 120 locations countywide through the experiential road shows.

The experiential road shows were further refined to enhance interpersonal communication and resulted in the development of the "four tent" model. Using this approach, fewer people gather under a tent to learn about HIV prevention and engage in meaningful exchange with the moderators. The four tent approach went to 120 communities in 2008 reaching 300,000 people.

In partnership with the HIPS project, AFFORD implemented a number of workplace programs targeting major companies and sugar and tea plantation workers. A total of 32,000 people in 16 workplaces were reached through this intervention with HIV prevention messages and products including condoms.

#### Interpersonal communication at the village level – Popular Opinion Leaders

AFFORD created the Popular Opinion Leader model in 2006 to complement its efforts at reaching Ugandans at the grassroots. Popular Opinion Leaders are volunteers recruited at the village level and trained to offer education on basic health issues including HIV/AIDS. To date over 700 POLs are operating in 18 districts. In FY 2008, 736 new POLs were trained in 23 districts. POLs use interpersonal approaches to raise awareness on condom use, HIV testing, discordance, and benefits of early treatments of STIs.

#### Addressing Alcohol and Sexual Violence

In FY 2008, AFFORD and its partner PULSE reached over 100,000 people in high risk locations in Uganda. AFFORD trained over 190 bar and lodge owners in condom use at the work place, STI and HIV referral, and sexual violence to staff and patrons. Working in collaboration with UPHOLD, AFFORD also oriented 231 bar and lodge owners in 12 districts on HIV in the workplace. The objective was to enhance bar and lodge owners' knowledge on 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 work place policies in their establishments.

### FY 2009 ACTIVITIES

In FY 2009 AFFORD will consolidate its gains by maintaining all its existing activities as mentioned above. The project will strengthen the quality of programming with the aim of reaching more under-served areas

**Activity Narrative:** and people with HIV prevention messages. AFFORD will use local languages and approaches that the intended population can appreciate and effectively participate in promoting the reduction of sexual partners and consistent and correct condom use. AFFORD expects to reach approximately 390,000 people directly through HIV prevention messages.

C

#### Condom Distribution

AFFORD will work on increasing its distribution by increasing the number of outlets stocking condoms. The following strategies will be adopted:

Increasing number of wholesale outlets with our products. The number of outlets is expected to increase to 50,000.

Recruit Fast Moving Consumer Goods (FMCG) distributor: AFFORD will recruit 3 FMCG distributors as means of reaching existing high risk locations (bars, lodges, hotels, etc). FMCG distributors (especially beer distributors) target the same locations as those for condom distribution. AFFORD piggybacks on distribution mechanisms of FMCG products like laundry soaps, toothpaste (Unilever products) and beers to increase availability and accessibility of condoms in high risk locations and outlets. Distributing condoms through HIV prevention stakeholders/organizations: Through the HIPS project, AFFORD will sell condoms to companies that employ large numbers of staff. This will be extended further to reach other NGO's working in the areas of HIV prevention, for example, MAVAP, AIC, IRC, and MSF, among others.

#### Condom promotion

AFFORD will concentrate on improving acceptability of condoms at MARPS locations and general retail outlets using the medium of karaoke in bars. The bars will also serve as channels for condom sales.

In order to encourage condom stocking by traders, AFFORD will carry out trade promotion, providing attractive incentives for traders that buy and restock condoms in good purchase quantities.

AFFORD will liaise with beer companies to hold joint promotions. This will cut costs of promotions and at the same time highlight responsible drinking, coupled with correct and consistent condom use.

AFFORD will also roll out a merchandising campaign to ensure condom visibility, emphasizing the affordability of the condoms. This campaign will ensure that point of sale materials are properly displayed and that condom stocks are available at these outlets.

The field teams (PMOs) will work together with night club management countrywide to organize condom promotions. Night clubs have proven to be locations for high risk behavior.

#### Targeting Most At Risk Populations

In FY 2009 AFFORD will continue MARPS interventions in its current districts, and work with the MARPS network and organizations to scale up interventions for fishermen, truckers and CSWs in 8 new districts. AFFORD will also expand the number of MARPS organizations it is working with from 8 to 10.

Peer Educators (PE) program: Through sub grants to MARPS organizations, AFFORD will conduct refresher training for the 607 previously trained PEs and train 500 new PEs for all four categories of MARPS (CSW, military, police and fishermen). AFFORD will support PEs to reach 100,000 people through interpersonal communication and community mobilization with HIV/AIDS messages and link them to needed products and services for reproductive health. AFFORD will reproduce and distribute support materials, job aids and tools needed by PEs to do their work. Support materials will focus on HIV prevention approaches and gender norms that increase the risk of HIV transmission, and address alcohol consumption and sexual violence. AFFORD will continue to target men with gender positive messages from the male perspective.

Access to friendly service outlets: AFFORD will continue to support MARPS to access friendly services for HCT, STI and family planning. Special and convenient places like previously supported drop-in centers for CSW will be supported and equipped to make them fully functional. AFFORD will support establishment of 2 additional drop in centers for CSW. Similarly 2 additional safe sailing boats manned by PEs to deliver services and products to fishermen and fishing communities in remote fish landing sites will be procured and equipped. Static condom outlets in military and police barracks and parking yards for long distance truck drivers will be procured for 10 new locations each.

Internally displaced persons (IDPs): Of the 31 priority districts supported by AFFORD, 4 have been under conflict, still have high populations of IDPs and have high HIV prevalence. In 2009 AFFORD, will extend HIV prevention interventions through our innovative communication campaign and use the product distribution mechanisms to step up condom promotion and addressing gender norms that increase the risk of HIV transmission. In addition, through sub grants, AFFORD will identify and support organizations providing tailored HIV prevention programs using community mobilization and interpersonal communication.

#### Good Life Campaign

In FY 2009 AFFORD will continue to use the Good Life campaign to address critical issues that drive the epidemic in Uganda. Mass media will reinforce community interventions, positive behaviors, risk perception and gender issues influencing people's behaviors. The Good Life Essence campaign will be launched, which will include better linkages to the AFFORD health messages and products through mass media, a loyalty scheme and rewards to consumers who recall, purchase and use the AFFORD products and messages. It will culminate into the Good Life awards rewarding households, communities, distributors and POLs who emulate the Good Life. The Good Life Show will also be shown in more community video halls and generate discussions thereafter while also scaling up the 4 tent model, which will cover the whole country.

#### Interpersonal communication at the village level – Popular Opinion Leaders

In FY 2009 AFFORD will continue to work with CDFU to consolidate gains registered in the 23 districts.

Refresher training for POLs to enhance their skills in interpersonal communication and community mobilization will be held. AFFORD will continue to strengthen this interventions aimed at preventing sexual



**Activity Narrative:** transmission of HIV to reach 100,000 people. Through this intervention AFFORD and CDFU will intensify activities in the 23 districts with more in depth activities for condom promotion, prevention among discordant couples and raise awareness on gender issues that increase the risk of HIV transmission. AFFORD will also intensify interventions for gender using the Be a Man campaign and the African Transformation Model, a skill building model to analyze gender stereotypes. Special attention will be given to strengthening interventions for fidelity and partner reduction by working with religious leaders and other community self help groups. Through this intervention AFFORD will reach 500 couples and 20,000 men with gender and HIV /AIDS prevention messages.

**Addressing Alcohol and Sexual Violence**

In FY 2009 bar and lodge owners, small local brewers, brothel owners and pimps who link sex workers to their clients and engage in alcohol and substance abuse will be sensitized through interpersonal activities. AFFORD will collaborate with organization like Serenity Center and Indigenous Knowledge Resource Center to mainstream alcohol and sexual violence training in all our prevention programs. AFFORD will train 50 peer educators and reach 60,000 people with alcohol and sexual violence messages.

AFFORD will also promote responsible drinking using consumer promotions, community activities and mass media. Mass media and community activities will target men using male dominated activities like soccer and drama. At these activities gender based violence and alcohol will be discussed and men's responsibility promoted. Direct condom promotion and sales events will take place.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14218

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14218	4385.08	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	6743	3340.08	Health Comm Partnership; AFFORD	\$1,100,000
9229	4385.07	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	4841	3340.07	Health Comm Partnership; AFFORD	\$1,100,000
4385	4385.06	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	3334	1032.06	Health Communication Partnership	\$1,000,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

### Refugees/Internally Displaced Persons

### Workplace Programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$400,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 9462.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 21859.09

**Activity System ID:** 21859

**Mechanism:** Technical Management Agent/Civil Society Fund

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** ██████████

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities, with another 90 expected to be awarded at the end of FY 2008. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community.

Resources for the Technical Management Agent (TMA) will primarily be used to provide technical support and capacity building to CSOs competitively selected to receive grants. The TMA will identify, obtain and adapt technical resources with the aim of producing a comprehensive and standard package of resources to be used by all grantees working in prevention and OVC service delivery. Through a variety of strategies, small workshops, one-on-one training, site visits and cross-visits among grantees, the TMA will provide necessary and critical support to ensure that grantees are implementing their programs with the most up-to-date technical information and best-practices available. The TMA will also support the CSF Secretariate at the Uganda AIDS Commission, supporting the operational functions of the Steering Committee and the institutionalization of transparent and competitive granting mechanisms used by the CSF to solicit, review and award civil society grants. These resources will be used to support a portion of the management fees (along with funding from other key program areas such as OVC) for the TMA, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Financial Management and Monitoring and Evaluation Agents. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the TMA component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9833.09	<b>Mechanism:</b> Health Communication Partnership
<b>Prime Partner:</b> Johns Hopkins University Center for Communication Programs	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 23924.09	<b>Planned Funds:</b> \$550,000
<b>Activity System ID:</b> 23924	

## Activity Narrative: Activity Narrative

### ACTIVITY UNCHANGED FROM FY 2008:

Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health's Center for Communication Programs that was awarded in July, 2007. 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 two multi-channel communication campaigns for young people—one discouraging transactional and cross-generational sex, and the other—the Be a Man campaign—promoting more gender equitable attitudes and behaviour among men. Both 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. expects to reach 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 2007, HCP assisted Y.E.A.H. to design a second phase “Be a Man” campaign, which will focus on alcohol, violence against women, multiple concurrent partners, and transactional sex. During FY 2008, Y.E.A.H. will have launched the second phase umbrella campaign, and rolled out two sequential focused campaigns on alcohol and violence against women as they relate to HIV. HCP will work with Y.E.A.H. and other partners to launch a hotline with telephone counselors prepared to answer callers' questions about these issues, as well as medical male circumcision, HIV counseling and testing, ARV treatment, family planning.

### ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

FY 2009 activities are a continuation of FY 2008 work and will have four components. The first component is to execute two more focused campaigns under the Be a Man umbrella—the first on transactional sex and the second on concurrent partners. 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 will be established during FY 2008 with a Ugandan non-governmental partner for personalized information and counseling.

The second component involves a continuation of training facilitators among men's groups and youth groups at community level, and vocational training institutions 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, and more compassionate attitudes toward people living with HIV and AIDS. 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. HCP will assist Y.E.A.H. to train 1,200 peer educators and community resource persons, and 50 police community welfare officers to facilitate group discussions and education sessions about alcohol abuse, concurrent partners, violence against women, transactional sex, and HIV/AIDS related violence. These peer educators and community resource persons will each counsel and facilitate discussions among 40 young people, for a total of 50,000 young men and women reached through community outreach with alcohol and HIV prevention information.

The third component is to assist Y.E.A.H. to mobilize resources to support future communication initiatives for young people. During FY 2008, Y.E.A.H. prepared three proposals for funding from non-USG sources, and received some supplemental financial and in-kind support for the Be a Man campaign from Save the Children and the British Council, and promises of funding through the Global Fund. Also during FY 2007, HCP assisted Y.E.A.H. to finalize a resource mobilization and advocacy strategy, which will be fully implemented during FY 2008 and FY 2009. The strategy focuses on leveraging private commercial sponsorship for Rock Point 256 comic books and radio programs; raising institutional support through private foundation funding; and applying for bilateral or multi-lateral donor funds to support future campaign activities. During FY 2009, HCP will hire a consultant to assist Y.E.A.H. to prepare and submit at least four proposals to private foundations and bilateral or multi-lateral donors, with the aim of obtaining funding from at least two non-USG sources.

The fourth component is to evaluate the reach and impact of Y.E.A.H. communication through a second household survey in the same 14 districts as were surveyed in FY 2007. Data from the 2009/10 survey will

**Activity Narrative:** be compared with data from the FY 2007 Y.E.A.H. survey, and will provide information about the reach and effectiveness of various communication messages and approaches which can be used to inform the design of future HIV/AIDS communication for young people, and particularly for young men.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$75,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 9858.09

**Mechanism:** NU APPROACH/NPI

**Prime Partner:** American Refugee Committee

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 23920.09

**Planned Funds:** \$0

**Activity System ID:** 23920

**Activity Narrative:** The American Refugee Committee (ARC) is a non-profit, non-sectarian humanitarian relief organization working for the survival, health, and well being of refugees, displaced persons and those at risk caught in the crossfire of civil violence, warfare and other disasters. Founded in 1979, ARC has grown to over 1,800 employees and has received recognition for its efficient and effective delivery of humanitarian assistance. Today, ARC operates in Guinea, Liberia, Pakistan, Rwanda, Sierra Leone, Sri Lanka, Sudan (Darfur and Southern Sudan), Thailand, and Uganda.

ARC has provided life-saving assistance to refugees, displaced persons, and other war-affected populations in post-conflict settings around the world and brings accumulated technical capability and experience in emergency relief, transitional relief, and post-conflict stabilization from 25 years of experience in Asia, Africa and Eastern Europe. ARC's sectors of expertise include HIV/AIDS awareness and prevention, primary and curative health care, community health education and awareness, vocational health training, water and sanitation, gender-based violence prevention and counseling, emergency shelter assistance and transition services, and microcredit/income generation. ARC strives not merely to provide emergency aid to those in need but also to enable them to achieve self-sufficiency; ARC's "refugee to return" model sees relief assistance not as an end to itself but rather as part of a process whose eventual goal is a population's durable return to their homes. ARC takes a community-based approach to developing and implementing all programs and encourages beneficiaries to take as much ownership and responsibility as possible.

ARC's PEPFAR project, NU APPROACH (Northern Uganda Access, Prevention, Referrals, and Organizational Assistance to Combat HIV/AIDS) focuses on three mutually supportive objectives focused on prevention, care and support, and organizational development/capacity building. These complementary components all link into the needs of the larger Ugandan health context. ARC is proposing to work with national community based partners in its response to HIV/AIDS, as community-level outreach and capacity-building, and support to the lower level Health Centers (Health Center level 2), remain serious gaps in Northern Uganda.

ARC's strategy will include a combination of increasing knowledge and facilitating behavior change, supporting key service provision, and capacity building of local systems and organizations to better respond to the situation. ARC's first objective will address the lack of basic HIV knowledge among the population. ARC and its partners will design and execute, based on best practices in Uganda, a Behavior Change Communication (BCC) strategy to educate high-risk groups about basic HIV facts, including the nature of the disease, modes of transmission, and prevention. These activities will target married couples, pregnant mothers, youth, members of the security forces, ex-combatants and ex-abductees, and women who engage in transactional sex. To implement the BCC strategy, ARC and its partner HIDO will establish peer education structures throughout IDP and returnee communities.

ARC's second objective will support the quality and accessibility of HIV-related services. Given the low availability of HIV Counseling and Testing (HCT) in the North, ARC will operate mobile HCT teams to bring HCT services closer to the people as they continue to leave the main camps and return to their original homes. ARC will also promote PMTCT access by training midwives and TBAs as sensitization and referral agents, creating a link between HIV+ mothers and PMTCT services. In the Home-Based Care sector, ARC will work with the wide range of existing HBC actors to better coordinate, standardize, and upgrade the services they offer. ARC will address the issue of treatment of STIs and opportunistic infections (OIs) by providing training to MOH health workers on syndromic management of STIs and on referral procedures for relevant cases. Lastly, ARC has secured an agreement from a major HIV service provider in Uganda, The AIDS Support Organization (TASO), to receive referrals of PLWHA from ARC and its partners; this will link TASO with the IDP population and thus expand treatment and service options for the displaced. Although ART treatment is not a direct component of this project ARC will prioritize referral of PLWHA to ART providers, including TASO and appropriate health facilities.

Finally, ARC's third objective will focus on improving the capacity of Ugandan actors operating in the North. ARC will work with local NGOs and CBOs to improve their technical and operational capacity. The capacity building will focus on upgrading the technical capacity of partners in areas such as BCC/IEC, peer education, HCT, HBC, and referral. It will also focus on improving those organizations' ability to manage and implement activities, and so will cover project planning, operational support, finance and administration, staff management, and fundraising. ARC has already identified its first principal partner, HIDO, and will also identify between 3- 5 other partners via a competitive process. Tailored capacity-building plans for those agencies will be elaborated by ARC in collaboration with the partners to establish a continuous capacity building process for them. Gradually, as the partners' capacities are strengthened, ARC will begin handing over responsibility of project implementation to them, via sub-grants.

Since the grant became operational in the beginning of June 2008, ARC has now reached the final stages of project start up and preparation. ARC has been dialoguing with USAID CTO to finalize all necessary revisions of the workplan and the supporting documentation and to formalize any modifications to the Cooperative Agreement.

Some of the main activities to date include:

- ? Logistical and administrative set up
- ? Liaising with key HIV stakeholders (District authorities and key partners)
- ? Staff recruitment initiated
- ? Elaboration of ToR for KAP Baseline Assessment Consultancy; discussions with CDC on development of survey tool and methodology; call for proposals for consultancy.
- ? Technical support to sub-grantee, HIDO, in development of their first year workplan, corresponding budget, budget narrative, timeline, and logframe; technical support in development of job descriptions and recruitment.
- ? Modification of JSI template sub-grant agreement for one year sub-grant with HIDO
- ? Elaboration of ARC "small grants package" for use with future partners (ongoing)
- ? HIDO has begun identification of available IEC materials for use in its BCC campaign
- ? Identification and consultative meetings held with key HBC actors

**Activity Narrative:** ? Gap analysis initiated

Specify geographic coverage. Please describe how this activity will address the emphasis area, and, reach the target population regardless of whether your target population is beyond refugees/IDPs and the military.

During this period, ARC sub-grantee, HIDO, will finalize the elaboration of their BCC strategy and initiate prevention activities, including: 1) Establishing a peer education network and sensitizing key community actors in HIV issues 2) facilitating radio listening clubs with peer education groups 3) development and distribution of relevant IEC materials 4) initiating participatory video project and talk-back sessions 5) establishing condom distribution mechanism through fixed sites and supported by trained peer educators. ARC will target groups engaging in high-risk behaviors including those below, taking into account the draft Uganda National Strategic Plan (NSP) for HIV/AIDS, which identifies discordant couples and pregnant mothers as primary focus groups.

- Members of married/partnered couples
- Pregnant mothers (assuming that this group will significantly overlap with the married couples group)
- Youth
- Drivers
- Members of the security forces
- Women engaging in transactional sex

**Peer education Network:**

ARC and HIDO will select and train peer educators, utilizing the YPEER methodology . HIDO will initiate its behavioral change and prevention activities through inter-personal communication (IPC) peer education sessions. HIDO will assist each of the PEs in forming 3 groups of 10 members. Once peer groups are formed, Peer Educators will be supported to carry out weekly meetings and appropriate educational activities; the peer groups will be involved in the radio listening discussion clubs and video awareness outreaches described below. In lines with the YPEER methodology, Lead Peer educators and Master Trainers will be identified based on their high performance and serve as supervisors and quality control agents. Following completion of both rounds of trainings, it is expected that about 90 Peer Educators will have been trained; and through them, a total of approximately 4,050 community members will have been reached in FY 2009.

In this period, HIDO will assess available IEC materials and develop any additional IEC resources required for the BCC campaign, such as educational videos, posters, pamphlets, fact sheets, radio broadcasts, and dramas. Subsequently, HIDO will produce, and disseminate these IEC materials to specified target audiences.

**Radio Listening Clubs:**

Development of radio messaging will be completed jointly by ARC-HIDO within the third quarter, focusing on prevention of HIV/AIDS, where to go for testing, the importance of testing pregnant women, discordancy and prevention for positives. In the fourth quarter, the radio show will be broadcast and peer education groups will be initiated into radio listening clubs. Using discussion guides elaborated by ARC-HIDO, the peer educators will direct the peer groups discussions to cover the key HIV messages for each radio episode; PEs will use interactive interpersonal communication (IPC) methods during the discussion sessions to engage members and increase internalization of knowledge. Pre- and post-tests will be administered to estimate levels of understanding and retention among the peer group members. As each peer educator group will double as a radio listening club, it is expected that in this period between 50 and 80 listening clubs will be formed.

**Participatory Video Project:**

Use of the participatory communications video methodology will increase HIDO's tool-kit of culturally appropriate methodologies to discuss difficult topics and to encourage prevention behaviors among men, women and youth. ARC, in collaboration with Communication for Change (C4C), plans to work with HIDO and provide an intensive 2-week training in proper video production including a strong focus on playback sessions, which is a key factor in monitoring behavior change. As the peer groups HIDO has identified will have received sufficient basic information on HIV through the radio listening clubs, it is expected that they would be able to produce culturally relevant and language appropriate dramas/skits that raise prominent issues on HIV in their communities, which would be video-taped and played back to the communities for discussion.

**Condom Distribution:**

The 5 identified condom distribution points will be managed through the Lead Peer educators. They will oversee the functioning of the condom distribution points, providing direct information sessions to community members selected to distribute condoms at the various fixed locations, such as bars, restaurants, kiosks, lodges, etc. In addition, these Lead PEs will themselves serve as condom focal persons in the communities, referring their peers to free condom access points and providing any counseling and information on correct use of condoms.

Additionally, throughout this period, ARC will be providing its sub-grantee, HIDO, with technical support and capacity building in terms of developing its BCC strategy, establishing and managing peer educator networks effectively.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 9212.09

**Mechanism:** Expanding Uptake for Interventions to Prevent the Transmission of HIV from Mother to their Children (PMTCT) by using Community-Based Strategies

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 26489.09

**Planned Funds:** \$25,040

**Activity System ID:** 26489

**Activity Narrative:** Integrated Community based Initiatives (ICOB), is an indigenous NGO formed in 1994 with a mission to improve the quality of life of people living in rural communities. Its headquarters are located in Kabwohetendero Town Council, Bushenyi district with a liaison office in Kampala. ICOBI has been involved in implementation of Health programs with community bias since its inception. Programs which ICOBI has implemented include: World Bank supported STI project (1995-2000), MAP Project (2001-2006) and Nutritional and Early Childhood Development Project (1999-2003); EGPAF supported facility based PMTCT in 15 health units in Bushenyi District (2002-2005); and CDC supported Full-access Door-to door Home based VCT in Bushenyi District (2004-2007). In April 2008, ICOBI started implementing the three year NPI supported OVC project in Bushenyi and Mbarara districts and in July 2008 it received two five year awards from CDC to implement a Home Based VCT project in 6 districts in Central Uganda and a national level Community PMTCT project with a special focus on 6 districts in South Western Uganda. The Community PMTCT project is entitled: Expanding Uptake For Interventions To Prevent The Transmission Of HIV From Mothers To Their Children (PMTCT) In The Republic Of Uganda By Using Community Based Strategies Under The President's Emergency Plan For AIDS Relief. The overarching goal of the project is to contribute towards the improvement of child survival through increasing the uptake of prevention of mother to child HIV transmission services and providing care & support to HIV infected parents and children using home/community based approaches. The project intends to achieve the following strategic objectives;

1. To promote innovative community based primary prevention of HIV through community mobilization and sensitization of pregnant women and their spouses for HIV counseling and testing at health facilities
2. To prevent un-intended pregnancies among women living with HIV by promoting use of modern contraceptives and other family planning strategies
3. To reduce HIV transmission from pregnant or lactating women living with HIV to their babies by referring them to health facilities for appropriate ART for PMTCT as well as other strategies
4. To enhance advocacy, capacity building and behavior change communication for community PMTCT interventions

In the Community PMTCT program, ICOBI intends to work with the community and health facility based structures and various partners including civil society organizations, faith based organizations, the district directorates of health services and EGPAF, the major partner in PMTCT in South Western Uganda. This project will be implemented at two levels: 1) in collaboration with the MOH, will conduct some national aspects of community involvement in general, 2) with a special focus on 6 districts in South Western Uganda. The districts are Bushenyi, Ntungamo, Mbarara, Ibanda, Isingiro and Kiruhura; with a total population of 2,446,600 people. The expected pregnancies are 122,330 and the expected HIV pregnant w

**New/Continuing Activity:** New Activity

**Continuing Activity:**



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$15,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 9211.09

**Prime Partner:** Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 15910.26444.09

**Activity System ID:** 26444

**Mechanism:** Traditional & Modern Health Practitioners

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$25,053

**Activity 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 15 years of experience implementing community-based health activities for underserved populations in both urban and rural areas of Uganda. In each district of operation, THETA has built a health and social services community delivery system that comprises of community lay providers (CLPs), a community support team, and district-based trainers. THETA's call has been in the area of HIV prevention and care for those infected and affected with HIV/AIDS. THETA received a notice of grant award in July 2008 from CDC to implement a program entitled "Community-based strategies to expand uptake of Prevention of mother-to-child transmission of HIV (PMTCT) interventions" (cooperative Agreement Grant Number: 1U2GPS001088-01, Program period: 07/01/2008-06/30/2013). This project will develop and implement a model of community support for PMTCT based on an active network of CLPs working in close collaboration with facility-based health workers. The project is in line with the Uganda National policy for reduction of Mother-To-Child HIV transmission. The goal of the project is to increase uptake of Uganda national PMTCT programme through strengthening/building community-based support models that can be replicated nationwide.

To date, THETA is in the preparatory stage for the implementation of this program by recruiting project staffs and setting up systems and structures A planning meeting is scheduled for the first week of September to map out clearly the implementation of the project. Full implementation of activities is pending approval of the FY 2008 work plan and budget. The program will cover the districts Amolatar, Oyam, Mbale, Sironko and Masaka in FY 2009 but also continue with implementation in Lira, Apac, Kumi, Tororo and Rakai districts.

The activity under this program area will focus on supporting the reduction of HIV transmission among married couples, individuals including girls and women by providing them with culturally sensitive and comprehensive HIV/AIDS prevention information aimed at promoting abstinence, faithfulness; reducing the number of sexual partners and supporting discordant couples not to transmit HIV to the negative pregnant women identified through the PMTCT program. In most communities in Uganda, women and girls are not empowered to make decisions or even allowed to get involved in activities without the consent of their male partners. This makes them vulnerable to the sexual demands of men. THETA will work with Community Lay Providers and peer educator to in the communities to enhance preventive counseling for long term risk reduction of HIV transmission; promote HIV testing among the male partners of HIV negative pregnant women through appropriate linkages with the general HCT services and promote correct and consistent use of condoms. In addition, this program will also promote Sexual HIV prevention targeting women of reproductive age groups and their partners to be though the general PMTCT community works. Adults of reproductive age groups will be targeted through community dialogues to ensure that when they decide to have children, they are not infected with HIV. Community dialogue is a process that fosters dialogue and collaboration within the community by assisting community members in identifying the positive aspects of their community and existing successful mechanisms, while at the same time encouraging lessons learnt on how existing social problems have been successfully dealt with. There is ample opportunity during the process for community participants to gain clearer, correct understanding of basic HIV/AIDS and PMTCT issues; and there is time for reflection and planning so that communities can begin to create more caring and supportive environments for HIV-affected families, using community-available resources. In FY 2009 it is anticipated that about 60,000 people within the target groups (couples, single women and girls) will be reached with sexual prevention interventions and over 380 CLPs will be trained.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15910

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15910	15910.08	HHS/Centers for Disease Control & Prevention	Traditional and Modern Health Practitioners Together against AIDS and other diseases, Uganda	9211	9211.08	Traditional & Modern Health Practitioners	\$25,046

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$20,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.03: Activities by Funding Mechanism****Mechanism ID:** 10934.09**Mechanism:** New Partners  
Initiative: Traditional & Modern  
Health Practitioners**Prime Partner:** Traditional and Modern Health  
Practitioners Together against  
AIDS and other diseases,  
Uganda**USG Agency:** HHS/Centers for Disease  
Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Sexual Prevention: Other  
sexual prevention**Budget Code:** HVOP**Program Budget Code:** 03**Activity ID:** 26096.09**Planned Funds:** \$0**Activity System ID:** 26096

**Activity 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 15 years of experience implementing community-based health activities for underserved populations in both urban and rural areas of Uganda. In each district of operation, THETA has built a health and social services community delivery system that comprises of community lay providers (CLPs), a community support team, and district-based trainers. THETA's call has been in the area of HIV prevention and care for those infected and affected by HIV/AIDS. THETA received a notice of grant award on June 2008 from NPI to implement a program entitled "Building Referral Networks to reach the underserved communities with comprehensive HIV prevention services and to improve the livelihood of orphans and vulnerable in Uganda". The goal of this program is to scale up access to comprehensive HIV/AIDS prevention services and improve the livelihoods of orphans and vulnerable children through building and strengthening community support structures and referral networks between the biomedical and traditional health care system in Luwero, Mukono, Kiboga, Apac and Hoima districts for three years. The program will use traditional systems in HIV prevention and strengthen community initiatives in the care for OVC. Currently THETA is strengthening the structures to enable proper implementation of the program. So far the process of recruiting staff to beef up the human resources is underway as well as the procurement of equipment.

In this program, THETA will recruit "Sengas" (paternal aunts) and male peer promoters who will be equipped with basic HIV/AIDS information and send them out to facilitate HIV education and awareness events in communities following the ABC strategy. They will organize age and gender appropriate community groups targeting the youth, couples and other interest groups to discuss HIV/AIDS prevention concerns at individual, family and community levels. Some of the program implementers will receive basic HIV counseling training to enable them provide psychosocial support at community level and provide appropriate referrals. Sengas and male peer promoter's activities will be linked with the bio-medical health practitioners to ensure successful referral for HIV testing as well as treatment, care and support. Community behavioral Change Communication will be further be reinforced by community sensitization and counseling support. In addition, there will be radio programs by the Sengas and male peer promoters to reach more people in the community with HIV prevention information. These programs will also promote cultural values like virginity, faithfulness in marriage, abstinence and increase couple communication. The Sengas and male peer promoters will also distribute condoms at the community level.

There will be continuous interaction between the biomedical health practitioners and the Sengas/male peer promoters. They will together meet and share challenges and successes on the program. There will be four-day training where both the community lay providers and the biomedical practitioners at the new sub-counties will undergo training about the program. The Sengas/male peer promoters from the other sub-counties where the program has been operating in FY 2008 will join the new recruits on the last day of the training to share experiences. Also there will be stakeholder meetings held annually at the district level where all players will come together and share lessons as well as map out implementation of the next period.

In addition to that there will be community dialogues. They will aim at educating communities with their full participation. Members will be given an opportunity to share their personal experiences, cultural practices related to HIV transmission in the presence of the health providers, local and cultural leaders. Myths and misconceptions will be addressed and at the end of each dialogue members will be informed about community based HCT and other HIV services. During the dialogues health services in the perspective of traditional and modern health care will be discussed. This will give opportunity for the providers to get a feed back to improve their services and make them more culturally sensitive.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.03: Activities by Funding Mechanism****Mechanism ID:** 5739.09**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda**Funding Source:** GHCS (State)**Budget Code:** HVOP**Activity ID:** 26481.09**Activity System ID:** 26481**Mechanism:** Expansion of National  
Pediatric HIV/AIDS Prevention,  
Care and Treatment Services  
and Training of Service  
Providers**USG Agency:** HHS/Centers for Disease  
Control & Prevention**Program Area:** Sexual Prevention: Other  
sexual prevention**Program Budget Code:** 03**Planned Funds:** \$152,686

## Activity Narrative: ACTIVITIES UNCHANGED FROM FY 2008

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 paediatric & family-centered 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/ Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and is due to open in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/ Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum). Other collaborating partners include Feed the Children-Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kirudu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala. In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

Progress to-date; activities and achievements on sexual prevention:

Baylor-Uganda took a leadership role in the development of the a national 'Positive Prevention' Curriculum, especially in the area of adolescent care and prevention of HIV transmission, e.g. disclosure of HIV status, sex and sexuality, sexual and reproductive health (including family planning) counseling and services provision. Over the period, more than 45,000 people have participated in our sexual prevention messages. Implementation of sexual prevention interventions is aimed at increasing the proportion of target audience adopting safer sex practices to reduce the risk of new HIV (re)infection.

Family Planning (FP) and STD/cervical cancer screening services have been introduced as part of the prevention services on Tuesdays during Adolescent Clinic and on Thursdays during Family-Clinic at PIDC since June 2007; with 57 women & adolescents receiving pap smear and 495 put on family planning methods. About 600 children in our HIV/AIDS care and treatment program are adolescents who have grown through the program, and who are likely to express their natural sexual, fertility and/or reproductive desires. Already 40 out of a probable 420 female HIV positive adolescents in our care and treatment program have become pregnant. This implies; they have had unprotected sex with likely risk of (re)infection to themselves and their partners and future risk of transmission to unborn babies. Untreated STIs increase the risk of HIV acquisition and transmission. Similarly, there are care givers who are also diagnosed with HIV at PMTCT, from other referral points or during care to their children. All these categories of people need HIV prevention services to avoid HIV (re)infection. Therefore, treating STIs and addressing their sexual & reproductive health needs in a manner that reduces the risk of HIV (re)infection with their partners is vital in our sexual prevention program. Our interventions include: health education talks, individual and group counseling, positive prevention, training for adolescent peer educators & counselors, peer support groups, condom promotion, STI management, development of IEC materials, etc. Baylor – Uganda has partnered with

**Activity Narrative:** Population Services International to provide Basic Care Package (which includes condoms), SCOT for development and implementation of adolescent and youth positive prevention programming, and with Ministry of Health for other contraceptive supplies.

The Baylor-Uganda sexual prevention interventions target HIV infected & affected adolescents and family members of HIV infected children (siblings, care givers, etc) utilizing HIV/AIDS care and treatment programs from our services delivery points. In UNICEF (NON-PEPFAR) supported Regional Centres of Excellence in Eastern (Soroti) & Western (Kasese) regions and other rural areas where Baylor- Uganda works indirectly through government facilities, support will be provided to community groups to provide similar messages during home visits, health education and counseling sessions, as well as over radio programs in the local languages.

For 2009; we plan to implement the following activities :

- oConduct of health education and counseling sessions at COE and Satellites on clinic days on AB and other prevention options (Target: 20,050 unique individuals/year).
- oHold monthly Adolescent & Youth peer support group meetings that include counseling, health education, condom distribution, etc. targeting about 120 adolescents per month (200/year).
- oConduct quarterly care givers meetings to discuss prevention messages with about 150 participants/meetings (600/year).
- oConduct routine Home Based HCT where sexual prevention messages and services are provided. (Target: 480 households will be visited for HBHCT, with 1920 HBHCT done for unique individuals who will be reached with sexual prevention messages.)
- oPurchase and equip home health workers/community volunteers with Home Based Care kits.
- oSupport related staff positions from this program area (counselors, social worker, etc.)
- oProcure, distribute and demonstrate effective use of condoms during counseling, health education talks and services delivery y counselors, clinicians & home health workers/community volunteers.
- oProvide sexual an reproductive health services: STI management, family planning methods, screening of cancer of the cervix, etc.
- oTrain youth and community volunteers in positive prevention.
- oSupport radio programs that disseminate messages on sexual prevention (AB and others).

#### ACTIVITIES MODIFIED FROM FY 2008

oWe have modified our Home Health Program. Instead of our staff doing community level mobilization and health educations sessions, we will work with and support 7 community based groups (one group of 30 participants in each of the 7 Divisions of Kampala) to make the necessary community link: home visits, community sensitization. Each Volunteer visits 2 homes/week, making 20,160 visits/year .

#### NEW ACTIVITIES

- oDevelopment of a standard communication strategy covering HIV/AIDS prevention, treatment & care in children, which will be used as a guide for all health education messages across the program.
- oTrain health care providers (integrated with other trainings) in addressing sexual and reproductive health needs of PHAs (Target: 300)
- oConduct 'teen' mothers support group meetings quarterly with about 50 adolescents participating in each meeting (200 participants).
- oCommunity mobilization and sensitization at parish level within the Home Health Program of Baylor – Uganda, with about 20 people/quarter/person/division (16,800)
- oTrain adolescents and members of community groups in Home Based Care, including sexual prevention of HIV transmission.
- oCommunity mobilization and sensitization in partnership with groups supported by Christian Children's Fund, Save the Children in Uganda, Plan International as part of strengthening community link component of the program and leveraging resources.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$220,500

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 3834.09

**Prime Partner:** International Medical Corps

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 4803.25177.09

**Activity System ID:** 25177

**Mechanism:** Refugee HIV/AIDS services in Kyaka II Settlement

**USG Agency:** Department of State / Population, Refugees, and Migration

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$24,506



**Activity Narrative:** The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12,115 however there are a group of refugees known as "population on Hold" who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel. In the FY 2009, IMC will conduct promotion campaigns to improve condom use in 13 villages. Building on the success of the previous year, IMC will provide condom dispenser outlets, train community educators and promotion campaign to targeting over 10,000 individuals. During FY 2008, IMC conducted two condom promotion campaigns in 13 villages targeting over 7,400 individuals, additionally, through the work of the community educators another 9,027 individuals were reached with messages on condom usage during social forums, public health shows, antenatal clinic days and ART clinic days. 27 Condom outlets were maintained during the period and the outpatient centers were also provided with condoms for distribution. About 533,277 condoms were distributed during the period. 35 individuals were trained in STI management through condom use which included 21 community educators and 14 community health workers

In FY 2009, 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 continue its condom promotion campaign in addition to ongoing door to door sensitization by community educators. The condom outlets will be increased from 27 to 42 in an attempt to cover the host population as well. 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 will continue. Friendly reproductive services will be instituted at the health center through the training of health staff, providing related supplies and materials, school talks and providing straight talk newspapers. One group of PHAs will be formed and trained on positive living and prevention of STIs including prevention of re-infection. 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 continue through door to door sensitization by community educators, IEC materials and routine health education. Those in need of the services will be referred to the nearest HC III. Since there is a clear correlation between alcohol and other substance abuse and HIV risky behavior, the project will continue to raise awareness of this linkage through drama, community meetings and publication of IEC materials drawing attention to that linkage

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16080

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16080	4803.08	Department of State / Population, Refugees, and Migration	International Medical Corps	7337	3834.08	Refugee HIV/AIDS services in Kyaka II Settlement	\$24,506
8300	4803.07	Department of State / Population, Refugees, and Migration	International Medical Corps	4801	3834.07	Refugee HIV/AIDS services in Kyaka II Settlement	\$24,506
4803	4803.06	Department of State / Population, Refugees, and Migration	International Medical Corps	3834	3834.06	Refugee HIV/AIDS services in Kyaka II Settlement	\$17,784

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Family Planning
- \* Safe Motherhood

### Refugees/Internally Displaced Persons

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** HVOP

**Activity ID:** 21462.24012.09

**Activity System ID:** 24012

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Sexual Prevention: Other sexual prevention

**Program Budget Code:** 03

**Planned Funds:** \$316,666

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – Eastern will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project will cover eight districts Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko.

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiple partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity; reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly refereed to as 'Boda boda in Uganda), discordant couples, fishermen and the Communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions
- Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'
- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.

**Activity Narrative:** • Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).

• Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.

• Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21462

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21462	21462.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	██████████

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechansim**

**Mechanism ID:** 7253.09

**Mechanism:** TBD - Districts South-Southwest

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 15919.24022.09

**Planned Funds:** ██████████



**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The USAID funded district-based HIV/AIDS/TB program will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The USAID funded district-based program – South – South Western will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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. The project in South – South Western will cover nine districts of Bulisa, Kibaale, Kamwenge, Kyenjojo, Isingiro, Kanungu, Ibanda, Kisoro and Kiruhura.

AB

Even with the positive trends among young people regarding delayed sexual debut and increased abstinence, secondary data HIV Sero Behavioral analysis shows that certain behaviors particularly among adults are regressing towards those of the late 1980s when HIV prevalence was at its peak in the country: there is an increase in casual sex, an increase in multiplicity of partners, and a decrease in condom use with casual partners. A secondary analysis of available faithfulness data from the Uganda HIV/AIDS Sero-Behavioral survey 2004-05 shows that 88% of men are not lifetime faithful, compared to 56% of women, and only 10% of couples are mutually lifetime faithful.

The district-based program will support the 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 will be complemented by other USG partners programs that focused on strengthening and scaling up of the national Presidential Initiative for AIDS Strategy. Other abstinence activities will focus on the following:

- Promoting tailor-made talk shows on various topics aimed at creating more risk-free community environments to address legal issues on sex abuse, harassments, value of virginity, stigma and discrimination, care for persons affected and infected with HIV/AIDS.
- Information, Education and Communication (IEC) messages targeting out-of-school youth, couples, and the general community. The IEC messages will focus on creating an enabling environment for sexually active youth to abstain from early sexual activity, reduce sexual partners and to remain faithful to each other.
- Promotion of other IEC mechanisms that may include but not limited to radio programs, civil society drama groups to perform other targeted music, dance and drama that fosters community dialogue, addressing issues like couple dialogue, faithfulness and non violent behaviors, gender based violence. All together, it is estimated that 150,000 will be reached by abstinence and faithfulness messages including couples and out of-school youth

Other Sexual Prevention:

Recent findings have shown that high risk populations, such as commercial sex workers (among whom prevalence is thought to be as high as 50% and on the increase), long distance truck drivers, urban motorcycles riders (commonly referred to as 'Boda boda in Uganda), discordant couples, fishermen and the communities living at the landing sites, and other mobile populations remain major pockets of HIV prevalence within generalized epidemic in Uganda.

The district-based program will use its financial and technical support to provide resources to civil society organizations (CSOs) to reach 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. Key activities to be supported will include but not limited to the following:

- Condom distributions to key commercial outlets such as lodges, night clubs and bars (approximately 200 outlets)
- Supporting communities living near the landing sites for fishing with prevention interventions

Promoting responsible behaviors such as couple counseling and mutual disclosure, consistent and correct condom use among discordant couples and casual partners and reduction of multiple concurrent partnership'

- Training community resources persons to undertake community based mobilization and education on gender based violence prevention.
- Empowering couples and communities to promote societal norms that reduce the risk of HIV transmission and promote use and access to HIV counseling and testing services.
- Encourage the use of IEC and behavior change communication (BCC) materials promoting couples testing together, promotion of mutual disclosure and increasing awareness of discordance among couples.

- Activity Narrative:**
- Promotion of prevention among positives through PLHA network activities that increase knowledge on the importance of partners testing, diagnosis of sexually transmitted infections (STIs), treatment and prevention, family planning and PMTCT.
  - Promotion of STI prevention through supporting CSO's access to MOH and other partners' STI treatment guidelines and education on Herpes Simplex type 2 virus (HSV-2).
  - Supporting sexually youth who are mainly out-of-school to access youth friendly services such as counseling and testing, treatment, information, entertainment and recreational services.
  - Training at least 2500 community volunteers from CSOs and most at risk populations with different skills related to HIV sexual prevention

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15919

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15919	15919.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11121.09	<b>Mechanism:</b> The Core Initiative
<b>Prime Partner:</b> CARE International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03

**Activity ID:** 6551.26762.09

**Planned Funds:** \$0

**Activity System ID:** 26762

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In FY 2009, CARE/CORE will continue to strengthen the capacity of Ministry of Gender and social Development (MGLSD) to increasingly build the capacity of districts through the established Technical Service Organizations in management, planning and coordination; monitoring and evaluation; and advocacy and communication of OVC response. CARE/CORE support will focus on improving the quality of OVC services and HIV prevention in order to strengthen district and civil society capacity to provide integrated and comprehensive services. Also, CARE/CORE will serve as the interim Technical Management Agent of the Civil Society Fund (CSF), helping in consolidating the established granting mechanism, provide operational and administrative support to the steering committee, and ensure the technical quality of the civil society OVC and HIV prevention portfolio. Key deliverables of CARE/CORE in FY09 include a) Strengthening district capacity to plan, manage, coordinate, monitor and evaluate their OVC programs, b) Supporting all districts in Uganda to roll out the OVC M&E framework and OVC MIS, and c) all civil society organizations in districts supported to implement OVC Quality Standards.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14184

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14184	6551.08	U.S. Agency for International Development	CARE International	6729	1030.08	The Core Initiative	\$375,000
8410	6551.07	U.S. Agency for International Development	CARE International	4827	1030.07	The Core Initiative	\$350,000
6551	6551.06	U.S. Agency for International Development	CARE International	2760	1030.06	The Core Initiative	\$550,000

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 26518.09

**Planned Funds:** \$170,000

**Activity System ID:** 26518



**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support, the national Information, Education and Communication/Behavior Change Communication (IEC/BCC) strategy has been critical in facilitation of the behavior change process. Many activities are done in collaboration with other MoH partners; UNICEF, WHO, GLIA, UNFPA, the Global Fund and with the District DHTs. The IEC/BCC plays a significant role in promoting the uptake and utilization of existing services; increasing over time and in scope and variety. The program creates awareness, influencing attitudes and beliefs, as well as promoting skills.

In FY 2008, 20,000 people received HIV/AIDS information through IEC/BCC and 1,500 were referred for services; In support of behavior change interventions through media, MoH provided capacity building activities for IEC partners in 20 local media outlets.

The MoH also accomplished advocacy meetings on male medical circumcision (MMC) in the Eastern and Northern regions. MMC educational sessions were held for 120 district leaders (cultural, political, administrative, technical (DHT), local surgeons (traditional circumcisers) to promote In addition, MoH conducted 20 community film shows in 4 strategic fishing locations along Lake Victoria and at long-distance truck drivers parking sites in Katuna (south western Uganda), Naluwerere (eastern Uganda), and Mbuya, (central region).

The IEC/BCC unit procured and distributed ABC promotion materials (2,000 bags for community condom distributors and penile models to 240 community condom distributors in 6 districts and provided technical supervision to interventions conducted in 10 districts.

The STI unit trained a district STD trainers from ten districts; held orientation meeting for MCH, antenatal and family planning providers in syphilis screening and syndromic STD case management in 8 districts, and supported on 52 radio sessions on two radio stations to educate the community about STI .

The challenges in FY2008 were bureaucratic delays in procurement of both goods and services. More activities were planned but could not be carried out as scheduled. Mass production of IEC materials was not made, and no logo condoms procured with support from UNFPA and USAID were not popular among users.

In FY 2009 the activities will continue. Sexual prevention will cover IEC/BCC, condom promotion and the management of Sexually Transmitted Infections (STIs). The implementation these project interventions, will be consistent with the country's efforts in scaling up a comprehensive integrated approach to HIV prevention. The focus of the IEC/BCC during this period will address the key emerging issues including: medical male circumcision, HIV discordance, high prevalence of Herpes Simplex type II infection, multiple concurrent partnerships, cross-generational sex, transactional sex and gender based violence. Similarly, IEC/BCC and condom promotion continue to play critical roles in ensuring the adaptation of risk reduction behaviors and in the promotion of the utilization of HIV and AIDS services. Consistent with the MoH mandate, the activities will focus on capacity building, development and dissemination of guidelines. These activities will include: production and distribution of print IEC/BCC materials including condom promotional materials; training of district focal persons on IEC/BCC; advocacy meetings on safe male medical circumcision; training of condom focal persons and promoters in districts; holding interactive radio talk shows, dissemination of guidelines through the life planning handbook and peer-educators handbook; development of HIV/AIDS mobilization guide for village health teams; producing educational films, and providing technical support supervision.

The management of sexually transmitted infections (STI) in health facilities is another important area in sexual prevention. STI syndromic case management remains the main stay of approach in Uganda. MoH will support building STI case management capacity at the district level via the following strategies: training of trainers programs, providing STI prevention education and information at the community level, and improve the STI drug supply. The training of STI trainers at district level, will reach more districts and supporting integrated HIV and reproductive health services -

UNICEF & WHO will specifically support the revision of comprehensive HIV/AIDS communication strategy, medical male circumcision advocacy strategy, and IEC/BCC promotion materials for male circumcision. GLIA, Global Fund MJAP/CDC /PEPFAR and UNFPA will focus their attention on the most at risk populations such as, sex workers and truck drivers to promote healthier sexual behaviors. The District will implement the activities.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 5740.09

**Mechanism:** Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 16753.26505.09

**Planned Funds:** \$50,000

**Activity System ID:** 26505

**Activity Narrative:** This is a newly funded activity and it is a component of Counseling and Testing and Adult Care and Treatment activities. Integrated Community Based Initiatives (ICOB) is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a Liaison office in Kampala. ICOBI's vision is a healthy and prosperous rural population and its mission is to improve the quality of lives of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely: Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple-S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project (NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing (HBCT) in Bushenyi district (October 2004-June 2007) with funding from CDC/PEPFAR. The home based counseling and testing program was able to offer HBCT services to about 270,000 adults and children, identified about 12,000 HIV+ clients and provide them with basic care package with collaboration of Bushenyi district health system. The current ongoing programs include Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID in Bushenyi district and OVC Care & support with funding from NPI/USAID for Mbarara and Bushenyi district.

Recently (June 2008), ICOBI received a notice of award from CDC to implement a program entitled "Provision of Full Access Home based confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda" (ICOB HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013). The program will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda but will be implemented using a phased approach beginning with Mubende and Mityana districts. The goal of the program is to provide 100% access to HIV confidential Counseling and Testing services to all adults and children at risk of HIV infection residing in the six districts in five years. In addition, the program is to provide basic HIV/AIDS care and support, strengthen TB/HIV integration services to all identified HIV infected individuals and their families. The program will also support primary prevention of HIV and prevention with positives activities. The program will be implemented by outreach counseling and testing teams who will be based at the Sub-counties and the resident community mobilizers who will be based at the Parishes. In addition, the village health teams and local councils will also be engaged during community mobilization and sensitization. Under sexual prevention, ICOBI will implement activities related to meeting the program specific objective of reducing new HIV infection in the population especially among the youth out of school, adults in marriage and or long term relationships and high risk populations. The people tested as HIV negative will be supported to remain HIV negative by encouraging adoption of appropriate prevention behaviors. HIV positive individuals will be encouraged not to spread the infection by adoption of safer practices. The prevention messages will be strengthened within the general population including those not tested and age appropriate information and messages will be communicated to targeted population groups throughout program implementation in the four districts. Ongoing supportive counseling will mainly target HIV infected individuals eg 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 partners at risk. Additionally ICOBI will target at high risk populations groups with relevant messages and other behavioral change prevention options. The groups of population to be targeted will include about 60,000 men and women in Mubende and Luwero districts respectively. Vendors, Motorcycle cyclists, long distance drivers, sex workers in urban centers, discordant couples, out of school youth, widows and divorcees. Strategies and activities to be implemented will reach about 20,000 young people out of school aged 10-19 years with messages on abstinence and behavioral change and about 80,000 adults in marriage and or long-term relationships /partnerships reached through activities targeting faithfulness, fidelity and HBCT, and about 200 discordant couples recruited as condom distributors. About 40,000 high risk individuals will be reached with safer sex messages and interventions during the program period from 1st October 2009 to 30th September 2010.

**Sexual prevention - Youth and Couples Peer enrollment, orientation & training:**  
ICOB will work with community volunteers (Resident Parish mobilizers/RPMs) and village health teams to map out high risk groups and their strategic sites in the program districts (where the high-risk groups and the youth people congregate for leisure and targeted employment). 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 other support to their groups. They will encourage their peers through 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. This strategy and related activities will be supported by the radio program, one hour each week. We hope to identify, enroll and train 295 youth as peer-educator and 46 model couples (1 per each sub county). We hope the 295 peer educators should be able to identify and induct others 2,405 based a village level who will be able to interact on one to one in one year at about 100 individuals thus reaching about 250,000 with abstinence and be faithful messages and behavioral change information.

#### **Strengthening Abstinence/Being Faithful**

Through peer education and interpersonal communication, community mobilization and provider education, AB messages to young people and Be-faithful messages, and or consistent and effective condom use will be strengthened. In addition AB messages will be communicated through home-based HIV counseling and testing (C&T) activities conducted in homes by CT teams in 46 sub counties. Other strategies and activities of communicating AB messages will include Film shows targeting young people, dance & drama shows by community groups trained to incorporate AB messages in their shows, Football and Netball competitions gatherings, community meetings where the community members will converge and the facilitator communicates relevant and age appropriate information related to AB. Specifically for be faithful message, Model couples will be identified and oriented in couple counseling and will hold community meetings and hold family dialogue sessions among couples so as to increase HBCT

**Activity Narrative:** uptake and to sustain B message communication in the program areas. Similarly all parishes will be mobilized to identify one person to be trained in peer education and communication of AB messages. The funds for this activity will be spent on community mobilization and Education (IEC), identification and training of peer educators, facilitating peer educators to carry out peer education sessions for commercial sex workers, PLHA in post test clubs, out of school youth (who include motorcycle cyclists) and military populations through drama at parish levels and communication of messages to targeted audiences.

Other sexual prevention: Community Mobilization for project activities and Condom Distribution  
Community mobilization will be done 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 and form post test clubs or expand and join the existing post test clubs in each parish. The referred clients who will get the starter kits already will have received and had demonstration on condom use by the health worker and will 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 295 parishes in the program four districts. The funds for this activity will be spent mainly on paying staff salaries, setting up of condom outlets in locations of populations at risk eg urban centers like bars, disco halls, hotels etc, training of community condom distributors (295), 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16753

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16753	16753.08	HHS/Centers for Disease Control & Prevention	To Be Determined	6423	5740.08	Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts	■

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.03: Activities by Funding Mechansim**

**Mechanism ID:** 11128.09

**Mechanism:** TASO

**Prime Partner:** The AIDS Support Organization

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 21457.26796.09

**Planned Funds:** \$0

**Activity System ID:** 26796

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN DECEMBER 2008. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

This activity will focus on community mobilization activities to promote positive behaviors such as: gender equity; couple dialogue; partner counseling and testing; disclosure; and accessing treatment together. Community mobilization activities will also be directed towards elimination of negative behaviors that bring about stigma and discrimination associated with HIV/AIDS. TASO will support to strengthening/setting up of PLHA networks through training and logistics support in 28 districts of Uganda. PLHA networks will increase community mobilization, address stigma, denial and discrimination among PLHAs and their communities, and facilitate referral for treatment. This support is expected to increase the overall capacity of PLHA networks to access additional funding opportunities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21457

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21457	21457.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$407,340

Program Budget Code: 04 - HMBL Biomedical Prevention: Blood Safety

---

**Total Planned Funding for Program Budget Code: \$4,900,000**

### **Program Area Narrative:**

Medical transmission is not a primary driver of the HIV/AIDS epidemic in Uganda, however biomedical transmission deserves continued attention because of the potential for spreading HIV infection in the health care setting, as well as the important contribution to health systems strengthening. Uganda's Ministry of Health (MOH) seeks to establish an environment where health workers, patients, and communities are better protected against transmission of blood borne pathogens. USG supports a comprehensive approach to both injection safety and blood safety in line with national priorities and to meet the needs of the Ugandan population.

A high rate of injections (3 per person per year) has been documented in Uganda, which underscores the importance of limiting unnecessary injections through Injection Safety interventions. Blood transfusion is an essential life-saving therapy; more than 3 out of 4 of the beneficiaries are children due to malaria-associated anemia and mothers with post-partum hemorrhage.

#### **Injection Safety**

With USG Track 1 funding the Making Medical Injections Safer (MMIS) project has continued to provide technical and financial assistance to the Ministry of Health (MOH) in prevention of medical transmission of HIV through rapid reduction of unsafe and unnecessary injections. Given that the country has adopted the use of auto-disable syringes and needles, there is need to build capacity among health workers countrywide on injection safety practices, management of medical waste, and logistics management. In order to increase coverage of infection control activities, the PEPFAR country program and WHO provided additional resources to support rapid scale up infection control activities.

The key strategies for the program include: improving service provider skills; behaviour change and communication aimed at reducing unnecessary injections; improving the logistics system to ensure regular 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 5 expansion districts while sustaining desired practices in the initial twenty districts. The main challenge envisaged in supporting injection safety activities is the anticipated phase out of USG centrally funded mechanism in FY09. The USG country program is not in position to bridge the gap due challenges associated with level funding.

The Injection Safety program has been operating for 4 years. Findings from the recently concluded Service Provision Assessment survey show that sharps boxes while not widely available were more available than other infection control items. Guidelines on injection safety were scarce at surveyed facilities being available in only 17% of them. Almost 70% of facilities surveyed had an adequate sharps waste disposal system. In addition almost all injections observed were administered using a new needle and syringe from a sealed sterile pack, and the majority of the time the used injection equipment was immediately disposed of appropriately.

FY09 is the last year during which the centrally funded MMIS project will be operational globally and in Uganda. The USG team plans to continue funding injection safety activities using country funds, albeit at a decreased level, to ensure that gains are not reversed. No decision has yet been reached on the type of option that is best suited to program injection safety activities beyond FY09 (e.g., directing funding of MOH or through USAID central mechanism).

#### **Health Care Waste Management**

Recognizing that final disposal of health care waste is one of the biggest challenges in medical transmission of HIV, and in response to the Ministry of Health policy of allocating at least 10% of the commodity budget towards Health Care Waste Management (HCWM), USG funds are being used to support the Ministry of Health to roll out the health care waste management policy in MMIS project areas of operation and to provide technical assistance to the PEPFAR partners who will meet the actual cost of their HCWM plans.

#### **Blood Safety**

The Government of Uganda is committed to ensuring elimination of HIV transmission through blood transfusion. Uganda's National HIV/AIDS Strategic Plan 2007-12, blood safety objective is "maintaining 100% blood transfusion safety, ensure 100% adherence to universal precautions and promote 100% access to PEP at ART centers". The program is, however, challenged to meet the increasing demand for blood and blood products, mainly due to rapidly growing population and upgrading of health facilities to Health Center IV and district hospital especially in the newly created districts.

Currently, the centrally funded PEPFAR blood safety program is the main donor to the Uganda blood safety program. While this support is expected to phase out in 2010, the blood safety program will still require substantial financial resources from the USG /PEPFAR country program, government and development partners in order to sustain and expand blood transfusion services.

The Blood Safety Program is implemented by the Uganda Blood Transfusion Service (UBTS) a semi autonomous institution under

---

the MOH and sub-partner Uganda Red Cross Society (URCS) a charitable, not for profit organization. Currently, about 100,000 patients receive blood or blood products annually in roughly 160 major public and private health facilities throughout the country. Nearly half of the recipients of blood or blood products in Uganda are pediatric, a quarter are obstetric, with the remaining recipients comprising medical (many HIV-related) and surgical patients.

USG/PEPFAR, through Track 1 funding, supports a comprehensive approach to blood safety in line with national priorities to meet the needs of the Ugandan population. 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. In addition, USG supports adequate and appropriate infrastructure, transport, supplies and equipment to ensure that program goals are met.

Blood transfusion needs are expected to grow by 20% annually to reach 200,000 units of blood in FY09, and with Uganda's rapidly growing population, blood transfusion needs are expected to grow in the subsequent years. Therefore, maintaining adequate quantities of safe blood and blood products will become an ever-increasing challenge. Community mobilization and education for donor recruitment is jointly implemented by the UBTS and URCS. Together, these institutions have built a countrywide network to access communities, schools and workplaces. Access to and regular communication with individuals and communities has greatly improved with the recruitment of additional staff, and purchase of additional transport 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, and this collaboration will continue in FY09. Compared to new donors, repeat donors have a lower HIV sero-prevalence. Repeat donors currently represent 55% of all donors, and in FY09, the proportion of repeat donors is targeted to increase by 10%. Retention of voluntary, non-remunerated HIV negative donors through URCS supported blood donor clubs is particularly vital for running a successful blood safety program. Recruitment and retention of voluntary, non-remunerated low-risk blood donors has been enhanced through increased use of electronic and print media, mobile phone text messages, and scheduled visits by counselors. Plans are in place to increase the participation of corporate bodies, churches and Rotary Club Uganda in community sensitization and mobilization activities in FY09.

Quality assurance activities, as well as the implementation of a newly developed quality assurance system covering all stages of the transfusion process, will be strengthened. Related QA manuals have been completed, along with staff training and supervision. Quality indicators have also been finalized and will be utilized to secure a safe blood supply.

Human capacity improvements have been made, and UBTS's staff structure has been approved by the Ministry of Public Service, and the MOH will continue to support salaries for these staff.

Maintaining high standards for blood collection, testing, storage and distribution is also critical to the program's strategy. UBTS tests all transfusion bloods for HIV and TTI (hepatitis B and C, and syphilis) using effective testing algorithms at the seven regional blood bank laboratories: Arua, Fort Portal, Gulu, Kitovu, Mbale, Mbarara and Nakasero. Development and expansion of blood bank infrastructure in the western and eastern regions (Mbarara and Mbale respectively) is being completed, while in FY08 under RPSO, work is in progress for the expansion and renovation of the national referral laboratory and the UBTS administrative offices in Kampala, Nakasero. The reference laboratory at Nakasero continues to offer technical assistance for HIV counseling and testing programs, and laboratory equipment for this purpose has been purchased for these centers. In addition, improvements in the cold chain and distribution of blood have been made with purchase of refrigerators, freezers and cold boxes.

CDC Uganda has provided technical assistance for strengthening the Management Information System (MIS) for the program, and this will continue through FY09. 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.

In FY09, capacity building will remain a priority for the program, particularly in the area of enhancing infrastructure. Inadequate infrastructure and space at the regional blood banks and the national referral laboratory remains a major challenge to the expansion of the program operations and meeting the ever-increasing demand for safe blood in the country. In FY 09, construction of 2 additional regional blood banks in northern (Gulu) and western Uganda (Fort Portal) will be undertaken. The MOH has offered the land for the construction of these new buildings. Availability of adequate transport is also crucial for running an effective blood safety program. Therefore, in FY09, more vehicles will be purchased to support mobilization, blood collection, and monitoring and evaluation activities.

To encourage repeat donations in FY09, post donation counseling will continue to be provided and appropriate referral of HIV-positive donors to HIV/AIDS care and treatment services will continue. Although not the main service of the program, thousands of potential and repeat donors benefit from the HIV and transfusion transmitted infections (TTI) prevention counseling and referral to HIV prevention and care services.

Training remains a critical component of the program. In FY09, varying approaches will be used to train all cadres of program staff in 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 will continue to be offered in the Netherlands. Additionally, UBTS and SCS will work to finalize blood safety course modules for adoption in pre-service curricula of medical training institutions, with the aim to foster appropriate clinical use of blood and blood products in the long term. In the interim, the program will continue with 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.

#### Medical Male Circumcision

Medical Male Circumcision (MMC) is being championed by the MOH as an effective prevention intervention, and is included in the

2007-2012 NSP. A situation analysis was conducted by the MOH and the Makerere University School of Public Health, with USG support, using the WHO and UNAIDS toolkit. Analysis of the results has been completed and public dissemination considered for November- December of 2008. A series of professional and public debates have been organized with press coverage in the local media. USG has supported the MOH in the development of a communication strategy for medical male circumcision, which will be finalized and disseminated in FY09.

In FY08, the USG team received a request from the MOH to support a scale up of MMC services in the country. As a result of this request, the USG team will provide assistance to the MOH to develop a MCC policy as well as a strategy for scale up of services, which will be based on the results of the situation analysis. Pending a scale up strategy, USG support for service delivery will proceed cautiously. To date, USG has supported the training of providers in a limited number of districts, particularly those adjoining Rakai District, who have requested assistance from the Rakai Health Sciences Program (RHSP) to support service delivery and supervision in selected facilities (Health Center IVs). Rakai Health Sciences Program (RHSP), which carried out one of the three definitive MCC trials, serves as the training center. The RHSP has a state-of- the art outpatient surgical facility and highly experienced surgical teams, and has been selected by WHO to serve as a regional MMC training center. RHSP has proposed to facilitate safe MMC by offering training to different cadres of medical personnel.

In FY09, MMC training, supervision and service delivery will extend to Kayunga Hospital which is supported by the Makerere University /Walter Reed Project (MUWRP). MUWRP is responding to a request from health authorities in Kayunga district to implement male circumcision services at the district hospital. A similar model will be followed with RHSP providing the training and supervision for providers at the Rakai district hospital.

There is still some reluctance in Uganda, outside of the MOH, to embrace MMC as an effective prevention intervention, due mainly to socio-political factors. In addition to proceeding cautiously on training and service delivery in FY09, the USG will continue to support advocacy efforts by the MUSPH and the MOH to improve understanding of MCC, increase acceptance and decrease opposition to this effective prevention measure.

During FY09 the USG will support 2 MMC service sites and the training of 45 MMC surgeons and 50 other MMC-related providers.

**Table 3.3.04: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11909.09	<b>Mechanism:</b> RPSO/Track 1.0
<b>Prime Partner:</b> Regional Procurement Support Office/Frankfurt	<b>USG Agency:</b> Department of State / African Affairs
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Biomedical Prevention: Blood Safety
<b>Budget Code:</b> HMBL	<b>Program Budget Code:</b> 04
<b>Activity ID:</b> 29188.09	<b>Planned Funds:</b> \$1,400,000
<b>Activity System ID:</b> 29188	

**Activity Narrative:** Activities during FY 2008 fell under the following areas: infrastructure development, blood collection and testing, promotion of appropriate clinical usage of blood, quality assurance, training, monitoring and evaluation, and sustainability. The UBTS operates 7 regional blood banks, of those, only 2 are purpose built with adequate space. The new regional blood bank in the east, at Mbale was commissioned and another one in the southwest, at Mbarara has also been completed. The national reference centre in Kampala, at Nakasero is now too small to conduct all activities, with FY 08 funding it is being expanded and renovated. The refurbishment of these administrative headquarters and reference laboratory at Nakasero blood bank will soon begin following the selection of a consultant and contractor by the Regional Procurement Support Office (RPSO). Two more regional blood banks will be constructed in FY2008 in the west, at Fort Portal and north, at Gulu to enable improved functioning of these regional blood banks. Laboratory equipment and back-up generators will be purchased and installed in these units. Another two regional blood banks will be constructed in northwest, at Arua and central, at Masaka in FY 2009.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.04: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 1250.09	<b>Mechanism:</b> Rapid Strengthening of Blood Transfusion Services
<b>Prime Partner:</b> Uganda Blood Transfusion Services	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Biomedical Prevention: Blood Safety



---

**Budget Code:** HMBL

**Program Budget Code:** 04

**Activity ID:** 4014.20885.09

**Planned Funds:** \$3,000,000

**Activity System ID:** 20885

**Activity Narrative:** Blood transfusion is an essential life-saving intervention; 3 out of 4 transfusions in Uganda are given to children suffering from malaria-associated anemia and mothers with post-partum hemorrhage. An increasing number of transfusions are being given to patients on ART. Provision of safe blood is an essential component of the minimum health care package of the Ministry of Health (MOH) and essential to attaining the key outcomes of the Uganda's Health Sector Strategic Plan II (2006-2011) including reduction of the infant mortality rate and maternal mortality as well as HIV/AIDS prevention and care. These outcomes have a direct relevance to the attainment of the Millennium Development Goals (MDG) 4, 5 and 6. The Uganda Blood Transfusion Service (UBTS) is the national blood service responsible for all blood safety activities for the entire country with the following: Vision 'To be a national, efficient, effective, well-resourced, accountable and sustainable organization' and Mission 'To achieve a safe, efficient and sustainable national blood transfusion service, based on healthy volunteer donors and able to meet the needs of Uganda's health care system while promoting a good blood transfusion system'. An adequate supply of safe blood screened and processed in a quality assured manner by the UBTS eliminates the risky donor selection, incomplete laboratory testing, and inadequate processing that occurs with hospital collections. The UBTS with their sub partner, the Uganda Red Cross Society (URCS) recruits voluntary blood donors through the 7 regional blood banks to obtain adequate blood for transfusion to supply over 166 health facilities. The PEPFAR program provides about 75% support to the UBTS operating budget; the MOH contributes the remainder of the operating budget in addition to UBTS personnel costs. URCS are responsible for about 40% of the activities in blood donor recruitment and provision of post-test counseling to blood donors. Established as an act of Parliament in 1936, URCS has been involved in blood donor recruitment in Uganda since 1954. Ten blood donor recruiters and 14 professional blood donor counselors from URCS work on teams that regularly visit schools, workplaces and churches for blood collection and post-test counseling.

Activities during FY 2008 fell under the following areas: infrastructure development, blood collection and testing, promotion of appropriate clinical usage of blood, quality assurance, training, monitoring and evaluation, and sustainability.

The UBTS operates 7 regional blood banks, of those, only 2 are purpose built with adequate space. The new regional blood bank in the east, at Mbale was commissioned and another one in the southwest, at Mbarara has also been completed. The national reference centre in Kampala, at Nakasero is now too small to conduct all activities, with FY 08 funding it is being expanded and renovated. The refurbishment of these administrative headquarters and reference laboratory at Nakasero blood bank will soon begin following the selection of a consultant and contractor by the Regional Procurement Support Office (RPSO). Two more regional blood banks will be constructed in FY2008 in the west, at Fort Portal and north, at Gulu to enable improved functioning of these regional blood banks. Laboratory equipment and back-up generators will be purchased and installed in these units. Another two regional blood banks will be constructed in northwest, at Arua and central, at Masaka in FY 2009. Procurement of laboratory equipment and reagents has been finalized; vehicles for use in blood donor recruitment and collection will also be received following completion of the procurement process.

Current work on blood donor registers for new and repeat donors, and donor clubs is being finalized, as well as continued mobilization, recruitment, retention and care of voluntary non-remunerated repeating blood donors. These are continuing activities, and are expected to lower the HIV sero-prevalence among blood donors from the current 1.4% to 1.2%, as well as result in a 10% decrease in the prevalence of hepatitis B, C and syphilis in the blood donor population. The main objective of pre-donation counseling is selection of low-risk healthy blood donors, whereas post-donation counseling (donor notification) gives opportunity to blood donors to learn their health status, make informed decisions about their lives, continue donating blood, as well as preventing infected blood donors from donating again. This will be continued during FY2009 to ensure that at least 70% of all blood donors receive post-donation (donor notification) counseling.

Repeat voluntary blood donors in Uganda are encouraged to join blood donor clubs, which are an equivalent of "Club 25" elsewhere. Members of donor clubs have the lowest infection risk and are particularly valuable for providing safe blood during school holidays. In FY2009, existing clubs will be encouraged to recruit more members and more clubs will be formed.

Blood units collected amount to 135,000 which constitute 75% of the FY 2008 target. All the blood was collected from voluntary, non-remunerated donors, half of whom are repeat blood donors. More than 80% of the blood is collected by mobile blood collection teams, who travel to communities after blood donor recruitment officers have visited the communities to mobilize, educate and provide IEC materials to groups of blood donors. UBTS has a network of 20 such mobile teams in the whole country. Further improvements in the efficiency of blood collection in FY 2009 will be achieved. The number of blood units collected in FY 2009 is expected to increase by 15%; from a projected annual collection of 150,000 to 172,500 units of blood. Effective use of text messages to mobile phone by recall centers, are expected to contribute significantly in the increased contact with repeat donors. Using these and already established strategies the proportion of repeat blood donors is expected to increase to 58% from the current 52%. The UBTS collaboration with the URCS in donor mobilization will continue in FY 2009. Other valuable partners include CDC Uganda, USAID, corporate bodies, institutions of learning and churches. Other organizations have shown willingness to collaborate in blood donor mobilization including the ROTARY clubs in Uganda. These opportunities will be further pursued in FY 2009 to ensure effective blood donor mobilization across the country.

All blood units collected from donors continue to be tested for HIV, Hepatitis B and C, and syphilis, using the most effective testing algorithm recently adopted by the reference laboratory at Nakasero. All regional blood bank laboratories operate an algorithm that includes use of a screening ELISA test and a confirmatory ELISA for high titer positive samples. Indeterminate and borderline samples are referred to the reference laboratory for further testing and confirmation. The reference laboratory has automatic laboratory equipment for high throughput and uses chemiluminescence based testing technology. Specialized blood processing into components that was previously only conducted at Nakasero, has been initiated in the new regional blood bank facilities at Mbale, and in the near future at Mbarara, following the availability of suitable premises at those regional blood banks. This allows for the provision of appropriate blood components for transfusion to match the requirements of patient treatment, rather than the indiscriminate use of whole blood, implying better patient management. In order to ensure the appropriate utilization of blood in hospitals, establishment of hospital transfusion committee will continue to cover at least 50% of the district hospitals. UBTS will support the revision and distribution of national clinical transfusion guidelines on

**Activity Narrative:** appropriate clinical use of blood and blood products. Further improvement in documentation will enhance haemovigilance in hospitals.

UBTS will continue to offer its expertise as a reference laboratory for other organizations involved in HIV counseling and testing (HCT) activities in the country, and will also continue to play a significant role in the care and support of HIV/AIDS patients who require blood transfusion, and malaria patients, especially children. Similarly, UBTS will continue to collaborate with the reproductive health departments to ensure timely management of emergencies in childbirth by providing sufficient blood needed to save mothers' lives. Through provision of safe blood, UBTS will continue to play a significant role in reduction of mother-to-child transmission of HIV/AIDS.

The quality assurance program was developed with collaboration of the Sanguin Consulting Services (SCS) and this will continue in FY 2009. Quality assurance manuals have been finalized, and a program of training in their application, especially the standard operating procedures (SOPs) is on going. Emphasis on use of standard operating procedures, as well as operating an effective quality control system are expected to further ensure the safety of blood supplied by UBTS. A blood banking information system (BBIS) was developed by the CDC Uganda office, and launched in September 2008. This BBIS will greatly support the computerization of testing and processing blood, data analysis and reporting. It is currently operational at the Nakasero headquarters, and the new regional blood bank facilities in Mbale and Mbarara. The monitoring and evaluation program is currently being developed, (taking advantage of the new BBIS) and is expected to be fully implemented in FY2009 to ensure further efficient and effective implementation of the blood safety activities, and ultimately provision of a safe blood in the country.

The Ministry of Health continues to provide funds for the UBTS staff salaries. Following the approval of the staff structure by the Ministry of Public Service, a full contingent of staff will have been appointed by the end of 2008. Deployment of staff and filling of the staff structure for the entire blood safety services has been a major activity to provide the necessary human resource and ensure sustainability of the organization.

UBTS has developed and implements training courses for all cadres of staff in the service. Important training activities included a seminar for 30 clinicians, training course for 15 senior technologists and short course for various cadres of staff which are still ongoing. UBTS staff benefit from counselor courses conducted by The AIDS Support Organization and the AIDS Information Center; it is expected that more blood donor counselors will be trained by those institutions. An extensive training program will be implemented in FY 2009 for all staff using a national training document that is already in place. Two regional blood bank directors have enrolled for the Masters Degree in Management of Transfusion Medicine (MMTM) in FY 2008 and 2 more will register in FY 2009. UBTS collaborates with training schools including clinical officers' schools at Fort Portal, Mbale and Gulu to teach clinical blood transfusion in these schools. These arrangements will continue in FY 2009. Plans by UBTS and Sanquin Consulting Services to develop a blood safety course for integration in the curricula of medical schools in the country will be finalized in FY 2009.

The approval of a national policy on blood transfusion, the staff structure, and the recently granted self-accounting status to the UBTS are important steps towards making the organization fully autonomous. A decision on the autonomy of the UBTS is expected in FY 2009. This will be a significant step in enhancing sustainability.

Priority activities in FY 2009 include:

1. Improvement of the infrastructure through provision of adequate premises at Nakasero Blood Bank, Fort Portal and Gulu regional blood banks (through RPSO) and provision of essential equipment, supplies and vehicles to support effective implementation of the program.
2. Effective mobilization, recruitment, retention and care of voluntary, non-remunerated repeating blood donors to ensure a consistent, adequate and safe blood supply.
3. Improved efficiency for collection, testing, storage and distribution of blood and blood products, to ensure that need for blood for transfusion is adequately met.
4. Continued collaboration between UBTS and Uganda Red Cross Society (URCS) and other departments in the health sector as well as development partners in the development of a sustainable, safe and cost-effective service for the people of Uganda.
5. Work with the Ministry of Health to accomplish activities leading to UBTS autonomy

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13320

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13320	4014.08	HHS/Centers for Disease Control & Prevention	Uganda Blood Transfusion Services	6442	1250.08	Rapid Strengthening of Blood Transfusion Services	\$3,000,000
8368	4014.07	HHS/Centers for Disease Control & Prevention	Uganda Blood Transfusion Services	4817	1250.07		\$3,000,000
4014	4014.06	HHS/Centers for Disease Control & Prevention	Uganda Blood Transfusion Services	3175	1250.06		\$1,800,000

**Table 3.3.04: Activities by Funding Mechanism**

**Mechanism ID:** 5457.09

**Mechanism:** Track 1.0

**Prime Partner:** Sanquin Consulting Services

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** Central GHCS (State)

**Program Area:** Biomedical Prevention: Blood Safety

**Budget Code:** HMBL

**Program Budget Code:** 04

**Activity ID:** 10334.20873.09

**Planned Funds:** \$500,000

**Activity System ID:** 20873

**Activity Narrative:** This activity relates to support of the Blood Safety program in Uganda, which is implemented by the Uganda Blood Transfusion Services (UBTS). The main activities include; blood safety, counseling and testing, infrastructure development and clinical use. The Sanquin Consulting Services (SCS) was founded in 2001 as an autonomous part of the Sanquin Blood Supply Foundation, Netherlands, with the goal of providing technical assistance on safe and sustainable blood supply systems in resource limited countries including Uganda.

Since late 2004, in collaboration with UBTS, the Sanquin team has provided technical assistance towards human capacity building through focused teaching and training at various levels of staff and clinicians involved in medical transfusion services and assisted in the development of a quality system and quality management system to strengthen the operations in the regional blood banks. Their assistance has led to an increase of both quantity and quality of blood collected and distributed by the national program. Also a major contribution was provided to the design and construction of appropriate good manufacturing practice (GMP) - compliant regional blood bank facilities in the eastern (Mbale) and south western regions (Mbarara); and the design of expanded renovated facilities for the national referral laboratory and UBTS headquarters in the capital city, Kampala.

The main areas of focus for SCS in FY 2009 will be on human capacity building at managerial and operational level (sustainability), technical advice in the design and construction of 2 regional blood bank facilities in the northern (Gulu) and western (Fort Portal) regions, which are paramount for the implementation of more advanced operations. Other areas of emphasis will include improving data collection to contribute to an increase of repeat donors and further reduction in their HIV prevalence; continued technical assistance towards the implementation of quality assurance activities - development of processes and standards, monitoring & evaluation to ensure effectiveness and efficiency; and the continuation of the program for the clinical interface and rational clinical use of blood.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13317

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13317	10334.08	HHS/Centers for Disease Control & Prevention	Sanquin Consulting Services	6440	5457.08	Track 1.0	\$500,000
10334	10334.07	HHS/Centers for Disease Control & Prevention	Sanquin Consulting Services	5457	5457.07	Track 1.0	\$300,000

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$130,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Program Budget Code:                                      05 - HMIN Biomedical Prevention: Injection Safety

**Total Planned Funding for Program Budget Code:    \$632,500**

**Table 3.3.05: Activities by Funding Mechansim**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Biomedical Prevention: Injection Safety

**Budget Code:** HMIN

**Program Budget Code:** 05

**Activity ID:** 4405.21230.09

**Planned Funds:** \$200,000

**Activity System ID:** 21230

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MOH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

The main role of the Infection Control Unit of the MOH is to prevent medical transmission of HIV/AIDS; where injection safety is a key component. The infection control program targets all health care settings but needs to begin addressing medical transmission of HIV in the community; given the expansion of home-based care services for AIDS patients.

In FY 2008, MOH, with additional support from WHO and the Making Medical Injection Safe (MMIS) Project, continued to build the capacity at the district level to initiate and implement Infection Prevention Programs. Post Exposure Prophylaxis (PEP) policy guidelines were printed and distributed to all hospitals and Health Centre IVs and PEP implementation guidelines are ready for dissemination. A review of the infection prevention and control audit tool based on National standards was completed. Work on the development of TB/HIV co infection assessment tool is progressing. Thus far, 856 health providers from 10 districts were trained, to use the new injection devices; technical support and supervision has been offered to 8 district hospitals. The main challenges in FY2008 was delay in getting funds for the activities, lack of understanding of nosocomial infections and lack of awareness of infection prevention among communities.

In FY 2009, a number of activities that started in FY 2008 are expected to continue. Training of trainers in comprehensive infection prevention will continue; 80 health workers on infection control committees will be trained to support and educate other health providers on this topic in their facilities. Approximately 20 hospitals will be assessed on their capacity to perform HIV/TB collaborative activities, and adhere to Standard Precautions in relation to TB infection prevention. Through this initiative, two TB/HIV co-infection awareness workshops will be conducted; 200 hospital managers and 80 health workers will be targeted and trained in TB/HIV co infection prevention and management.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13295

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13295	4405.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$200,000
8344	4405.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$200,000
4405	4405.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$65,466

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.05: Activities by Funding Mechanism**

**Mechanism ID:** 8348.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Mechanism:** John Snow, Inc./Injection Safety/country funded

**USG Agency:** U.S. Agency for International Development

**Program Area:** Biomedical Prevention: Injection Safety

---

**Budget Code:** HMIN

**Program Budget Code:** 05

**Activity ID:** 4383.21722.09

**Planned Funds:** \$382,500

**Activity System ID:** 21722



**Activity Narrative:** Activity Narrative: The USAID funded John Snow Incorporated (JSI/Making Medical Injections Safer (MMIS) project is a PEPFAR Track 1 project. It has continued to support the Ministry of Health (MOH) to scale up interventions aimed at reduction of medical transmission of HIV and other blood borne pathogens through rapid reduction of unsafe and unnecessary injections. So far, project interventions are benefiting 30 districts. The project is assisting the MOH to: Implement policy and standards for injection safety and health care waste management; implement injection safety activities in 30 districts, including improving the managers' and service providers' skills; supported the MOH and districts to procure and manage safe injection equipment and supplies; advocate for reduced demand for injections; and develop and implement an advocacy strategy for wider decision makers' and public understanding. So far, project interventions are benefiting 30 districts covering 46% of the population. The districts are: Pallisa, Nebbi, Yumbe, Mpigi, Mbale, Manafwa, Bududa, Budaka, Kayunga, Luweero, Kampala, Kabarole, Wakiso, Mbarara, Ibanda, Isingiro, Kiruhura, Kabale, Hoima, Mulago, Mityana, Masindi, Sironko, Soroti, Mukono, Rukungiri, Butaleja, Mubende, Kamuli, and Apach.

Contributions to overall program: The project has continued to register significant progress that includes introducing syringes with re-use prevention features. To date, a total of 19,702 health workers have been equipped with knowledge and skills in injection safety and HCWM. A bigger proportion of service providers (over 85%) are observing critical steps in injection administration. A total of 26,691,250 needles and syringes have been distributed to the project districts over a period of four years. Findings of observations made during supervision visits continue to show that 100% of injection devices used on clients come from new sterile packs making medical transmission of HIV through curative injections very unlikely. The average number of injections person per year in the project districts is estimated to be 1.3, lower than the national average of 3 injections per person per year. The majority of health facilities in the project districts and at PEPFAR implementing sites have a cleaner working environment with over 80% of the health units within the project area having medical waste/safe injection programs in place. This is a great improvement from the baseline of 15% when the project started four years ago. Data on progress made and lessons learned has been systematically collected, documented and disseminated to stakeholders. All information collected is shared with the district health teams and individual feedback is given to each facility supervised by the project staff. Mechanisms to achieve national coverage through stakeholder support and policy change have been put in place and will continue to be pursued to ensure sustainability of achievements.

Intervention areas: In FY 2009 the project will not expand but consolidate the achievements in the 30 districts. Continued funding for the MMIS project through FY2009 will ensure continued injection safety practices in the current 30 districts and will prevent the districts that are supported through this program to revert back to the re-usable needles and syringes. A lot of PEPFAR activities are generating a lot of infectious medical waste. These include Counseling and Testing, laboratory, blood transfusion, sero-surveys, to mention but a few. At the moment, the MMIS project is the only project that is providing technical assistance for addressing health care waste management in the country. FY2009 funding for MMIS will ensure continued improvement and support to all PEPFAR Implementing Partners in health care waste management. The interventions used for the MMIS program include: supporting the development of policy guidelines for safe injection practices, improving skills of injection providers, ensuring full supply of injection commodities therefore eliminating the need to re-use, conducting behavior change campaigns aimed at; reducing the demand for unnecessary injections among communities, promoting use of and compliance with oral formulations, and improving stock status for oral formulations. Other intervention areas include enhancing appropriate health care waste management and promoting health workers safety, through protection against needle pricks and promotion of Post Exposure Prophylaxis. The project will continue to advocate for incorporation of injection safety and HCWM activities into on going budgeting processes both in the government and private sector. Collaboration with the education sector will be strengthened with the objective of integration of injection safety practices in the medical training curricula. Pre- and in-service training will be provided to 2000 health workers and 250 waste handlers in the expansion areas each financial year. The training will be cascaded from national to districts and will be offered to workers both in public and private facilities. Training topics will include; safe injection practices, appropriate health care waste management, logistics management and communication and behavior change. During the training, policy documents and norms and standards on injection safety and HCWM will be widely distributed. Standard precautions on infection prevention and control will be emphasized. Desired practices will be further enhanced through on job support supervision and cross unit visits. The project will continue to support the Ministry of Health (MoH) coordination mechanisms, including the national infection control committee and the Uganda National Injection Safety task Force (UNISTAF). The private sector will be supported to implement the injection safety practices, including use of single use injection devices and health care waste management.

Provision of technical assistance in injection device security: The project will in a procurement review meeting address knowledge gaps in interpreting the developed injection device specifications among some procurement and regulation agencies. The specifications will be widely disseminated to local manufacturers to encourage the companies to start local production. The project will work with the pharmacy department to revise order forms used at National Medical stores (NMS). Revised forms will be printed and distributed to the 35 MMIS districts to facilitate health facilities switching back to MoH credit line support. Operators of private pharmacies and drug shops will be equipped with skills in demonstrating techniques of using new injection technology. This is to enable the operators provide timely user assistance when introducing the new devices to their clients' in the private sector. The expansion districts will receive needles and syringes with re-use prevention features, devices for blood drawing and intravenous procedures, safety boxes, waste segregation bins, bin liners, and protective gear for waste handlers.

Provision of technical assistance to in HCWM to PEPFAR implementing partners: Recognizing that unsafe final disposal of HCW poses a risk in medical transmission of HIV/AIDS, and in response to the MoH policy of allocating at least 10% of the commodity budget to HCWM, FY09 PEPFAR funds will be used to support the ministry to roll out the health care waste management plan at PEPFAR implementing sites. This activity aims at improving the working environment of health workers, while at the same time better protecting patients, and communities against transmission of HIV/AIDS and other pathogens. Priority will be given to partners generating potentially infectious waste like providers of CT, Blood transfusion, injection safety,

**Activity Narrative:** laboratory services, and male circumcision. MMIS project will provide technical assistance in areas of assessing practices, prioritizing interventions, developing work plans, selecting options for safe treatment and disposal and in supervision. Staff generating waste and waste handlers will be trained in appropriate ways of waste segregation, storage and selecting final disposal options. Waste handlers from the PEPFAR programs will be trained to safely handle infectious waste including used needles and syringes, used blood transfusion sets, soiled swabs, lancets, and gloves, and other health care medical waste materials, and in proper maintenance of a medical waste pit. PEPFAR programs will be expected to use their program funds to support the actual cost of their HCWM plans. In addition, the MMIS project will support construction of 60 medical waste pits in six of the MMIS project districts (10 each).

Exit strategy: At the time of inception, the MMIS project supported strategies for sustaining project activities that include; working within existing structures, improving program efficiency by looking for cheaper alternatives, and using strong advocates for safe injection practices. The exist strategy for the project that is to start in FY2009 are:

- i. Phasing out the procurement of ADs in the final year of operation (FY2010) and handing over this function to the National Medical Stores, with the 30 MMIS districts using the credit lines to procure the ADs for their districts;
- ii. Preparation of the private sector to locally produce the medical waste equipment line disposal bins, bin liners, and equipment for the waste handlers (gum boots, gloves, gowns);
- iii. Preparing the 30 MMIS districts to carry out reorientation courses for the service providers; and
- iv. Preparing the 30 MMIS districts to implement low cost and affordable technologies for the final disposal of infectious waste and sharps.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14216

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14216	4383.08	U.S. Agency for International Development	John Snow, Inc.	8348	8348.08	John Snow, Inc./Injection Safety/country funded	\$382,500
8430	4383.07	U.S. Agency for International Development	John Snow, Inc.	4838	701.07	Track 1	\$318,336
4383	4383.06	U.S. Agency for International Development	John Snow, Inc.	3332	701.06	Track 1	\$2,392,584

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$120,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.05: Activities by Funding Mechansim**

**Mechanism ID:** 690.09

**Mechanism:** N/A

**Prime Partner:** US Department of Defense

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Biomedical Prevention:  
Injection Safety

**Budget Code:** HMIN

**Program Budget Code:** 05

**Activity ID:** 8856.21595.09

**Planned Funds:** \$50,000

**Activity System ID:** 21595

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. Uganda initiated programs for high-risk groups in the early phases of the epidemic and continues to promote excellent principles of nondiscrimination in its National Strategic Framework. Starting in 1987, the Minister of Defense developed an HIV/AIDS program after finding that a number of servicemen tested HIV positive. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated with the military, with up to 50% of patient visits being non-military. PEPFAR funding has supported HIV clinical and ART capacity at 8 UPDF hospitals and sick bays across the country. The UPDF health workers are still using the ordinary disposable syringes which carry a risk of being re-used. Medical waste management is poor with improper segregation, no color-coding, inadequate containers for waste collection and general lack adequate knowledge on the part of health workers in relation to injection safety and waste management. COP08 was the first year PEPFAR funding was provided for injection safety. The activities scheduled include: undertake a situation analysis and needs assessment, train medical workers, procure auto-disabling syringes, and proper waste disposal containers.

2. Progress to-date. A needs assessment has been planned and will be implemented followed by pilot programs at 3 of the UPDF medical clinics.

3. Planned activities for FY 2009. ACTIVITY HAS BEEN MODIFIED TO expand activities promoting injection safety and proper handling of medical waste to the other 5 military medical facilities. Activities will include procurement of more auto disabling syringes, training of more health workers, procurement of medical waste disposal containers, construction of a sample incinerator. This expansion will extend the coverage to 80 percent of the target population.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16066

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16066	8856.08	Department of Defense	US Department of Defense	7336	690.08		\$50,000
8856	8856.07	Department of Defense	US Department of Defense	4821	690.07		\$50,000

- Emphasis Areas**
- Military Populations
- Human Capacity Development**
- Public Health Evaluation**
- Food and Nutrition: Policy, Tools, and Service Delivery**
- Food and Nutrition: Commodities**
- Economic Strengthening**
- Education**
- Water**

Program Budget Code: 06 - IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use

**Total Planned Funding for Program Budget Code: \$0**

Program Budget Code: 07 - CIRC Biomedical Prevention: Male Circumcision

**Total Planned Funding for Program Budget Code: \$1,623,587**

**Table 3.3.07: Activities by Funding Mechansim**

<p><b>Mechanism ID:</b> 5033.09</p> <p><b>Prime Partner:</b> Family Health International</p> <p><b>Funding Source:</b> GHCS (State)</p> <p><b>Budget Code:</b> CIRC</p> <p><b>Activity ID:</b> 9097.24382.09</p> <p><b>Activity System ID:</b> 24382</p>	<p><b>Mechanism:</b> Contraceptive and Reproductive Health Technologies and Utilization (CRTU)</p> <p><b>USG Agency:</b> U.S. Agency for International Development</p> <p><b>Program Area:</b> Biomedical Prevention: Male Circumcision</p> <p><b>Program Budget Code:</b> 07</p> <p><b>Planned Funds:</b> \$300,000</p>
--	--

**Activity Narrative:** Activity Narrative, revised –

The Uganda PEPFAR team proposes to conduct an assessment of adverse events (AE) among traditional circumcisers to empirically demonstrate dangers of the practice and to understand high HIV prevalence among ethnic groups that rely on traditional male circumcision (TMC).

Almost 75% of men in Uganda are uncircumcised. Among those who are circumcised, an estimated 90% are circumcised by traditional circumcisers. The overall goal of the Ministry of Health (MOH) in Uganda, supported by PEPFAR and other development partners, is to scale up the provision and uptake of male circumcision by medically trained providers, following UNAIDS / WHO recommendations. Studies from Bungoma in Kenya show that TMC results in higher AE rates than MMCs. Should this assessment demonstrate similar findings, the evidence will be provided to advance strategies that promote MC by medically trained providers.

Additionally, there is skepticism among Ugandans regarding the effectiveness of male circumcision for HIV prevention. Skeptics argue that communities which have practiced circumcision for generations also have high HIV prevalence rates, like the non circumcised. The aim of the proposed assessment is to use ethnographic approaches to document the nature of TMC and contrast it with the surgical guidance provided by the WHO, to explain why TMC - as opposed to MMC - will not impact HIV prevention.

At a recently held meeting with the MMC task force of the MOH, terms of reference were outlined, including surveillance. Based on the meeting, the Ministry of Health declared its intention to institute ongoing surveillance. The results of the proposed assessment will inform the surveillance, and data generated will be used by the MoH and partners to advocate for MMC as a safe and effective prevention tool to be added within the current prevention approaches advocated in Uganda.

The assessment and related sample size will be designed and calculated in a way to answer the objectives, and appropriate formulae to compute sample size for this kind of design will be applied. It is anticipated that the minimum sample size for men who have undergone circumcision will be 216 for each of two districts, giving a total sample size of 432. For the directly observed circumcisions, a minimum of 20 operations will be observed. The assessment will also include a qualitative piece: FGDs and in-depth interviews will be held with men, women, traditional circumcisers, and community opinion leaders. Typical to qualitative methods, interviews will be held until saturation is achieved, which is expected at approximately 6-8 in depth interviews for each category per district and approximately 3 FGDs of 6-8 participants per category per district.

The system for management of identified AEs will be well outlined in the protocol. The teams will include medically trained physicians / clinical officers with clinical training in MC procedures to help assess AEs and advise on referral and / or on site management. Participants with identified AEs requiring clinical care will be referred for specialized care if they cannot be managed by the assessment team. In cases of very severe AEs requiring hospitalization, the team will facilitate a transfer of participants to hospitals. An agreement with the District Health Office and the District Hospital will be reached to ensure that study participants who may require medical attention get quality care promptly.

In addition to the strategy for clinical management of AEs, outlined above, the study will be conducted in collaboration with the District Health Office (DHO) which is responsible for supervision of TMCs. Periodic reports will be provided to the DHO and any information on AEs, with recommendations from the study team will be transmitted to them to address during training and supervision.

It is expected that at least three attributes of TMCs may render them unsuitable for HIV prevention. They include 1) Nature of the cut – an inadequate amount of the foreskin may be removed; and lack of apposition of cut edges leaves a large surface area susceptible to entry of HIV (Brown, 2002); 2) There is often an early resumption of sexual intercourse before certified wound healing; 3) The cultural rites that accompany the circumcision which may include excessive alcohol consumption and sexual liberty, which may in turn lead initiates into unprotected sexual activity prior to the circumcision and/or prior to wound healing; 4) Intra-circumcision practices like use of same gloves, same knife, etc. that can increase the likelihood of infection

Different methodologies will be used to document these dimensions. First, through direct observations of circumcisions, the nature of the cut and intra-circumcision practices will be observed and contrasted with the WHO-established surgical guidelines. Secondly, through observation and interviews with initiates and community leaders and members, the processes immediately before circumcision and during the post-operative period will be documented to bolster arguments about the inherently unsafe nature of the TMC rites. It is anticipated that cultural issues might arise, as findings from the AE assessment are shared. However experience from Kenya (FHI and others) suggests that engaging in a medical dialogue, versus a cultural one, can advance local support for safe and voluntary MC. The support of the MOH and THETA, an association of Ugandan traditional healers, in conducting this assessment will go a long way in ensuring buy-in from the various political and cultural leaders in Uganda.

Although the results of this assessment are critical, they are not essential to begin working with TMCs, except in the context of reducing the impact of complications and improving post operative management of severe AEs, as recommended by Bailey et al in their 2006 study in Bungoma. The intention in this assessment is to understand and describe why TMC does not lead to HIV reduction rather than to begin employing traditional circumcisers to scale up circumcision. Another assessment approved in the COP FY2008 is exploring the complementary roles (e.g. counseling, referral, post operative care) that TMCs can be encouraged to play in supporting MMC interventions. Both assessments abide by the UNAIDS/WHO recommendation for culturally sensitive services and procedures offered by trained providers. Results of both assessments may allow a determination of the extent to which initiates may be willing to undergo MMC instead of TMC, or whether they see a promising combination of both (eg the ceremonial part remains traditional whereas the actual incision is performed by a medically trained provider). It is however important to note that it may be difficult for the initiates to know the difference between MMC and TMC. Also since data collection will be soon after the TMC procedure, there may be a risk of having responses that are biased by the pain and discomfort the participants will still be enduring.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14191

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14191	9097.08	U.S. Agency for International Development	Family Health International	6735	5033.08	Contraceptive and Reproductive Health Technologies and Utilization (CRTU)	\$300,000
9097	9097.07	U.S. Agency for International Development	Family Health International	5033	5033.07	Contraceptive and Reproductive Health Technologies and Utilization (CRTU)	\$300,000

**Table 3.3.07: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1245.09	<b>Mechanism:</b> Makerere University Walter Reed Project (MUWRP)
<b>Prime Partner:</b> Walter Reed	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Biomedical Prevention: Male Circumcision
<b>Budget Code:</b> CIRC	<b>Program Budget Code:</b> 07
<b>Activity ID:</b> 26458.09	<b>Planned Funds:</b> \$107,000
<b>Activity System ID:</b> 26458	

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs. These activities link to MUWRP activities under Treatment, Care, OVC, HCT, Prevention, and Strategic Information. The Biomedical Prevention program as described below is part of a comprehensive program and its execution linked to other program areas. Program activities that are included in this comprehensive approach, such as care, treatment, and prevention services, will be budgeted under their respective program areas.

The Uganda Ministry of Health has recently approved the roll out male circumcision services. During FY 2009 MUWRP, responding to a request from health authorities in Kayunga District, intends to begin the process of developing and partnering with the District in the implementation of a circumcision services program at the Kayunga District Hospital. This program will also involve partnering with the Rakai Health Services program in Rakai, Uganda for the purposes of training at least 5 Kayunga District medical officers in surgical circumcision techniques and other program essentials. Clinical officers will also be trained in service provision when that curriculum becomes available. The program will initially be geared toward providing service to HIV negative men as a potential means of reducing HIV transmission. When the Uganda MOH policy is extended to include service provision to infant males, MUWRP will include that age group in circumcision services. The surgical theatre at the Kayunga District Hospital will be renovated and supported throughout the program so that safe circumcision services and counseling can be effectively carried out. This will include provision of a changing room for clinicians and an anti-room for scrubbing and sterilization. Further, other materials such as gowns, gloves, and air conditioners will need to be supported. Finally, a recovery room for service recipients will need to be arranged and equipped. Over the past year, it has become very clear to MUWRP staff that the success of a circumcision program, while proven scientifically effective through 3 independent randomized control studies, will depend on the perception of those persons receiving the service. MUWRP intends to roll this program out carefully focusing on the perception of circumcision recipients prior to service delivery and incorporating a robust patient and community education component on the need to continue safe sexual practices. Clear policies and procedures and IEC materials will be developed using PEPFAR guidance on this issue as well as an advertising campaign utilizing a billboard message located in the center of Kayunga town council. Toward this end, program counselors will be trained (vendor TBD) to ensure that each service recipient fully understand the value and the risks associated with male circumcision as to ensure that this program accomplishes its designated task of reducing HIV transmission.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$19,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.07: Activities by Funding Mechansim**

**Mechanism ID:** 9833.09

**Mechanism:** Health Communication Partnership

**Prime Partner:** Johns Hopkins University  
Center for Communication Programs

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Biomedical Prevention: Male Circumcision

**Budget Code:** CIRC

**Program Budget Code:** 07

**Activity ID:** 23921.09

**Planned Funds:** \$516,587

**Activity System ID:** 23921

**Activity Narrative:** Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs that was awarded in July, 2007. Its purpose is to provide communication support to the Government of Uganda, PEPFAR and USAID HIV/AIDS and health programs and to strengthen capacity for strategic, evidence-based HIV/AIDS and health communication in Uganda.

Since November, 2007, HCP has been assisting the Ministry of Health and Uganda AIDS Commission 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 is 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. During FY2007, 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. During FY2008, HCP plans to orient District Health Educators from 82 districts and incorporate accurate information about MMC and HIV prevention into training materials for Village Health Teams (VHTs) and other community volunteers; incorporate sessions on MMC and HIV for broadcast during a distance learning radio series for health workers; continued community education about safe circumcision in the Bagisu region; and plans to establish a hotline for men that offers counseling and information about medical male circumcision and prevention of HIV acquisition, as well as male norms that increase risk of HIV transmission, including violence against women and multiple sexual partners.

ACTIVITY UNCHANGED FROM FY 2008; ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: HCP will continue to provide technical assistance to the Makerere University School of Public Health (SPH) to strengthen its ability to design and manage advocacy and communication programmes, specifically in support of male circumcision for HIV prevention, incorporating results from the MMC assessment conducted in FY2007 and planned for dissemination in the first quarter of FY2009. HCP will work with the SPH to translate key results of the situation analysis into advocacy materials supporting the development of a MMC policy and strategy for service delivery/scale up appropriate to Uganda's health and socio political setting. HCP will assist SPH to evaluate male circumcision advocacy activities and approaches conducted over the previous years, and build on successful approaches. During FY2009, HCP and SPH will work with religious, cultural and community leaders to provide correct information about male circumcision and HIV. HCP and SPH will also work with the MOH to provide public education about MC and its relationship to HIV prevention, and provide client education materials and training for health workers in counseling and client education concerning circumcision for health and HIV/AIDS prevention. Specifically, HCP and SPH will assist the MOH to train 20 national trainers, who will in turn train 172 district and NGO trainers. These trainers will train health workers in hospitals and HCIV, 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 will 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).

**New/Continuing Activity:** New Activity

**Continuing Activity:**



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$43,164

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.07: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Biomedical Prevention: Male Circumcision

**Budget Code:** CIRC

**Program Budget Code:** 07

**Activity ID:** 12431.21216.09

**Planned Funds:** \$700,000

**Activity System ID:** 21216

**Activity 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 Phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE). The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a smaller extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old. The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. The range of tests carried out include: HIV testing by 2 ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others.

The RHSP medical male circumcision program: Three trials of male medical circumcision (MMC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MMC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MMC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. As part of the MMC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as a regional MC training center.

1.Provision of circumcision to 2700 men. Currently, preparations have been made and the provision of circumcision service has been initiated. We have so far provided circumcision service and post operative care and follow up for over 1500 men. As part of the preparations RHSP conducted the following activities; Held internal planning meetings to lay down a detailed work plan; Held meetings with stakeholders including Community Advisory Board members (CAB), community opinion leaders, and Rakai program community mobilizers to discuss means and ways of mobilizing communities for this service; Recruited personnel as outlined in the budget and work plan, who are conducting the activities; Drafted forms that are used to collect service information/records, and drew plans on how records will be managed; All recruited staff have been fully trained and certified to perform the various activities. These include Medical officers, clinicians, nurses, counselors, health educators, follow up team members, theatre personnel, data, technical and administrative staff; Necessary supplies procured (including theatre supplies); Secured space for overnight stay for the clients who come from far and wish to spend a night. Community mobilization, sensitization and health education about the MMC activities were started and are ongoing. Community mobilization

**Activity Narrative:** messages have already been developed and are in use. About 2000 men have already been sensitized and mobilized for this activity.

The demand for MMC in Rakai and neighboring districts is enormous yet our capacity to handle this demand is limited, more so for people living long distances from the Rakai center. Plans are being made to address this challenge by increasing the number of operating rooms at the central facility in order to be able to offer more surgeries per day. The programme plans to pilot test mobile circumcision services so as to take the service near to the people. The programme plans to work hand in hand and create linkages with trainees who will graduate from the Rakai MMC training center to ensure that they put what they learn in practice when they go back to their units. These linkages will require close supervision and monitoring and therefore need for an additional facilitation.

2. Training of Health personnel to perform safe surgery - Preparations for this activity are still on going. The following have already been accomplished;

Contacted district Medical officers and the district medical team to help us identify priority units and staff whom we need to consider for training first. Units which already have the capacity to offer circumcision but need training in order to be able to offer a complete circumcision package as recommended by WHO have been identified; Identified 50% of the potential trainees who will be invited for the training, the identification process is still ongoing; Identified 7 trainers and sent them for a trainer of trainers course which they successfully complete and were certified by WHO as trainers; Developed a training curriculum/syllabus for the training; Identified accommodation for the trainees; Space for training and training aids are available; Closely monitor and supervise the trainees. This exercise will go a long way in decentralizing circumcision services and ensuring sustainability of the service. This exercise will require additional transport facilitation since trainees will come from all parts of the country.

Increase the number of surgeries to be offered in a year from 2700 to 3500 and to pilot test mobile MMC services targeting areas that are far from the Rakai center and far from health level 4 centers. The RHSP will continue to provide circumcision services to ~3500 men aged 13-49 residing in Rakai and neighboring districts, in FY 2009. The services will be offered within the Rakai Health Sciences Center (RHSC) which contains three fully equipped operating theatres, a recovery room, sluice, autoclaves and sterile storage, and a dormitory for overnight stay for men who reside far from the facility; Men will be offered free VCT prior to surgery, but this will not be mandatory and HIV positive men will be referred to the Rakai Suubi clinic for HIV care. The VCT component of MMC will be supported through the CT budget; Circumcised clients will remain in the RHSP dormitory overnight and will be discharged after examination for short-term complications. Arrangements will be made for patients to contact RHSP in case of complications after discharge. Furthermore, men will be asked to return 1 week and 4 weeks post-surgery to certify wound healing. Patients will be instructed in wound care and be told to abstain from sexual intercourse until full wound healing is certified; Records will continue to be maintained of any adverse events related to surgery and compliance with instructions on abstinence until complete healing is achieved; After resumption of intercourse, men and their partners will be advised to practice safe sex (i.e., abstinence, monogamy with an uninfected partner, or use of condoms); - Provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT; Conduct community-level health education for both men and women regarding HIV Prevention (ABC) and MC and provide this information through town meetings, sports events, drama groups and videos; Involve women in the MMC program, they need to be informed that MMC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus; HIV-infected individuals identified through MMC service will be referred for free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they will be offered HAART and clinical monitoring via RHSP clinics. This will be supported by the adult care and ART budget/component of the RHSP; Propose to pilot test mobile MMC services to areas that are a long distance from the Rakai center and far from health center IV and therefore have no easy access to the MMC services.

2. Training - The RHSP has experienced surgeons and nursing staff to provide training to health personnel and will train an additional 45 physicians and/or clinical officers, and approximately ~ 50 theatre nurses and counselors in FY09. Priority will be given to trainees from Level 4 health centers in Uganda, but training will also be provided to appropriate government and private health professionals from neighboring districts. Trainees will first study the WHO manual and observe surgeries conducted by experienced practitioners. They will then conduct a minimum of 24 supervised surgeries until certified as competent. Service records will be maintained on the number of surgeries done, the time required to complete each procedure, and on any operative or post-operative complications. Theatre nurses will be trained in theatre procedures, sepsis and post-operative care, whereas counselors will be trained in MMC counseling. Each health professional trained by the RHSP will be observed performing or assisting circumcisions in the first 3 months after their initial training, in order to assess their proficiency post-training. The follow up may occur in their place of work, or they may be invited back to the RHSC, depending on logistics. Their surgical records on the MC services they provided will be reviewed.

3. Needs Assessment - RHSP will conduct a needs assessment in an additional five Level 4 health facilities which are equipped with operating theatres, in Rakai and neighboring Districts. This will determine the needs for facility improvements, equipment and supply needs in the district. The information will be provided to the MOH for use in planning program expansion. Some of the trainees proposed above will be initially from these facilities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13233

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13233	12431.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$20,000
12431	12431.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$54,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$340,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Program Budget Code:    08 - HBHC Care: Adult Care and Support

**Total Planned Funding for Program Budget Code:      \$23,191,954**

## Program Area Narrative:

With PEPFAR support, Uganda is making significant progress towards providing care and support, and antiretroviral therapy (ART) to people living with HIV/AIDS (PHA). In FY08, PEPFAR funded care and support for 340,000 people and provided over 130,000 with ART (90% of all people receiving ART nationally). However, the number of people needing ART is approximately 350,000 (UNAIDS estimate), so only about 40% of those in need of ART are receiving it. Challenges for providing greater coverage of services include human resources, counseling and testing, measuring care and treatment outcomes, lab infrastructure, and the logistics system.

### Care and treatment services

Care and support is broadly defined to include all activities that enhance the quality of life of HIV-infected persons, from diagnosis through end-of-life. Services vary in scope, coverage and quality, and are delivered in a variety of settings including health facilities, communities and homes. Community and home-based models have gained prominence due to their cost-effectiveness and the fact that some care does not need to be provided in facilities. Few organizations can offer the full range of services, however, so coordination and establishment of referral networks to co-manage clients are essential elements of service delivery. Generally, services are most comprehensive and accessible in urban areas, making it necessary to implement strategies that bring services to rural areas where more people live.

### The FY08 Program

In FY08 there was a significant increase in number of PHA in the country receiving the Basic Care Package (BCP) with over 80% of PHAs routinely receiving cotrimoxazole. As noted, the number receiving ART increased. Adherence to ART has remained high (95%) although retention on ART remains a challenge. The national treatment policy was revised in 2008, changing the eligibility cut-off for ART initiation from CD4<200 cells/mm<sup>3</sup> to <250. All TB/HIV co-infected persons and HIV infected pregnant women with CD4<350 will also be eligible for ART. Moving to the WHO-recommended level of <350 increases the estimated number of adults requiring ART from 250,000 to 350,000, the new UNAIDS/WHO estimate.

A pilot survey at 40 treatment sites was conducted at the end of 2007 by the national HIV Drug Resistance Working Group. Half of the sites experienced drug stock outs in the previous quarter, and weak data collection prevented measuring adherence and delays in drug pickup. (None of the drug stock outs occurred in PEPFAR-supported sites, and stock outs at other sites were mostly covered by USG-provided buffer stocks.) Another survey at a larger number of sites, plus surveys of treatment-acquired resistance, are planned. These data are critical to inform the appropriate use of ARV regimens in the context of emerging drug resistance.

### FY09 strategies and activities

A review of national needs and the existing response identified six key areas that require attention to achieve widespread, sustainable and high quality care and treatment. These are:

- (1) expand pain management in care and treatment;
- (2) scale up nutrition interventions and livelihood initiatives;
- (3) integrate prevention, care and treatment services and link them to reproductive health and cervical cancer screening;
- (4) use innovative strategies to provide alternative sources health care workers, including task shifting and the increased involvement of PHAs and institutions of higher learning;
- (5) expand distribution of the basic care package (BCP) and prevention with positives activities;
- (6) identify and provide early treatment for HIV-positive pregnant women with follow-up of mother-infant pairs during post-natal care and immunization visits.

An additional strategy will be to decentralize the provision of services to more rural areas through Health Center IIIs and community-based care.

### Care and Treatment

In FY09, the USG will have a special focus on clinical care at all supported facilities to improve: (1) routine screening of all HIV-positive persons to determine ART eligibility; (2) pain management and symptom control through regular screening and assessment of pain, and treatment or referral; (3) treatment and prevention of OIs including STIs and TB; (4) routine clinical and immunological monitoring of those on ART; (5) support for drug adherence; (6) linkages to the Presidential Malaria Initiative for supply of insecticide-treated bed nets and diagnosis and management of malaria. Ongoing capacity building for ART monitoring will be expanded beyond adult care to include aspects of pediatric ART, PMTCT, ARV drug resistance surveillance and Early Warning Indicators.

### Food and Nutrition

In FY09, the USG will integrate comprehensive food and nutrition interventions within care and treatment services. These include: (1) assessments to determine nutritional status, food access and availability; (2) nutrition counseling, prevention of food and waterborne diseases, and infant and young child nutrition feeding options; (3) targeted food and nutrition support including food rations for HIV/AIDS affected households, food supplements for high risk groups and those with mild-to-moderate malnutrition, supplementary and therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants. 40,000 PHAs on care and treatment will receive nutritional assessment and education of whom an estimated 10,000 malnourished individuals will receive therapeutic foods. 800 staff will be trained to provide food and nutrition interventions at 77 service outlets. Those graduating from therapeutic and supplementary food support will be linked to

---

sustainable livelihood initiatives through social support activities.

#### Integration of services

The USG will strengthen the scope of non-ART services at all supported sites and establish coordinated linkages and delivery of these services. The non-ART services include: (1) provider-initiated HCT; (2) HIV primary care and distribution of the BCP; (3) TB diagnosis and management; (4) family planning and reproductive health (RH) services for HIV-positive women; (5) nutritional assessment and counseling; (6) prevention-with-positives (PWP). RH services will include screening for cervical cancer. The USG has identified cervical cancer prevention among HIV-positive women as an area of special focus for FY09. Three sites will pilot the "see and treat" approach to cervical cancer prevention. They will conduct training, perform histopathology and quality assurance for visual inspection with acetic acid screening, and provide advanced cervical cancer treatment.

#### Human Capacity Development

In response to the shortage of health care workers, and in an attempt to build a sustainable workforce, USG will expand its support of pre-service training. A program is proposed to place health care trainees in internships and develop structured approaches to assessing the quality of care provided once trainees are in the workplace. Innovative strategies to increase the availability of human resources for HIV/AIDS service delivery will be implemented. These strategies include: (1) improved supportive supervision; (2) "task-shifting" in the health sector with special emphasis on non-traditional health workers such as volunteers and PHAs (as "expert clients"). This will require establishing systems for training, certification and policy change by the GOU and professional associations to permit volunteers and PHAs to provide care; (3) direct support to the Health Service Commission, professional medical councils, MOH human resources division and the District Health Officers to recruit, train and retain health workers.

#### Basic Care Package and Prevention with Positives (PwP)

The Basic Care Package (BCP) is a minimum set of evidence-based care interventions for HIV infected persons. The BCP includes cotrimoxazole for OI prophylaxis, insecticide treated bed nets (ITN), a safe water vessel, water purification solution, information on PWP written in local languages, and condoms as appropriate. In FY09, there will be a special focus on providing the BCP to HIV-positive pregnant women attending antenatal-care and PMTCT programs. Through increased support to National Medical Stores (NMS) and Joint Medical Stores (JMS), PEPFAR will ensure that the BCP is available to all patients accessing care and treatment services at MOH sites. Through support to social marketing the BCP will be made available to a wider clientele including the private sector.

The PwP approaches involve (1) provider-initiated family-based HCT, (2) supported disclosure of HIV status, and (3) counseling on mother-to-child transmission, family planning services, and STI screening and management. In collaboration with MOH, USG partners will continue to train care and treatment providers to provide HCT and manage referrals to community-based care and PHA networks. A national behavior change communication campaign to increase PwP will continue to increase awareness of the need for and availability of PWP programs.

#### Pregnant Women and Mother-Infant Pairs

Improved care and treatment of HIV-positive pregnant women and post-natal follow-up of mother-infant pairs is an FY09 focus area. All USG supported sites offering ART and/or antenatal services will provide PMTCT and/or referrals to ensure mother-infant pairs have post-delivery follow-up in an HIV/AIDS clinic. To reduce loss-to-follow-up, 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. Through these activities, over 15,000 HIV-exposed infants will access early infant diagnosis services. All identified HIV positive infants will be started on ART irrespective of CD4 count as per the revised MoH guidelines.

#### Linkages, referral mechanisms and systems

A key focus of this year is to strengthen referral mechanisms and linkages between in-patient, clinic and home-based care, and with OVC care and support services. As hospitals and Health Center (HC) IVs reach capacity, clinically stable patients will be referred to lower levels (e.g., HC IIIs and community-based care). Network Support Agents will play an increasing role in ensuring that referrals and linkage between health facilities and the community actually happen. They will track patients, provide adherence counseling, provide at-home services, and support caregivers. This approach will be scaled up to cover over 41 out of 82 districts.

With the rapid scale-up of care and treatment services in an environment of chronic shortages in human resources, USG will support programs to build capacity of PHAs to improve referrals and linkages between facilities and communities, provide adherence counseling and support, increase ART literacy, identify HIV-infected children in the community and link them to services, and support efforts to improve PWP initiatives. All PHAs will be linked to PMTCT, food and nutrition interventions, TB/HIV, family planning and family-based care. PHAs will be trained as caregivers and a structured support mechanism established to mentor them. Activities aimed at ensuring personal, food and environmental hygiene will be included. BCP kits will also be distributed through PHA groups and networks.

Through increased support to programs that mobilize and build capacity of PHA groups and networks, the USG will ensure that PHAs are linked to involved in the following social support: (1) food security interventions, income generating activities and sustainable livelihood strategies; (2) community mobilization and promotion of awareness of HIV/AIDS prevention, HIV counseling and testing, and care and treatment; (3) stigma reduction; (4) support for caregivers. Significant aspects of this program will be achieved by leveraging non-PEPFAR resources.

Linkages between care and treatment and the laboratory system will be strengthened in FY09. This is necessary in order to comply with guidelines for CD4 cell assessment of HIV infected individuals every 6 months, for viral load measurements, and for early infant diagnosis. The capacity of regional referral laboratories and designated district laboratories in both the public and private sector will be built to act as hubs for providing diagnostics. Support for establishing referral networks between lower health center laboratories and the hubs will be scaled up to cover the whole country. Priority will be given to HIV-exposed infants, patients under care but not yet enrolled on ART, TB/HIV co-infected patients, and HIV-positive pregnant women. This will significantly increase number of TB/HIV co-infected patients and HIV-positive pregnant women on ART.

#### Gender issues

Analysis of USG supported activities shows that more than 65% of clients accessing HIV/AIDS services are women. This raises two issues: 1) the need to increase awareness of HIV testing and care among men, and 2) the challenge of disclosure by women to male partners and families. The failure to disclose directly affects adherence to treatment, PMTCT initiatives, family planning and significantly increases the opportunity cost of HIV/AIDS care.

In addition, most caregivers are women. Caregivers often deal with high rates of burnout due to lack of professional supervision and support, the time burden, and emotional stress. USG supported programs will work to improve personal and organizational support for caregivers. There will be increased targeting of men to improve their roles in care giving, to encouraged men to seek HCT and care, and to provide support to female caregivers.

#### Monitoring and Reporting

PEPFAR will monitor and enhance the quality of facility-based HIV care and treatment through the activities of HIVQUAL and HCI. The two partners will work with other PEPFAR and non-PEPFAR partners in improving data recording, analysis and utilization. Data will be used to analyze treatment outcomes among a cohort of patients on ART at 6 and 12 months. To improve quality of care and treatment services, partners will: (1) institutionalize quality of care approaches (2) integrate supportive supervision for all health workers; (3) develop and implement performance indicators; and (4) set up quality improvement teams at health facilities and sub-districts.

**Table 3.3.08: Activities by Funding Mechansim**

<p><b>Mechanism ID:</b> 5738.09</p> <p><b>Prime Partner:</b> Makerere University School of Public Health</p> <p><b>Funding Source:</b> GHCS (State)</p> <p><b>Budget Code:</b> HBHC</p> <p><b>Activity ID:</b> 4023.21217.09</p> <p><b>Activity System ID:</b> 21217</p>	<p><b>Mechanism:</b> Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District</p> <p><b>USG Agency:</b> HHS/Centers for Disease Control &amp; Prevention</p> <p><b>Program Area:</b> Care: Adult Care and Support</p> <p><b>Program Budget Code:</b> 08</p> <p><b>Planned Funds:</b> \$200,000</p>
--	---

**Activity 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 three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 2) The SPH-CDC HIV/AIDS Fellowship Program is an 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkin University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention.

The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. Through the medical male circumcision service, clients seeking male circumcision service are also offered counseling and testing. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis.

Services offered include: health education, On-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, provision of antiretroviral therapy, prevention for positives, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated).

The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by 2 ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstinence from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus.

Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care



**Activity Narrative:** Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics.

In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

Progress to date:

Basic care:

In this financial year (FY 2008), we proposed to provide basic HIV care to 5000 HIV positive clients. In this program, HIV basic care comprises of continuous health education which is given on every clinic day before the clinical sessions begin. These sessions cover a wide range of health issues including PMTCT, feeding/nutritional issues, family planning, drug adherence, couple counseling, and disclosure among other topics. Treatment of opportunistic infections, on-going HIV counseling, provision of HIV basic care package for prevention of diarrheal diseases and malaria.

Education on prevention of domestic violence is also provided through the "Safe Homes and Respect for Everyone" (SHARE) program.

In the first 6 months of this financial year, the program had enrolled 4501 HIV positive clients and 4111 were under regular care.

Clients in regular care receive the basic care package and we are currently pilot testing an evaluation of the utilization of these basic care packages provided to HIV-positive clients through impromptu (unannounced) home checks.

Laboratory monitoring: The program laboratory has the capacity to carry out various screening and monitoring tests. These include: CD4 testing, viral load chemistry tests, hematology, serology, and microbiology. Each patient enrolled for care have CD4 count testing at least 6 monthly to assess eligibility for antiretroviral therapy or monitor immunological improvement while on ART. All patients on ART have 6 monthly viral loads to assess virologic failure.

In this financial year, Number of tests performed include: HIV testing: 7524 Elisa tests, 499 Western blot tests, 2510 PCR tests (of these, 1700 were from the HIV clinic and 57 were for infant diagnosis, others from other Rakai studies), 4076 CD4 counts, of which 2806 were for the HIV clinic and 457 for other health centers in the district (Lyantonde and Kitovu hospital). 5370 RPR and 401 TPPA tests for syphilis diagnosis, 310 Elisa for HSV-2 diagnosis, 20 serum CRAG and hepatitis-B tests.

Laboratory support to other health units: The program currently provides CD4 count testing for HIV positive patients of Lyantonde hospital.

ART: In the first 6 months of FY 2008, we initiated 305 clients onto ART, making the total cumulative number of patients on ART as of to 1594.

In FY 2009, emphasis to be put on:

- Screening for Sexually transmitted infections like syphilis.
- Provision of health education at the HIV clinics and at the community level via community meetings.
- Preventive services like the basic care package, provision of condoms at both
- Treatment and prophylaxis of opportunistic infections like Tuberculosis, cryptococcal meningitis, PJP
- Prevention of gender-based violence.
- Training of HIV care providers based at the program and those providing care at district health centers.
- On-going support and counseling at the clinics and through the resident counselors.
- Appropriate laboratory monitoring through the central laboratory based at the Kalisizo station.
- Family involvement/ testing

Geographical coverage

These services are provided to Rakai and Lyantonde district and a few residents of the neighboring districts of Masaka and Mbarara, via 17 outreach/mobile clinics which operate on a bimonthly basis.

The program targets all persons residing in these districts. Via community meetings, the population is encouraged to visit the clinics for HIV testing and those who turn out HIV positive are retained for HIVcare.

All clinics are located at already existing government health centers. This in part has reduced the stigma among our clients because the health center serves both HIV positive and negative persons.

Other non-PEPFAR support:

Most of the routine viral load testing is supported by NIH-ICER.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13234

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13234	4023.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$250,000
8328	4023.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$229,565
4023	4023.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$136,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7631.09

**Mechanism:** PEPFAR/PMI Collaboration

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 17048.21193.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21193

**Activity Narrative:** THIS ACTIVITY IS UNCHANGED FROM FY 2008.

In FY07 the Uganda President's Malaria Initiative (PMI) program under the direction of the MOH Malaria Control Program established a national electronic database to track and map the distribution of LLITNs. PMI also established four sentinel surveillance sites to collect malaria indicators in Apac which has been identified as having one of the highest malaria rates in the world, with an infectivity rate of 1564 bites/per person/per year. Additionally as reported in the Uganda AIS, Apac is located in the north-central region which has an 8.2% HIV prevalence. Given the high disease-burden of both diseases in Apac, this district is uniquely placed to provide a forum for a district-wide PMI-PEPFAR collaboration. Apac has a total population of 480,000 settled in 100,000 households and is located at the edge of the conflict region in northern Uganda making it vulnerable to all the concomitant issues.

Following the OGAC directive to program an additional \$4 million specifically for new initiatives with a focus on sexual transmission, especially discordant couples, this PEPFAR-PMI collaboration proposal will initiate a district-wide door-to-door counseling and testing program in collaboration with the current PMI activities.

In FY08 a door-to-door counseling and testing program including provision of the basic care package and referrals for care and treatment to all HIV+ individuals identified will be initiated. The PMI program will support malaria diagnosis using the same blood draws from the HIV test. In addition PMI will measure the district malaria prevalence rates and provide valuable information on the long-term impact of the two large scale PMI prevention interventions (IRS in all residences annually with support from PMI and universal coverage of LLITNs by the MOH) using the national electronic database to track the distribution of LLITNs they established in 2007 and PDAs to map all households with GIS and record household demographics and bed net use.

Through leveraging the PEPFAR and PMI initiatives in Apac with reliable data readily available to both programs the district will gain a better understanding of the population-based impact of the programs' interventions: identifying discordance, use of basic care package commodities, especially bed-net usage and, IPTp (intermittent preventive malaria treatment during pregnancy).

Finally, the performance of district-level ANC clinics will be enhanced by merging the HIV and Malaria surveillance activities including the strengthening of laboratory services in all district health center IIIs and IVs; training of health care providers; and, expansion of diagnosis and treatment of both HIV and malaria and will contribute to improved PMTCT services throughout Apac.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17048

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17048	17048.08	HHS/Centers for Disease Control & Prevention	To Be Determined	7631	7631.08	PEPFAR/PMI Collaboration	[REDACTED]

**Table 3.3.08: Activities by Funding Mechansim**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4404.21231.09

**Planned Funds:** \$198,975

## Activity System ID: 21231

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support, the Ministry of Health has trained health workers from district health facilities in comprehensive HIV/AIDS care and management of ART. Health workers trained included medical officers, clinical officers, nurses, counselors and nursing assistants who provide direct HIV care and treatment. To date over 3000 health workers have been trained in ART provision. In addition, longitudinal data management has been supported, updating, production and dissemination of ART data management tools, mentoring of staff in ART data management, supporting supervision to all accredited health facilities providing ART services including their management of longitudinal data. The MOH also led the national treatment workgroup in the review and updating of the national ART policy, treatment guidelines and training materials that have been completed. The next step will be updating of ART data management tools and reporting forms and strengthening the data management and treatment outcome system. The Care and support program has obtained support from WHO, USG, GFATM and UNICEF. In FY2008, health facilities accredited to offer ART increased from 305 to 358. 100 District TB/HIV managers from 10 districts and 60 health workers from 10 problem districts were trained in the IMCI/HIV complementary course. In addition, 24 health workers from sites with low enrolment of children into HIV care were attached to PIDC and Mildmay and post-training supervision will be carried out in 12 districts that were trained in the IMCI/HIV Complementary course. A total of 160 people comprising HMIS officers, ART district coordinators and health workers will be trained in data management and cohort analysis. In addition, data quality audits for ART will be carried out in 20 health facilities and 40 sign language instructors trained in comprehensive HIV prevention and care and sites with weak history of ART data management and reporting will be supported. Under the HIVQUAL and HCI program, the MoH had established HIV Quality of Care activities in 226 sites. The program developed an HIV Counseling and Testing module which will be piloted in ten health facilities. The HIVQUAL program initiated 20 more facilities into quality improvement, assessed and built quality management infrastructure in 130 health facilities from 40 districts, conducted 600 coaching and mentoring sessions, 10 continuous quality improvement trainings in 4 regions for total of 180 of health workers, 8 data management trainings in 4 regions for 120 data management staff, 4 regional learning network meetings, trained 120 trainers of trainees, sensitized 40 districts and 70 national stakeholders, supported data collection and reporting tools at 130 health facilities, supported 40 districts to monitor the implementation of quality improvement activities. The final draft ART treatment guidelines were produced and should be ready for dissemination.

In FY 2009, activities under this program shall continue. New and selected districts affected by staff attrition and transfers will be supported to conduct comprehensive HIV care training including ART and the IMCI Complementary HIV course. Post-training support supervisions for health facility staff from 20 districts trained in HIV care, ART and data management will be carried out two weeks after each district-level training. These support supervision visits will also contribute to the process of accreditation of newly trained facilities as ART sites. An additional 40 new health facilities will be accredited to provide ART services. An additional 40 ART sites will be involved in monitoring and evaluation including ART cohort tracking and data analysis. New sites will be trained in data management for enrolled cohorts using standardized tools. Mentoring and support supervision of existing ART sites will be carried out as part of quality improvement coaching activities. Data quality audits will be carried out as part of mentoring activities. Districts with health facilities that have low enrollment of children into HIV care will be supported to provide placements for some of their staff in Mildmay Center and the Pediatric Infectious Disease clinics. A total of 30 health facilities will be supported to improve pediatric HIV care and treatment. The program aims at strengthening districts and regional level systems to support and sustain quality improvement activities. District health teams supported by central HIVQUAL staff shall provide 600 coaching and mentoring sessions. Central HIVQUAL teams shall conduct 12 sessions of QI training for 320 health workers and train 120 additional workers in data management. The program will roll out quality improvement activities to an additional 20 facilities providing HIV care with Anti retroviral treatment. The revised ART treatment guidelines will be also disseminated to all health workers at the ART sites. In collaboration with stakeholders, the program will review quality of care indicators including HIV Counselling and testing indicators. The program will continue to implement regional learning networks to promote peer learning and sharing, coaching and mentoring, districts and regional facilities.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13296	4404.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$331,625
8343	4404.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$331,625
4404	4404.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$276,354

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1255.09

**Mechanism:** Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals

**Prime Partner:** Research Triangle International

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4044.20869.09

**Planned Funds:** \$550,000

**Activity System ID:** 20869

**Activity 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 providing Routine HIV Counseling and Testing (RCT) and basic care (BC) services to patients in district hospitals and health center (HC) IV facilities. In this partnership, RTI contributes to the national response by addressing the significant service gaps in the provision of HIV counseling and testing (HCT) and basic palliative care services.

In FY 2008, RTI expanded its palliative care (PC) services to 16 facilities in four new districts, as part of program scale-up. By July 30, 2008, 19,613 HIV-positive clients had been identified. The clients were started on septrin prophylaxis (Cotrimoxazole) and then linked to RTI supported health facilities. At these facilities, continual PC services are provided, including septrin prophylaxis, basic care kits and specialized care. RTI's capacity building efforts have led to the strengthening of the referral system for HIV-positive persons; approximately half of the identified HIV+ persons enroll in the HIV clinics within three months after diagnosis. However, over the past year, RTI observed that the level of support provided in this program area needed further strengthening. In light of this finding, the project proposes to strengthen PC services in 38 existing health facilities and initiate PC services in three additional facilities for a total of 41 health units, during FY 2009. Referrals will be made primarily in chronic care clinics and health facilities where RTI operates. When necessary, existing chronic care clinics will be supported through the sponsorship of chronic care management courses for medical and clinic officers. Furthermore, the project will provide comprehensive support to six HIV clinics (two in each region) during 2009. This support will include supporting CD-4 testing for patients, ensuring no stock out of septrin at the clinics and instituting quality improvement measures in service delivery. Similarly, RTI will collaborate with other partners to perform specialized PC services; including psychosocial counseling, support to prevent sexual HIV transmission, and STI treatment and family planning.

Due to the existing human resource gaps in the health facilities, volunteer health workers and PHAs will be recruited and trained. PHAs will be selected and trained to work as 'expert clients' to provide on-going support to HIV-positive individuals, couples and groups. They will support the provision of the following on-going PC needs: counseling, psychosocial support, help patients to develop safer sexual behaviors, and assist with drafting individual care and treatment plans in order to prevent HIV transmission and improve treatment adherence. All new health care workers employed in the RTI supported health facilities (including the three new facilities), will be trained to provide facility-based palliative care and be able to refer HIV-positive individuals for further assessment and specialized care. Refresher training and technical support supervision will be provided as needed, to ensure quality delivery of PC services. The project will also distribute MOH standard operating procedures, protocols and job aids on PC to all supported health facilities. In order to minimize stock-outs, RTI will support health unit staff to enable them forecast and requisition for the right amounts of septrin and other basic care supplies.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13314

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13314	4044.08	HHS/Centers for Disease Control & Prevention	Research Triangle International	6439	1255.08	Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals	\$550,000
8517	4044.07	HHS/Centers for Disease Control & Prevention	Research Triangle International	4872	1255.07	Routine Counseling and Testing in Two District Hospitals	\$350,000
4044	4044.06	HHS/Centers for Disease Control & Prevention	Research Triangle International	3184	1255.06	Routine Counseling and Testing in Two District Hospitals	\$233,000

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

---

**Prime Partner:** The AIDS Support  
Organization

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4054.20875.09

**Activity System ID:** 20875

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$684,000



**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

About 81,000 active adult clients were served at various service delivery venues operated by TASO Centers. In FY 2008, the TASO priorities for Adult Care & Treatment were: providing counseling services to clients and their family members; screening and treating opportunistic infections; screening and treating sexually transmitted infections (STI); providing vital information to clients (cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT); enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing LLITN (long lasting insecticide treated nets) and promoting malaria prevention; providing condoms to sexually active clients; conducting various courses to train service providers to provide HIV care and support. By March 2008, TASO had 19,000 adult clients accessing ART at the 11 TASO Centers nationwide (including 1,200 clients of HBAC Tororo). 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 facilities (i.e. 11 TASO Centers) and the community (i.e. clients' homes and Community Drug Distribution Points). Field Officers delivered ARV drugs to Community Drug Distribution Points and clients' homes. TASO continued supporting models that meaningfully involve PHA; the 1,000 expert clients who had been trained as Community ART Support Agents (CASA) continued playing a grassroots' support role in to ART clients in the community, these TASO trained resource persons also support clients in the community accessing treatment from other partners). The 11 Centers continued running multidisciplinary case conferences to: assess eligibility for ART initiation; assessing client readiness for ART initiation; switching 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 Centers on appointment. The system was also aimed at enhancing the quality of services through adequate preparation by service providers. TASO Centers 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 record filing/archives 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

**Activity Narrative:** models; resolving ART implementation challenges; and other key issues.

During FY 2009, 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 Centers 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 & Treatment services. The Adult Care & Treatment package will comprise: counseling for clients and family members; provision of antiretroviral therapy (ART); screening and treating opportunistic infections; pain and palliative care management, STI screening and management; promoting and providing cotrimoxazole prophylaxis, safe water, nutrition counseling, PMTCT and family planning; 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; and procurement/provision of nutritional supplements for clients. In order to reach the targeted beneficiaries, TASO will provide Adult Care & Treatment through various venues and using appropriate and proven service delivery models (TASO is a key partner in developing innovative client-friendly and community-friendly service delivery models). The TASO Centers will deliver services to clients through the 11 static outlets, clients' homes and 34 outreach clinics sites (each of the 11 TASO Centers 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. In partnership with Population Services International (PSI Uganda), TASO will target 20,000 clients to receive a basic care starter kit consisting of safe water vessels and chlorine solution (Waterguard®), LLITN for prevention of mosquito bites, cotrimoxazole prophylaxis and condoms to sexually active clients. Additionally Prevention with Positives (PWP) interventions will be provided; including partner and family-based counseling and testing, supported disclosure, STI management, PMTCT and FP services or referral, and safe sex counseling. All adult clients will have the option to access condoms, and the sexually active clients will be empowered to appreciate, access and use condoms correctly and consistently. The 80,000 clients currently on cotrimoxazole and 20,000 new clients including children will be provided with cotrimoxazole prophylaxis and Dapsone will be procured as alternative medicine for a few clients that are allergic to cotrimoxazole. TASO will target to have at least 95% of ART recipients and 75% of overall active clients accessing cotrimoxazole prophylaxis. Client sensitization on the importance of the various Care & Treatment services in improving the quality of clients' lives 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/behaviors, gender equity, women's rights and gender violence. The various TASO field teams will monitor use of Care & 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 Centers 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 arising from improved health due to ART. During FY 2009, TASO Centers will scale up cervical cancer screening for the female clients above the FY 2008 level. Clients will continue to receive ARV drugs both through the facility arm (i.e. 11 TASO Centers) 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 exploring more client-friendly service delivery models. 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 by FY 2007) and supporting the few clients with low adherence through follow-up. Gender-related challenges often impede the success of adult care and treatment services. TASO will continue addressing gender issues affecting care and 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 (QA) 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 Care & 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. The activities under this Program Area are also linked to other USG funding through USAID focusing on Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13226

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13226	4054.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$730,000
8358	4054.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$565,836
4054	4054.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$565,836

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 699.09

**Prime Partner:** Population Services  
International

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4400.20859.09

**Activity System ID:** 20859

**Mechanism:** Basic Care Package  
Procurement/Dissemination

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$3,496,718

**Activity Narrative:** 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 is an affiliate of PSI with operations in Uganda since 1998. The organization aims to measurably improve the health of vulnerable Ugandans, with added emphasis on rural populations. PSI utilizes evidence based social marketing and other proven techniques to educate and promote sustained behavior change. PSI is committed to an effective partnership with the Ministry of Health (MOH) and supports various priority areas including, but not limited to, HIV/AIDS, malaria, child health and reproductive health. There are approximately 1.2 million Ugandans are living with HIV. The morbidity and mortality due to HIV-related opportunistic infections (OIs) is quite significant; in spite of sufficient evidence that supports simple interventions to prevent these OIs. Since September 2004, PSI has received PEPFAR funding through CDC. PSI Uganda has been implementing a HIV Basic Preventive Care Program (BCP), which is focused on reducing HIV-related morbidity and mortality and HIV transmission. Currently, BCP includes identification of PHAs through family based counseling and testing. PSI BCP interventions are prolonging and improving the quality of life of PHAs, by preventing OIs, and through prevention with positives interventions (PWP). The PWP interventions strive 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); safer sex practices including abstinence and fidelity with correct and consistent use of condoms. The program's implementation is supported by a multi-faceted communications campaign. Its aim is to educate PHAs on how to prevent OIs and live longer and healthier lives. This is accomplished in the following manner: use of cotrimoxazole prophylaxis; prevention of diarrheal diseases using household water treatment and safe storage; utilization of insecticide treated nets (ITN) for malaria prevention; and the prevention of HIV transmission to sexual partners and unborn children. 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), PSI 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, which are simple for PHAs and their families to implement. 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. PSI manages the procurement, packaging and distribution of all health commodities to ensure a consistent supply of the basic care starter kits and refills of the different commodities.

In FY 2008, PSI has partnered with 151 HIV/AIDS care and support organizations in 54 districts including public and private hospitals, CBOs, FBOs, and NGOs to implement the BCP program. The program funding has increased tremendously over the last fiscal year, enabling the scale up of the program and enlisting of additional implementing partners. In FY 07, BCP was expand to non CDC partners including International HIV/AIDS Alliance, Elizabeth Glaser Pediatric AIDS Foundation, Hospice Africa Uganda, International Medical Corps, International Rescue Committee, Inter-Religious Council Uganda, Joint Clinical Research Centre, Makerere University Walter Reed project, Northern Uganda Malaria AIDS and Tuberculosis program, Peace Corps, and Uganda People's Defense Forces. Further expansion and scale up of the program to public sites has been completed. The scale up to non CDC and government partner sites serves to increase the production, access and utilization of BCP health products and services among PHA.

FY 2008 Adult Care and Treatment Achievements (October 1, 2007 to September 30, 2008)	
Indicator	Target Achievement to date (July 31, 2008)
Number of service outlets	90 151 (Cumulative for 3 years)
Number of adult PHA provided with BCP Starter kit	68,000 70,999

Total number of individuals trained to provide BCP 1,450 2,964 (1,825 providers, 1,139 peer educators) Since program inception in September 2004, 203,305 adult PHA have received starter kits. 4,871 health service providers and 2,444 peer educators have been trained on BCP. Over 1,608,150 people have been reached with the IPC (peer education) activities. BCP is currently implemented in 54 of the 80 districts of Uganda. Of the 151 BCP service outlets, 78 are public/government facilities. From October 1, 2007 to July 31, 2008, PSI distributed 73,748 starter kits, including; 106,882 bottles of chlorine solution for water treatment and 1,731,517 condom pieces as refills for adult PHA. Peer educators have conducted 13,521 peer education sessions reaching an estimated 774,187 people. 269,165 IEC materials including posters, client guides, brochures and stickers have been distributed mainly through health units to clients and providers. To support the IEC campaign, STF has developed and aired 37,198 radio messages in eight local languages on 12 radio stations countrywide. Similarly, STF has developed 112 parent talk programs in 8 local languages on eight radio stations across the regions of Uganda. This radio program provides information to the general population and PHA in particular, on the benefits of the basic and palliative care components. During FY 2008, PSI also worked closely with stakeholders to revise BCP/PWP training curriculum and IEC program materials. PSI coordinated the development of technical content through collaborative efforts with the Ugandan MOH, CDC Uganda and World Health Organization (WHO) to ensure that all materials are in line with the relevant MOH strategic plan and relevant guidelines. Furthermore, PSI has begun developing new IEC materials with a focus on TB, nutrition, pain and symptom management. The relevant approvals are being finalized before the IEC materials are completed and disseminated. Advocacy and social support for BCP was built through aggressive involvement of the host district leadership through four annual regional stakeholder meetings. These meetings also exhibited work of all BCP stakeholders, and provided a platform for networking and linkages between the various partners.

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 HIV Counseling and testing models (HCT) to assist in the scale up of family based CT and increasing the number of PHA who know their status; more people are opting to access BCP and other HIV care. Due to the influx of the large number of clients, BCP service provision has increased dramatically at existing partner sites. This influx can help to explain why BCP targets are consistently higher; suggesting that there is an unmet need not included in the initial program projections. The adult care and treatment activity is expanding access to cotrimoxazole prophylaxis, long lasting treated bed nets, safe water systems, pain and symptom relief, TB HIV and IEC and education on

**Activity Narrative:** nutrition. In FY 2009, emphasis will be placed on strengthening sustainability of BCP and development of a phase out plan. Activities will include:

1. Through existing and new sites nationwide, 36,240 starter kits (each kit contains 2 LLINs, a safe water vessel, filter cloth, 60 condom pieces and 4 bottles of water treatment solution) will be distributed to new adult clients.
2. Replacement of bed nets and safe water vessels for 73,456 adult clients who received starter kits in year two (FY 2006) of program implementation will commence. PSI will distribute 550,000 bottles of water treatment solution, 5,600,000 condom pieces, and 109,733 filter cloths refills to all old clients.
3. In FY 2009, ten new sites will be enrolled, the preference being public facilities in hard to reach areas; such as, islands in Lake Victoria and the Karamoja region. No new sites will be enrolled in FY 2010, as the project terminates in March 2010.
4. PSI will work with the MOH and National Medical Stores to train and support partner sites to generate timely and accurate cotrimoxazole orders to National and Joint Medical stores. This will ensure sustained availability of cotrimoxazole to the clients.
5. Plans for program sustainability include:
  - a. PSI collaborating with the local manufacturers and other partners; such as Uganda Health Marketing Group. This partnership will continue to make BCP commodities available in the commercial sector. It is hoped that all these commodities will be available nationwide through sustainable channels.
  - b. BCP activities will be further scaled up through district health structures including PMTCT sites.
  - c. Trainings will be supplemented by a mentorship program. Added emphasis will be placed on training and mentoring all public sector trainers on BCP; in addition to the whole site trainings that are currently conducted at all BCP service outlets. Each service outlet supervisor will also be trained (or retrained) and mentored as a BCP trainer.
  - d. Refresher trainings and preliminary training for new health service providers and peer educators in preventive care and prevention with positives initiatives will continue in FY 2009.
  - e. BCC will focus on sustaining BCP-related behavior change. This project will be implemented by Straight Talk Foundation; through the development and production of radio spots, parent talk programs and radio by acquiring political support and utilizing testimonies of well known HIV authorities. Furthermore, by learning intensive inter personal communication strategies; PHAs will attain social support in their communities.
  - f. PSI will maintain a regional network of implementing partners and facilitate study trips with partner sites. The regional network will target unit heads and staff involved in BCP activities; to learn about each others best practices, and improve integration of BCP activities.
6. Communicate phase out plan to partners in the second quarter of FY 2009. The phase out plan will focus on:
  - a. Logistics management. PSI will build capacity of partner sites to manage BCP commodity procurement and distribution at individual sites.
  - b. The peer educators will continue to participate in routine site activities.
  - c. Distribution of IEC materials.
  - d. Updating and sharing of BCP partner sites service database.
7. Monitoring activities to track program implementation will also continue in FY 2009.
8. End of project evaluation

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13308

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13308	4400.08	HHS/Centers for Disease Control & Prevention	Population Services International	6437	699.08	Basic Care Package Procurement/Dissemination	\$3,496,718
8353	4400.07	HHS/Centers for Disease Control & Prevention	Population Services International	4812	699.07	Basic Care Package Procurement/Dissemination	\$3,309,093
4400	4400.06	HHS/Centers for Disease Control & Prevention	Population Services International	3341	699.06	Basic Care Package Procurement/Dissemination	\$2,306,214

---

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$610,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4419.20795.09

**Activity System ID:** 20795

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$204,000

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trial. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 10,822 clients received palliative care/basic health care and support (including children) under MU through 9 sites and RO through 3 sites. 437 were trained in palliative care and support. There were 1,294 new naïve adult clients (+ 15 years) receiving ARVs and 6,548 who had ever received ARVs. Two specialist clinics were started. Eye clinic was opened in November 2007 to screen and treat patients with HIV related eye conditions. 28% of the clients seen in the eye clinic are children. The community programme was introduced in February 2008. Stable adult patients are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The trainings run at MU target the management of HIV/AIDS in adults. 410 health care workers were trained in HIV/AIDS treatment. These included doctors and nurses, allied health professionals; counsellors, physiotherapists, occupational therapists, nutritionists and informal caregivers; carers of patients. Training not only focuses on the physiological processes of HIV/AIDS but also on the psychosocial and spiritual needs of patients living with HIV. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration.

During FY 2009 MU will continue providing HIV services and training activities at 12 sites of MU and 4 sites of RO. In FY 2009, 15,422 adults will receive basic health care and support; of these 6025 will be at MU, 6000 at the satellite clinics and 3397 at RO. The funds for this programme area will finance the purchase of drugs for management and prevention of OIs, along with symptom control and pain management. Family planning services will be provided at MU as part of the care and treatment. The target population is people living with HIV/AIDS in a 60-kilometre radius for TMC and population at its 12 rural sites and military populations in the catchment area of RO plus persons who left the IDP camps and settled around RO. MU will train 1500 individuals through formal courses and clinical placements. MU will also work in collaboration with PSI to make the basic care kit (including 2 mosquito nets, safe water vessel, water guard, and condoms) available to patients; MU will screen an estimated 500 HIV infected women at risk of cervical cancer using both the visual method (VIA), and the pap smear. In addition, patients will be assessed for mental illness and those found seen by a psychiatrist who runs a weekly clinic on site. In addition all patients starting ART will be assessed for CMV retinitis to prevent blindness and those found with CMV treated by a visiting ophthalmologist who runs a weekly clinic on site. Disabled (hemiplegic and paraplegic) patients in care will be provided with transport to and from their homes whenever necessary but the home visitors will also ensure that these patients receive their services at home. The patients whose homes are visited will have an opportunity to have their family members tested for HIV and those already stable in care will have their drugs and support provided at selected community sites with the help of community-based



**Activity Narrative:** volunteers (CBVs). This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. Care and treatment plus training activities will be provided at 12 sites and 4 sites at RO. MU will continue training at the Centre as well as upcountry in targeted districts. Together with Emerging Markets Group, a USAID – funded project MU will also train health practitioners in the private sector in HIV management. MU will train – individuals through formal courses and clinical placements.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13285

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13285	4419.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$340,000
8338	4419.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$280,000
4419	4419.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$172,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 629.09

**Mechanism:** Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services

**Prime Partner:** National Medical Stores

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 12443.20817.09

**Planned Funds:** \$600,000

**Activity System ID:** 20817

**Activity 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 health facilities throughout Uganda. NMS has developed a countrywide distribution supply chain for essential medicines and supplies; as well as providing HIV/AIDS-related Laboratory materials which are supported by PEPFAR funding. Health facilities and HIV Counseling and Testing Centers (HCT), can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. Following the national credit line for essential medicines, the Ministry of Health (MOH) provides a 20% contribution to JMS for faith-based and mission health facilities and NMS allocates the same 20% of PEPFAR funding for JMS to procure and store HIV/AIDS-related laboratory commodities.

In FY 2005, this NMS project received expansion funds, to provide an increased stock of Cotrimoxazole tablets following the national policy to prescribe all HIV + persons with daily Cotrimoxazole prophylaxis. Using this stock over the past three years, both NMS and JMS have successfully expanded their distribution to accredited treatment sites. NMS has established a frame work contract with an in-country manufacturer (long-term agreement which allows multiple shipments), to ensure distribution to the health facilities. Similarly, NMS established an updated distribution mechanism for USG implementing partners and private sector who can not procure directly; the percentage to JMS was increased from 20 to 30%. Of the 60,000 units (unit = one tin of 1,000 tablets) procured to-date, 38,000 units have been distributed to health facilities. NMS estimates, that the remaining units will be utilized by the facilities and implementing partners during the third quarter of the FY 2008 project period. The next Cotrimoxazole procurement will be delivered in-country by January 2009; for inclusion in the NMS health facility credit line, with 30% of the funds going to JMS for procurement to supply USG Implementing Partners and the private sector.

In FY 2009, the funding level will increase to \$750,000. NMS will allocate \$375,000 for procurement and distribution to national health facilities; and JMS will receive \$375,000, which is an increase from previous years' allocations (from 30 to 50%) for procurement and distribution to USG care and treatment partners and private sector facilities. These activities will continue to contribute greatly to the success of HIV care programs in Uganda as both NMS and JMS will have an expanded supply of Cotrimoxazole for HIV+ patients, and expand access by leveraging Global Fund procurements for the public sector.

In addition, both NMS and JMS will support training their management and support staff, building internal human resource capacity; thus improving the supply chain system. NMS has also received support from DANIDA in several areas, most recently for the construction of a 20,000 m3 volume extension to the main warehouse in Entebbe. This additional space will eliminate the need for rented warehousing. In FY 2008, the World Health Organization (WHO) supported NMS by conducting a business process and information systems assessment review. This WHO technical assistance will also identify gaps, outline strategies, and improve NMS management capacity to fully implement the national supply chain system. Finally, JMS had recently been supported by the PEPFAR funded Supply Chain Management System (SCMS) project to conduct a business process review, and assist JMS with the acquisition of a new logistics management information system.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13303

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13303	12443.08	HHS/Centers for Disease Control & Prevention	National Medical Stores	6435	629.08	Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services	\$750,000
12443	12443.07	HHS/Centers for Disease Control & Prevention	National Medical Stores	4810	629.07		\$600,000

**Table 3.3.08: Activities by Funding Mechansim**

**Mechanism ID:** 1107.09

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

---

**Prime Partner:** Makerere University Faculty of  
Medicine

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4032.20761.09

**Activity System ID:** 20761

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$1,387,000

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI, health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART), and people living with HIV receive free clinical care including ART. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komaboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are implemented in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

Currently, the MJAP Adult Care and Treatment activities are implemented at 15 outlets as listed above. By June 2008, the 15 service outlets had served over 45,000 patients cumulatively of which 37,365 were still in active care and 8,154 (48.58%) were receiving antiretroviral therapy. Of the patients on ART, 7,404 patients receive their ARV drugs from Global Fund for AIDS, TB and Malaria, and the Clinton Foundation HIV/AIDS Initiative (CHAI). The number of HIV patients in all the clinics continues to increase with the expansion of Routine HIV Testing and Counselling (RTC) in the hospitals: over 25,000 HIV infected persons were identified through RTC in FY 2008 and a good proportion were linked to care at MJAP supported sites. MJAP provides mainly adult care and treatment while pediatric patients are handled through collaborative partnerships with other providers namely e.g. PIDC, KCC, and MOH. KCC provides clinic space and drugs for management of OIs. NTLP provides TB medications and support supervision. VCT is provided by AIDS Information Centre, PMTCT under PREFA, ART under MOH-Global Fund Program, and OVC support through Ministry of Gender, Labour and Social Development. These programs are working together to ensure comprehensive care for families affected by HIV/AIDS while avoiding duplication of service.

The demand for HIV basic care and ART services is very high in all the care and treatment sites compared to the available staffing and space. The basic care and ART programs are integrated: all patients on ART receive basic care, and all patients receiving basic care are regularly evaluated for ART eligibility. The palliative basic care programs include provision of a basic care package comprising of daily cotrimoxazole for prophylaxis, insecticide treated mosquito nets, safe water vessels for safe water provision, diagnosis and treatment of opportunistic infections (OI) treatment and prophylaxis. Newly diagnosed HIV positive patients from the RTC program also receive a month's supply of cotrimoxazole prophylaxis and are provided with referrals for follow-up care in the HIV clinics. Up to 70% of HIV positive patients identified through the RTC program are ART eligible. Before patients get initiated on ART, they undergo counseling to prepare them for ART including basic facts on ART, issues of adherence, side effects, duration of treatment, among others. Patients who fulfill the eligibility criteria receive a second orientation meeting with their treatment supporter. ARVs are initiated on the third visit if the medical officer is satisfied that the patient is ready to begin therapy. Patients are seen by the adherence nurse counselor on day 0, day 15, 1 month and then monthly for counseling and ARV refills. Adherence to ARVs is monitored by self report using a visual analogue scale, ART patient cards and pill counts (patients return the bottles with any remaining pills). The program also carries out routine ART monitoring tests that include CD4+ cell count, haematology, serology and routine TB screening. Currently, the clinics get support for follow-up of patients from the home visitors and the family based care team of MJAP. In both Mulago and Mbarara ISS clinics, we estimate that about 80% of clinically eligible patients are receiving ART.

In addition to the support for ART, the program provides special attention to discordant couples at all the treatment centres with currently over 100 couples attending the special clinics. The couples are provided with psychosocial support, prevention and treatment of OIs, positive living package and disclosure support. MJAP has trained over 800 health care providers in the provision of antiretroviral therapy and strengthened systems for ART delivery including staffing, laboratory support, and logistics and data management. By the end of FY 2008, the program expects to provide adult care and treatment services to over 70,000 individuals. Over 10,000 patients shall be supported to initiate ART at the supported sites.

In FY 2009, MJAP will consolidate existing services; scale up to 4 new service outlets, bringing the total to 19. The location of the new clinics shall be determined based on the current demand for care and treatment services. Funds will go towards additional staffing and training of new and existing staff. A limited number of staffs shall be hired with emphasis being placed on transferring the management of the current existing clinics/ services to the local government systems.

**Activity Narrative:** MJAP will provide care and treatment services to 85,000 HIV-infected persons with at least 38,000 being on ART (15,000 of whom will receive their ARVs from GFTAM and CHAI sources). Thirty thousand (30,000) newly- identified HIV infected persons (through the RTC program) will receive a month's supply of cotrimoxazole at the time of diagnosis before referral into care. At least 10,000 patients will be supported to initiate antiretroviral therapy. The program will reinforce adherence counseling and support, and follow-up of ART patients through modifications in the current adherence support mechanisms at all clinics. As a quality improvement strategy, patients that are stable on ART shall be moved from routine clinician visit to the pharmacy-only and nurse-only visit programs to reduce both the waiting time and need for staffing. In this arrangement, patients shall only see a clinician/doctor only once in three months while in all the other visits they are either picking their drugs from the pharmacy directly or are seen by a nurse. The program will continue to carry out routine ART monitoring tests that shall include CD4+ cell count, haematology, serology TB screening.

MJAP will strengthen prevention with positives counseling and support including HIV testing for spouses and other family members of index patients attending the HIV clinics. Many more Family clinic days will be held in order to reach out to many more patients. In all the clinics MJAP will provide comprehensive HIV/AIDS care and treatment for families including children in partnership with other programs where applicable. Pregnant mothers registered in the clinic shall be evaluated for ART eligibility and provided with ARVs in accordance with the national PMTCT guidelines. Patients with opportunistic infections shall be offered treatment and where necessary referred for further specialised care. MJAP will provide cotrimoxazole prophylaxis and other OI care, malaria diagnosis and treatment, and Population Services International (PSI) will provide safe water supplies and insecticide treated mosquito nets. The clinic based activities will be further supported by the Family-based Care team and health visitors who will conduct follow up visits to support disclosure, trace treatment defaulters, provide support on home care for HIV positive persons, test other family members and refer the HIV positive ones to the clinics for further care.

MJAP will support efforts to identify and provide care and treatment services to new HIV infected persons by extending RTC services to HC IVs in the catchment areas of the already supported regional referral hospitals. In order to achieve the above objectives, MJAP will enhance the human resource capacity in various ways. MJAP will hire and train additional and existing staff: - up to 500 health care providers will receive training in ART delivery. In collaboration with Makerere and Mbarara universities, the program will provide pre-service training to students (offering courses of bachelor of medicine and surgery, dental surgery, pharmacy degree, nursing degree and post-graduate studies) in provision of HIV care and treatment services. A total of 400 students will receive training through both lectures and practical attachment to the MJAP supported centres. To ensure sustainability, MJAP will continue to support the improvement of existing infrastructure and systems. This will include the improvement of data management and reporting to all stakeholders within the districts to MOH; 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, MJAP has recently developed and is already implementing a strategy for involvement of people living with HIV/ AIDS (PHAs) in aspects of patient care following appropriate training.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13273

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13273	4032.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,460,000
8315	4032.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,400,000
4032	4032.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$935,587

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism****Mechanism ID:** 8670.09**Mechanism:** Provision of Full Access Home-based Confidential HIV Counseling and Testing and Basic Care Services in Kalangala District and the Surrounding Fishing Communities**Prime Partner:** Kalangala District Health Office**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Care: Adult Care and Support**Budget Code:** HBHC**Program Budget Code:** 08**Activity ID:** 9434.20752.09**Planned Funds:** \$286,000**Activity System ID:** 20752

**Activity Narrative:** In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing and basic care in Kalangala district and the surrounding fishing communities. The objectives of the four 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 and 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 was specifically targeted with this program to respond to the prevailing needs of the fishing communities related to vulnerability to HIV. Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited and 8 habited due to fish migratory patterns and harsh weather conditions. Kalangala's unique geographical location has resulted in limited health and human services to this marginalized population of 36,661 (2002 Census) and projected population of 100,000 people (2008). The district is served by only eleven health units: two Health Centre (HC) IVs, six HC IIIs and three HC IIs. There is no hospital located within the district. Referrals for patients with complicated health problems are made to mainland Entebbe, Kitovu, and Masaka Regional Referral Hospitals which is 80 kilometers from the main island. Results from the 2005 Uganda National Health and Behavioral Survey (USHBS) demonstrate that the central region, in which Kalangala is located, has the highest HIV prevalence in the country, reported at 8.5%. The secondary analysis of the USHBS central region data indicate that Kalangala District, has a prevalence of 27% which is approximately five times the national average, thus this population of fishermen and their families have been identified as a very-high risk group.

By July 31st 2008, the program office had been established and equipment procured; project staff including 45 full time staff and 100 mobilisers had been recruited and trained; 3,401 individuals including 155 couples had received HIV counseling and testing and 711 HIV-positive individuals had been identified and provided basic palliative care and referred for chronic care management. Through this program PHAs, discordant couples, and family members are 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 Masaka and Kitovu Hospitals, for more specialized care. The program has 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), 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 PEPFAR partner Population Services International (PSI) to provide adequate Basic Care Packages for HIV+ individuals and their families. This basic care initiative is fully integrated through referrals to Kalangala Health Centre IV, Entebbe, Masaka and Kitovu Hospitals to ensure that all patients have access to chronic care services and ART eligibility screening. In addition, Kalangala HBVCT program has supported the strengthening of the referral system for HIV-positive persons leading to about less than 10% of the identified HIV+ persons were enrolled in the HIV clinics within two months after diagnosis. The major reason for low enrollment in the chronic care clinics remains the high cost of water transport between the health facilities and the islands. 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.

In FY 2009, the program will continue to work to provide access to basic and palliative HIV/AIDS care services and support to PHAs in Kalangala. Cotrimoxazole, treatment of OI, and diagnosis and treatment of malaria will continue to be provided to PHAs. 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 PSI Uganda 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13223

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13223	9434.08	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8670	8670.08		\$286,000
9434	9434.07	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8792	8792.07		\$200,000

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Prime Partner:** Walter Reed

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4506.20033.09

**Activity System ID:** 20033

**Mechanism:** Makerere University Walter Reed Project (MUWRP)

**USG Agency:** Department of Defense

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$428,000



**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

The Adult Care and Treatment program described below continues to be part of a comprehensive program and activities do link to other program areas. Specific program activities that are included in this comprehensive program include prevention, SI, CT, laboratory, ARV drugs, and OVC services. During FY2008, MUWRP greatly expanded adult care and treatment services to the north of Kayunga District, to the rural, underserved, fishing communities of Galilyra. This was done by supporting an HIV clinic at the Galilyra Health Center III, and training local clinicians and capacity building. Two other HIV clinics, the Kayunga District Hospital and the Bbaale Health Center IV, were completely renovated during FY2008 to successfully address issues of patient flow, confidentiality, waiting times, and staff morale. MUWRP supportive supervision was expanded during FY2008 for all MUWRP supported HIV clinics, to four visits per week. This included two MUWRP supported nurses, two clinical officers, one pharmacist, and one medical officer. One primary focus of the MUWRP FY2008 adult Care and Treatment program was to train 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 treatment patients – each of the farms has already had one successful harvest and all patients have benefited regardless of the percent time they have spent working on the farms. Treatment club volunteers have also distributed over 1200 basic care packages to adult care and treatment patients and spearheaded 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. Also during FY2008, MUWRP supported the implementation of Post Exposure Prophylaxis Programs at each of the 5 HIV clinics in Kayunga for victims of rape, defilement, or any other person who has had immediate exposure to HIV and also supported 30 District clinicians in a two-week training on reproductive health. Finally, Because ART and 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 ART or OI drug stock outs.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

During FY2009, MUWRP will meet increasing adult care and treatment patient burden by expanding services to one additional health facility in Kayunga and also expand services to the District of Mukono South sub-district. The rate of adult care and treatment enrollment is rising in Kayunga due to HIV+ referrals from a house-to-house counseling and testing program which started in July 2008. Beginning in FY2009 MUWRP will partner with the remote Busana Health Center III in eastern Kayunga so this clinic can begin to provide HIV services, including adult care and treatment, to address the rising requirement for services in this district. Additional activities in Kayunga will include the renovation of two more HIV clinics in Kayunga, the Galyiria Health Center IV and the Busana Health Center III. In order to operate at capacity these clinics will need to be renovated to address issues of patient flow, confidentiality and waiting times.

Also during FY2009 MUWRP intends to expand services into Mukono District in order to support the Kojja Health Center IV. The initial aims of this support will be to promote care, treatment, laboratory services and counseling and testing services for the entire sub-district of Mukono South; including supporting three surrounding health center III's for the same services via mobile VCT outreaches into the surrounding fishing communities. Presently, the only HIV service provision at Kojja is a PMTCT component including a treatment club for mothers supported by EGPAF. Mukono South sub-district has a population of 120,000 persons and using data from the Uganda sera-survey, we can expect approximately 12,000 HIV positive residents; at least 80% of these (9,600) would be HIV+ adults. Other FY2009 initiatives under this program area include: (1) partnering with AIDS Treatment Information Center (ATIC) so that District HIV clinicians in rural areas can receive a medical consultation over the phone from a HIV/AIDS specialist, (2) expansion of adult care and treatment service provision to HIV+ prisoners residing in Bulawula (3) retraining of all HIV clinic staff as the Uganda MOH has recently revised its policies on ART, and (4) support of the District HIV team to meet weekly and conduct supportive supervision to the HIV clinics monthly (this is in addition to the weekly MUWRP supportive supervision). The final new activity for FY2009 Funding will support the expansion, training, technical assistance, transportation, capacity building, remodeling and provision of commodities (including pain medication) to five HIV clinics operating in Kayunga District and expansion of comprehensive services to Mukono South sub-district.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15710

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15710	4506.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$435,000
8526	4506.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$317,000
4506	4506.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$134,999

### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$120,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$27,000

### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$2,500

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$22,000

### Education

### Water

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

---

**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 12442.20058.09

**Activity System ID:** 20058

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$120,000

**Activity Narrative:** 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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kirudu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant and will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

By June 2008, there were 328 ART accredited sites in Uganda, most of which (60% – 70%) are urban based and mostly in central part of Uganda. At Baylor – Uganda, there are over 7,500 children and their care givers who are in active HIV/AIDS care from Baylor - Uganda Center of Excellence, 6 satellite centres in Kampala, 4 regional centres in Soroti and Kasese areas and now 32 public rural health facilities. Adults make up 2,275 and 792 of those in active HIV/AIDS care and on ART respectively. Baylor – Uganda provides HIV/AIDS family-clinic twice a week in Naguru and Kawempe Health Centre IV and once a week at the COE and in three Satellite Clinics. Rural facilities are being supported to provide integrated family/child HIV/AIDS clinic, but because of large number of people enrolled on ART, this programme will only provide support for contingency and buffer supplies. As such, as children are being enrolled into HIV/AIDS care and treatment, their care givers are provided with services too, in order to enhance adherence, observance of return visits and reduce costs associated with seeking care from multiple sources for same family members, but with different age groups. In 2008, Baylor – Uganda has integrated pediatric HIV/AIDS services in 33 health facilities and through this initiative more than 1,200 and 305 children and care givers have been enrolled in active HIV/AIDS care and ART respectively within three months period. This demonstrates immense potential for patient recruitment, but also shows the opportunity to increase equitable access to HIV/AIDS care and treatment. However, our initial ART Site Preparedness Assessment showed gaps in capacities of these lower level health facilities to initiate and sustain integrated pediatric and adult HIV/AIDS services in the area of infrastructure; number, skills and motivation of personnel; pharmacy and logistics management; laboratory support; data management & use; support supervision; etc. Population Services International provides support to Baylor – Uganda with Basic care kit for people living with HIV/AIDS (PHAs).

In FY2009, Baylor – Uganda will continue providing adult HIV/AIDS care and treatment services in the context of family clinic of family-centered services at the Baylor- Uganda Center of Excellence (COE), Satellite clinics & rural health facilities. The following will be the key activities to be implemented over this

**Activity Narrative:** period:

- Provision of ART services to eligible care givers and continual clinical and laboratory monitoring of those in HIV/AIDS care and on ART.
- Prevention & management of opportunistic infections (excluding TB), malaria, diarrhea, pain & symptom relief, nutritional support, etc.
- Procurement and distribution of pharmaceuticals (non-ARVs), basic care package (ITNs, safe water vessels, etc) to all supported sites.
- Working with partners to train/orient health workers and lay community volunteers in adult HIV/AIDS management, Home based Care, etc.
- Continuous provision of technical support to rural health facilities through on-site mentorship (at least for 3 consecutive months to develop systems and competencies of trained staff) and routine support supervision & monitoring.
- Minor infrastructure improvements such as renovations, painting to make service areas user-friendly, building of tents as waiting space for facilities without such provisions
- Procurement and distribution of basic supplies for managing adult HIV/AIDS where needed.
- Support for personnel involved in the training, national expansion program, monitoring & evaluation and former Plus-Up sites in Anyeke Health Centre IV and Kagadi & Kiryandongo Hospitals.
- Support for pediatric HIV/AIDS training curriculum development for in-service in order to incorporate aspects of family-centered care/treatment.
- Support for data management and utilization through strengthening capacities of Baylor – Uganda, District Health Offices and targeted health facilities with computers, internet connectivity, hands-on training, in various data management programs/packages, routine data collection and analysis, with report writing.
- Routine monitoring and evaluation of the program for ARV services, bi-annual regional program review meetings, and best practice documentation and dissemination will also be covered under this program area.
- Formation & working in partnership with other actors will be important in rolling out adult ARV services and related care needs for nutrition, income generating activities, etc.
- Community mobilization on family-centered HIV/AIDS treatment and care through radio and community dialogues, etc.
- Provision of activity related incentives for rural health facility staff such as staff tea break, overtime allowance, across the facility.

Undertake quality improvement initiatives in all sites with support from HIVQUAL; a capacity building program for quality improvement in HIV care and treatment.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13258

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13258	12442.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$600,000
12442	12442.07	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	4798	1186.07	Pediatric Infectious Disease Clinic	\$600,000

---

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$50,519

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Adult Care and Support
<b>Budget Code:</b> HBHC	<b>Program Budget Code:</b> 08
<b>Activity ID:</b> 4395.20739.09	<b>Planned Funds:</b> \$296,000
<b>Activity System ID:</b> 20739	

**Activity 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

In FY 2008, AIDSRelief expanded its services to four new LPTFs and three community based organizations. It also decentralized services by encouraging LPTFs to open satellite sites and outreach clinics. As of July 31, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. AIDSRelief has supported a comprehensive continuum of care for adults living with HIV, in order to enhance their quality of life throughout the entire span of their illness. The adult care and treatment component has been built on existing clinical and social services in all LPTFs. Clinically, the program continued providing adults with 1st line, alternative 1st line, and 2nd line therapies, clinical follow-up, laboratory testing (including CD4), and treatment of opportunistic infections. Social services supported consist of psychosocial and spiritual support, as well as nutrition counseling and education were available to all 55,781 HIV+ adult patients enrolled in care in FY 2008.

To get services closer to the PHAs, AIDSRelief has encouraged and supported LPTFs to open up satellite clinics and this has increased accessibility of these services to those in rural areas. All LPTFs had outreach teams led by a community nurse/clinical officer and are linked with community based volunteers, many of whom were PLWHAs on treatment. Emphasis has been placed on excellent adherence in order to achieve durable viral suppression. As a result there has been very good retention rate for patients on ART, low drug toxicity, and an average adherence rate of over 95%. The teams also provided community based and household ARV treatment support and preventative services which included education on the importance of using ITNs, basic hygiene and good nutrition. Emphasis has been put on the creation of linkages within the different services provided at the LPTFs and other service providers. The referral linkages between ANC, PMTCT and ART services have been encouraged at the LPTFs to enable HIV+ mothers, their partners and their babies to access ART services through the facilities.

AIDSRelief also continued employing a model of 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 and appropriate referral for management of opportunistic infections (OIs), as well as supply of the basic care package (ITNs, safe water, information on cotrimoxazole prophylaxis and prevention for positives). Activities were expanded to 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. The program has recognized the strong link between nutritional and Antiretroviral therapy and adherence to ART but this 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) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

By the end of FY 2008, 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 were included in this analysis, grouped into three cohorts (36, 24 and 12 months) representing the length of time they had received therapy.

In FY2009, due to projected flat-lined funding, AIDSRelief activities will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites in order to maintain 17,200 adult patients on AIDSRelief provided ARVs and 55,781 adult patients in care. Support will consist of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. A major focus will be to increase the devolution of services to alternate cadres of service providers through 'task shifting,' and networking with facilities and with other service providers including the Ministry of Health. At the LPTFs, this strategy will focus on protocols enabling nurses and clinical officers to do routine follow-up of stable patients and manage non-critical acute symptoms as well as enabling nurses and pharmacy staff to do routine medication dispensing to stable patients. This will increase service delivery, and ensure greater coordination and integration of services provided within the community. Should additional funding from the USG become available, AIDSRelief is poised to expand the services it supports to other underserved areas of Uganda to reach an additional 6300 adult patients on ARVs and 10,000 adults in care.

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, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV + patients enrolled in care in 18 LPTFs and their satellites. There will also be strengthened linkages between other health facility services, especially for PMTCT and TB.

The AIDSRelief technical team will provide comprehensive training and technical assistance to 290 medical and 720 non-medical staff to increase the capacity of LPTFs to appropriately manage and monitor patients with HIV infection. This will include the recognition and management of opportunistic infections, treatment failure, adult counseling, and psycho-social assessments. AIDSRelief will follow-up didactic training with

**Activity Narrative:** on-site clinical mentorship for clinicians and site level support for other cadres of workers. AIDSRelief will also establish 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.

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. 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 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 symptom monitoring, disclosure counseling, secondary prevention, and family-based testing and education.

In FY 2009, 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 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.

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 PSI and UHMG (Uganda Health Marketing Group) will be strengthened in order to increase access to ITNs 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.

Coordinated by Constella Futures, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AIDSRelief will ensure that 100% of the LPTFs use the new PMM system, IQCare, and other IT solutions that enhance data use, like IQTools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, and collect data across all program areas. This will support the program to reach and report on its patients. During the year, great efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. Staff will be given skills to analyze their own data, and use the information to carry out quality of life analyses to be able to take informed clinical decisions. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services. These indicators will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcoholism. LPTFs will also be able to track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs, like malaria, and chest infections, and overall patient morbidity trends.

Through the already established CQI plans, and the "small test of change" methodology that is being used at all LPTFs, staff will be assisted in generating, collecting and using patient level outcome information to continuously assess, define gaps and improve the services they provide. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed as a team. This will enhance better understanding and ownership of the program, and indicators that enhance good clinical practice. The program will also promote these 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 also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care services. This capacity strengthening will include human resource support and management, financial management, infrastructure improvement, and strengthening of health management information systems.



**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13263

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13263	4395.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$370,000
8292	4395.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$200,000
4395	4395.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$110,362

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Adult Care and Support
<b>Budget Code:</b> HBHC	<b>Program Budget Code:</b> 08
<b>Activity ID:</b> 23925.09	<b>Planned Funds:</b> ██████████



**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to ARV drugs, Adult Treatment, PMTCT, Pediatric Care and Treatment, Counseling and Testing, Laboratory Infrastructure, TB/HIV.

In FY 2008, the SCMS project provided procurement services and technical assistance to the Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), and UPHOLD (now ended) to improve the availability and management of ARV drugs in their sites. SCMS also provided funds to the MOH for emergency ARV procurements. To-date, a total of \$1,795,000 of ARVs and related commodities has been procured through SCMS for these partners. SCMS will also procure ARVs for EGPAF. NUMAT, in partnership with SCMS, established logistic management systems and procedures for ARV supply in its ART sites and a working arrangement was developed with Joint Medical Stores, a central warehouse for FBOs and other private sector organizations, to deliver to the partner sites based upon requisition. NUMAT technical officers trained and mentored ART teams in logistics management to ensure smooth system performance and logistics tools and materials adopted from MOH formats were distributed to the ART sites to ensure proper reporting of drug consumption. During the period, two cycles were delivered of first and second line adult ARV formulations for 17 existing ART sites and later for 6 additional newly accredited ART sites in the nine districts. Gaps in pediatric support were identified, which led to negotiations with Baylor Children College (Uganda) to provide the ART clinics with ARV formulations for young children. The choices of ARV drugs selected by the program were determined by the current GoU ARV policy that took into consideration efficacy, adverse effect profile, and pill burden. The ARV drugs selected also took into consideration needs of the clients gaining entry through the other program areas of PMTCT and TB.

SCMS also procured ARVs and drugs for opportunistic infections for the IRCU program. Technical staff have been trained in forecasting drug needs for the program and on the ARV logistics management system. A computerized logistics management information system was installed using standard software to track consumption and stock levels at the individual sites. Thirteen implementing sites are currently submitting bimonthly ARV drug reports and orders to the IRCU Logistics Officer. The partnership with SCMS and JMS has been successful to date and has guaranteed steady availability of ARVs at all IRCU supported sites. In addition, as a result of this partnership, IRCU has been able to procure quality ARVs at the most competitive rates available on the market, guaranteeing that its clients are accessing quality products and, with the savings, enabling the program to recruit more ART clients.

At the national level, SCMS provided technical assistance to the MOH to forecast and quantify the country's ARV needs, coordinate procurement with donors, and train new district and new ART site staff on logistics management and reporting. SCMS also assisted in support supervision activities at district level to improve facility level performance. Specific achievements include 683 health workers country-wide trained on the redesigned MOH ART logistics management system, 28 MOH regional pharmacists and senior dispensers trained on management of ART logistics activities, and 92 health workers from 38 newly accredited ART sites trained on the logistics management system. The SCMS supervisory team visited a total of 174 ART sites to monitor performance and provide on-the-job support to health workers charged with logistics management. Efforts to harmonize ARV procurement among PEPFAR partners and communicate supply issues continued through various technical working groups and technical support was provided to the GFTAM third party procurement agent (WHO/UNICEF). In FY08, technical assistance was provided to JMS to completely overhaul its warehousing and inventory management system including installation and training in the new warehouse management information system (MACS) and the financial system (SAGE) software. Support was also provided to NMS to assess its warehousing and inventory management system, the recommendations of which were endorsed by the NMS Board of Directors.

Capacity building in ARV logistics management will continue in FY 2009 at the PEPFAR-supported sites and national level but through the new partner (TBD). Technical assistance will be provided to build capacity and improve logistics management at IRCU and NUMAT sites as well as sites supported through the new district-based HIV/AIDS programs. This new partner will provide the logistics management technical assistance that SCMS used to provide, including commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the

**Activity Narrative:** well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submit timely reports to keep the system moving. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution to health centers in selected districts.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 21882.09

**Planned Funds:** ██████████

**Activity System ID:** 21882

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening



**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4699.21726.09

**Activity System ID:** 21726

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$800,000

**Activity Narrative:** This activity also relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

In FY2008, NUMAT continued to strengthen relationships with stakeholders in the various district local governments and the communities. Working partnerships were forged with various agencies for example WHO, NGEN+, PSI, JCRC, CNAPSIS and others as their respective areas of expertise were exploited to improve the access and quality of treatment, care and support for the HIV positive population of Northern Uganda. NUMAT partnered with WHO, the AIDS control programme and Palliative Care Association of Uganda to provide training for 170 health workers in various aspects of adult care and treatment, including pain and symptom management for HIV patients, management of OIs, and integrated management of Adult infectious diseases (IMAI). The trainings were augmented with on site mentorship by technical support teams from NUMAT and the Ministry of Health. NUMAT also supported training of trainers in comprehensive HIV care and aspects of palliative care that would add to the professional resource of the region. Medical students from Makerere University were also engaged to gain experience as they supported the human resource gaps at the various sites. In a bid to support the training young doctors at Gulu University, NUMAT intends to support the publication, printing and dissemination of the 2008/2009 Gulu University Medical Journal that will carry an HIV related theme. Meanwhile after a year of putting structures and processes in place to support an efficient ARV drug supply, the drugs were finally delivered to 17 sites supported by NUMAT, 6 additional sites were identified for assessment and were subsequently accredited by MOH. All the NUMAT supported health facilities are district hospitals, health centre IV and III that chronically lack adequate staffing and laboratory capacities. In effort to improve confidence and utilization of these 23 ART sites and decongest larger health facilities like the regional referral hospitals, several complimentary areas of support for treatment, care and support were addressed. In conjunction with JCRC and CNAPSIS Free CD4 and full blood count testing were offered to all clients accessing care at the health facilities. This resulted in a 65 percent increase of enrolment of clients onto ART as a result of the free CD4 tests provided. Health workers felt motivated to work by this support. Limitations in community follow up were addressed by promoting and motivating the set up and development of PHA groups and Networks. The JSI arm of NUMAT supported the mobilization and training of 103 PHA volunteers to work as Network support agents (NSA) in 45 health facilities. Other than their role to link fellow PHAs and family members to community and health facility- based care and treatment services, the NSAs also supported counseling, community based care and support. Further home based care was provided through World Vision's community care coalition (CCC) that came into being when 750 home based care providers from the nine districts were trained to support HIV adults in the community by monitoring their health, monitoring adherence, offering on going counseling and identifying needs for wrap around services that guided referral for appropriate care.

#### ACTIVITY UNCHANGED FROM FY 2008

In FY 2009, NUMAT will continue to coordinate, promote and implement adult care and treatment activities. HIV related care activities will be scaled up and consolidated in lower health units, Sub County, parish level and small transit IDP camps with special emphasis on hard to reach and high risk communities. Paramount in this effort is the adoption of the "Model Site Concept" that will make it possible for PHAs and all the communities in these unique settings to receive holistic prevention, treatment, care and support services. This will involve implementing synchronized activities from all the NUMAT program areas as well as that of the collaborators. NUMAT will also continue to improve linkages for PHAs and their families to essential clinical and wrap around services including food, material support, and family planning in the project catchment area. Training and motivation of Network support agents and community health workers will continue promoting both community and facility based adherence monitoring, tracing and follow up. It is envisaged that by participation of PHAs themselves, more patients will be encouraged to seek and remain in care. The expansion of community care services and referral networks will be promoted by PHAs working in collaboration with health facilities, NGOS, CBOs and the World Vision promoted Community Care Coalitions (CCC). NUMAT through strengthening collaborating partnerships with other USG supported programs like PSI, IRCU, AFFORD, IHAA, NuLife will improve the availabilities of wraparound services for PHAs. These services will include delivery of prevention & care packages for PHAs including Cotrimoxazole prophylaxis for opportunistic infections (OIs), ITNs, peer psychosocial support, IEC/BCC for prevention among the positives, condoms and ART. At health facility level, on site mentorship for health workers for Adult HIV treatment and care will continue. Specific formal trainings, especially in ART and OI management and the various aspects of palliative care will be carried out to keep up with gaps created by the high turnover of the human resource in many of the health facilities. Both financial and non financial forms of motivation will be provided to the health workers. Non financial motivation will include sponsorship for workshops, seminars and exchange visits where appropriate. NUMAT will also be involved in Adult comprehensive care training and related programs when the Gulu University Journal is produced carrying a relevant HIV related theme. IEC/BCC materials that were produced and translated in the previous period will be printed and disseminated. The Ministry of Health will continue to provide support supervision and spearhead assessment and accreditation of additional ART clinics to achieve the target of 30 clinics. As the ART clinics are rolled out and strengthened, NUMAT will carry out a baseline survey on patient retention and adherence on the ART programs. Results of the survey will support further evaluations of the quality of care at the sites. NUMAT will offer a total of 21,880 free CD4 tests and about 600 full hemogram tests to PHAs through AIC and CNAPSIS. This is an increase from 4800 CD4 tests offered in the last FY. NUMAT has supported capacity building as regards CD4 testing by conducting training for health workers in HIV care and by on site mentoring focusing on CD4 utilization. Threshold sentinel testing of ARV drug resistance will also commence according to work plan in a bid to ensure efficacy of ARV drugs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15480

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15480	4699.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$1,000,000
8468	4699.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$871,966
4699	4699.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$871,966

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$40,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4365.21715.09

**Planned Funds:** ██████████

**Activity System ID:** 21715



**Activity Narrative:** Faith-based organizations (FBOs) have been strong partners in delivery of health services in Uganda. Through their established and extensive network of health units, they support 47% of the country's health care services. Besides the wide coverage, FBO health services target and reach the most remote areas of the country. FBOs have also been incredible partners in the national response to the HIV and AIDS epidemic.

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 (8,787 males and 14,959 females) into care and 2,605 (964 males and 1,641 females) on treatment through its eighteen partner sites. Twelve of these sites jointly deliver care and treatment, an approach that has been proved to alleviate pressure on the already overstretched capacity of the partner health units, particularly personnel.

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 (TBD) will be to sustain the individuals already enrolled in care and treatment and to further build the capacity of faith-based health units and NGOs in delivery of quality and sustainable services. Priority activities will, among others, include continuing to update service providers on emerging challenges and new approaches to AIDS care and treatment, strengthening linkages with other and non-PEPFAR activities to maximize synergies, continuous improvements in quality of services as well as reaching out to new and underserved populations. 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 existing AIDS care and treatment services. 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.

By the end of FY 2009, the follow-on program (TBD) will have provided care to 35,000 people living with HIV/AIDS of whom 7,200 will be on treatment. From the baseline number of 2,065 individuals receiving treatment in March 2008, IRCU anticipates to have enrolled a further 1,000 individuals by the end of September 2008, bringing the total to 3,065. By June 2009 when it winds up, IRCU will have enrolled an additional 2500 new individuals in treatment, bringing the total to 5,565. The follow on program will enroll a further 1,635 new adult individuals between July and September 2009 and train a total of 100 health workers 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 1000 community and religious leaders in basic HIV and AIDS care and treatment to serve as HIV and AIDS resource persons and to link facilities with communities.

The HIV and AIDS basic preventive care approach has continued to grow in prominence as a cost-effective approach to care and treatment given its proven effectiveness in warding off opportunistic infections and hence delaying the need for ART. IRCU has been engaged in rolling out elements of preventive care. Using FY 2006 funds, IRCU procured and distributed 38,000 long lasting insecticide treated mosquito nets (ITNs) to PHA and their immediate families through its network of FBOs. It will further procure and distribute another 5,000 ITNs using FY 2007 funds.

Albeit with procurement challenges, IRCU has been prescribing prophylactic Cotrimoxazole as a standard practice in care and treatment in accordance with the Ministry of Health (MOH) guidelines and policy. The follow-on program (TBD) will be required to continue rolling out these basic care elements with a key focus on strengthening procurement and distribution systems. While providing free basic care elements, the follow-on program (TBD) will simultaneously raise awareness among its clients on the availability of these commodities on the open market as a medium term strategy to eventually phase out free distribution in order to guarantee sustainable access.

Ensuring a steady and demand sensitive system for supplying care and treatment commodities 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 required to assess the efficiency and viability of the SCMS procurement mechanism and if found effective, further strengthen it. If not, the follow on program will be required to explore other alternatives that enhance efficient delivery.

IRCU has worked closely with the Ministry of Health and its partner health units to reinforce Post Exposure Prophylaxis (PEP) for the health workers. The Ministry of Health has recently released guidelines on occupational health and safety within the health sector, in which procedures for PEP management are well articulated. In addition, the guidelines also provide guidance on creating a good working environment for HIV-positive health workers and ensuring that they don't pose a transmission risk to their patients, especially in aspects of health care that involve invasive procedures. The follow-on program (TBD) will be required to glean and disseminate the relevant components of the guideline and ensure that infection control is a mundane practice within all the supported HIV/AIDS care and treatment facilities.

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

**Activity Narrative:** ensure that criteria for ART eligibility, prescription practices and adherence monitoring protocols are all in line with the national policy.

To the extent possible, care and 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14210

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14210	4365.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8424	4365.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4365	4365.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities [REDACTED]

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 3340.09

**Mechanism:** AFFORD

**Prime Partner:** Johns Hopkins University Center for Communication Programs

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

---

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4409.21736.09

**Planned Funds:** \$1,840,000

**Activity System ID:** 21736

## Activity Narrative: INTRODUCTION

The AFFORD Health Marketing Initiative (AFFORD) is a cooperative agreement awarded to the Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs in October 2005. AFFORD has the following objectives:

1) Increase accessibility and affordability of HIV/AIDS, reproductive health, child survival and malaria products and services for Ugandans using innovative private sector approaches; 2) Enhance knowledge, and correct use of HIV/FP/CS/Malaria products and services to encourage and sustain healthy behaviours and lifestyles; 3) Strengthen/establish indigenous organization(s) for sustainable and self sufficient delivery of key health marketing functions, including product distribution and promotion. AFFORD is a consortium of 6 organizations, three international and three local. All 6 consortium members have contributed to the creation of an indigenous organization, the Uganda Health Marketing Group (UHMG), and are building the required skills and capacity to continue in the footsteps of AFFORD when the project comes to an end. UHMG is now incorporated as a not for profit company and is working alongside other consortium partners. UHMG continues to build its technical, managerial and financial capacity to effectively deliver the objectives of AFFORD now and in the future.

AFFORD has worked through the private sector to provide quality health maintenance products to PLHAs as well as provide counseling and referral services for clients. In 2008 HCT became a main part of the AFFORD care and support program through its carefully selected 100 private clinics. The project's numerous communication channels are used to promote these services. Through this intervention the private sector is increasingly contributing more to HIV prevention and health maintenance.

### PROGRESS TO DATE

In FY 2008 AFFORD realized that in order to effectively provide care for PLHAs who seek palliative basic care services from the private commercial sector, it is important to establish their serostatus. Because most people avoid the public health facilities for various reasons including stigma, AFFORD supported the establishment of HCT services in 100 private clinics to ease access to HCT services without fear of stigmatization. Selection of eligible clinics was done in collaboration with the Ministry of Health (MOH) and Central Public Health Laboratories (CPHL) using an assessment tool jointly developed with AFFORD. Service providers from these clinics were trained by MOH trainers using national curricula for HIV counseling and laboratory practice. The Making Medical Injections Safe (MMIS) project trained providers in these clinics in health care waste management. These Good Life Clinics were provided with test kits and other consumables. Good Life Clinics have since provided excellent and convenient facilities for people to know their serostatus. Through the Good Life Clinics 11,113 people have tested and received their HIV test results. Data collection tools and laboratory practice standard guidelines used by the clinics are provided by MOH. Good Life Clinics are now linked through a network of geographically spread out clinics providing an assemblage of services for family planning, HIV, child health and malaria prevention among other medical services provided.

#### Adult treatment and care

In FY 2008, AFFORD's palliative basic care included strengthening the capacity of health workers in private commercial clinics and drug shops with knowledge and skills to deliver basic palliative care services. Identification of palliative care outlets was done in collaboration with District Officials with using a database of registered drug shops and clinics generated by the National Drug Authority. In total 1557 health workers, each representing an outlet, were trained using a module developed by AFFORD. Among these 410 were clinics and 1147 drug shops. To ease access to a range of palliative care products AFFORD linked these clinics to AFFORD's product distribution network. Job aids and support materials for providers and client information is available to all participating outlets. To date palliative care clinics have reached 100,962 people with services and products while many more PLHAs have accessed and been referred for needed services through participating drug shops.

#### Health Maintenance Products and OI Drugs

AFFORD has developed products that are being promoted to PLHAs for health maintenance. These products include Aquasafe water purification tablets, Restors Low Osmolarity ORS, Cotrimox (one month pack cotrimoxazole), Acyclovir tablets and cream for adults and children in the treatment of HSV2 and a triple action topical cream of dermatological infections. All these products are in distribution with the exception of the Acyclovir and triple action cream which will be introduced on the market in November 2008. In addition, the project works with six commercial net distributors to make LLINs affordable to PLHAs. Though AFFORD carries its own brand of products, it promotes several brands of health maintenance products and OI drugs through its wide network of pharmacies and drug shops. About 1147 pharmacists and drug shop operators have been trained to provide palliative care counseling and provision of health products. The retailers have been linked to major pharmaceutical distributors and wholesalers to get continuous supply of these products. 510 private clinics have also been trained and are carrying a wide range of health maintenance products and OI drugs.

#### 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. The Good Life campaign launched with The Good Life! Show, a highly popular TV, radio and experiential game show that uses edutainment to increase knowledge, facilitate couple communication, promote healthy behaviors, and increase demand for products and services. Areas of HIV focus included health maintenance for PLHA, risk perception, condom use, HIV testing, disclosure, and PMTCT. In FY 2008, 24 episodes were broadcast on 3 TV stations, 20 radio stations in 5 languages and appeared in 120 locations countywide through the experiential road shows. The experiential road shows were further refined to enhance interpersonal communication and resulted in the development of the "four tent" model. Using this approach, fewer people gather under a tent to receive messages and are able to ask pertinent questions which they otherwise would not have been able to ask. The four tent approach went to 120 communities in 2008 reaching 300,000 people.

In partnership with the HIPS project, AFFORD implemented a number of workplace programs targeting major companies and sugar and tea plantation workers. A total of 32,000 people in 16 workplaces were reached through this intervention.

Recruitment, training and management of 100 model clinics

**Activity Narrative:** Selection of eligible clinics was done in collaboration with MOH and CPHL using an assessment tool jointly developed with AFFORD. Clinics were assessed on various areas including management policies, logistics management, personnel, range of services offered and work load in each service area, infection control, availability of MOH guidelines and policies on treatment and service provision as well as willingness to partner with AFFORD. Service providers from the selected clinics were trained by MOH trainers using national curricula for HIV counseling and HIV Rapid Testing by CPHL trainers. Clinics were then provided with testing kits and consumables, as well as data collection tools and supported to integrate HCT services in their ongoing medical services. The providers were also trained in other critical areas supported by AFFORD including malaria prevention and treatment, family planning, and child health. Post training support is provided to ensure that clinics have basic management systems like basic data collection tools to enable them to collect and submit data to the district health office, documentation of their experiences, supply chain and stores management to help minimize stock out and knowledge of national policies and guidelines for implementation of various medical services. Periodic support supervision is provided by the technical teams composed of AFFORD and MOH staff. Support supervision teams provide on-site mentoring and assess quality issues related to HCT service delivery.

#### FY 2009 ACTIVITIES – Reaching 108,000 people with care and treatment

In FY 2009 AFFORD will consolidate its successes over the past three years and expand its activities geographically to reach more people who need services. We will increase the number of PLHAs reached with care and treatment from 100,000 in 2008 to 108,000 through our various channels. The clinics offering HCT will be increased by another 100 making a total of 200 clinics. Refresher trainings will be organized for the wide range of service providers supporting the provision of health maintenance products and making crucial referrals to appropriate health facilities. Various communication approaches will continue to raise awareness of the usefulness of health maintenance as well as promote facilities where services can be sought.

The following are the details of programmes planned for FY 2009:

##### Adult treatment and care

In FY 2009, AFFORD will scale up its intervention reaching PLHAs with treatments and care services through clinics, PLHA networks, midwives, other partner organizations. Through 610 clinics offering palliative care services we expect to reach 78,000 PLHAs. With an increase in the good life clinics providing HIV counseling and testing services from 100 in 2008 to 200 in 2009 we expect 36,000 people to test and receive their results and others referred for other needed services including ART. AFFORD will procure test kits according to the recommended algorithm as follows: 40,000 determine test AFFORD will also work with the Uganda Private Midwives Association (UPMA) to train its membership and link them to distribution networks for palliative care products. Together with health workers from private clinics, midwives will be trained in health care waste management and provided with safety boxes and color coded waste bins to ensure safe disposal of waste. A total of 400 people will be trained to support delivery of HCT services through private clinics and midwifery's. Through the UPMA 5000 people will be reached. . AFFORD provides continued management and technical support supervision to the newly recruited 100 clinics along side the previous 100 clinics.

Training: In FY 2009 AFFORD will conduct training and onsite mentoring to 2767 health workers in palliative care services outlets. Private health providers will also be oriented on new products introduced on the market including Cotramox, Acyclovir and a triple action topical cream of dermatological infections among others. We will work together with the Association of Private Medical Practitioners to design refresher training modules based on frequently asked questions from health workers in private practice. The health workers will also be provided with the Palliative Care Handbook for continued reference as well as other job aids and client materials.

AFFORD will conduct in-depth scale up of palliative care to the drug shop operators through its district based trainers and field staff. More in depth detailing for the products already on the market and those newly introduced for palliative care will be conducted, including ensuring steady supply for other products such as Protector condom, condom 'O', Aquasafe water purification tablet, Zinkid, Restors, and LLINs. AFFORD will work with PLHA organizations to increase members' access to health maintenance products and services. In collaboration with National Forum for PLHAs in Uganda, AFFORD will reach PLHA groups like Positive Men's Union (POMU), National Community of Women Living with HIV/AIDS (NACWOLA), and Young Positives. District networks of PLHAs will be supported to train their members in palliative care, and availed with options on available outlets for service provision. A total of 500 PLHAs will be oriented and these will in turn reach 15,000 PLHAs with palliative care information and products.

Through the Good Life communication platform, AFFORD will target PLHAs, their caretakers and families with palliative care and health maintenance messages and direct them to outlets and providers that stock quality products for health maintenance.

In FY 2009 AFFORD will also strengthen collaboration with other palliative care stakeholders to extend products and services to a wider community beyond our targeted districts. AFFORD will collaborate with organizations like The AIDS Support Organization (TASO), Joint Clinical Research Center (JCRC), International AIDS Alliance and NUMAT to extend quality services to PLHAs. Through this intervention AFFORD will reach 10,000 people with palliative care services and products.

##### Purchase and Distribution of OI Drugs

AFFORD will continue to use traditional social marketing to distribute a range of high quality palliative care products targeted at PLHAs through private commercial channels (drug shops, pharmacies, clinics and midwiferies). The range of products will include Cotrimoxazole (Cotramox) and Acyclovir (Clovirex), LLINs, condoms, and multivitamin (Nutriboost). It should be noted that the palliative care program will leverage the existence of products supported with child survival funds. These include Aquasafe (water purification product), Zinkid (Zn) and Restors (ORS) and others like LLINs, condoms, and multivitamin (Nutriboost). AFFORD plans to avail it through selected specialized clinics hospitals and other distribution networks for AFFORD products.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity: 14222**

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14222	4409.08	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	6743	3340.08	Health Comm Partnership; AFFORD	\$2,300,000
8440	4409.07	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	4841	3340.07	Health Comm Partnership; AFFORD	\$2,000,000
4409	4409.06	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	3340	3340.06	AFFORD	\$2,000,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

Refugees/Internally Displaced Persons

Workplace Programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$610,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 9220.09

**Prime Partner:** To Be Determined

**Mechanism:** TBD - HCT/AIC Follow on

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 21470.21571.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21571

**Activity Narrative:** This activity is an on-going program related to the CSF/Deloitte and Touche HIV Counseling and Testing program that was approved in COP 08 implemented by a national indigenous organization contributing towards the national goal of scaling up HIV counselling and testing services in Uganda. The goal of this program is to support the MOH, districts, private sector; and Community based Organizations (CBOs)/ Non-governmental organizations (NGOs) to scale up provision of integrated HCT services at the Regional HCT Centers of Excellence, public, private, and CBO/NGO/FBO HCT sites. This program will establish Regional HCT Centers of Excellence and scale up HCT services to cover all Regional referral hospitals, all District hospitals, all private hospitals, and all health centers up to H/C II sites that are not covered by the USAID funded District based program and other PEPFRAR HCT implementing partners. In addition, the program will establish HCT outreaches to the communities in collaboration with existing HCT service providers and CBOs in order to increase access to most at risk populations and remote areas. Outreach activities will include those held in schools, fishing landing sites, military/police establishments, mobile populations including internally displaced persons (IDPs), truck drivers, institutions of higher learning and People with Disabilities. The Regional HCT Centers of Excellence will be a focus point for coordination of M&E systems, Operational research, External quality assurance, training and mentoring of other HCT service providers within the health system in accordance with national and international guidelines.

As a continuation of the FY 2008 activities, Linkages to care, treatment and support services for HIV-infected clients and their families will be strengthened at all levels of the health system. HCT services will be provided as an integrated HIV/AIDS service in addition to 1) treatment of opportunistic infections (OIs) and minor ailments; 2) STD diagnosis and management; 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.

Service points will complement HCT services with AB, OP and palliative care activities funded in-house or by other USG and/or other donors. Individuals will be able to know their sero-status, encouraged to adopt prevention options of their choice and receive a minimum palliative care package and referred where necessary. Persons living with HIV/AIDS (PHA) networks, youth friendly services, couple HCT services and post-test clubs will be enhanced to strengthen referral linkages to prevention, care, treatment, and support. There will also be increased gender equity in HCT programs and addressing male norms and behaviors. In the outreach sites and mobile clinics, HIV+ clients will receive the first doze of Cotrimoxazole for one month and additional referral information for further care and treatment services.

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 at improving quality of life of PHAs. The HIV+ client will be encouraged to mobilize other family members and community 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21470

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21470	21470.08	U.S. Agency for International Development	To Be Determined	9220	9220.08	TBD/HCT	[REDACTED]

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* TB

Military Populations

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development



## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 21145.21576.09

**Activity System ID:** 21576

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$544,000



**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric care and treatment, TB/HIV, ARV drugs, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to six districts in the East Central region of Uganda including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba. Whereas these districts are estimated to have more than 74,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically services shall be tailored to the existing MoH HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- 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.
- 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.
- 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

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

This activity will also endeavor scaling up of adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members;

**Activity Narrative:**  
**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 16008.21545.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21545

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. USAID will award the new agreement by March 2009. This will ensure smooth transition between the current JCRC program and the follow-on mechanism.

In FY 2009 the major focus of the activity will be to ensure continuity of life saving services, smooth transition and capacity building of the 11 regional referral hospital and expansion of district wide HIV/AIDS care and treatment services in 40 facilities located in the 11 districts hosting the regional referral hospitals. Specific activities will include: training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis(TB) and HIV. The program will train physicians and non-physicians to provide ART services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, ART literacy, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for prevention with positives and linkages to basic preventive package and wrap-around services.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites (district hospitals and HCIVs), the program will support infrastructure development for ART services and build the capacity of the Directorate of Health Services to manage ART services in the district. The program will provide technical and financial support for districts to carry out quarterly support supervision activities. The program will ensure consistent availability of care and treatment services of patients currently under JCRC mechanism.

Critical emerging issues like adherence, surveillance for resistance, Infant Diagnosis using DNA-PCR and screening of patients under palliative care for ART eligibility will be supported. The program will provide financial support in the form of grants to Civil society organizations and Networks of PHAs to carry out activities that support improved ART literacy, adherence, patient tracking, prevention with positives and linkages to wrap around services.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites, the program will provide care and support services to 40,000 clients not yet eligible for ART. This brings the total number of patients under care, including those on ART, to over 85,000. The program will provide clinical care services including diagnosis and treatment of opportunistic infections (OIs), nutritional assessment and counseling, psychosocial support and screening for ART eligibility. Patients under palliative care will be screened for tuberculosis and those diagnosed with TB will receive treatment. The program will provide a comprehensive preventive basic care package to the 40,000 clients under care.

The program will train and support 120 expert clients and community volunteers from 60 groups of People Living with HIV/AIDS to facilitate referrals and linkages between facility-based and community based care. The groups will facilitate referrals to wrap around services available in the communities. 350 health workers will be trained to provide palliative care services.

The program will scale-up TB/HIV integration activities including setting facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16008

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16008	16008.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$340,000

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1311.09

**Mechanism:** State Department

**Prime Partner:** US Department of State

**USG Agency:** Department of State / African Affairs

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4763.21605.09

**Planned Funds:** \$176,629

**Activity System ID:** 21605

**Activity 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 (OVC). 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 (Palliative Care), 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 grass root 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 for PHAs in the following areas: clinical care, psychological care, social care and prevention care services.

With FY 2007 resources, The Community Grants Program funded voluntary counseling and testing for 3,500 clients of whom, 500 tested positive and all 500 are receiving treatment. The Community Grants Program also funded a one-year supply of septrin for 580 clients and funded a motorcycle for a small Home-Based Care Program in Iganga District. We are working with TASO Jinja to support the PHAs in this district. In addition, FY 2007 resources were used to fund 3 community gardens to provide nutritional support for HIV positive clients.

In FY 2008, we are funding voluntary counseling and testing to enable more Ugandans to know their HIV status; office equipment for a HIV/AIDS clinic in Kabale, care and treatment for 200 PHAs; the provision of 13 water tanks for rainwater harvesting to 13 health centers in the Fort Portal Diocese – the water tanks will ensure safe and clean water to PHAs and OVCs being treated and cared for in the 13 health centers; 4 motorbikes for a Home Based Care Program; funding for Community HIV/AIDS Sensitization Program and a Community Demonstration Farm and Piggery and Goat Rearing Project that will serve as an income-generating activity for PHAs.

In FY 2009 the Community Grants Program will continue to provide care and support to 500 PHAs and strengthen 4 service outlets providing HIV-related palliative care throughout Uganda.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16405

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16405	4763.08	Department of State / African Affairs	US Department of State	7426	1311.08	State Department	\$80,000
8394	4763.07	Department of State / African Affairs	US Department of State	4822	1311.07	State Department	\$80,000
4763	4763.06	Department of State / African Affairs	US Department of State	3455	1311.06	State Department	\$80,000

---

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$20,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$10,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$20,000

**Education****Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 690.09

**Prime Partner:** US Department of Defense

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 3968.21597.09

**Activity System ID:** 21597

**Mechanism:** N/A

**USG Agency:** Department of Defense

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$28,800

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated with the military, with up to 50% of patient visits for HIV care and treatment being non-military. Thus the demand to provide quality ARV services is continually growing. With PEPFAR support, 8 sites now provide ART and HIV care services. ARV services have been strengthened through training of health care providers, via the Infectious Diseases Institute (IDI) based in Kampala, and a partnership with San Diego DHAPP. A critical cornerstone of safe, effective ARV treatment is high compliance. Military personnel have unique challenges and obstacles for medication adherence, given barracks living, deployments, and the stigma associated with HIV/AIDS. A pilot adherence program is being initiated to specifically address ARV compliance in the military, and will be centered at Bombo Barracks and Mbuya Hospital.

UPDF continues to have HIV challenges due to a lack of trained clinical staff, an automated medical information system, and inadequate laboratory diagnostics for OIs and co-infections. These inadequacies are being systematically addressed via the support from the USG, initially in the Kampala based Bombo military hospital, and Mbuya military Hospital, with expansion to military medical facilities in Nakasongola and Wakiso. Drugs for OI prophylaxis and treatment are being procured for these 3 sites. Particular attention is paid to widows and OVCs that are eligible for services. A course has been developed for nurses and clinical officers through the Infectious Diseases Institute, Kampala and for the past 2 years this training has been used to ramp up care in HIV clinical management, to include addressing military specific issues.

There are currently 4,000 active duty UPDF personnel, family members and civilians followed for ART and HIV clinical management. Current plans are to support expansion of ARV services in training of UPDF personnel and modify and extend the adherence protocol to the other 6 treatment sites. This program will also be evaluated, and clinic procedures modified to include adherence practices as standard protocol. Additional training of physicians (6) and nurses and clinical officers (25), through the IDI in Kampala and the DHAPP program (2) will also be conducted. The IDI in collaboration with the UPDF have developed a 4 week (and 2 week respectively) course aimed to ramp up skills in ARV use, recognition and management of OIs and PMTC. Monitoring of clinical services with a medical information systems (MIS) to optimize clinical management will be initiated. There will be more of an emphasis on integration of prevention care and treatment programs; and increasing the availability of materials for client-provider interaction.

Currently these activities (diagnosis and treatment of OIs, drug procurement, training, lab services), are expanding beyond the 2 major clinical sites in Kampala and 2 outside Kampala sites to all 8 sites within the military health network providing ARV access. STI diagnostics and therapeutics and training for HCWs is being initiated. A new and extremely important expansion, given the recent compelling data confirming efficacy, plans are underway to provide access to the Basic Health Care Package (impregnated mosquito nets; safe water vessel; co-trimoxazole) to the UPDF HIV positive personnel and family members plus piloting the use of the BHC package in deployment/field scenarios.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: A Prevention for Positives program which includes elements relevant to the military, will be developed and piloted in 2 of the ART sites. This will have an emphasis on discordant couples as well as factors that increase risky behavior such as alcohol misuse.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16068

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16068	3968.08	Department of Defense	US Department of Defense	7336	690.08		\$134,000
8386	3968.07	Department of Defense	US Department of Defense	4821	690.07		\$134,000
3968	3968.06	Department of Defense	US Department of Defense	3156	690.06		\$134,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$5,000

**Table 3.3.08: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1222.09	<b>Mechanism:</b> Peace Corps
<b>Prime Partner:</b> US Peace Corps	<b>USG Agency:</b> Peace Corps
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Adult Care and Support
<b>Budget Code:</b> HBHC	<b>Program Budget Code:</b> 08
<b>Activity ID:</b> 3991.21611.09	<b>Planned Funds:</b> \$707,820
<b>Activity System ID:</b> 21611	



**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

The Peace Corps Uganda Emergency Plan program supports the USG Strategy of the Emergency Plan (the EP) for Uganda. By supporting the EP Strategy Peace Corps Uganda contributes to the Uganda National Strategic Plan (NSP) for HIV/AIDS, and, in turn, to the goals and objectives of our partner organizations which are hosting Volunteers. The program is designed so that Volunteers are closely engaged with a community through one or more hosting organizations, providing technical assistance for capacity building, and developing close personal relationships necessary for effective innovation in underserved areas. The EP allows Peace Corps Uganda to strengthen community and Volunteer HIV/AIDS expertise and service delivery, and to support highly focused community organizations in a variety of HIV/AIDS functions.

The major portion of Peace Corps Uganda's Care and support program is building the capacity of community based organizations, faith based and other, operating in underserved areas to improve and expand access to care through enhanced understanding of and ability to deliver services to those affected by HIV/AIDS. Peace Corps Volunteers will work with local organizations to undertake activities that develop organizational capacity to provide care, provide opportunities to practice improved skills, and develop systems to sustainably increase organizational ability to deliver services. In addition to organizational development, activities will address innovative ways to ensure clients have access to the basic preventive care package, including low labor/low input gardening for improved nutrition, improved clean water access, treated bed net use among families affected by HIV, improved sanitation and hygiene, access to cotrimoxazole, and in-house access or referral to treatment and prevention services. Volunteers and Counterparts will work with PLWA and OVC caregivers to develop income generating activities, especially those that can contribute to improved nutrition such as vegetable production and other permaculture activities. Small projects may include livestock improvements, piggeries, and food security support among others.

From FY 2006 to date, 55 PEPFAR funded two-year Volunteers have been added to Peace Corps Uganda's portfolio. Through these Volunteers, ongoing training and small project support activities, Peace Corps has been able to strengthen community and Volunteer HIV/AIDS expertise and support HIV/AIDS-focused community organizations to enhance their organizational capacity to implement a variety of HIV/AIDS prevention and care interventions. Currently, a group of 25 PEPFAR-funded two year community health trainees are undergoing pre-service training and will be deployed at the end of October. From FY 2007 to date, Peace Corps Uganda has been able to reach 4069 individuals of whom 1726 are males and 2343 females and trained 360 service providers. In all assignments, Volunteers are prepared through pre-service training to encourage their partner organizations to either; 1) incorporate a full range of prevention, care and treatment services, or 2) to actively seek out and use local referral opportunities to ensure all individuals and families receive necessary services.

In FY 2009, Peace Corps Uganda is planning to scale up the palliative care-basic program by recruiting and deploying more community health and economic development Volunteers to work with USG and non USG funded partners focusing on basic care and support for the infected and affected individuals in the communities. With FY 2009 funding, 12 PEPFAR funded two-year Volunteers will be added on to our country program of which 12 will be placed with partners implementing basic care and support programs. An additional 4 short term (6-12 months) Volunteers (Peace Corps Response Volunteers) with specific skills and expertise in areas such as networking, partnerships, organizational development, strategic planning and management, post conflict reconstruction for Northern Uganda, education systems support and food security will be recruited and placed with organizations targeting HIV/AIDS infected and affected groups. In FY 2009 and 2010, Peace Corps Uganda intends to reach 7200 (2500 males & 4700 females) and 8000 (3000 males & 5000 females) individuals respectively and train 1500 caregivers. Peace Corps Volunteers working with host organization staff will continue to provide technical skills through training and mentoring, practical knowledge and information sharing in areas of improved household food production through permaculture, socio-economic support to PLWHA, caregivers and families and psychosocial support. The program will ensure that the targeted beneficiaries access comprehensive services through networks and referrals with other service providers including education.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15233

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15233	3991.08	Peace Corps	US Peace Corps	7091	1222.08	Peace Corps	\$557,820
8395	3991.07	Peace Corps	US Peace Corps	4823	1222.07	Peace Corps	\$290,100
3991	3991.06	Peace Corps	US Peace Corps	3162	1222.06	Peace Corps	\$132,900

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources

### Health-related Wraparound Programs

- \* Malaria (PMI)

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.08: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5028.09	<b>Mechanism:</b> HIPS (Health Initiatives in the Private Sector)
<b>Prime Partner:</b> Emerging Markets	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Adult Care and Support
<b>Budget Code:</b> HBHC	<b>Program Budget Code:</b> 08
<b>Activity ID:</b> 9081.21754.09	<b>Planned Funds:</b> \$750,000
<b>Activity System ID:</b> 21754	

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

Under the adult care and treatment program area, the HIPS Project implements Care and Support and HIV/AIDS treatment / ARV services. 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, technical assistance in setting up workplace AIDS treatment programs, and procurement of equipment. To date, job aids for HIV treatment providers have been developed, while more than 150 private practitioners have undergone HIV treatment training from the Mildmay center and the DELIVER/ SCMS project. HIPS also facilitates links between smaller companies without on site clinics and private clinics that offer services including AIDS treatment, and facilitates the referral system among private facilities for services such as CD4 tests and other tests necessary for patient follow up. To date, over 1200 clients have been newly initiated on ART, while up to 2200 clients are currently receiving ART services and more than 2,800 have ever received ART from private facilities supported by HIPS. The palliative care section is focused on extending services to the community through training of homecare givers, health workers and the provision of logistical support to partner facilities. To date over 200 community members have received training and kits to provide palliative care to their community members. Up to 28 of the HIPS facilitated private facilities offer palliative care and support services to over 2200 clients. Services received range from cotrimoxazole prophylaxis, communication materials, psychosocial support, safe water and ITNs among others.

The activities for FY 2009 include but are not limited to the following:

1. Continue to facilitate MOH accreditation of workplace and private clinics to offer ARVs across the country, and linking them to the ARVs supply chain.
2. Train up to 200 providers in ART including pediatric ART, ART logistics, PMTCT and PEP and management of opportunistic infections, including TB and palliative care. The training will focus on recruiting more providers from private clinics.
3. Strengthen referral networks between smaller companies with no on site treatment clinics and clinics that have been accredited to offer these services.
4. Increase informal sector access to treatment by linking informal sector associations and groups to accredited partner clinics.
5. Expand training of care givers and health care workers in palliative care and support to 250.
6. Enhanced support to partner clinics to enable them offer treatment, care and support services. Support will also be extended to improve the diagnostic capacity and referral for specialist tests like CD4 and Viral loads.
7. Expand work with insurance companies to extend insurance schemes to community groups (especially out growers and company supply chains) to access free ART and other health services at a low cost.
8. Conduct home based care support supervision visits for the primary care givers who have been trained.
9. Review the ART drug logistics systems in partner clinics and identify strategies to promote efficiency and improve patient adherence to treatment.
10. Develop systems to continually track progress in health initiatives with the private sector, while building capacity of the private sector to effectively measure progress.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14172

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14172	9081.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$150,000
9081	9081.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$100,000

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$210,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1258.09

**Mechanism:** Roads to a Healthy Future/ROADS II-SafeTStop Project

**Prime Partner:** Family Health International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4510.21761.09

**Planned Funds:** \$440,000

**Activity System ID:** 21761

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these sites, truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The three sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. Adult care and treatment services in Malaba, Busia and Katuna have been underdeveloped. For example, in Malaba, before ROADS initiated activities in the community there was little palliative care for people living with HIV and AIDS (PHA) beyond psychosocial support through a small post-test club meeting weekly at Malaba Health Centre 3. In Busia, PHA have organized numerous groups to advocate for services, though there are still gaps in care and support, particularly among faith-based organizations and the private sector. This is among the factors leading PLHA to cross into Kenya for basic palliative care. Similarly, PHA in Katuna have had to travel significant distances for basic services.

Since launching SafeTStop in Busia, Malaba and Katuna, ROADS has reached 4,100 people with palliative care services (January 2006-March 2008), focusing on nutrition, hygiene, basic medical care, counseling on positive living, prevention for positives, referral to clinical services, pain management, and provision of such non-clinical services as psychosocial and spiritual support. ROADS has trained 375 individuals to provide palliative care. Note that in FY 2008 we did not implement treatment programming though we referred and generated uptake for treatment; however, we propose treatment targets in FY 2009 and FY 2010.

In FY 2009 the project will extend palliative care in Busia, Malaba and Katuna. In FY 2009, the project will reach 4,000 adults (1,960 males and 2,040 females) with care (18+) through 100 service outlets; in FY 2010 we will reach 4,600 (2,254 males and 2,346 females) people with care (18+) through 100 outlets. We will provide direct food/nutrition support to food-insecure PLHA and dependents as needed, or link them with World Food Programme and/or other agencies. We will train 400 individuals to provide care and support in FY 2009 and 460 in 2010. ROADS will continue providing the basic care package developed in Uganda with the U.S. Centers for Disease Control and Prevention. The package includes condoms, water purification tablets, cotrimoxazole and isoniazid prophylaxis, insecticide-treated bed nets and micronutrients (including vitamin A). As part of its family-centered approach to care, HBC volunteers will identify and refer family members for C&T (or facilitate home testing) and other needed services. As part of the micronutrient component, ROADS will build skills in home food production for PLHA and their dependents. Training in business and entrepreneurial skills and job creation through the LifeWorks Partnership will enhance economic well-being of AIDS-affected households and caregivers. The project will also harness the reach and convenience provided by neighborhood pharmacies/drug shops, the first line of care for many community residents but particularly truck drivers and their immediate networks. Through Howard University/PACE Center, the project will continue upgrading pharmacy/drug shop providers' skills in palliative care, including counseling on OIs and ART. The pharmacies/drug shops will expand pharmacy-based C&T for members of AIDS-affected families and transport workers, and provide outreach for care through the SafeTStop resource centers. The project will integrate family planning/reproductive health, safe motherhood, malaria and TB into care and support programming and expand alcohol counseling and treatment options for PHA, particularly ART patients. Strengthening care for truck drivers will also be a particular area of emphasis through the Amalgamated Transport and General Workers Union and North Star Foundation, which will integrate primary health wellness centers into resource centers. Recognizing the emotional and physical toll that HIV care and support can have on caregivers, ROADS will introduce programming specifically to address the needs of caregivers, i.e., by providing psychosocial support, education/training in nutrition, medical and social services, and access to economic strengthening through agriculture and other business development.

**SUSTAINABILITY:** Almost all partners on the project are local entities that exist without external funding, including private and most public outlets that offer HIV care and support services. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project, including those that can provide community-based care and support, were established without outside assistance and will continue functioning over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

**EXPANSION SITES:** Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DRC; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14194

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14194	4510.08	U.S. Agency for International Development	Family Health International	6736	1258.08	ROADS - SafeTstop Project	\$550,000
8418	4510.07	U.S. Agency for International Development	Family Health International	4833	1258.07	Northern Corridor Program/Uganda Section	\$525,000
4510	4510.06	U.S. Agency for International Development	Family Health International	3366	1258.06	Northern Corridor Program/Uganda Section	\$75,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$10,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$50,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 9320.09 **Mechanism:** Community-based Care and Support/TASO Follow on  
**Prime Partner:** To Be Determined **USG Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State) **Program Area:** Care: Adult Care and Support  
**Budget Code:** HBHC **Program Budget Code:** 08  
**Activity ID:** 21469.21769.09 **Planned Funds:** ██████████

**Activity System ID:** 21769

**Activity Narrative:** This is follow-on to USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to Government of Uganda and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting a large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated capacity to manage USAID programs as prime partners.

In FY 2007 USG has reached more than 80,000 clients with HIV/AIDS care and support services through TASO.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrate competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from a sole sourcing or subgrant approach to a direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs

USAID will use this proposed mechanism to support adult HIV/AIDS care and support services through civil society, public health and community outreach structures in the proposed geographic area. Services will include diagnosis and treatment of Opportunistic Infections (OIs) and STIs; pain and symptom relief; nutrition assessment and counseling; psychosocial support; support adherence to OIs, and linkage to wraparound services including nutrition, family planning, and livelihood support.

Through this mechanism the US intends to reach an estimated 80,000 clients comprehensive with HIV/AIDS care and support services. The program will also train more than 500 health workers and volunteers on national standards and protocol for HIV/AIDS care. The mechanism will also build the technical and management capacity of indigenous organizations that would participate in program implementation as prime and sub partners.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21469

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21469	21469.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$1,954,780

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 1124.09

**Prime Partner:** HOSPICE AFRICA, Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 3990.21764.09

**Activity System ID:** 21764

**Mechanism:** HOSPICE

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$1,386,000



**Activity Narrative:** Hospice Africa Uganda commenced its activities in 1993 with three major objectives. (i) To provide an appropriate Palliative Care service to patients with cancer and/or HIV/AIDS and their families with defined operational areas, (ii) To enable the provision of Palliative Care services in Uganda, through Advocacy, Education and training and (iii) To facilitate the initiation and expansion of Palliative Care in Africa by providing an affordable African model. Since October 2005, Hospice Africa Uganda (HAU) has been in partnership with USAID/Uganda to expand access to and scope of quality palliative care to PHA and their immediate families. HAU has adopted three approaches, namely, (i) direct service delivery and (ii) indirect expansion through training and supporting AIDS care and support organisations, including public and private agencies to integrate pain management, symptom control and end of life care into their services and (iii) advocacy in palliative care, to scale up access to palliative care. Over the last two years of partnership with USAID/Uganda, HAU has grown as an accredited leader and the only institution in Uganda with technical expertise to provide and build capacity for pain and symptom management services. HAU has grown into a beacon service modeling affordable and culturally acceptable palliative care and a 'centre of education' to enable increased access to comprehensive palliative care and education in Uganda. (HAU provides and supports palliative care interventions in accordance with WHO definition, 2002).

The Hospice Cooperative Agreement with USAID ends in September 2008. Although access to ART continues to improve with increased resources, the need for palliative care services remains real. Under the current HAU program, the symptom burden of PHAs is significant, with a high incidence of pain and multiple symptoms experienced throughout the course of the disease, from the point of diagnosis to end of life care and bereavement support. The HAU experience demonstrates palliative care can improve the quality of life throughout the continuum of illness. In addition to managing the symptom burden, HAU also undertakes preventive care focusing on condom education and distribution especially targeting discordant couples and delivery of family planning information. Other elements of preventive care delivered by HAU include prevention of malaria by improving access to insecticide treated bed nets, counseling for disclosure of status, and HIV testing of family members whose status is unknown. To strengthen its quality of care delivery, HAU participated in the development of a tool to measure the effectiveness and quality of palliative care in Africa, the African Palliative Outcome Scale (APOS). The APOS quality of care audit revealed that palliative care is highly effective in pain and symptom control. The HAU experience establishes the importance of providing palliation from the point of diagnosis, and moves away from the traditional view of palliative care as a specialist area introduced at the end of the patient's life.

Since 2005 HAU has seen over 2,700 patients with HIV/AIDS or HIV/Cancer, of whom 1,500 were admitted onto program as they required specialist palliative care for pain and symptom management or end of life care. The care provided has been a mix of home visits, out-patient care, outreach and hospital consultations. In an effort to ensure comprehensive care, HAU has strengthened linkages with other AIDS care and support organizations, to provide shared and complementary care and avoid duplication of services. For instance HAU refers PHAs to HIV support organizations for social support interventions such as income generating activities while the same providers also refer to HAU the PHA that need pain and symptom control. HAU has developed a training program in collaboration with some HIV in reach centers where the staff of the in reach centers are trained by Hospice, carry out placements in Hospice and practice under the guidance of Hospice staff at their sites. There's also a new initiative of community day cares which are organized by the communities where Hospice staff provide clinical services. The service aims to support the patient and their families by providing patients with social activities and making clinical care available nearer to their homes. The activities appear to be successful with the communities organizing and managing the activities and hospice clinical staff providing the clinical care and support as needed.

Currently two in three HIV patients receive shared care. In addition Hospice has established a relationship with Makerere University and Mbarara teaching University. Medical students in their fourth year have placements with Hospice for training in Palliative Care. This is in addition to the many other organizations and institutions that send their students for placements. These initiatives need to be sustained beyond the current HAU program.

One of the main factors inhibiting palliative care service development and expansion in Uganda is not only the lack of trained palliative care personnel, in both basic and specialist palliative care, but also lack of career progression for health workers considering specialization in palliative care. Since 2005, HAU training units has successfully carried out palliative care education program. In sum 865 health and allied health professionals and 391 community members were trained, totaling 1256. The capacity of 23 training institutions was strengthened to teach modules on palliative care, and palliative care was also incorporated into 5 national health professional curricula and four training institutions. In addition HAU has developed some IEC materials to educate the public about Palliative Care and to dispel the myths about the use of morphine for pain relief. Other than the short courses that are conducted on site HAU has been able to conduct Palliative Care training in 5 districts upcountry. These are Gulu, Rakai, Mukono, Arua and Bushenyi. However rigorous follow up of trainees is yet to be done for all trainees. In the follow up of trainees in clinical tutors schools Hospice has been able to identify some of the challenges in the field and support the tutors to carry out Palliative Care training.

In FY 2009, HAU will support the direct provision of specialist palliative care/consultations using modern methods of pain and symptom control and end of life care to an estimated 2,200 PHAs, at times and places convenient for the PHA and their carers', in a culturally and socially sensitive way. Home based care and community care will form the backbone of these direct care services during the critical stages of illness. HAU through networks and formal collaborations with other public and private service providers such as Mulago Hospital, TASO, and Meeting Point will co-manage patients so as to maximize synergies, reduce duplication of care, and enable PHA's to access broad spectrum of services.

Hospice will continue to provide direct clinical services to patients and also act as a centre for Palliative Care excellence, where trainees from various organizations can have placements after training. Hospice will also continue to deliver preventive care which include but is not limited to: prevention for PHAs, delivery of the basic care package and support disclosure and testing of family members.

**Activity Narrative:** Hospice will build capacity of at least 1000 multi-disciplinary care providers and community workers through training/education to incorporate pain and symptom control, spiritual care, and end of life care and bereavement into their existing programs. Hospice will strengthen the institutionalization of PC through the establishment of departments for palliative medicine at Makerere and Mbarara Medical Schools. Hospice will modify its district training program to cover regions and carry out more than one comprehensive 6 months training within a region to create a critical mass of palliative care practitioners.

Hospice will continue to advocate for the inclusion of pain management and symptom control as integral elements of essential care in Ugandan palliative care policies. This will be through engaging policy makers.

Hospice will continue to advocate for the implementation of palliative care policies at the national and local levels, and the establishment of palliative care services through the already established institutions. HAU will work closely with MOH/PCAU/APCA and other palliative care providers for joint advocacy and in the setting of standards, technical assistance and development of appropriate resources such as referral guidance and IEC for palliative care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14197

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14197	3990.08	U.S. Agency for International Development	HOSPICE AFRICA, Uganda	6737	1124.08	HOSPICE	\$811,000
8419	3990.07	U.S. Agency for International Development	HOSPICE AFRICA, Uganda	4834	1124.07	HOSPICE	\$811,000
3990	3990.06	U.S. Agency for International Development	HOSPICE AFRICA, Uganda	3161	1124.06		\$600,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$900,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7287.09

**Mechanism:** SPEAR

---

**Prime Partner:** World Vision International

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 25050.09

**Planned Funds:** \$353,302

**Activity System ID:** 25050

**Activity Narrative:** Activity Narrative

This activity relates to sexual prevention and Counseling and testing.

Building on the USG public sector programs, this activity is a follow-on to the Education Sector Workplace AIDS Policy Implementation (ESWAPI) that provided support to the education sector that ended in July 2008. The new follow-on program called Supporting Public sector workplaces to Expand Action and Responses against HIV/AIDS (SPEAR) is the USG prime mechanism for leveraging public sector support to increase access to and utilization of HIV/AIDS treatment, prevention and care services to selected sectors that include: ministries of Internal Affairs (MoIA); Local Government (MoLG); and Education and Sports (MoES). The SPEAR program is supporting 3 sectors that have worked with the National HIV/AIDS Program to develop and integrate HIV/AIDS into their work place through operationalization of the new National HIV/AIDS workplace policy. World Vision is the lead implementing agency for the USAID funded-five year program. The SPEAR initiative, which begun in June 2008 aims to achieve three key results:

1. Supporting public sectors have policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees
2. Increasing 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
3. Improving 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

On the overall, ESWAPI which ended in July 2008 facilitated over 1,000 MoES employees and their immediate dependants to access one or more forms of palliative care over a period of 3 years.

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. Access to anti-retroviral treatment leads to reduction in absenteeism and turnover, improves morale and productivity. In addition, increased access to care and treatment enhances stigma reduction, disclosure and utilization of positive prevention. A challenge identified during the implementation of ESWAPI was that employees who know their HIV-positive status may not risk disclosing their status to seek care and treatment. This finding suggests the need for effective training of peer counselors, human resource officers and behavior change agents with an emphasis on upholding counselors' ethics and improving employees' confidence in the confidentiality of counseling sessions.

In FY 2009, SPEAR project activities under the program area -Adult Care and Treatment (Care and support) will contribute towards improving access to and utilization of a range of HIV-related care and support services (excluding TB) as well as wrap around services for HIV-positive public sector workers and their families. The specific activities will include: Training workplace-based health workers in palliative care: To enhance quality care services, SPEAR will work with other ongoing programs to strengthen the capacity of health care providers in target workplaces, including school nurses and health workers in police, prisons and local government health facilities (that have not yet been trained by other programs) through training and refresher training in palliative care according to MoH protocols and guidelines. Training will emphasize clinical skills including: diagnosis, prevention and treatment of 10 opportunistic infections (OIs), nutritional assessment, treatment of psychological conditions, as well as anti-retroviral therapy (ART) eligibility assessment, adherence monitoring and counseling. Additionally, health care providers will be trained in the skills needed to ensure continuity of service provision from testing to care and treatment for PHA. Workplace-based health workers will also be trained in recognizing the need for referral to clinics and community-based delivery systems to strengthen activities for prevention of opportunistic infections through the administration of septrin (cotrimoxazole) and fluconazole prophylaxis and a scale-up of treatment literacy.

Training of lay volunteer palliative caregivers: In addition to health workers, SPEAR will support the respective AIDS Control Program units and partners to carry out refresher training and training of more volunteer public sector workers and their family members in palliative care (including counseling, psychosocial support), 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. During this first year, SPEAR will facilitate training of 200 volunteers in palliative care/ART knowledge and skills to supplement the efforts of 100 health workers.

The Public Sector workplace policy identifies a range of care and support services including wellness programs, psychosocial support, home based care, treatment (OI & ART) and legal advice for HIV/AIDS positive employees. This activity is 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 teachers and MoES employees living with HIV/AIDS. SPEAR will create awareness among teachers and public sector employees of the targeted line ministries, i.e MoES, MoIA & MoLG about available care and treatment services within their communities and encourage them to seek, participate in and benefit from these programs. Formation and activities of associations of public sector employees living with HIV/AIDS will also be supported. SPEAR will establish formal collaboration with local and national HIV/AIDS service providers and 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. SPEAR targets, with improved palliative care and referral skills, to reach 1,000 individuals with HIV-related palliative care and 200 with ART services within FY 2009.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$75,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 15990.24023.09

**Activity System ID:** 24023

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** ██████████

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric care and treatment, TB/HIV, ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically services shall be tailored to the existing MoH HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- 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.
- 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.
- 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

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

This activity will also endeavor scaling up of adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members;

**Activity Narrative:**

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15990

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15990	15990.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**Prime Partner:** Management Sciences for Health

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 15622.24015.09

**Planned Funds:** \$544,000

**Activity System ID:** 24015

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and the TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts with poor infrastructure, few accredited ART sites and underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services.

During FY 2009 the project will ensure delivery of quality of ART services in all 16 health center IVs and district hospital in the eight districts. In subsequent years the project will work with respective districts and health facilities in order to ensure that selected health center III's are also accredited for HIV care and treatment services. This is very critical as these districts have limited number of health center IV's. This would require renovation of clinical space, build lab infrastructure, ensure availability of skilled health workforce, and task shifting.

The program will also 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, coverage of and utilization of care and treatment services.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically, services shall be tailored to the existing Ministry of Health HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- Promotion of a 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.
- 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.
- 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.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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,



**Activity Narrative:** mapping community resources; and create community and facility networks.

This activity will also endeavor to scale up adult care and treatment services through community partnerships, through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15622

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15622	15622.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	■

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7406.09

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**Prime Partner:** Infectious Disease Institute

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity System ID:** 22811

**Activity Narrative:** This activity is not new as tagged by the database - it is a continuation of Funding Mechanism 7406.08, Activity ID 16308.08.

The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Dean of the Faculty of Medicine. IDI has trained 2,394 course participants from 26 African countries in the areas of HIV/AIDS, malaria, pharmacy, lab and data management. Twenty-six research projects are in progress, focusing on identifying best practices and models for prevention, care and treatment of HIV/AIDS and related infectious diseases in sub-Saharan Africa. Almost 9,000 people are receiving care at the IDI clinic, and 5,741 people are on anti-retroviral therapy (ART). In addition, a total of 3,004 people are being cared for at four Kampala City Council clinics supported by IDI, and 1,339 people are receiving ART across the four sites.

In August 2008, IDI was awarded a CDC Cooperative Agreement to build capacity for scaling up of HIV/AIDS services in Kibaale and Kiboga, two rural underserved and high prevalence districts in Uganda. IDI intends to implement this service in conjunction with the respective District Health Offices, The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) projects. These latter two organizations will support the HIV/AIDS Care and treatment and training functions respectively. Specifically the project will: (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. At the end of the project period, IDI will have scaled-up routine HIV Counseling and Testing in at least six health facilities and tested 200,000 people. In addition, the project will provide at least 3,000 HIV-infected people with a care package and to start or maintain at least 1,500 HIV-positive people on ART. Other measurable outcomes include training for at least 200 health workers in comprehensive HIV/AIDS Care and starting 900 HIV+ people on TB treatment.

In FY 2009, IDI and its partners will provide adult care and treatment services at the 6 centres in Kibaale and Kiboga districts. All the 10,000 active adult clients will be facilitated to access a comprehensive package of high quality Adult Care & Treatment services. The Adult Care & Treatment package will comprise of: 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; enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing LLITNs and promoting malaria prevention; providing condoms to sexually active clients; conducting various courses to train service providers to provide HIV care and support; and procurement/provision of nutritional supplements for clients. In order to reach the targeted beneficiaries, IDI and its main partner TASO, will provide Adult Care & Treatment through various venues and using appropriate and proven service delivery models. The broad service delivery strategies will include mobilization and sensitization, capacity-building, beneficiary involvement, greater PHA involvement, partnership and collaboration and others. In partnership with PSI and TASO, IDI will provide a basic care kit consisting of safe water vessels and chlorine solution (Waterguard®), LLITNs (bed nets) for prevention of mosquito bites, cotrimoxazole prophylaxis and condoms to sexually active clients. The targets for the basic care kit are: 3,000 clients given water vessels and chlorine solution for preventing contamination of drinking water by pathogenic organisms thereby preventing water borne diseases like diarrhea; 3,000 clients given LLITNs to prevent malaria which is Uganda's highest cause of mortality and morbidity; 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; and 3,000 new clients will be provided with cotrimoxazole prophylaxis. IDI in conjunction with TASO 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 all service outlets. Staff at the 11 Centres will educate clients on various Care & Treatment issues through individual and group sessions. The IDI project field teams will monitor use of Care & Treatment services during regular visits to clients' homes. IDI 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 for STI, supported to mobilize sexual partners for STI treatment, provided with condoms and condom education. Field teams at the 6 facilities will follow up specific STI cases and refer for specialized care where necessary. Teams will support clients to uphold the high adherence levels and will support clients with low adherence through follow-up. Quality assurance of services will be done through ensuring conformity with 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.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7257.09

**Prime Partner:** University Research Corporation, LLC

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 23928.09

**Activity System ID:** 23928

**Mechanism:** Health Care Improvement Project - HCI/NuLife

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$600,000

**Activity Narrative: Activity Narrative (Adult)**

The Food and Nutrition Intervention for Uganda – (NuLife) is being implemented by University Research Co., LLC (URC) to support to Ministry of Health (MOH), CBOs/NGOs, Networks of People Living with HIV/AIDS and USG implementing partners to integrate and expand food and nutrition into HIV/AIDS prevention, care and treatment programs. The focus of the program is to increase the utilization, adherence to and efficacy of anti-retroviral treatment (ART) and improving the nutritional and health status of PLHIV. The program's three primary objectives include: 1) provision of technical and financial support to the MOH, CBOs/NGOs, PLHIV Networks, USG partners to integrate food and nutrition interventions in HIV and AIDS prevention, care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable RUTF made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities. The program will provide targeted food and nutrition support that includes food supplements for vulnerable groups including OVCs, HIV-positive pregnant and lactating mothers and those with mild-to-moderate malnutrition, therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants.

During FY 2008, NuLife has provided technical assistance in drafting the National Nutrition and HIV and TB Strategy (2008-2010). NuLife has reviewed both national and international guidelines, training curricula, educational materials and other documents related to food and nutrition for PLHIV; supported the updating and expansion of the National Infant and Young Child Feeding (IYCF) Guidelines and the development of related counseling tools and other job aids. It has facilitated a critical review of the draft National Guidelines on the Integrated Management of Acute Malnutrition (IMAM). NuLife secured a position for a nutritionist on the Core Team at the national level and expanded the role of the current HCI-supported Quality Improvement (QI) collaborative teams to include a nutrition focal person at each level. 223 health workers from 120 ART facilities were sensitized in the basics of integrating food and nutrition in health facilities. Working with the IHAA and the Northern Uganda Malaria and HIV/AIDS TB (NUMAT) program, 605 network support agents (NSAs) and 100-health facility in charges from 36 districts received an initial orientation and package of educational materials on the special food and nutrition needs of PLHIV. A Geographic Information System (GIS) was established for use in prioritizing areas of operation, program planning and visual reporting; 32 phase one priority sites across 29 districts were selected and a community mobilization strategy was developed. The specifications for the production of a local RUTF were developed and the identification and selection process for a Ugandan manufacturer was completed.

FY2009 activities include: 1) Building on and consolidate its FY2008 achievements as it expands its technical and financial support for HIV-related food and nutrition interventions. NuLife will support training of both facility and community health staff in 32 Phase One and 45 Phase Two sites participating communities related to 1) nutrition and HIV/AIDS for Adult Care and Treatment programs, including nutritional assessment, counseling, and food by prescription (FBP); 2) Integrated Management of Acute Malnutrition (IMAM) in the context of HIV/AIDS; and Community Mobilization for Behavior Change related to nutrition and HIV. Support materials will include: a) a counseling materials for use with PLHIV, b) patient take home flyers; c) training materials and d) equipment. NuLife will greatly support the capacity building effort of the MOH and other partner for integration of nutrition care and support within adult care and treatment services by training a core national team of 100 trainers. The trainers will in turn train health workers, community based volunteers and district teams in IMAM, FBP guidelines and community mobilization. Working through the Health Care improvement (HCI) program and USG partners, NuLife will select at least 12 health workers from each district and regional health facilities and 8 health workers from each HCIV including members from the quality improvement (QI) ART teams, in the provision of food and nutrition care and support (nutrition counseling, assessment and food by prescription) services. 1600 health workers from Phase One and Two health facilities and participating communities will be trained. 654 community health workers will be trained under the NuLife community mobilization model. NuLife will continue to promote a close collaboration with USG partners and will work through a number of official MOH structures and mechanisms including the MOH Sub-Committee on Nutrition MOH Sub-Committee and the MOH/Quality of Care Initiative.

2) USG Partner Coordination: The program will focus collaborative efforts with USG partners implementing Adult Care and Treatment programs in the selection of health care providers to be trained. Adult patients participating in programs supported by USG partners will also be able to access food and nutritional care and support counseling services. 3) NuLife has supported the establishment of and will continue to provide support to the MOH Sub-Committee on Nutrition (SCN) under the MCH cluster to provide overall guidance and coordination for development of policies, strategies, materials and curriculum related to nutrition. This sub-committee, which will meet monthly, is responsible for the selection of national nutrition and HIV 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. 4) NuLife is collaborating closely with the MOH/Quality of Care Initiative (QoCI) in the introduction of food and nutrition interventions in health facilities providing ART throughout the country. The mechanisms through which NuLife will collaborate with the national QoCI including support for the participation of selected nutritionists or nutrition focal persons in the national-level Core Team (made up of technical staff from MOH, URC/HCI staff and key USG HIV care and treatment partners), the Regional Coordinator Teams (5-6 member); and the District Quality Improvement (QI) Teams. During FY2009, NuLife will introduce food and nutrition interventions in selected HCI sites through training in priority areas during learning sessions, and will provide follow-up through monthly supervision or coaching visits to Phase One and Phase Two Sites. Under the HCI model for sustainability purposes, the district QI teams are assuming the roles of the Regional Coordinator Teams in the supervision and support to participating health facilities in relation to implementation of ART guidelines, data collection and management, and improving the quality of care and services. NuLife has worked with the HCI program to strategically start with districts where there is a presence of URC- supported facilities and orienting the districts in food and nutrition interventions for PLWHAs. 246 staff from DHT teams will be trained to provide support supervision to health facilities supported by NuLife. 5) Community mobilization will create demand for comprehensive food and nutrition services for PLHIV, mobilizing internal resources to the response, reaching the most vulnerable, and addressing the underlying causes of malnutrition. Approximately 400 network support agents and peer counselors within the catchment area of the 32 Phase One and 45 phase Two facilities will be trained and supported to integrate food and nutrition interventions for PLHIV. Using the Community Action Cycles (CACs) approach, NuLife will work with USG partners to initiate relationships with existing community-based groups (volunteer networks, family support groups, and community leaders) to promote good nutrition

**Activity Narrative:** practices. Other support activities will be identification and follow up of malnourished cases. For each of the ART QI teams, at least 2 people from the community groups will be seconded to the QI team whose roles will be to coordinate the community component and linking the community with the health facility. At the sub-county level, a community core group (CCGs) of 4-5 persons will be formed to provide overall coordination of activities at the sub-county level including development and implementation of community action plans for food and nutrition. Trained volunteers will primarily identify and follow up malnourished PLHIV children using the mid upper arm circumference (MUAC) and simple criteria of danger signs to determine those in need of referral. Working with ACDI/VOCA and other partners, like World Vision, WFP, LWF, linkages will be made to programs that provide supplementary feeding, food assistance and livelihood assistance programs for households of PLHIV.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

#### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Safe Motherhood

Refugees/Internally Displaced Persons

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$163,000

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$150,000

#### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$50,000

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 3166.09

**Mechanism:** Expanding the Role of Networks of People Living with HIV/AIDS in Uganda

**Prime Partner:** International HIV/AIDS Alliance

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4688.24480.09

**Planned Funds:** \$512,000

**Activity System ID:** 24480

**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008 the project has 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 such as family planning and broader reproductive issues. The project has trained 839 Network Support Agents (NSAs) who have been seconded to 416 Health centers across the 40 districts of operation. A total of 29 consortiums of PHA groups have been formed at Health Sub district level to participate in the delivery of HIV-related services. The NSA and the PHA groups have carried out ART education, ART adherence counseling and they have followed up clients in their homes to support patients with drug adherence and general welfare. As a result, a total of 238,800 individuals were reached with ART education, 40,434 reached with follow up counseling, 31,242 reached through home visits. In addition, through the project, the Alliance has linked the PHA groups with PSI which has provided basic care kits that prevent opportunistic infections like safe water vessels, insecticide treated nets and pharmaceuticals. Working in partnership with NuLIFE, the program is training NSA in integration of nutrition in care and support programs for PHA. A total of 580 NSA have been trained.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

In FY 2009, the project will consolidate activities in the 40 districts. An additional 100 consortiums of PHA groups will be formed and supported financially and technically to strengthen care and treatment support provision to their members and other PHAs identified in the community. The groups will therefore carry out home visits, couple counseling and support for disclosure and ART adherence counseling. 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. The project will also continue supporting post test clubs because they facilitate transition from counseling and testing to care, treatment and prevention services. The project has specifically targeted Post Test Clubs (PTCs) comprised of military populations in order to extend care and support services to this key population.

As members of the PLHIV groups, the trained NSAs in addition to undertaking activities outlined above, will play a critical role in mobilization of PHAs, making referrals to health facilities and creating linkages between the clients and the PHA group for continued care and support. As the number of people accessing HIV/AIDS related services increases, the importance of ensuring quality services and drug adherence remain critical. The presence of the NSAs at the health facilities makes this possible and the Alliance proposes to lobby the Ministry of Health to integrate the NSAs into the formal district health care delivery system since they provide an alternative source of manpower for health care.

Gender norms and practices are a barrier to people accessing care and support services. The project plans to 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 Project plans to strengthen Prevention for Positive programs in order to provide PHAs with the skills they need to take control over the disease in their lives. Working closely with SCOT (Strengthening Counselor Training Program), the project will build the capacity of PHA groups to provide patient education, conduct behavioral counseling and to support patients develop personal prevention strategies. IEC materials will also be provided to reinforce education on prevention for PHAs within the continuum of care. The PHA groups will also be supported to conduct "HIV stops with Me" campaigns in order to reduce stigma associated with HIV.

As part of the capacity building process of the PHA groups, the project plans to continue supporting refurbishment of Common Facility Centers. These centers provide space for people living with HIV to meet regularly for peer support and shared learning, and to conduct health education programs for the community members. The centers will also house vocational training workshops, provide space for setting up demonstration gardens and act as a reference point for the groups.

The project will continue to partner with PSI and other malaria control partners to provide basic care commodities to the PHAs and their families. Commodities include mosquito nets, water vessels and pharmaceuticals. The partnership with NULIFE will be expanded to cover 12 new districts in Mid Western Uganda that have not been covered in FY 2008 as well as increase capacities of groups to conduct nutritional assessments, carry out nutrition counseling and education. The project will also facilitate

**Activity Narrative:** linkages of PHA groups to Government programs like NAADS and other existing agricultural programs to provide skills in vegetable growing and horticulture for purposes of improving nutrition. The community engagement strategy will continue to be employed to further link PHA groups to other organizations providing wrap around services e.g. family planning, reproductive health, supplementary feeding, livelihood programs and water and sanitation programs.

The project proposes to strengthen the link between the groups and the local government at district and county levels and hence ensure that the local government provides leadership, technical support and mobilizes resources for PLHIV groups and networks in order to sustain care and support programs beyond the project life. The Alliance will therefore provide technical assistance to local governments to institutionalize the network model and strengthen capacity of PHA groups' to leverage local resources.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14200

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14200	4688.08	U.S. Agency for International Development	International HIV/AIDS Alliance	6738	3166.08	Expanding the Role of Networks of People Living with HIV/AIDS in Uganda	\$640,000
8462	4688.07	U.S. Agency for International Development	International HIV/AIDS Alliance	4851	3166.07	Expanding the role of People Living with HIV/AIDS Networks	\$840,000
4688	4688.06	U.S. Agency for International Development	International HIV/AIDS Alliance	3166	3166.06	PHA Network	\$640,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Military Populations

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$324,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,000

## Food and Nutrition: Commodities

## Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$49,000

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 7406.09

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**Prime Partner:** Infectious Disease Institute

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 27234.09

**Planned Funds:** \$100,000

**Activity System ID:** 27234

**Activity Narrative:** This PHE activity, 'Change Agents Program,' was approved for inclusion in the COP. The PHE tracking ID associated with this activity is UG.08.0171.

**New/Continuing Activity:** New Activity

**Continuing Activity:**



<b>Emphasis Areas</b>
<b>Human Capacity Development</b>
<b>Public Health Evaluation</b>
Estimated amount of funding that is planned for Public Health Evaluation \$100,000
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>
<b>Food and Nutrition: Commodities</b>
<b>Economic Strengthening</b>
<b>Education</b>
<b>Water</b>

**Table 3.3.08: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11128.09	<b>Mechanism:</b> TASO
<b>Prime Partner:</b> The AIDS Support Organization	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Adult Care and Support
<b>Budget Code:</b> HBHC	<b>Program Budget Code:</b> 08
<b>Activity ID:</b> 21469.26797.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26797	
<b>Activity Narrative:</b> ACTIVITY UNCHANGED AND ENDING IN DECEMBER 2008. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.	
<p>This activity will focus on community mobilization activities to promote positive behaviors such as: gender equity; couple dialogue; partner counseling and testing; disclosure; and accessing treatment together. Community mobilization activities will also be directed towards elimination of negative behaviors that bring about stigma and discrimination associated with HIV/AIDS. TASO will support to strengthening/setting up of PLHA networks through training and logistics support in 28 districts of Uganda. PLHA networks will increase community mobilization, address stigma, denial and discrimination among PLHAs and their communities, and facilitate referral for treatment. This support is expected to increase the overall capacity of PLHA networks to access additional funding opportunities.</p>	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 21469	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21469	21469.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$1,954,780

**Table 3.3.08: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11126.09	<b>Mechanism:</b> TREAT (Timetable for Regional Expansion of ART)
<b>Prime Partner:</b> Joint Clinical Research Center, Uganda	<b>USG Agency:</b> U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 16008.26789.09

**Planned Funds:** \$0

**Activity System ID:** 26789

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY 2008, this activity will focus on training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis(TB) and HIV.

In the selected 25 focus districts and over 60 sites, the program will provide palliative care services to 15,000 clients not yet eligible for ART. This brings the total number of patients under care including those on ART to over 45,000. The program will provide clinical care services including diagnosis and treatment of opportunistic infections(OIs), nutritional assessment and counseling, psychosocial support and screening for ART eligibility. Patients under palliative care will be screened for tuberculosis and those diagnosed with TB will receive treatment. The program will provide a comprehensive preventive basic care package to the 10,000 clients under care.

The program will train and support 120 expert clients from 60 groups of People Living with HIV/AIDS to facilitate referrals and linkages between facility-based and community based care. The groups will facilitate referrals to wrap around services available in the communities. 900 health workers will be trained to provide palliative care services.

The program will scale-up TB/HIV integration activities including setting facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16008

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16008	16008.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$340,000

**Table 3.3.08: Activities by Funding Mechansim**

**Mechanism ID:** 11125.09

**Mechanism:** IRCU

**Prime Partner:** Inter-Religious Council of Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 4363.26781.09

**Planned Funds:** \$0

**Activity System ID:** 26781

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to address mutually identified development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. IRCU coordinates the largest network of faith-based health units in Uganda, which together deliver close to 50% of the health care services in Uganda. In June 2006, IRCU initiated a program to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR).

The National HIV Sero-Behavior Survey 2004/05 showed that approximately 900,000 are living with HIV/AIDS in Uganda and all of them require palliative care. Palliative care remains the main hub for HIV/AIDS care in Uganda, even with increased access to ART. Effective palliative care services are needed to delay the onset of symptoms and hence the need for ART. Despite being on ART, individuals still need intensive palliative care to adhere to the treatment regimens and to prevent opportunistic infection. Currently less than 50% of PHA in Uganda access palliative care. Services are more accessible in urban, than in rural areas. Working in partnership with its partners and stakeholders, the Uganda AIDS Commission (UAC) has developed a new National HIV and AIDS Strategic Plan (NSP) 2007/8 – 2011/12, which provides a road map for HIV/AIDS interventions over the next five years. Palliative care is one of the priority components of the NSP with a goal of improving the quality of life of PHA by mitigating the health effects of HIV/AIDS. The key focal areas for the NSP in regard to palliative care include increasing equitable access to quality services by those in need, from 105,000 to 240,000 by 2012; increasing access to prevention and treatment of opportunistic infections; expanding the provision of home based care as well as strengthening referral systems between health facilities and complementary services.

In support of the UAC vision to expand access to palliative care, IRCU delivers basic care in 22 sites. Of these 12 are hospital based, 6 are health-Centers of level III and five are community based organizations. Using FY 2006 funds, IRCU provided care to 24,000 PHA. The care offered includes prevention and treatment of opportunistic infections (OIs), psychosocial care, as well as pain and symptom control. Services are delivered through static facilities, outreaches to communities as well as home based care. In FY07 IRCU will continue to expand its palliative care program and targets to enroll an additional 20,000 PHA by September 2008. With FY 2008 funds, IRCU will enroll further 31,000 new clients bringing a cumulative total of 75,000 by September 2009.

A study carried out in Eastern Uganda showed that Cotrimoxazole prophylaxis given as routine care in HIV clinics was associated with a reduction in overall HIV related mortality as well as reduction in malaria morbidity, even in an area with high bacterial resistance. These results reinforce the need for large-scale provision of Cotrimoxazole prophylaxis for all HIV-positive patients in developing countries including Uganda. A combination of Cotrimoxazole, antiretroviral therapy, and insecticide-treated bed nets substantially reduced the frequency of malaria in adults with HIV. IRCU has been engaged in rolling out these elements of preventive care. Using FY 2006 funds, IRCU procured and distributed 38,000 long lasting insecticide treated mosquito nets (ITNs) to PHA through its network of FBOs. This activity will continue in FY 2007 and through FY 2008, with the vision of accessing ITNs to all the targeted 74,000 clients. In addition, IRCU will continue prescribing Cotrimoxazole prophylaxis as standard care in accordance with the Ministry of Health (MOH) guidelines and policy.

IRCU has initiated collaboration with Population Services International (PSI) to distribute the preventive package kits (ITNs, safe water vessels, water guard solution, and Information Education Communication (IEC) materials) in at least 10 sites. This partnership will greatly complement IRCU's efforts in expanding access to preventive care for its clients. IRCU has committed to facilitate follow up on usage of the components in the community throughout FY 2008. PSI is committed to carry out on-site training sessions on the use of the prevention package in collaboration with IRCU

In FY 2006, IRCU had key challenges in implementing basic HIV care. The main ones included delays in supply of drugs to treat OIs, lack of ARV drugs for PMTCT and post exposure prophylaxis, and lack of standardized home based care. IRCU is working in partnership with Supply Chain Management System (SCMS) to procure some specific drugs essential in managing critical OIs, but not supplied through the national essential drugs program. Examples of these drugs include Amphotericin B, Acyclovir, Antifungal ointments and Ciprofloxacin. Besides procurement of drugs, IRCU partnership with the SCMS project is envisaged to further strengthen and improve commodity procurement and delivery systems within our partner facilities. IRCU will promote the new home based guidelines developed by MOH at all its sites. To harmonize this home based care, IRCU will work with MOH to carry out on site training sessions for new community home based model. This will involve training both facility and community based workers in the new guidelines. They will also be trained on the standard data to be collect while carrying home based care.

With FY 2006 funds, IRCU built endeavored improve the human resource capacity for palliative care in its partner health centers. This entailed training and re-training of existing health staff and in some cases filling staffing gaps through volunteer and locum arrangements. IRCU trained 40 health workers in psychosocial care, pain and symptom control through Hospice Africa Uganda, In addition, Hospice Africa Uganda also trained 15 spiritual leaders in spiritual counseling and care. In FY 2008, IRCU will provide refresher courses for 40 health workers, 25 community volunteer workers and 15 religious leaders on pain assessment rating scale, the use of oral morphine including its safety requirements, legal counsel, spiritual and end of life care. IRCU will also train 100 health workers on the basic HIV care through our partnerships with Mildmay International and Infectious Disease Institute (IDI).

By the end of 2008, IRCU plans to care for 75,000 people living with HIV/AIDS, train a total of 140 health workers in basic HIV care, 25 community workers and will continue to carry out training of the 1270 religious leaders carried forward from FY 2007.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14207

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14207	4363.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,200,000
8422	4363.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,200,000
4363	4363.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$1,500,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 3370.09

**Prime Partner:** Chemonics International

**Funding Source:** GHCS (State)

**Budget Code:** HBHC

**Activity ID:** 4525.26764.09

**Activity System ID:** 26764

**Mechanism:** AIDS Capacity Enhancement Program (ACE)

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Adult Care and Support

**Program Budget Code:** 08

**Planned Funds:** \$0

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program to provide organizational development technical assistance and engage highly specialized local consultants to build the capacity of targeted Ugandan institutions for improved HIV prevention, care and treatment program outcomes. This program also aimed at strengthening administrative and managerial systems to fortify in a sustainable manner the targeted institution's ability to respond effectively to emerging opportunities resulting from the vast increases in HIV/AIDS funding. The program, named AIDS Capacity Enhancement (ACE) currently works with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), and the Ministry of Health Resource Centre (MOH RC). Three organizations, JCRC, HAU, and IRCU play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda. UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The Chemonics/ACE program will continue to consolidate the achievements to date and support the target organizations through the entire first phase of PEPFAR. ACE has made substantial progress in building the capacity of the targeted organizations.

In the past year, ACE has worked with several palliative care providers, building their capacity to provide and expand high quality services. Specifically, ACE worked with IRCU to strengthen its sub-granting mechanism to support the expansion of palliative care services through its network of faith based service delivery sites. ACE built the capacity of IRCU to manage their grants program which supports facility-based and community-based groups in the provision of palliative care. Grantees provide a full spectrum of palliative care services including disease prevention through appropriate use of health products such as LLINs, cotrimoxazole, safe water products and nutritional supplements and symptom and pain management and control of opportunistic infections. ACE worked directly with these grantees, training them in financial management, management and leadership, USAID compliance, and monitoring and evaluation. These management skills will help the grantees to run higher quality programs, comply with PEPFAR regulations, and build their sustainability. In FY 2007, ACE will continue to work with the IRCU Secretariat and the grantees to improve their management, M&E, financial systems, and communications so that they have the capacity to deliver palliative care services effectively. This will be done through a training of trainers approach that first trains the Religious Coordinating Body (RCB) staff in monitoring and evaluation, financial systems and accounting, and other skills such as planning, reporting, and management. The RCB staff will then provide training and regular support supervision to the grantees in these areas. ACE will be instrumental in facilitating the entire process, but will work towards building capacity and systems within IRCU and RCB staff that can be sustained beyond ACE.

In FY 2008, ACE will continue to work with palliative care grantees, supporting new grantees that are selected by IRCU in all the areas described above. In addition, ACE will work with all the palliative care grantees to strengthen their service provision. Together with the IRCU staff, the ACE project will facilitate the development of programs that will ensure that quality of care standards are clearly articulated, and that grantees are trained and provided with support supervision in upholding these standards. Connecting with wider palliative care networks such as the Palliative Care Association of Uganda (PCAU) and the African Palliative Care Association (APCA) will be a priority activity for IRCU sub-grantees in FY 2008. This will give them access to additional resources and skills for further improving their services.

With JCRC, ACE helped them to plan for the remainder of the TREAT project and has supported them in planning for their expanded sites and services. ACE's ongoing work includes improving data collection and collaborations between the JCRC HQ, the regional centres and the satellite sites. In FY 2008, ACE will continue working with JCRC to ensure that the TREAT program continues to expand and remains relevant to the HIV/AIDS situation in Uganda.

Hospice specializes in HIV/AIDS symptom control, pain management and culturally appropriate end-of-life care and now trains both public and private service providers and sites to offer these services to HIV + individuals and their immediate families. In the past year, ACE strengthened HAU's capacity to deliver these services by working with them to improve their organizational structure, governance practices, human resources policies, M&E, financial systems, and communications. These have given HAU the tools and platform from which it can grow effectively. An important component of this for improving palliative care in Uganda is the communications and advocacy strategy. ACE is working with HAU to develop a strategy that will give the organization and the palliative care community in Uganda the tools it needs to more effectively communicate about the importance of palliative care for HIV/AIDS patients in Uganda. It will also help them develop an advocacy program that can have nationwide impact on the availability of morphine for those experiencing extreme pain. In FY 2007, ACE will continue to finalize this strategy and to support HAU in rolling it out so that decision-makers at the national and district levels have increased awareness on the role of palliative care in an HIV/AIDS program and are able to make important policy changes that will improve the lives of AIDS patients.

In FY 2008, HAU will require support in developing plans for expanding their services, helping them identify potential additional sites or mechanisms and partnerships whereby they can expand the numbers they reach with palliative care services. In addition, HAU is a leading provider of training in palliative care in Uganda, filling a crucial gap in provider knowledge of pain management. ACE will work with HAU to develop an expansion strategy that is consistent with its capacity and resources, while at the same time addressing national needs. More importantly, the new program will be tasked to assist HAU to expand its training services to more health care providers and to develop business models that allow for this expansion.

ACE will be required to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to ensure the sustained ability of these indigenous institutions to expand access to high quality palliative care services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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,

**Activity Narrative:** education, microfinance and micro-credit support programs.

Finally, as more HIV/AIDS resources become available, and new partners come on board, the capacity building needs also grow. Therefore, in FY 2008, besides consolidating the achievements of ACE within the partner institutions, ACE will be expected to expand to include new client organizations as identified in consultation with USAID. As the civil society basket fund becomes the primary mechanism for funding a number of local organizations, ACE will be a resource of capacity building to recipients of funds, working with identified organizations in a participatory way to identify their strengths and weaknesses and then designing capacity building interventions tailored to their needs. This will be crucial for leveraging the investment the USG is making in the basket fund and will strengthen a wider array of organizations, enhancing their capacity to manage HIV/AIDS programs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15627

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15627	4525.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$650,000
8458	4525.07	U.S. Agency for International Development	Chemonics International	4850	3370.07	AIDS Capacity Enhancement Program, ACE	\$500,000
4525	4525.06	U.S. Agency for International Development	Chemonics International	3370	3370.06	Capacity Building of Indigenous Institutions	\$200,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 5740.09

**Mechanism:** Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Adult Care and Support

**Budget Code:** HBHC

**Program Budget Code:** 08

**Activity ID:** 26655.09

**Planned Funds:** \$260,100

**Activity System ID:** 26655

**Activity Narrative:** Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a Liaison office in Kampala. ICOBI's vision is a healthy and prosperous rural population and its mission is to improve the quality of life of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely. Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple-S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project(NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing in Bushenyi district (October 2004-June 2007) with funding from CDC/PEPFAR,ICOBI was able to offer HBVCT to about 270,000 adults and children, identified about 12,000 and provide them with basic care package with collaboration of Bushenyi district health system. Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID (on going in Bushenyi district); and recently April 2008; OVC Care & support with funding from NPI/USAID for Mbarara and Bushenyi district. ICOBI received a notice of ward on 30th June 2008 from CDC to implement a program entitled "Provision of Full Access Home based confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda". ICOBI HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013. The program will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda. The goal of the program is to provide 100% Full access Home Based HIV confidential Counseling and Testing services to all adults and at risk children residing in the six districts in five years. The program will provide preventive basic care and support to all identified HIV infected individuals and their families in five years. ICOBI received notice of award on 30th June 2008. Currently we are in preparatory stages of identifying, recruiting and training staff, procurement of equipment, materials, services and opening of project offices for the program. ICOBI is still waiting for the final approval of the work plan and budget after responding to technical review comments from CDC and hopes to start actual implementation of the HBCT in homes and communities at the end of September 2008.

The prevalence of HIV infection in the Central region/districts of Mubende, Mityana, Luwero and Nakaseke is about 10%. 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 program and 10% of these about 1,500 HIV infected children will be identified during HBCT in the four districts by the counseling and testing teams. We shall also identify about 100 HIV infected pregnant mothers who will be referred to health center 4 and hospitals for preventive services provided by PMTCT programs by respective district health systems and other providers and about 200 infants and children born to HIV infected mothers of six weeks to 18 months will also be identified during HBCT in the four districts. The counseling teams will collect blood samples from the children and submit them to centers carrying out HIV DNA PCR virologic tests to confirm HIV infectivity (enhance early infant diagnosis). All HIV exposed children <2 years will be referred to health units for immunization updates as well as growth development, promotion and monitoring. The children > 2years to 14 years born to HIV infected mothers or any other potential risk of HIV infection identified will have HIV counseling and tested using the three tier test algorithm. ICOBI counseling and testing teams will refer all children infected with HIV using referral forms to health units(hospitals and health center fours) and service providers offering pediatric HIV care and treatment and the referral centers for pediatric care and treatment. Paediatric care and treatment is offered at hospitals and health center 4s in the districts. In the four districts the services are offered at about 10 centers (both public and private).

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. With the help of CDC and PSI we will procure these commodities deliver these commodities to referral centers/health units and the health workers will provide the HIV infected clients with basic care commodities. Cotrimoxazole will be initiated at 190 health centers (includes hospitals, health center4s, health center3s and health center 2) in Mubende (55 health units), Mityana (53 HUs), Luwero (61 HUs) and Nakaseke (21HUs) districts and will be replenished at the health centers or by resident parish mobilisers/community volunteers (drug distributors/peer educators). Bed nets and safe water vessels including water guard refills will be supplied by the 295 resident parish mobilisers with collaboration with the village health teams and health workers at health center 3 and 2.

In order to ensure success, health workers (doctors, midwives, nurses, health educators etc) at health center 4 and hospital level and all HBCT counselors and laboratory assistants will be trained in paediatric HIV care and treatment, paediatric 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. Further more to ensure that the HIV+ children receive paediatric care and treatment; priority is given to collaboration with other institutions offering paediatric care like JCRC that can provide services related to ART eligibility assessment, existing, OVC programs and strengthening of the Mubende, Mityana, Luwero 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 numbers of clients visiting hospitals and sub district hospitals that are approved to offer paediatric care and treatment (ART). within in the districts and logistics (stipend for staff) to handle the HVI+ 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 funds under this activity will be used for procurement of commodities, community mobilization and sensitization of parental groups, training of health workers ,HBCT counselors and laboratory assistants, community volunteers in paediatric counseling, home care for the HIV positive children and for supporting the districts' healthy system in

**Activity Narrative:** handling and tracking the HIV+ children referred for care.  
**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

Program Budget Code: 09 - HTXS Treatment: Adult Treatment

**Total Planned Funding for Program Budget Code: \$36,468,274**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 11126.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)

**Prime Partner:** Joint Clinical Research Center, Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 15791.26792.09

**Planned Funds:** \$100,000

**Activity System ID:** 26792



**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY 2008, this activity will focus on training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis (TB) and HIV.

The program will train physicians and non-physicians to provide ART services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, ART literacy, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for prevention with positives and linkages to basic preventive package and wrap-around services.

In the selected 25 focus districts and over 90 sites, the program will support infrastructure development for ART services and build capacity of the Directorate of Health Services to manage ART services in the district. The program will provide technical and financial support for districts to carry out quarterly support supervision activities. It is estimated that a total of 6,000 new patients will be initiated on treatment bringing the total number of patients supported to over 24,000.

Critical emerging issues like adherence, surveillance for resistance, Infant Diagnosis using DNA-PCR and screening of patients under palliative care for ART eligibility will be supported. The program will provide financial support in form of grants to Civil society organizations and Networks of PHAs to carry out activities that support improved ART literacy, adherence, patient tracking, prevention with positives and linkages to wrap around services.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

The program will scale-up TB/HIV integration activities including setting up facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services.

In FY2008, the program will continue to support the Department of Defense (DOD) ART programs through Walter Reed in Kayunga district and Uganda People Defense Forces (UPDF) in Gulu, providing ART to 2,000 additional clients.

In conjunction with Supply Chain Management Systems (SCMS), the program will continue to explore the introduction of the Smart Card and an ART Dispensing Tool in all public health ART sites. This will improve patient tracking.

To complement these efforts, this new activity will also focus on integrating family planning and HIV/AIDS services. Such integration has the potential to create synergistic relationships between programs, reduce missed opportunities, and ultimately maximize the effectiveness and impact of services by providing comprehensive reproductive health care that holistically addresses clients' dual risks of HIV infection and unintended pregnancy. With increased access to HIV/AIDS treatment, more people living with HIV/AIDS are regaining their sexual activity. Among HIV-infected women, the prevention of unintended pregnancies is essential and highly cost-effective for prevention mother-to-child transmission of HIV and reducing the number of children orphaned when parents die of AIDS-related illnesses.

The program will develop programmatic strategies for strengthening linkages between family planning and HIV/AIDS services such as voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), and antiretroviral treatment (ART). This activity will leverage USAID funding for family planning and ensure that linkages between HIV/AIDS and family planning are established and institutionalized.

The program will disseminate the recently developed tools and materials that contain guidance for providers who offer contraceptive counseling to clients with HIV, including those on ARV therapy. The information will be designed to be used in a variety of settings by providers who regularly offer family planning services and by those who want to begin integrating contraceptive services with HIV treatment and care services.

300 health workers will be trained to integrate family planning in HIV/AIDS care and treatment services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15791

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15791	15791.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$4,800,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 3370.09 **Mechanism:** AIDS Capacity Enhancement Program (ACE)

**Prime Partner:** Chemonics International **USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State) **Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS **Program Budget Code:** 09

**Activity ID:** 4530.26766.09 **Planned Funds:** \$0

**Activity System ID:** 26766

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

ACE provides organizational development technical assistance and engages highly specialized local consultants to build the capacity of targeted Ugandan institutions for improved HIV prevention, care and treatment program outcomes. This program also strengthens administrative and managerial systems to fortify in a sustainable manner the targeted institution's ability to respond effectively to emerging opportunities resulting from the vast increases in HIV/AIDS funding. ACE works with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), and the Ministry of Health Resource Centre (MOH-RC), among others.

In FY 2008, ACE will work with IRCU ART grantees, providing technical support in organizational development, building financial and accounting systems for new grantees selected by IRCU. Additionally, ACE will work with all the ART sub grantees to strengthen their service provision. The program will facilitate the development of programs to ensure that quality of care standards are adhered to and that service providers receive the necessary training needed to maintain these standards. ACE will partner with organizations, like the Infectious Disease Institute (IDI) that are specialized in ART services provision training so as to source their services. Cross learning from partner organizations that have carried out ART programs much longer than IRCU will be sought and encouraged. The program will work to ensure that a network that facilitates the sharing of critical managerial and technical information, lessons learned, and the dissemination of best practices is developed and supported. The program will also continue to support the core function of the IRCU secretariat: governance and management; grants systems; financial systems, M&E; and communications as these are all vital for the success of ART services provision.

In FY 2008, ACE will continue to upgrade the data collection systems across JCRC sites and will help JCRC to set up a master database that can import and aggregate data from all the sites. ACE will also work with JCRC Headquarters (HQ) staff to improve communication systems between Regional Centers of Excellence (RCE) and its vast network of ARV service delivery satellite sites. This will enable JCRC HQ and Regional Centers of Excellence to be more supportive of and responsive to lower level service delivery sites resulting in improved ART service quality. ACE will work with JCRC in recruiting and training finance officials at RCEs so that there is better reporting and accountability of use of resources of the ART program.

In FY 2008, ACE will continue to consolidate its work in these core areas of organizational development, M&E, communications and other management systems such as finance and ICT so that both the headquarters and the RCEs will be able to further strengthen and expand their services to other areas. ACE will continue to work with JCRC and the RCEs in investing in the development of the human capacity that delivers ART services. ACE will continue to work with JCRC to ensure that all systems developed will continue to support the smooth running of the ART program.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15629

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15629	4530.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$200,000
4530	4530.06	U.S. Agency for International Development	Chemonics International	3370	3370.06	Capacity Building of Indigenous Institutions	\$75,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 27124.09

**Planned Funds:** \$478,786

**Activity System ID:** 27124

**Activity Narrative:** This is not new activity but a continuation of Activity Number 4407.08

The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support, the Ministry of Health has trained health workers from district health facilities in comprehensive HIV/AIDS care and management of ART. Health workers trained included medical officers, clinical officers, nurses, counselors and nursing assistants who provide direct HIV care and treatment. To-date over 3000 health workers have been trained in ART provision. In addition, longitudinal data management has been supported, updating, production and dissemination of ART data management tools, mentoring of staff in ART data management, supporting supervision to all accredited health facilities providing ART services including their management of longitudinal data. The MOH also led the national treatment workgroup in the review and updating of the national ART policy, treatment guidelines and training materials that have been completed. The next step will be updating of ART data management tools and reporting forms and strengthening the data management and treatment outcome system. The Care and support program has obtained support from WHO, USG, GFATM and UNICEF. In FY2008, health facilities accredited to offer ART increased from 305 to 358. 100 District TB/HIV managers from 10 districts and 60 health workers from 10 problem districts were trained in the IMCI/HIV complementary course. In addition, 24 health workers from sites with low enrolment of children into HIV care were attached to PIDC and Mildmay and post-training supervision will be carried out in 12 districts that were trained in the IMCI/HIV Complementary course. A total of 160 people comprising HMIS officers, ART district coordinators and health workers will be trained in data management and cohort analysis. In addition, data quality audits for ART will be carried out in 20 health facilities and 40 sign language instructors trained in comprehensive HIV prevention and care and sites with weak history of ART data management and reporting will be supported. Under the HIVQUAL and HCI program, the MoH had established HIV Quality of Care activities in 226 sites. The program developed an HIV Counseling and Testing module which will be piloted in ten health facilities. The HIVQUAL program initiated 20 more facilities into quality improvement, assessed and built quality management infrastructure in 130 health facilities from 40 districts, conducted 600 coaching and mentoring sessions, 10 continuous quality improvement trainings in 4 regions for total of 180 of health workers, 8 data management trainings in 4 regions for 120 data management staff, 4 regional learning network meetings, trained 120 trainers of trainees, sensitized 40 districts and 70 national stakeholders, supported data collection and reporting tools at 130 health facilities, supported 40 districts to monitor the implementation of quality improvement activities. The final draft ART treatment guidelines were produced and should be ready for dissemination.

In FY 2009, activities under this program shall continue. New and selected districts affected by staff attrition and transfers will be supported to conduct comprehensive HIV care training including ART and the IMCI Complementary HIV course. Post-training support supervisions for health facility staff from 20 districts trained in HIV care, ART and data management will be carried out two weeks after each district-level training. These support supervision visits will also contribute to the process of accreditation of newly trained facilities as ART sites. An additional 40 new health facilities will be accredited to provide ART services. An additional 40 ART sites will be involved in monitoring and evaluation including ART cohort tracking and data analysis. New sites will be trained in data management for enrolled cohorts using standardized tools. Mentoring and support supervision of existing ART sites will be carried out as part of quality improvement coaching activities. Data quality audits will be carried out as part of mentoring activities. Districts with health facilities that have low enrollment of children into HIV care will be supported to provide placements for some of their staff in Mildmay Center and the Pediatric Infectious Disease clinics. A total of 30 health facilities will be supported to improve pediatric HIV care and treatment. The program aims at strengthening districts and regional level systems to support and sustain quality improvement activities. District health teams supported by central HIVQUAL staff shall provide 600 coaching and mentoring sessions. Central HIVQUAL teams shall conduct 12 sessions of QI training for 320 health workers and train 120 additional workers in data management. The program will roll out quality improvement activities to an additional 20 facilities providing HIV care with Anti retroviral treatment. The revised ART treatment guidelines will be also be disseminated to all health workers at the ART sites. In collaboration with stakeholders, the program will review quality of care indicators including HIV Counseling and testing indicators. The program will continue to implement regional learning networks to promote peer learning and sharing, coaching and mentoring, districts and regional facilities.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 11125.09

**Prime Partner:** Inter-Religious Council of  
Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4366.26786.09

**Activity System ID:** 26786

**Mechanism:** IRCU

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$0

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to address mutually identified development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. IRCU coordinates the largest network of faith-based health units in Uganda, which together deliver close to 50% of the health care services in Uganda. In June 2006, IRCU initiated a program to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR).

By the end of December 2006, there were 24.7 million HIV infected adults and children living in Sub Saharan Africa (SSA) with 2.8 new infections that year. SSA contributed to 72% of the HIV related deaths in 2006. In Uganda, we have approximately 1 million people living with HIV and of these, just over 80,000 are on the life saving antiretroviral therapy (ART). Despite the national scale up of the ART program in Uganda, there are still many HIV infected people in need of ART but can not access the services. The burden on women still remains high as they are the most infected at a prevalence rate of 8% and most affected as they carry the burden of caring for those with the disease. In view of this, IRCU has established linkages with faith based organizations in 12 districts in Uganda to build the capacity of specific health facilities and their catchment communities as means of improving the channels and access to HIV related services and in particular ART services.

To date, IRCU has worked with 13 sites to provided ART services and drugs to 2,900 PHA. Of these, 900 were new (treatment naïve) clients. IRCU supported these sites through a sub granting mechanism which supported reinforcement of human resources, limited refurbishment of the clinical rooms and patient waiting areas, provision of drugs, support for laboratory tests and training of various cadres of staff including community workers and religious leaders affiliated to the sites. In partnership with the Joint Clinical Research Center (JCRC) IRCU also trained 40 laboratory staff. To reinforce the adherence monitoring program, IRCU procured motorcycles and other relevant equipment for the sites. IRCU is currently assessing ten additional sites which will bring the total number of supported sites to 23 by the end of FY 2008. The sites have mainly been selected from areas recovering from war and conflict particularly the north and north-eastern regions of Uganda.

The IRCU approach is to integrate the ART services with existing HIV care and overall health services at the implementing facilities to mitigate pressure on the already overstretched capacity of our partners. In FY 2008, IRCU will consolidate the ART services at these 23 sites with emphasis on quality of care.

In FY 2008, the ART services shall continue to be integrated and linked to counseling and testing services; PMTCT; palliative care and prevention programs through inter departmental referrals and linkages to ensure that all HIV positive individuals are screened for ART and those eligible treated. All sites carry out WHO clinical staging and baseline CD4 count for each client referred and enrolled into care. Sites will be encouraged to adhere to the guidelines of initiating ART through support supervision and training.

IRCU like other partners delivering ART has invested resources in setting up optimal adherence monitoring systems. In FY 2008, IRCU will focus on strengthening the human capacity, development of logistics systems, strengthening laboratory systems as well as building networks at community level to build a strong and coordinated adherence monitoring mechanism. IRCU will support each site to establish an adherence team comprising of 10 members constituted by a mix of health professionals, PHAs (expert clients), family members and religious leaders. These teams will monitor adherence at the family and community level.

Currently IRCU uses two adherence monitoring methods at the sites, namely, pill counts and three day self recall methods. In FY 2008, IRCU will train clinical teams on site to use the visual analogue scale (VAS) instead of 3 day self recall method and continue to carry out pill counts at drug refills. We will also initiate the use of electronic pharmacy records in this period. For the latter, IRCU will engage the technical assistance of Supply Chain Management System (SCMS) to install the needed soft ware and train the dispensing staff at the units to ably use the new program using FY 2008 funds.

The number of children with HIV infection is steadily growing with a paradoxical low growth in pediatric care services. In FY 2008, IRCU will continue to target children for ART as a special and vulnerable population and to take a leadership role in expanding access to pediatric ART beyond the major urban areas. In FY 2008, IRCU will continue training all cadres of staff in comprehensive pediatric HIV care including pediatric counseling skills. IRCU is working with the Infectious Disease Institute (IDI) and Mildmay International, both PEPFAR partners, to offer this specialized training. IRCU is currently setting up systems at the 23 sites to enhance pediatric care, in particular ART, by initiating HIV testing for all exposed infants. To date, IRCU has tested over 50 and will continue to consolidate these services in FY 2008. IRCU is targeting to test over 600 infants by the end of FY 2008. These children will be enrolled into care and also assessed for eligibility for ART.

IRCU has been strengthening PMTCT activities at all 13 implementing sites. These sites carry out both clinical and community based PMTCT services. Using FY 2008 funds, IRCU will set up PMTCT-support clubs at the sites to support the newly diagnosed mothers and also encourage male involvement. For mothers not returning for set antenatal and postnatal appointments, the PMTCT team will track the mothers and once found, they will either counsel the mother to continue seeking care at that particular health unit or refer them to the nearest center.

IRCU has worked closely with the administration at all units to reinforce Post Exposure Prophylaxis (PEP)

**Activity Narrative:** for the health workers. In FY 2008, IRCU will continue to ensure that the sites have the needed protocols, information about PEP, ARV drugs, and we will identify PEP focal persons to coordinate these activities. In FY 2008, IRCU will continue to upgrade the skills of 127 cadres of staff running the HIV/ART clinics in all its 23 supported sites. This will entail training them in comprehensive adult and pediatric HIV and ART service provision with key focus on pediatric care, treatment efficacy, drug resistance and drug counter-indications. A total of 1,270 religious leaders will also be trained in adherence monitoring and in mobilization skills to encourage the people to seek services.

IRCU has initiated partnership with IDI to ensure quality assurance and capacity maintenance. In FY 2008, IRCU will continue to work with IDI in monitoring the quality of care at the 23 sites and continue to carry out baseline resistance studies as biomarker of quality. Currently we annually take 20 blood samples from patients who have been on ART for at least six months at the sites including women referred from the PMTCT program to determine the extent of Nevirapine resistance. In FY 2008, IRCU plans to work with SCMS to streamline the procurement and timely supply of these drugs.

In FY 2008, IRCU will support 1,600 new adult clients and 500 new Pediatric clients on ART as well as maintain care for the 3,010 IRCU clients from FY 2006/07. By the end of FY 2008, we shall have over 5,110 clients on ART through this program. IRCU plans to train a total of 127 health workers in ART care and will continue to carry out training of the 1,270 religious leaders carried forward from FY 2007.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14212

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14212	4366.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,010,000
8425	4366.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,010,000
4366	4366.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$1,010,000

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 12194.09

**Mechanism:** TBD - EMRG

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 29693.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 29693

**Activity Narrative:** FY08 Collaborative Ugandan PHE- UG.08.0201: Multi-country CART Evaluation of Interventions to Reduce Early Mortality among Persons Initiating ART in Emergency Plan Countries

The multi-country PHE "An Evaluation of Enhanced Tuberculosis Case-finding to Reduce Mortality among Persons with Advanced HIV Presenting For HIV Care in Emergency Plan Countries" will be conducted in Cote d'Ivoire, Nigeria, Uganda, and Zambia. The objective of this study is to evaluate the efficacy of enhanced tuberculosis case-finding to reduce six-month mortality and morbidity among patients with advanced HIV disease presenting for care at HIV clinics. A two arm randomised trial in a total of 40 ART sites from all 4 countries will enroll 6000 clients to either receive the intervention (comprehensive TB screening and enhanced laboratory testing or current standard of care)

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9833.09	<b>Mechanism:</b> Health Communication Partnership
<b>Prime Partner:</b> Johns Hopkins University Center for Communication Programs	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 23764.09	<b>Planned Funds:</b> \$482,500
<b>Activity System ID:</b> 23764	



**Activity Narrative:** Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs that was awarded in July, 2007. Its purpose is to provide communication support to the Government of Uganda, PEPFAR and USAID HIV/AIDS and health programs and to strengthen capacity for strategic, evidence-based HIV/AIDS and health communication in Uganda.

ACTIVITY UNCHANGED FROM FY 2008. ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: This activity is a continuation of activities implemented in FY2007 and FY2008. Health Communication Partnership (HCP) has been providing technical assistance to the Joint Clinical Research Center (JCRC), the Ministry of Health, and other HIV/AIDS treatment partners to improve the quality of ART client education and adherence counseling, provide public education about ART, increase the uptake of HIV services among children with HIV/AIDS, and reduce stigma and discrimination against people living with HIV/AIDS. In FY 2007 and 2008, HCP assisted JCRC to launch a pediatric ART campaign focused on care givers of children at risk of HIV, HIV positive adolescents on ART, and caregivers of children on ART. The multi channel campaign aimed at motivating care givers to take their children for HIV testing and, for those who are positive, start them on ART and maintain adherence to medication. HCP supported JCRC to conduct outreach counseling and testing for over 2,200 children and their care takers in Kampala, and to develop and disseminate support materials for use by caretakers and health workers when counseling HIV positive children. In FY 2008, HCP, JCRC, PIDC, EGPAF, and Mildmay plan to launch a communication campaign encouraging prevention of transmission among HIV-positive adolescents, and adherence to ART among adolescent clients. Also during FY2008, HCP will provide technical support to JCRC to develop the course curriculum and training materials for a diploma training course for university graduates in treatment adherence and disease management counseling.

In FY 2007 and FY 2008, HCP also worked with a group of HIV/AIDS stakeholders and groups of People living with HIV/AIDS (PHA) to design a national cross-cutting communication strategy to reduce HIV-related stigma. According to qualitative studies, stigma is one of the main reasons given for not getting testing for HIV, and for ART clients to stop taking their drugs. Stigma is also a major reason given by HIV-positive men and women, and parents of HIV-positive children for not disclosing their HIV status; it is also a major reason why couples often do not use condoms. This activity aims to improve uptake of HIV counseling and testing, to improve ART adherence, and to increase condom use by reducing stigma associated with HIV/AIDS. According to Uganda's HIV/AIDS National Strategic Plan 2007/2008 – 2011/2012 (NSP), stigma is an underlying factor that must be addressed in order to reach national goals for treatment and prevention. During FY 2009, HCP plans to provide support to the Uganda AIDS Commission to implement a HIV/AIDS stigma reduction strategy designed during the previous year to increase uptake and adherence to ARVs among adults and children.

Over the past three years, HCP has worked with a variety of ART providers and PHA groups to roll out two communication campaigns on ART literacy, and paediatric ART. These partners include: JCRC, PIDC, the Mildmay Center, Reach Out Mbuya, Young Positives, EGPAF, HIPS Project, NUMAT, and NACWOLA. During FY2009, HCP plans to expand this network of HIV/AIDS treatment/care providers to include additional new and existing care and treatment partners.

HCP will assist this expanded network to critically assess progress under the ART communication strategy developed in 2006, and to identify communication needs for future focus. HCP will 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, possibly, 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, 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 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.

Many partner organizations support community based volunteers and clinical providers, and have a structure and system for training and supervision. HCP will work together with representatives of these programs and the MOH to train the trainers and supervisors of community volunteers, including PHA treatment support agents, and clinical providers, in interpersonal communication skills and in the use of common materials that provide comprehensive information about prevention, treatment, positive living, and stigma reduction. HCP anticipates training 100 trainers and supervisors of community and PHA volunteers, who will integrate training in the use of common tools and materials into their organization's training plans.

HCP will monitor the number of trainers trained in each organization through direct counts; and will monitor the quality of community outreach activities after training through observational visits to selected communities. Each partner organization will monitor the numbers of outreach activities conducted using common tools, and the estimated number of people reached through these activities through their routine monitoring systems. HCP will monitor the quantity of print materials produced and distributed; and will monitor radio broadcasts to ensure they are broadcast on schedule and to estimate the number of people reached.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 15913.24017.09

**Activity System ID:** 24017

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$1,646,933

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and the TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts with poor infrastructure, few accredited ART sites and underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services.

During FY 2009 the project will ensure delivery of quality of ART services in all 16 health center IVs and district hospital in the eight districts. In subsequent years the project will work with respective districts and health facilities in order to ensure that selected health center III's are also accredited for HIV care and treatment services. This is very critical as these districts have limited number of health center IV's. This would require renovation of clinical space, build lab infrastructure, ensure availability of skilled health workforce, and task shifting.

The program will also 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, coverage of and utilization of care and treatment services.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically, services shall be tailored to the existing Ministry of Health HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- Promotion of a 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.
- 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.
- 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.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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,

**Activity Narrative:** mapping community resources; and create community and facility networks.

This activity will also endeavor to scale up adult care and treatment services through community partnerships, through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15913

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15913	15913.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7253.09	<b>Mechanism:</b> TBD - Districts South-Southwest
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 15920.24027.09	<b>Planned Funds:</b> [REDACTED]



**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric care and treatment, TB/HIV, ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically services shall be tailored to the existing MoH HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- 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.
- 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.
- 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

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

This activity will also endeavor scaling up of adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members;

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15920

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15920	15920.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* Family Planning

\* Malaria (PMI)

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 3444.09

**Prime Partner:** New York AIDS Institute

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 9137.24818.09

**Activity System ID:** 24818

**Mechanism:** HIVQUAL

**USG Agency:** HHS/Health Resources Services Administration

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$386,000

**Activity Narrative:** The HIVQUAL Program in Uganda (HIVQUAL-U) is implemented under the leadership of the Ministry of Health (MoH) in close collaboration with CDC-Uganda for program management and technical support. This activity compliments other quality monitoring (QM) activities supported by WHO, UNICEF and the USG in Uganda. QM in Uganda is focused on facility level data collection, data management and building capacity for quality management activities at the clinic level. These activities feed directly into the MoH QM priority areas of quality assurance, monitoring and evaluation.

Facilities implementing HIVQUAL-U are selected through a coordinated planning approach led by MOH to minimize duplication with other partners. Indicators measured through HIVQUAL-U include: continuity of HIV care, access to antiretroviral therapy (ART), CD4 monitoring, TB screening, HIV prevention education, adherence assessment and cotrimoxazole prophylaxis. Documentation systems are enhanced through these activities; leading to the development of tracking systems that improve clinical monitoring of patients and retention in care.

Facility-specific data is aggregated, to provide population-level performance reports that indicate priorities for national and regional quality improvement activities. Both internal and external factors influencing the quality of care in a negative manner are identified and where possible improved; the former within the clinic and the latter by raising issues to the MOH HIVQUAL-U team. HIVQUAL-U provides special support to regional and district networks of providers who are engaged in quality improvement (QI) activities thus fostering coordinated approaches to address challenges unique to each region, including: human resource shortages, coordination of care among multiple agencies and donors, and community follow-up and adherence services.

In the previous year, pediatric care and treatment indicators were introduced to an additional 20 public and Non Governmental Organizations (NGO) ART sites in collaboration with UNICEF in Northern Uganda. In addition, the second round of data collection was completed and a report issued. Several QI trainings were completed in addition to a training-of-trainers (TOT) program.

In FY 2009, HIVQUAL-U will expand upon its work initiated in FY 2006 thru FY 2008; from 20 facilities in 2006 to 130 facilities in 2009 (currently 110 facilities are active). In collaboration with UNICEF, pediatric indicators were developed to measure growth monitoring, provision of bed-nets and referrals from PMTCT programs. The specific emphasis of this activity is based at the clinic-level, where HIVQUAL-U is adapting methods of quality improvement (QI) to each organization's particular systems and capacities. An expansion of this project will occur in 20 new health facilities; the QI will consist of monitoring both pediatric care and treatment indicators, in addition to the adult indicators. Provider meetings will be held to share best practices and QI strategies.

HIVQUAL-U team will also lead coaching and mentoring sessions for indigenous partner organizations (e.g. TASO, Mildmay), as well as international consortium partners (e.g. AIDS Relief) to promote the development of their agency-wide QM programs. Sponsorship by district health officers will be encouraged. HIVQUAL-U and its Ugandan partners will be providing additional QI training to adult and pediatric providers. Similarly, TOT programs will work with health training organizations to expand the capacity of QI trainers within Uganda. The U.S. HIVQUAL team will continue to mentor the HIVQUAL-U team to strengthen the following skills: 1) to oversee quality management programmatic activities, 2) evaluate the progress of the HIVQUAL-U program and 3) recommend growth and improvement activities to the HIVQUAL-U team. A Pilot of HIVQUAL in PMTCT programs will continue during this year. The data collected from participating pilot sites, will generate performance data reports. These QI project reports will include comparative analyses and indicators will be refined for data collection in consultation with MOH and key stakeholders.

John Snow Inc. (JSI) has been contracted to evaluate the work of HIVQUAL-International (HRI). JSI will also assess if HRI is achieving its desired goals of building capacity for quality management. The JSI team will meet with key stakeholders to interview them about the work of HIVQUAL and also visit several participating sites. HIVQUAL-U is expected to reach 130 sites that offer PMTCT, pediatric, adult care and treatment services Travel support for key staff in the Ministry of Health to participate in an international QI conference has been allocated; the conference will further educate the staff, in the methods and theory of QI which are not available in Uganda.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13306

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13306	9137.08	HHS/Health Resources Services Administration	New York AIDS Institute	6436	3444.08	HIVQUAL	\$500,000
9137	9137.07	HHS/Health Resources Services Administration	New York AIDS Institute	4811	3444.07	HIVQUAL	\$500,000



---

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 24376.09

**Activity System ID:** 24376

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$1,647,705

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric care and treatment, TB/HIV, ARV drugs, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to six districts in the East Central region of Uganda including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba. Whereas these districts are estimated to have more than 74,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific adult care and treatment activities to be supported under this mechanism will include:

- Training health workers in delivery of quality care and treatment services that adhere to national and international standards, guidelines and protocols. Specifically services shall be tailored to the existing MoH HIV/AIDS care and treatment guidelines, treatment eligibility criteria and standard 1st and 2nd line treatment regimens.
- Provision of comprehensive care and support including treatment and prophylaxis for OIs, psychosocial support, as well as basic preventive care to people living with HIV/AIDS (PLHAS) in all the target districts.
- Provide support to PLHAs with a focus on strengthening/setting up of PLHA networks to serve as hubs for community level care, adherence monitoring and referral.
- Integrating symptom, pain management, spiritual as well as culturally appropriate end of life care into routine HIV/AIDS care.
- Ensure that patients under HIV/AIDS care and treatment receive regular laboratory tests for HIV-disease monitoring including a CD4 cell count every six months and samples for viral load collected and transferred to regional labs at least once a year.
- Support districts to establish functional networks within and between health facilities and communities to improve access to and uptake of HIV/AIDS care and treatment services.
- Support districts to institutionalize infection control procedures as standard integral practices within the services delivered both at facility and community level.
- Support best practices and proven interventions and approaches that would improve access to continuum of HIV/AIDS services, including critical services not directly supported by PEPFAR or other activities.
- 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.
- 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.
- 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

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

This activity will also endeavor scaling up of adult care and treatment services through community partnerships through efficient and transparent grant mechanism and by providing technical support to civil society organizations.

Moreover, the activity will explore approaches and best practices for strengthening the network model of service delivery; innovative ways of using existing structures like village health teams, community volunteers and family members;

**Activity Narrative:**  
**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 10444.09

**Prime Partner:** University Research Corporation, LLC

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 15773.24379.09

**Activity System ID:** 24379

**Mechanism:** HCI (Health Care Improvement Project)

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$2,084,400

**Activity Narrative:** The Health Care Improvement (HCI) Project provides technical support to the Ministry of Health (MOH) Quality of Care (QoC) Initiative in HIV/AIDS using a quality improvement (QI) approach to ensure the quality of service delivery and ART provision. In 2 years, HCI has established a structure for sustainable QI in 120 health facilities. The project started in 2006 with 57 sites in all 12 regions and spread to an additional 32 sites in 2007 and 31 sites in 2008. A Core Team at the national level and 60 Regional Coordinators trained and coached facility-level teams in QI methodologies. Site QI teams are made up of representatives from HIV/ART clinics, related services such as PMTCT/ANC, TB, family planning and laboratory services and community and PLHIV representatives. Teams are trained to assess the quality of their services through monthly collection of data and to take steps for developing, testing and implementing improvements in their system of care. HCI supports sites through training in QI, monthly on-site coaching and 'Learning Sessions' in which facility-level QI teams have the opportunity to share best practices from their sites and receive focused training, such as changes in MOH policy. HCI contributes to Adult and Pediatrics Care and Treatment by working with sites to improve the quality of services provided and to develop best practices which are shared with other sites.

#### FY 2008 Results

As of July 2008, HCI trained 280 providers to deliver ART services; 328 providers on HIV-related institutional capacity building; 280 providers on treatment for TB to HIV infected individuals; and held 5 Learning Sessions (LS) in which providers were trained on QI approaches and methods, the application of chronic care model in HIV, MOH policies, clinical updates on aspects of adult and pediatric ART and HIV care, logistics management, and use of MOH patient monitoring, cohort analysis and reporting tools. HCI supported 540 site visits to provide follow-up coaching in these areas. In June 2008, HCI graduated the 57 sites which began in 2006. These sites have shown the ability to collect and utilize data on a regular basis, implement QI activities with minimal supervision, sustain improvements and assist other facilities in QI. Following up on an assessment conducted in June 2007, HCI held a laboratory training session in collaboration with Central Public Health Laboratories (CPHL) for a lab representative from 85 sites in January 2008 to introduce QI principles and encourage lab participation on the QI team.

QI site teams have introduced changes to improve record keeping, filing and retrieval systems, documentation and use of MOH patient monitoring tools, and timely reporting to MOH and procurement requests. HCI sites have a higher average of timely correct reporting to the MOH than the national average. They have implemented changes such as providing continuous medical education sessions for facility staff; introducing triage systems to streamline visits and reduce waiting time; task shifting of care between staff or to lower level facilities; including clients in peer counseling; improving referral systems and integration with TB, FP and PMTCT services; dispensing commodities such as ARVs and family planning (FP) within ART clinic instead of the pharmacy; organizing the provision of TB and HIV treatment in the same clinic or on the same day; and linking with community based health workers to follow up clients on TB/ART co-treatment. QI teams created links with pediatric services to improve referrals of dry blood spot samples for DNA-PCR for early infant diagnosis; coordinate with outreach workers to improve case finding and follow-up of exposed infants; schedule the same appointment dates for children and parents/caretakers; provide Septrin prophylaxis at PMTCT clinic; assess for ART eligibility and increase initiation on ART; and introduce specific clinic days for children. HCI sites have achieved the following results: 45% of sites have reached an ARV adherence level of 95% or more in at least 95% of their patients; 69% of sites are assessing 95% or more of their patients for ART eligibility at every clinic visit; 71% of sites are prescribing Septrin prophylaxis to 95% or more of their patients at every clinic visit; 66% of sites are screening 95% or more of HIV patients for active TB at every clinic visit; 96% of sites are referring 95% or more of HIV patients identified with active TB for TB treatment; 71% of sites are assessing 95% or more of infants and children for ART eligibility at every clinic visit; and 47% of sites are conducting CD4 tests for their clients every six months for 50% or more of their clients.

#### FY 2009 Activities

HCI will continue activities to improve HIV care and ART in 114 of its original 120 sites. As HIVQUAL and HCI overlapped in some sites, the two projects have agreed to divide follow-up; 6 will now be HIVQUAL sites. HCI will follow up 51 of the 57 graduated sites through quarterly coaching visits. The remaining 63 sites will be supported through monthly coaching visits. HCI will conduct 3 Learning Sessions for these groups and plans to graduate the all sites by the end of FY 2009. Learning sessions are an opportunity to provide targeted training on areas of ART service delivery which are found to be weak during site visits. Approximately 575 site visits are planned for the 114 continuing HCI sites, which consist of 1 national referral hospital, 6 regional referral hospitals, 53 general/district hospitals, 48 health center IVs, 5 health center IIIs, and 1 health center II. Sites are located in 66 districts distributed throughout 12 regions of Uganda.

The primary focus of technical assistance will shift from facilities to District Health Teams (DHT). HCI aims to further spread ART care in both breadth and depth through expanding to new sites and building capacity at the district level. The goal is to sustain and institutionalize a culture of continuous improvement in the DHT. HCI will build capacity of DHTs to coach teams to plan, manage, monitor and spread QI activities in HIV/AIDS in their districts. In addition to the DHTs, HCI will build capacity of other institutions to support the DHTs including health sub-district managers, key staff from district hospitals, and representatives from NGO clinics and CBOs. HCI will have up to four phases of implementation over 3.5 years with each phase including between 15 and 30 districts. Each phase is expected to last 1.5 – 2 years with 6 to 9 months between the start of each phase. The first two phases will begin in FY 2009. Each district coaching team will work with 2 to 3 facilities consisting of current HCI and new sites. HCI will support the DHTs through coaching visits for the first three months followed by quarterly visits. HCI, Core Team and Regional Team members will work with DHTs to conduct QI trainings at new sites. The DHTs will in turn support sites to implement improvement changes and monitor their progress. DHTs will have the opportunity to share their experiences in implementing QI activities and on the progress of their sites in improving the quality of HIV services in learning sessions every 4 to 6 months. These activities will develop the management and leadership capacity at the district level and within sites as they learn to monitor the quality of their services, take action to improve them and expand to other health areas. HCI will continue to spread the best practices mentioned in FY 2008 Results in adult and pediatric care and treatment within its current and new sites. We will also build DHT capacity to manage the health care teams to improve their engagement and

**Activity Narrative:** productivity. Specific activities planned include 3 Learning Sessions (LS) for Phase I districts, 1 4-day training on HIV care and ART for District Managers for each Phase, 1 Stakeholders' Meeting for Phase II districts, 1 LS for Phase II districts, on-site training in QI for 60 new sites, and around 120 district coaching visits during which HCI, Core Team, and Regional Coordinators will conduct close to 350 facility visits with DHTs. QI training at LSs and on-site at facilities provides the DHTs and site team members with the tools they need to analyze gaps in service and take steps to test possible solutions to improve ART service provision and develop more effective and efficient work processes within existing resources. HCI will introduce a framework on the quality of ART services to address quality gaps in access, retention and wellness to improve service outcomes and universal access. HCI will build capacity of DHTs and site teams to monitor the proportion of PLHIV eligible for ART who actually receive ART, proportion of PLHIV who are started ART and are still on therapy at any given time and the proportion of PLHIV who are currently on therapy and have good clinical outcomes. Districts and facilities will be encouraged to develop strategies for chronic care management to provide their clients with self management support and links to community support. HCI will work with sites in monitoring ART drug resistance through early warning indicators indentified with MOH, such as measures of declining clinical outcomes. HCI supports MOH M&E activities by collecting and using data to inform facility QI activities, review progress at coaching visits and aggregate indicators to determine quality of the national ART program. We will continue to assist the MOH by training sites in the use of the pre-ART and ART cards, cohort analysis, logistics requisition, and reporting data. HCI plans to conduct small operations research studies to assist the MOH in the implementation of ART programs through investigating factors affecting loss to follow-up and referrals of PMTCT mothers and infants following delivery and comparing of adherence rates in facility-based and home-based care programs.

For the DHT capacity building activities there will be 15 districts in Phase I and 20 districts in Phase II distributed in 12 regions. All Phase I and II districts will be from the current 66 HCI districts. HCI will add at least 60 new sites which will be a mix of Health Center IVs and IIIs. HCI's target population is all HIV positive adults and children and exposed children who are in need of and receiving ART services. HCI reaches this population through working with QI teams consisting of health care providers, outreach workers, and expert clients to improve the quality of services at the clinic including improved screening, referral systems with other services such as VCT/RCT, PMTCT and TB, and connections with outreach workers, such as Network Support Agents, at the facility and district level.

In partnership with Business PART Project, HCI included four private for profit (PFP) facilities in the 32 sites which started in 2007. HCI has conducted a quality assessment in 30 PFP sites and will use the assessment findings and recommendations, such as improving record keeping, follow-up of patients, and referral systems, to develop a strategy for QI in ART for PFP sites. DHTs will be encouraged to support a PFP site within its catchment area. HCI will partner with HIPS project to support additional PFP sites. HCI will also draw on existing partnerships with IDI, Mildmay, SCMS, and NMS to find opportunities that will support PFP sites in technical area and logistics systems training.

HCI will continue our work in improving laboratory processes such as referrals for samples, adherence to MOH laboratory standard operating procedures (SOP) and reducing supply stock outs through participation of lab representatives on QI teams and experience sharing at learning sessions. Lab Regional Coordinators in all 12 regions provide feedback to lab personnel during regular coaching visits. HCI is working together with the MOH and Core Team representative from CPHL on activities including development and distribution of policy documents, feedback on lab logistics problems, and the status of major equipment at facilities. Each district coaching team will include a representative of lab management and will be encouraged to improve adherence to lab SOP and referrals.

#### Partner Collaboration

NuLife will be utilizing the existing HCI structure to roll-out activities related to nutrition and HIV, specifically nutritional assessment/counseling and prescription of RUTF as needed, infant feeding in the context of HIV, and integrated management of acute malnutrition in selected HCI facilities. A nutritionist will be added to the Core Team and nutrition focal persons will be added to Regional Teams, District QI teams and site QI teams. Nulife will introduce food and nutrition interventions through HCI Learning Sessions with follow-up during monthly and quarterly coaching visits.

HCI will continue to maximize its program's impact through close partnerships with other USG-funded projects, such as NUMAT and other projects working at the district level, to coordinate activities and leverage funding. HIVQUAL and HCI are coordinating activities to maximize the impact of QI activities by covering different facilities; harmonizing indicators and data collection processes where possible; and ensuring that DHTs can coach for all sites. HCI will coordinate with the MOH, IDI and Mildmay to prepare and conduct trainings on HIV care and ART for district managers. HCI coaches will refer public, NGO and PFP facilities to IDI and Mildmay for HIV/AIDS and lab trainings. HCI will provide monthly feedback from sites on the availability of logistics (ARVs, HIV testing kits, patient monitoring tools) to NMS and SCMS. HCI will coordinate with FHI and EngenderHealth to disseminate FP and HIV integration best practices during LSs and coaching visits. HCI will strengthen partnership with institutions involved in TB/HIV care integration such as WHO, MOH Makerere-Mbarara Joints AIDS Program, National Tuberculosis and Leprosy Programme, and TB CAP. HCI will partner with PIDC and JCRC for CD4 testing and DNA-PCR tests and with EGPAF to review and develop training materials on pediatric treatment and care. Most of the partners listed are members of the Core Team and will continue to participate in monthly review meetings and as needed participate in coaching visits and LSs to provide training, policy updates and solutions to problems at regional, district and facilities levels.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15773

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15773	15773.08	U.S. Agency for International Development	University Research Corporation, LLC	7257	7257.08	HCI (Health Care Improvement Project)	\$2,700,000

**Emphasis Areas**

Health-related Wraparound Programs

- \* Family Planning
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$1,485,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 8655.09	<b>Mechanism:</b> Technical Assistance for data use/M&E systems strengthening for Implementing Partners
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 4423.26513.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 26513	

**Activity Narrative:** In FY 2009 the university technical assistance (UTA) mechanism will be competed to continue provision of high quality expert technical support for PEPFAR programs in Uganda. The focus of this assistance will be in three key program areas.

Treatment services technical assistance will be concentrated on enhancing comprehensive care and treatment interventions to strengthened partners' clinical programs. In FY08 the primary focus will be to review patient management and record keeping systems at treatment sites and identify areas and implement improvements in the clinic operations to substantially improve patient outcomes.

The strategic information component of UTA will be to assist the PEPFAR program in using the substantial amounts of program area data collected over the past five years in combination with country surveillance data to provide a better understanding of PEPFAR outcomes and contributions to the national portfolio. Examining the data from multiple sources will provide the country team will a more comprehensive analysis to assist with future programming directions.

For systems strengthening/policy development the UTA technical expertise will be transferred to local partners through a series of in-country workshops for advanced data analysis and triangulation and training on how to interrupt the results for policy guidance and program direction; and, training on how to prepare technical presentations and manuscripts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13325

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13325	4423.08	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	8655	8655.08	UCSF	\$120,000
8371	4423.07	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	4818	1273.07	University of California San Francisco - UTAP	\$120,000
4423	4423.06	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	3345	1273.06	University of California San Francisco - UTAP	\$120,000

**Table 3.3.09: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 5028.09	<b>Mechanism:</b> HIPS (Health Initiatives in the Private Sector)
<b>Prime Partner:</b> Emerging Markets	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 9077.21757.09	<b>Planned Funds:</b> \$1,061,500
<b>Activity System ID:</b> 21757	

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

Under the adult care and treatment program area, the HIPS Project implements Care and Support and HIV/AIDS treatment / ARV services. 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, technical assistance in setting up workplace AIDS treatment programs, and procurement of equipment. To date, job aids for HIV treatment providers have been developed, while more than 150 private practitioners have undergone HIV treatment training from the Mildmay center and the DELIVER/ SCMS project. HIPS also facilitates links between smaller companies without on site clinics and private clinics that offer services including AIDS treatment, and facilitates the referral system among private facilities for services such as CD4 tests and other tests necessary for patient follow up. To date, over 1200 clients have been newly initiated on ART, while up to 2200 clients are currently receiving ART services and more than 2,800 have ever received ART from private facilities supported by HIPS. The palliative care section is focused on extending services to the community through training of homecare givers, health workers and the provision of logistical support to partner facilities. To date over 200 community members have received training and kits to provide palliative care to their community members. Up to 28 of the HIPS facilitated private facilities offer palliative care and support services to over 2200 clients. Services received range from cotrimoxazole prophylaxis, communication materials, psychosocial support, safe water and ITNs among others.

The activities for FY 2009 include but are not limited to the following:

1. Continue to facilitate MOH accreditation of workplace and private clinics to offer ARVs across the country, and linking them to the ARVs supply chain.
2. Train up to 200 providers in ART including pediatric ART, ART logistics, PMTCT and PEP and management of opportunistic infections, including TB and palliative care. The training will focus on recruiting more providers from private clinics.
3. Strengthen referral networks between smaller companies with no on site treatment clinics and clinics that have been accredited to offer these services.
4. Increase informal sector access to treatment by linking informal sector associations and groups to accredited partner clinics.
5. Expand training of care givers and health care workers in palliative care and support to 250.
6. Enhanced support to partner clinics to enable them offer treatment, care and support services. Support will also be extended to improve the diagnostic capacity and referral for specialist tests like CD4 and Viral loads.
7. Expand work with insurance companies to extend insurance schemes to community groups (especially out growers and company supply chains) to access free ART and other health services at a low cost.
8. Conduct home based care support supervision visits for the primary care givers who have been trained.
9. Review the ART drug logistics systems in partner clinics and identify strategies to promote efficiency and improve patient adherence to treatment.
10. Develop systems to continually track progress in health initiatives with the private sector, while building capacity of the private sector to effectively measure progress.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14174

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14174	9077.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$1,100,000
9077	9077.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$1,100,000



## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$210,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 690.09

**Prime Partner:** US Department of Defense

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4552.21601.09

**Activity System ID:** 21601

**Mechanism:** N/A

**USG Agency:** Department of Defense

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$193,000

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated with the military, with up to 50% of patient visits for HIV care and treatment being non-military. Thus the demand to provide quality ARV services is continually growing. With PEPFAR support, 8 sites now provide ART and HIV care services. ARV services have been strengthened through training of health care providers, via the Infectious Diseases Institute (IDI) based in Kampala, and a partnership with San Diego DHAPP. A critical cornerstone of safe, effective ARV treatment is high compliance. Military personnel have unique challenges and obstacles for medication adherence, given barracks living, deployments, and the stigma associated with HIV/AIDS. A pilot adherence program is being initiated to specifically address ARV compliance in the military, and will be centered at Bombo Barracks and Mbuya Hospital.

UPDF continues to have HIV challenges due to a lack of trained clinical staff, an automated medical information system, and inadequate laboratory diagnostics for OIs and co-infections. These inadequacies are being systematically addressed via the support from the USG, initially in the Kampala based Bombo military hospital, and Mbuya military Hospital, with expansion to military medical facilities in Nakasongola and Wakiso. Drugs for OI prophylaxis and treatment are being procured for these 3 sites. Particular attention is paid to widows and OVCs that are eligible for services. A course has been developed for nurses and clinical officers through the Infectious Diseases Institute, Kampala and for the past 2 years this training has been used to ramp up care in HIV clinical management, to include addressing military specific issues.

There are currently 4,000 active duty UPDF personnel, family members and civilians followed for ART and HIV clinical management. Current plans are to support expansion of ARV services in training of UPDF personnel and modify and extend the adherence protocol to the other 6 treatment sites. This program will also be evaluated, and clinic procedures modified to include adherence practices as standard protocol. Additional training of physicians (6) and nurses and clinical officers (25), through the IDI in Kampala and the DHAPP program (2) will also be conducted. The IDI in collaboration with the UPDF have developed a 4 week (and 2 week respectively) course aimed to ramp up skills in ARV use, recognition and management of OIs and PMTC. Monitoring of clinical services with a medical information systems (MIS) to optimize clinical management will be initiated. There will be more of an emphasis on integration of prevention care and treatment programs; and increasing the availability of materials for client-provider interaction.

Currently these activities (diagnosis and treatment of OIs, drug procurement, training, lab services), are expanding beyond the 2 major clinical sites in Kampala and 2 outside Kampala sites to all 8 sites within the military health network providing ARV access. STI diagnostics and therapeutics and training for HCWs is being initiated. A new and extremely important expansion, given the recent compelling data confirming efficacy, plans are underway to provide access to the Basic Health Care Package (impregnated mosquito nets; safe water vessel; co-trimoxazole) to the UPDF HIV positive personnel and family members plus piloting the use of the BHC package in deployment/field scenarios.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: A Prevention for Positives program which includes elements relevant to the military, will be developed and piloted in 2 of the ART sites. This will have an emphasis on discordant couples as well as factors that increase risky behavior such as alcohol misuse.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16072

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16072	4552.08	Department of Defense	US Department of Defense	7336	690.08		\$250,000
8391	4552.07	Department of Defense	US Department of Defense	4821	690.07		\$250,000
4552	4552.06	Department of Defense	US Department of Defense	3156	690.06		\$250,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7207.09	<b>Mechanism:</b> TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 15791.21551.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21551	

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. USAID will award the new agreement by March 2009. This will ensure smooth transition between the current JCRC program and the follow-on mechanism.

In FY 2009 the major focus of the activity will be to ensure continuity of life saving services, smooth transition and capacity building of the 11 regional referral hospital and expansion of district wide HIV/AIDS care and treatment services in 40 facilities located in the 11 districts hosting the regional referral hospitals. Specific activities will include: training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis(TB) and HIV. The program will train physicians and non-physicians to provide ART services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, ART literacy, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for prevention with positives and linkages to basic preventive package and wrap-around services.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites (district hospitals and HCIVs), the program will support infrastructure development for ART services and build the capacity of the Directorate of Health Services to manage ART services in the district. The program will provide technical and financial support for districts to carry out quarterly support supervision activities. The program will ensure consistent availability of care and treatment services of patients currently under JCRC mechanism.

Critical emerging issues like adherence, surveillance for resistance, Infant Diagnosis using DNA-PCR and screening of patients under palliative care for ART eligibility will be supported. The program will provide financial support in the form of grants to Civil society organizations and Networks of PHAs to carry out activities that support improved ART literacy, adherence, patient tracking, prevention with positives and linkages to wrap around services.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites, the program will provide care and support services to 40,000 clients not yet eligible for ART. This brings the total number of patients under care, including those on ART, to over 85,000. The program will provide clinical care services including diagnosis and treatment of opportunistic infections (OIs), nutritional assessment and counseling, psychosocial support and screening for ART eligibility. Patients under palliative care will be screened for tuberculosis and those diagnosed with TB will receive treatment. The program will provide a comprehensive preventive basic care package to the 40,000 clients under care.

The program will train and support 120 expert clients and community volunteers from 60 groups of People Living with HIV/AIDS to facilitate referrals and linkages between facility-based and community based care. The groups will facilitate referrals to wrap around services available in the communities. 350 health workers will be trained to provide palliative care services.

The program will scale-up TB/HIV integration activities including setting facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15791

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15791	15791.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$4,800,000

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 7257.09

**Mechanism:** Health Care Improvement Project - HCI/NuLife

**Prime Partner:** University Research Corporation, LLC

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 15773.21780.09

**Planned Funds:** \$733,400

**Activity System ID:** 21780

**Activity Narrative: Activity Narrative (Adult)**

The Food and Nutrition Intervention for Uganda – (NuLife) is being implemented by University Research Co., LLC (URC) to support to Ministry of Health (MOH), CBOs/NGOs, Networks of People Living with HIV/AIDS and USG implementing partners to integrate and expand food and nutrition into HIV/AIDS prevention, care and treatment programs. The focus of the program is to increase the utilization, adherence to and efficacy of anti-retroviral treatment (ART) and improving the nutritional and health status of PLHIV. The program's three primary objectives include: 1) provision of technical and financial support to the MOH, CBOs/NGOs, PLHIV Networks, USG partners to integrate food and nutrition interventions in HIV and AIDS prevention, care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable RUTF made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities. The program will provide targeted food and nutrition support that includes food supplements for vulnerable groups including OVCs, HIV-positive pregnant and lactating mothers and those with mild-to-moderate malnutrition, therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants.

During FY 2008, NuLife has provided technical assistance in drafting the National Nutrition and HIV and TB Strategy (2008-2010). NuLife has reviewed both national and international guidelines, training curricula, educational materials and other documents related to food and nutrition for PLHIV; supported the updating and expansion of the National Infant and Young Child Feeding (IYCF) Guidelines and the development of related counseling tools and other job aids. It has facilitated a critical review of the draft National Guidelines on the Integrated Management of Acute Malnutrition (IMAM). NuLife secured a position for a nutritionist on the Core Team at the national level and expanded the role of the current HCI-supported Quality Improvement (QI) collaborative teams to include a nutrition focal person at each level. 223 health workers from 120 ART facilities were sensitized in the basics of integrating food and nutrition in health facilities. Working with the IHAA and the Northern Uganda Malaria and HIV/AIDS TB (NUMAT) program, 605 network support agents (NSAs) and 100-health facility in charges from 36 districts received an initial orientation and package of educational materials on the special food and nutrition needs of PLHIV. A Geographic Information System (GIS) was established for use in prioritizing areas of operation, program planning and visual reporting; 32 phase one priority sites across 29 districts were selected and a community mobilization strategy was developed. The specifications for the production of a local RUTF were developed and the identification and selection process for a Ugandan manufacturer was completed.

FY2009 activities include: 1) Building on and consolidate its FY2008 achievements as it expands its technical and financial support for HIV-related food and nutrition interventions. NuLife will support training of both facility and community health staff in 32 Phase One and 45 Phase Two sites participating communities related to 1) nutrition and HIV/AIDS for Adult Care and Treatment programs, including nutritional assessment, counseling, and food by prescription (FBP); 2) Integrated Management of Acute Malnutrition (IMAM) in the context of HIV/AIDS; and Community Mobilization for Behavior Change related to nutrition and HIV. Support materials will include: a) a counseling materials for use with PLHIV, b) patient take home flyers; c) training materials and d) equipment. NuLife will greatly support the capacity building effort of the MOH and other partner for integration of nutrition care and support within adult care and treatment services by training a core national team of 100 trainers. The trainers will in turn train health workers, community based volunteers and district teams in IMAM, FBP guidelines and community mobilization. Working through the Health Care improvement (HCI) program and USG partners, NuLife will select at least 12 health workers from each district and regional health facilities and 8 health workers from each HCIV including members from the quality improvement (QI) ART teams, in the provision of food and nutrition care and support (nutrition counseling, assessment and food by prescription) services. 1600 health workers from Phase One and Two health facilities and participating communities will be trained. 654 community health workers will be trained under the NuLife community mobilization model. NuLife will continue to promote a close collaboration with USG partners and will work through a number of official MOH structures and mechanisms including the MOH Sub-Committee on Nutrition MOH Sub-Committee and the MOH/Quality of Care Initiative.

2) USG Partner Coordination: The program will focus collaborative efforts with USG partners implementing Adult Care and Treatment programs in the selection of health care providers to be trained. Adult patients participating in programs supported by USG partners will also be able to access food and nutritional care and support counseling services. 3) NuLife has supported the establishment of and will continue to provide support to the MOH Sub-Committee on Nutrition (SCN) under the MCH cluster to provide overall guidance and coordination for development of policies, strategies, materials and curriculum related to nutrition. This sub-committee, which will meet monthly, is responsible for the selection of national nutrition and HIV 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. 4) NuLife is collaborating closely with the MOH/Quality of Care Initiative (QoCI) in the introduction of food and nutrition interventions in health facilities providing ART throughout the country. The mechanisms through which NuLife will collaborate with the national QoCI including support for the participation of selected nutritionists or nutrition focal persons in the national-level Core Team (made up of technical staff from MOH, URC/HCI staff and key USG HIV care and treatment partners), the Regional Coordinator Teams (5-6 member); and the District Quality Improvement (QI) Teams. During FY2009, NuLife will introduce food and nutrition interventions in selected HCI sites through training in priority areas during learning sessions, and will provide follow-up through monthly supervision or coaching visits to Phase One and Phase Two Sites. Under the HCI model for sustainability purposes, the district QI teams are assuming the roles of the Regional Coordinator Teams in the supervision and support to participating health facilities in relation to implementation of ART guidelines, data collection and management, and improving the quality of care and services. NuLife has worked with the HCI program to strategically start with districts where there is a presence of URC- supported facilities and orienting the districts in food and nutrition interventions for PLWHAs. 246 staff from DHT teams will be trained to provide support supervision to health facilities supported by NuLife. 5) Community mobilization will create demand for comprehensive food and nutrition services for PLHIV, mobilizing internal resources to the response, reaching the most vulnerable, and addressing the underlying causes of malnutrition. Approximately 400 network support agents and peer counselors within the catchment area of the 32 Phase One and 45 phase Two facilities will be trained and supported to integrate food and nutrition interventions for PLHIV. Using the Community Action Cycles (CACs) approach, NuLife will work with USG partners to initiate relationships with existing community-based groups (volunteer networks, family support groups, and community leaders) to promote good nutrition

**Activity Narrative:** practices. Other support activities will be identification and follow up of malnourished cases. For each of the ART QI teams, at least 2 people from the community groups will be seconded to the QI team whose roles will be to coordinate the community component and linking the community with the health facility. At the sub-county level, a community core group (CCGs) of 4-5 persons will be formed to provide overall coordination of activities at the sub-county level including development and implementation of community action plans for food and nutrition. Trained volunteers will primarily identify and follow up malnourished PLHIV children using the mid upper arm circumference (MUAC) and simple criteria of danger signs to determine those in need of referral. Working with ACDI/VOCA and other partners, like World Vision, WFP, LWF, linkages will be made to programs that provide supplementary feeding, food assistance and livelihood assistance programs for households of PLH.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15773

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15773	15773.08	U.S. Agency for International Development	University Research Corporation, LLC	7257	7257.08	HCI (Health Care Improvement Project)	\$2,700,000

**Emphasis Areas**

- Gender
  - \* Increasing gender equity in HIV/AIDS programs
- Health-related Wraparound Programs
  - \* Child Survival Activities
  - \* Safe Motherhood
- Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$166,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$165,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$50,000

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

---

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4687.21718.09

**Activity System ID:** 21718

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** [REDACTED]



## Activity Narrative: Activity Narrative:

Faith-based organizations (FBOs) have been strong partners in delivery of health services in Uganda. Through their established and extensive network of health units, they support 47% of the country's health care services. Besides the wide coverage, FBO health services target and reach the most remote areas of the country. FBOs have also been incredible partners in the national response to the HIV and AIDS epidemic.

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 (8,787 males and 14,959 females) into care and 2,605 (964 males and 1,641 females) on treatment through its eighteen partner sites. Twelve of these sites jointly deliver care and treatment, an approach that has been proved to alleviate pressure on the already overstretched capacity of the partner health units, particularly personnel.

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 (TBD) will be to sustain the individuals already enrolled in care and treatment and to further build the capacity of faith-based health units and NGOs in delivery of quality and sustainable services. Priority activities will, among others, include continuing to update service providers on emerging challenges and new approaches to AIDS care and treatment, strengthening linkages with other and non-PEPFAR activities to maximize synergies, continuous improvements in quality of services as well as reaching out to new and underserved populations. 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 existing AIDS care and treatment services. 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.

By the end of FY 2009, the follow-on program (TBD) will have provided care to 35,000 people living with HIV/AIDS of whom 7,200 will be on treatment. From the baseline number of 2,065 individuals receiving treatment in March 2008, IRCU anticipates to have enrolled a further 1,000 individuals by the end of September 2008, bringing the total to 3,065. By June 2009 when it winds up, IRCU will have enrolled an additional 2500 new individuals in treatment, bringing the total to 5,565. The follow on program will enroll a further 1,635 new adult individuals between July and September 2009 and train a total of 100 health workers 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 1000 community and religious leaders in basic HIV and AIDS care and treatment to serve as HIV and AIDS resource persons and to link facilities with communities.

The HIV and AIDS basic preventive care approach has continued to grow in prominence as a cost-effective approach to care and treatment given its proven effectiveness in warding off opportunistic infections and hence delaying the need for ART. IRCU has been engaged in rolling out elements of preventive care. Using FY 2006 funds, IRCU procured and distributed 38,000 long lasting insecticide treated mosquito nets (ITNs) to PHA and their immediate families through its network of FBOs. It will further procure and distribute another 5,000 ITNs using FY 2007 funds.

Albeit with procurement challenges, IRCU has been prescribing prophylactic Cotrimoxazole as a standard practice in care and treatment in accordance with the Ministry of Health (MOH) guidelines and policy. The follow-on program (TBD) will be required to continue rolling out these basic care elements with a key focus on strengthening procurement and distribution systems. While providing free basic care elements, the follow-on program (TBD) will simultaneously raise awareness among its clients on the availability of these commodities on the open market as a medium term strategy to eventually phase out free distribution in order to guarantee sustainable access.

Ensuring a steady and demand sensitive system for supplying care and treatment commodities 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 required to assess the efficiency and viability of the SCMS procurement mechanism and if found effective, further strengthen it. If not, the follow on program will be required to explore other alternatives that enhance efficient delivery.

IRCU has worked closely with the Ministry of Health and its partner health units to reinforce Post Exposure Prophylaxis (PEP) for the health workers. The Ministry of Health has recently released guidelines on occupational health and safety within the health sector, in which procedures for PEP management are well articulated. In addition, the guidelines also provide guidance on creating a good working environment for HIV-positive health workers and ensuring that they don't pose a transmission risk to their patients, especially in aspects of health care that involve invasive procedures. The follow-on program (TBD) will be required to glean and disseminate the relevant components of the guideline and ensure that infection control is a mundane practice within all the supported HIV/AIDS care and treatment facilities.

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

**Activity Narrative:** 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, care and 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14211

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14211	4687.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,000,000
8428	4687.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,000,000
4687	4687.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$100,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

---

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4705.21730.09

**Activity System ID:** 21730

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$617,600

**Activity Narrative:** This activity also relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

In FY2008, NUMAT continued to strengthen relationships with stakeholders in the various district local governments and the communities. Working partnerships were forged with various agencies for example WHO, NGEN+, PSI, JCRC, CNAPSIS and others as their respective areas of expertise were exploited to improve the access and quality of treatment, care and support for the HIV positive population of Northern Uganda. NUMAT partnered with WHO, the AIDS control programme and Palliative Care Association of Uganda to provide training for 170 health workers in various aspects of adult care and treatment, including pain and symptom management for HIV patients, management of OIs, and integrated management of Adult infectious diseases (IMAI). The trainings were augmented with on site mentorship by technical support teams from NUMAT and the Ministry of Health. NUMAT also supported training of trainers in comprehensive HIV care and aspects of palliative care that would add to the professional resource of the region. Medical students from Makerere University were also engaged to gain experience as they supported the human resource gaps at the various sites. In a bid to support the training young doctors at Gulu University, NUMAT intends to support the publication, printing and dissemination of the 2008/2009 Gulu University Medical Journal that will carry an HIV related theme. Meanwhile after a year of putting structures and processes in place to support an efficient ARV drug supply, the drugs were finally delivered to 17 sites supported by NUMAT, 6 additional sites were identified for assessment and were subsequently accredited by MOH. All the NUMAT supported health facilities are district hospitals, health centre IV and III that chronically lack adequate staffing and laboratory capacities. In effort to improve confidence and utilization of these 23 ART sites and decongest larger health facilities like the regional referral hospitals, several complimentary areas of support for treatment, care and support were addressed. In conjunction with JCRC and CNAPSIS Free CD4 and full blood count testing were offered to all clients accessing care at the health facilities. This resulted in a 65 percent increase of enrolment of clients onto ART as a result of the free CD4 tests provided. Health workers felt motivated to work by this support. Limitations in community follow up were addressed by promoting and motivating the set up and development of PHA groups and Networks. The JSI arm of NUMAT supported the mobilization and training of 103 PHA volunteers to work as Network support agents (NSA) in 45 health facilities. Other than their role to link fellow PHAs and family members to community and health facility- based care and treatment services, the NSAs also supported counseling, community based care and support. Further home based care was provided through World Vision's community care coalition (CCC) that came into being when 750 home based care providers from the nine districts were trained to support HIV adults in the community by monitoring their health, monitoring adherence, offering on going counseling and identifying needs for wrap around services that guided referral for appropriate care.

#### ACTIVITY UNCHANGED FROM FY 2008

In FY 2009, NUMAT will continue to coordinate, promote and implement adult care and treatment activities. HIV related care activities will be scaled up and consolidated in lower health units, Sub County, parish level and small transit IDP camps with special emphasis on hard to reach and high risk communities. Paramount in this effort is the adoption of the "Model Site Concept" that will make it possible for PHAs and all the communities in these unique settings to receive holistic prevention, treatment, care and support services. This will involve implementing synchronized activities from all the NUMAT program areas as well as that of the collaborators. NUMAT will also continue to improve linkages for PHAs and their families to essential clinical and wrap around services including food, material support, and family planning in the project catchment area. Training and motivation of Network support agents and community health workers will continue promoting both community and facility based adherence monitoring, tracing and follow up. It is envisaged that by participation of PHAs themselves, more patients will be encouraged to seek and remain in care. The expansion of community care services and referral networks will be promoted by PHAs working in collaboration with health facilities, NGOS, CBOs and the World Vision promoted Community Care Coalitions (CCC). NUMAT through strengthening collaborating partnerships with other USG supported programs like PSI, IRCU, AFFORD, IHAA, NuLife will improve the availabilities of wraparound services for PHAs. These services will include delivery of prevention & care packages for PHAs including Cotrimoxazole prophylaxis for opportunistic infections (OIs), ITNs, peer psychosocial support, IEC/BCC for prevention among the positives, condoms and ART. At health facility level, on site mentorship for health workers for Adult HIV treatment and care will continue. Specific formal trainings, especially in ART and OI management and the various aspects of palliative care will be carried out to keep up with gaps created by the high turnover of the human resource in many of the health facilities. Both financial and non financial forms of motivation will be provided to the health workers. Non financial motivation will include sponsorship for workshops, seminars and exchange visits where appropriate. NUMAT will also be involved in Adult comprehensive care training and related programs when the Gulu University Journal is produced carrying a relevant HIV related theme. IEC/BCC materials that were produced and translated in the previous period will be printed and disseminated. The Ministry of Health will continue to provide support supervision and spearhead assessment and accreditation of additional ART clinics to achieve the target of 30 clinics. As the ART clinics are rolled out and strengthened, NUMAT will carry out a baseline survey on patient retention and adherence on the ART programs. Results of the survey will support further evaluations of the quality of care at the sites. NUMAT will offer a total of 21,880 free CD4 tests and about 600 full hemogram tests to PHAs through AIC and CNAPSIS. This is an increase from 4800 CD4 tests offered in the last FY. NUMAT has supported capacity building as regards CD4 testing by conducting training for health workers in HIV care and by on site mentoring focusing on CD4 utilization. Threshold sentinel testing of ARV drug resistance will also commence according to work plan in a bid to ensure efficacy of ARV drugs.

New/Continuing Activity: Continuing Activity

Continuing Activity: 15488

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15488	4705.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$800,000
8472	4705.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$800,000
4705	4705.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$755,000

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$25,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 21883.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21883

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening



**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 5091.09

**Prime Partner:** National Drug Authority

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 9226.21794.09

**Activity System ID:** 21794

**Mechanism:** NDA

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$300,000

**Activity Narrative:** National Drug Authority (NDA) is the Drug Regulatory Agency of Uganda mandated by the Uganda National Drug Policy and Authority Act (Chapter 206) 1993 to ensure that all medicines, medical devices and supplies entering the country are safe and of good quality and efficacy. NDA implements the above law under four technical departments charged Drug Assessment and Registration, Drug Inspectorate, National Drug Quality Control Laboratory (NDQCL) and the Drug Information Department. In 2005, NDA was designated as a National Pharmacovigilance Centre (NPC) to monitor the efficacy and safety of all drugs. This center is an associate member of the WHO Uppsala Monitoring Centre.

ACTIVITY UNCHANGED FROM FY 2008: With FY 2008 funds, NDA/NPC is in the process of establishing a system for collecting, monitoring, researching, assessing and evaluating information from healthcare providers and patients on the adverse effects of ARVs with a view to identifying new information about hazards associated with medicines and preventing harm to patients. Using field reports the NPC coordinates the collection, analysis and evaluation of adverse drug reactions PLWHA. To-date NPC has coordinated 100 out of 266 reports of suspected Adverse Drug Reactions (ADRs) received through spontaneous reporting. Information about drugs with a compromised risk/benefit ratio was obtained. Consequently, Viracept a first line ARV was recalled and destroyed. The NPC works with several stakeholders to collect reports on adverse drug reactions and provide necessary feedback to health care providers. The pharmacovigilance initiatives in Uganda are now linked to the WHO International Drug Monitoring Program and generated reports will be sent to the Uppsala Monitoring Center for processing.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS**

Renovation of the NDQCL.

The National Drug Quality Control Laboratory (NDQCL) will be renovated to create space for the equipment and personnel dedicated to the analysis of ARVs.

Establishment of additional regional pharmacovigilance centers with pharmacovigilance core team through conducting sensitization meetings by NDA Regional Offices for private and public sector health centers. The NPC will establish additional four (4) pharmacovigilance centers with pharmacovigilance core teams at National regional referral Hospitals. The core teams will receive intensive training on analysis of suspected ADR reports and will be made aware of medicine related problems. The core teams will be sensitized on the significance of pharmacovigilance in drug regulation; and on the potential of medication errors, herbal ADRs, and counterfeit medicines which compromise safety of medicines in all patients including HIV patients. The core teams will be facilitated to report ADRs using the web based database – Vigiflow, given various reference materials (e.g. BNFs) for use when assessing an ADR. The core teams will also provide timely initial feed back to health workers who report ADRs. These teams will be able to follow-up ADRs that require follow-up, thereby reporting to the NPC on their findings. The target population is PLWHA in the country. Through supporting the core teams and facilitating them, they will be able to monitor ADRs experienced by AIDS patients who are/are not on ARVs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14168

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14168	9226.08	U.S. Agency for International Development	National Drug Authority	6722	5091.08	NDA	\$300,000
9226	9226.07	U.S. Agency for International Development	National Drug Authority	5091	5091.07	Support to National Drug Authority	\$300,000

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 4961.09

**Mechanism:** TBD/Drug Logistics

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 12489.21815.09

**Planned Funds:** ██████████

**Activity System ID:** 21815



**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to ARV drugs, Adult Care, Pediatric Care and Treatment, CT, TB/HIV, and Laboratory Infrastructure

In FY 2008, the SCMS project provided procurement services and technical assistance to the Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), and UPHOLD (now ended) to improve the availability and management of ARV drugs in their sites. SCMS also provided funds to the MOH for emergency ARV procurements. To-date, a total of \$1,795,000 of ARVs and related commodities has been procured through SCMS for these partners. SCMS will also procure ARVs for EGPAF. NUMAT, in partnership with SCMS, established logistic management systems and procedures for ARV supply in its ART sites and a working arrangement was developed with Joint Medical Stores, a central warehouse for FBOs and other private sector organizations, to deliver to the partner sites based upon requisition. NUMAT technical officers trained and mentored ART teams in logistics management to ensure smooth system performance and logistics tools and materials adopted from MOH formats were distributed to the ART sites to ensure proper reporting of drug consumption. During the period, two cycles were delivered of first and second line adult ARV formulations for 17 existing ART sites and later for 6 additional newly accredited ART sites in the nine districts. Gaps in pediatric support were identified, which led to negotiations with Baylor Children College (Uganda) to provide the ART clinics with ARV formulations for young children. The choices of ARV drugs selected by the program were determined by the current GoU ARV policy that took into consideration efficacy, adverse effect profile, and pill burden. The ARV drugs selected also took into consideration needs of the clients gaining entry through the other program areas of PMTCT and TB.

SCMS also procured ARVs and drugs for opportunistic infections for the IRCU program. Technical staff have been trained in forecasting drug needs for the program and on the ARV logistics management system. A computerized logistics management information system was installed using standard software to track consumption and stock levels at the individual sites. Thirteen implementing sites are currently submitting bimonthly ARV drug reports and orders to the IRCU Logistics Officer. The partnership with SCMS and JMS has been successful to date and has guaranteed steady availability of ARVs at all IRCU supported sites. In addition, as a result of this partnership, IRCU has been able to procure quality ARVs at the most competitive rates available on the market, guaranteeing that its clients are accessing quality products and, with the savings, enabling the program to recruit more ART clients.

At the national level, SCMS provided technical assistance to the MOH to forecast and quantify the country's ARV needs, coordinate procurement with donors, and train new district and new ART site staff on logistics management and reporting. SCMS also assisted in support supervision activities at district level to improve facility level performance. Specific achievements include 683 health workers country-wide trained on the redesigned MOH ART logistics management system, 28 MOH regional pharmacists and senior dispensers trained on management of ART logistics activities, and 92 health workers from 38 newly accredited ART sites trained on the logistics management system. The SCMS supervisory team visited a total of 174 ART sites to monitor performance and provide on-the-job support to health workers charged with logistics management. Efforts to harmonize ARV procurement among PEPFAR partners and communicate supply issues continued through various technical working groups and technical support was provided to the GFTAM third party procurement agent (WHO/UNICEF). In FY08, technical assistance was provided to JMS to completely overhaul its warehousing and inventory management system including installation and training in the new warehouse management information system (MACS) and the financial system (SAGE) software. Support was also provided to NMS to assess its warehousing and inventory management system, the recommendations of which were endorsed by the NMS Board of Directors.

Capacity building in ARV logistics management will continue in FY 2009 at the PEPFAR-supported sites and national level but through the new partner (TBD). Technical assistance will be provided to build capacity and improve logistics management at IRCU and NUMAT sites as well as sites supported through the new district-based HIV/AIDS programs. This new partner will provide the logistics management technical assistance that SCMS used to provide, including commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the

**Activity Narrative:** well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submit timely reports to keep the system moving. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14235

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14235	12489.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$300,000
12489	12489.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$300,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 9832.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 15921.22930.09

**Activity System ID:** 22930

**Mechanism:** Western Region / PMTCT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** ██████████

**Activity Narrative:** This narrative is a component of other EGPAF activities that include PMTCT supported through USG funding. EGPAF also supports treatment services at 5 sites using private funds donated through the Abbott Fund. The Elizabeth Glaser Pediatric AIDS Foundation (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. The Foundation directly supports programs in 27 districts to provide HIV counseling and testing, ARV prophylaxis, HAART, psychosocial support, community mobilization, training, adequate counselor and laboratory technician staff, upgraded laboratory facilities and counseling rooms, management information systems and strengthened MCH/FP services. The Foundation's staff provides technical support to the district programs and by participating in MOH technical committees such as pediatric ART and PMTCT. The Foundation works closely with the Uganda MOH and other PMTCT and treatment partners in Uganda including SCMS, JCRC, Uganda Cares, AIM, UPHOLD and UNICEF to coordinate support and maximize coverage of PMTCT and HIV treatment services.

#### Progress and Achievements

The Foundation has worked directly or in partnership with other USG implementing partners to provide comprehensive care and treatment services within the 363 EGPAF PMTCT service outlets. Over the last 6 months, EGPAF is directly supporting care and treatment services to 17 service outlets that are not supported by a PEPFAR Implementing partners. This development has increased access to critical antiretroviral therapy for individuals identified through PMTCT. 1254 HIV positive clients received care and treatment services in the 17 service outlets of which, 3.2% of were children. Peer educators have been introduced at 41 sites to strengthen follow-up patient care by taking over less skilled tasks from the already over burdened health workers. The Foundation's comprehensive family care model includes community level linkages to increase identification of HIV exposed children and their families, PMTCT services, care and treatment with an emphasis on pediatric care and an innovative psychosocial support effort that includes children's support groups. By providing support for care and treatment, the Foundation will continue to integrate affordable, family-based quality HIV/AIDS care and ART services into health care facilities through ensuring that a continuum of services is available and accessible: from PMTCT, to care and treatment, to psychosocial support via a Family Care Model.

#### FY 2009 Activities

Activity Objective: Scale up model Family focused HIV Care Clinics within MOH Health Centers and directly enroll HIV-positive mothers and family members in HIV comprehensive care including treatment. Key activities: 1) HIV care and treatment activities. During the past year, the Foundation initiated Care and Treatment support to 20 health centers bringing urgently needed ARVs to the primary care level. Building on the success of the initial roll out, the Foundation will scale up a family centered model of care and treatment to an additional 20 health centers. The Foundation will provide training and technical support to address logistical challenges especially quantification/forecasting and distribution of ARVs. This will develop the services providers' capacity, and ensure regular supplies of ARVs and other needs. Quality improvement systems will be strengthened through the standardization of operating procedures and improvement of data management systems. As a result at least 15,000 individuals will be enrolled in HIV comprehensive care and 3,000 will be initiated on ART by the end of FY08. HIV counseling and testing will cover both outpatient and inpatient wards at the selected health facilities as well as the surrounding communities. TB clinics will be specifically targeted for routine HIV counseling and testing. The possibility of providing HIV care and treatment within the TB will also be explored. As stock outs of important medications have unfortunately been a common occurrence, the Foundation will purchase ARVs to provide a backup supply and avoid stock outs. A major component of expansion activities will be ensuring that quality laboratory services are available in each center providing ART. Referral laboratory services will be utilized for the monitoring of patients receiving HIV care and treatment. Where possible the Foundation will explore the possibility of improving and equipping laboratory facilities (especially at district hospitals) for optimal patient care. Each site will be assessed and needed upgrades in these areas will be developed. 2) Improve access to pediatric treatment. Capacity building activities to promote pediatric HIV/AIDS care will continue to be addressed during FY09. The clinical mentorship program to support pediatric HIV/AIDS care will be expanded to include a focus on pediatric nursing/counseling. The training activities will strengthen skills of lower level facility personnel to provide pediatric ART through a training package developed with the MOH Child Health Department, comprising of pediatric counseling, modified IMCI (HIV) and early infant HIV diagnosis components. This is aimed at equipping service providers with knowledge and skills to identify HIV-infected children and offer pediatric HIV/AIDS care. 3) Involving People Living with HIV/AIDS. PLWHA networks will be supported to facilitate clinical care at 40 health facilities. The programs based on the peer educator concept will utilize focal support group members in these activities. The scope of work will be site specific but will include activities such as streamlining client flow, directing clients to the different departments, health education, and registration of clients in MCH, and supplementing counseling sessions through live testimonies. The PLWHAs will be enabled to carry out home visit activities to the PMTCT and ART clients, community mobilization and sensitization. These activities aim to improve follow up of PMTCT clients at the facilities. Family support groups will continue to form a critical avenue for the provision of psychosocial support to families infected and affected by HIV/AIDS. The recently launched Ariel Clubs guidelines have formalized approaches to providing psychosocial services to HIV infected children through child focused support groups. 4) Longitudinal follow-up of HIV-positive mothers within MCH including during well-child visits. HIV care and treatment services will be strengthened through the development of mechanisms to offer continuum of care to HIV-positive mothers and their families. EGPAF will scale up Early Infant Diagnosis by expanding access to DNA PCR testing and routine HIV counseling and testing at key pediatric service points within the health facilities. Collaboration and coordination with partner organizations supporting HCT will enable expanded access to routine HIV testing. Capacity building initiatives for this activity will emphasize care for the HIV exposed infant alongside its mother and other family members. The provision of care and support services to eligible individuals has been shown to improve the uptake of all other PMTCT services. Capacity will be built to support the scale up of the program for early infant diagnosis of HIV. Focus will be directed at strengthening the enrollment of identified HIV-exposed and infected infants into continuum of care programs. Standardized operating protocols and job aides will be developed as part of this effort. Following the successful involvement, PLWHA networks in the provision of HIV care at five-health center IVs the Foundation rolled out this initiative to 41 sites. The

**Activity Narrative:** integration of peer mothers and fathers (drawn from the Family Support Groups) into the regular HIV/AIDS services at health facilities will be expanded to support the follow up of the mother-baby pair in the community. The provision of peer counseling to parents of HIV exposed infants and guiding them through the various services on offer at the health facility has reduced loss to follow up of identified HIV exposed infants. HIV infected families will roll out use of revised infant feeding materials to support the adoption of safe infant feeding practices. 5) Training activities will reflect the integral nature of the HIV/AIDS care with a bias towards family based care of HIV. Crucial knowledge and skills in ART compliance and adherence monitoring will be included in the training activities. The capacity of teams at health sub district/district/regional levels will further be built by involving all the trained trainers in supervisory roles. The Foundation will continue to conduct Continuing Medical Education (CME) approach and using the mentoring approach from five regional hospitals in order to reinforce skills development among health facility staff with the goal of improving program uptake. The technical development of MOH staff in the supported districts will ensure sustainable capacity for program implementation. Overall, the Foundation will train up to 600 health workers during FY09 in both PMTCT and ART services with the focus primarily targeting health workers in the Maternal and Child Health departments in the remaining Health Center IIIs in supported districts. Clinicians, nursing/midwifery and laboratory staff will be trained as integrated teams for HIV/AIDS patient care. Training activities will reflect the expanded nature of the PMTCT program with a strong bias towards integrating preventive and treatment aspects of HIV/AIDS. Special emphasis will be made towards increasing the use of more efficacious (combination) regimen for PMTCT and the repackaging of oral ARV medications for HIV exposed infants. 6) Monitoring and Evaluation Plan: The Foundation will continue to support the MOH's M&E network through the provision of evaluation reports on key PMTCT and HIV care and treatment indicators. Field support 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. 7) Nutrition Support: The Foundation will in collaboration with the NuLife Project initiate a therapeutic feeding program in 20 EGPAF supported districts. This will also involve the development of resource materials like job aides, pamphlets for infant feeding and nutrition of pregnant women. 8) The Foundation will work to ensure that sites provide quality clinical care services. Antiretroviral treatment will be provided in accordance with Uganda treatment guidelines and the procurement and ARV distribution will utilize the MOH systems. Collaboration will be sought from other USAID funded programs e.g. QAP to design quality improvement interventions of HIV care and treatment and provide ongoing technical guidance in this critical area.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15921

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15921	15921.08	U.S. Agency for International Development	Elizabeth Glaser Pediatric AIDS Foundation	6734	6159.08	EGPAF	\$2,039,364

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* Family Planning

- \* Malaria (PMI)

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 7406.09

**Prime Partner:** Infectious Disease Institute

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 21592.22690.09

**Activity System ID:** 22690

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$627,250

**Activity Narrative:** The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Dean of the Faculty of Medicine. IDI has trained 2,394 course participants from 26 African countries in the areas of HIV/AIDS, malaria, pharmacy, lab and data management. Twenty-six research projects are in progress, focusing on identifying best practices and models for prevention, care and treatment of HIV/AIDS and related infectious diseases in sub-Saharan Africa. Almost 9,000 people are receiving care at the IDI clinic, and 5,741 people are on anti-retroviral therapy (ART). In addition, a total of 3,004 people are being cared for at four Kampala City Council clinics supported by IDI, and 1,339 people are receiving ART across the four sites.

In August 2008, IDI was awarded a CDC Cooperative Agreement to build capacity for scaling up of HIV/AIDS services in Kibaale and Kiboga, two rural underserved and high prevalence districts in Uganda. IDI intends to implement this service in conjunction with the respective District Health Offices, The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) projects. These latter two organizations will support the HIV/AIDS Care and treatment and training functions respectively. Specifically the project will: (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. At the end of the project period, IDI will have scaled-up routine HIV Counseling and Testing in at least six health facilities and tested 200,000 people. In addition, the project will provide at least 3,000 HIV-infected people with a care package and to start or maintain at least 1,500 HIV-positive people on ART. Other measurable outcomes include training for at least 200 health workers in comprehensive HIV/AIDS Care and starting 900 HIV+ people on TB treatment.

In FY 2009, IDI and its partners will provide adult care and treatment services at the 6 centres in Kibaale and Kiboga districts. All the 10,000 active adult clients will be facilitated to access a comprehensive package of high quality Adult Care & Treatment services. The Adult Care & Treatment package will comprise of: 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; enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing LLITNs and promoting malaria prevention; providing condoms to sexually active clients; conducting various courses to train service providers to provide HIV care and support; and procurement/provision of nutritional supplements for clients. In order to reach the targeted beneficiaries, IDI and its main partner TASO, will provide Adult Care & Treatment through various venues and using appropriate and proven service delivery models. The broad service delivery strategies will include mobilization and sensitization, capacity-building, beneficiary involvement, greater PHA involvement, partnership and collaboration and others. In partnership with PSI and TASO, IDI will provide a basic care kit consisting of safe water vessels and chlorine solution (Waterguard®), LLITNs (bed nets) for prevention of mosquito bites, cotrimoxazole prophylaxis and condoms to sexually active clients. The targets for the basic care kit be: 3,000 clients given water vessels and chlorine solution for preventing contamination of drinking water by pathogenic organisms thereby preventing water borne diseases like diarrhea; 3,000 clients given LLITNs to prevent malaria which is Uganda's highest cause of mortality and morbidity; 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; and 3,000 new clients will be provided with cotrimoxazole prophylaxis. IDI in conjunction with TASO 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 all service outlets. Staff at the 11 Centres will educate clients on various Care & Treatment issues through individual and group sessions. The IDI project field teams will monitor use of Care & Treatment services during regular visits to clients' homes. IDI 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 for STI, supported to mobilize sexual partners for STI treatment, provided with condoms and condom education. Field teams at the 6 facilities will follow up specific STI cases and refer for specialized care where necessary. Teams will support clients to uphold the high adherence levels and will support clients with low adherence through follow-up. Quality assurance of services will be done through ensuring conformity with 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21592

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21592	21592.08	HHS/Centers for Disease Control & Prevention	Infectious Disease Institute	12197	12197.08	Expansion of Routine HCT and provision of Basic Care in Clinics, Hospitals and HC IVs	\$650,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3166.09	<b>Mechanism:</b> Expanding the Role of Networks of People Living with HIV/AIDS in Uganda
<b>Prime Partner:</b> International HIV/AIDS Alliance	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 25009.09	<b>Planned Funds:</b> \$926,400
<b>Activity System ID:</b> 25009	

**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008 the project has 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 such as family planning and broader reproductive issues. The project has trained 839 Network Support Agents (NSAs) who have been seconded to 416 Health centers across the 40 districts of operation. A total of 29 consortiums of PHA groups have been formed at Health Sub district level to participate in the delivery of HIV-related services. The NSA and the PHA groups have carried out ART education, ART adherence counseling and they have followed up clients in their homes to support patients with drug adherence and general welfare. As a result, a total of 238,800 individuals were reached with ART education, 40,434 reached with follow up counseling, 31,242 reached through home visits. In addition, through the project, the Alliance has linked the PHA groups with PSI which has provided basic care kits that prevent opportunistic infections like safe water vessels, insecticide treated nets and pharmaceuticals. Working in partnership with NuLIFE, the program is training NSA in integration of nutrition in care and support programs for PHA. A total of 580 NSA have been trained.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

In FY 2009, the project will consolidate activities in the 40 districts. An additional 100 consortiums of PHA groups will be formed and supported financially and technically to strengthen care and treatment support provision to their members and other PHAs identified in the community. The groups will therefore carry out home visits, couple counseling and support for disclosure and ART adherence counseling. 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. The project will also continue supporting post test clubs because they facilitate transition from counseling and testing to care, treatment and prevention services. The project has specifically targeted Post Test Clubs (PTCs) comprised of military populations in order to extend care and support services to this key population.

As members of the PLHIV groups, the trained NSAs in addition to undertaking activities outlined above, will play a critical role in mobilization of PHAs, making referrals to health facilities and creating linkages between the clients and the PHA group for continued care and support. As the number of people accessing HIV/AIDS related services increases, the importance of ensuring quality services and drug adherence remain critical. The presence of the NSAs at the health facilities makes this possible and the Alliance proposes to lobby the Ministry of Health to integrate the NSAs into the formal district health care delivery system since they provide an alternative source of manpower for health care.

Gender norms and practices are a barrier to people accessing care and support services. The project plans to 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 Project plans to strengthen Prevention for Positive programs in order to provide PHAs with the skills they need to take control over the disease in their lives. Working closely with SCOT (Strengthening Counselor Training Program), the project will build the capacity of PHA groups to provide patient education, conduct behavioral counseling and to support patients develop personal prevention strategies. IEC materials will also be provided to reinforce education on prevention for PHAs within the continuum of care. The PHA groups will also be supported to conduct "HIV stops with Me" campaigns in order to reduce stigma associated with HIV.

As part of the capacity building process of the PHA groups, the project plans to continue supporting refurbishment of Common Facility Centers. These centers provide space for people living with HIV to meet regularly for peer support and shared learning, and to conduct health education programs for the community members. The centers will also house vocational training workshops, provide space for setting up demonstration gardens and act as a reference point for the groups.

The project will continue to partner with PSI and other malaria control partners to provide basic care commodities to the PHAs and their families. Commodities include mosquito nets, water vessels and pharmaceuticals. The partnership with NULIFE will be expanded to cover 12 new districts in Mid Western Uganda that have not been covered in FY 2008 as well as increase capacities of groups to conduct nutritional assessments, carry out nutrition counseling and education. The project will also facilitate



**Activity Narrative:** linkages of PHA groups to Government programs like NAADS and other existing agricultural programs to provide skills in vegetable growing and horticulture for purposes of improving nutrition. The community engagement strategy will continue to be employed to further link PHA groups to other organizations providing wrap around services e.g. family planning, reproductive health, supplementary feeding, livelihood programs and water and sanitation programs.

The project proposes to strengthen the link between the groups and the local government at district and county levels and hence ensure that the local government provides leadership, technical support and mobilizes resources for PLHIV groups and networks in order to sustain care and support programs beyond the project life. The Alliance will therefore provide technical assistance to local governments to institutionalize the network model and strengthen capacity of PHA groups' to leverage local resources.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

#### Health-related Wraparound Programs

- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

#### Military Populations

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$323,939

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,000

### Food and Nutrition: Commodities

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$49,859

### Education

### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

---

**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4381.20064.09

**Activity System ID:** 20064

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$1,594,775

**Activity Narrative:** 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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/ Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/ Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kirudu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is ongoing. We hope these will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

By June 2008, there were 328 ART accredited sites in Uganda, most of which (60% – 70%) are urban based and mostly in central part of Uganda. At Baylor – Uganda, there are over 7,500 children and their care givers who are in active HIV/AIDS care from Baylor - Uganda Center of Excellence, 6 satellite centres in Kampala, 4 regional centres in Soroti and Kasese areas and now 32 public rural health facilities. Adults make up 2,275 and 792 of those in active HIV/AIDS care and on ART respectively. Baylor – Uganda provides HIV/AIDS family-clinic twice a week in Naguru and Kawempe Health Centre IV and once a week at the COE and in three Satellite Clinics. Rural facilities are being supported to provide integrated family/child HIV/AIDS clinic, but because of large number of people enrolled on ART, this programme will only provide support for contingency and buffer supplies. As such, as children are being enrolled into HIV/AIDS care and treatment, their care givers are provided with services too, in order to enhance adherence, observance of return visits and reduce costs associated with seeking care from multiple sources for same family members, but with different age groups. In 2008, Baylor – Uganda has integrated pediatric HIV/AIDS services in 33 health facilities and through this initiative more than 1,200 and 305 children and care givers have been enrolled in active HIV/AIDS care and ART respectively within three months period. This demonstrates immense potential for patient recruitment, but also shows the opportunity to increase equitable access to HIV/AIDS care and treatment. However, our initial ART Site Preparedness Assessment showed gaps in capacities of these lower level health facilities to initiate and sustain integrated pediatric and adult HIV/AIDS services in the area of infrastructure; number, skills and motivation of personnel; pharmacy and logistics management; laboratory support; data management & use; support supervision; etc. Population Services International provides support to Baylor – Uganda with Basic care kit for people living with HIV/AIDS (PHAs).

In FY2009, Baylor – Uganda will continue providing adult HIV/AIDS care and treatment services in the context of family clinic of family-centered services at the Baylor- Uganda Center of Excellence (COE), Satellite clinics & rural health facilities. The following will be the key activities to be implemented over this

**Activity Narrative:** period:

- Provision of ART services to eligible care givers and continual clinical and laboratory monitoring of those in HIV/AIDS care and on ART.
- Prevention & management of opportunistic infections (excluding TB), malaria, diarrhea, pain & symptom relief, nutritional support, etc.
- Procurement and distribution of pharmaceuticals (non-ARVs), basic care package (ITNs, safe water vessels, etc) to all supported sites.
- Working with partners to train/orient health workers and lay community volunteers in adult HIV/AIDS management, Home based Care, etc.
- Continuous provision of technical support to rural health facilities through on-site mentorship (at least for 3 consecutive months to develop systems and competencies of trained staff) and routine support supervision & monitoring.
- Minor infrastructure improvements such as renovations, painting to make service areas user-friendly, building of tents as waiting space for facilities without such provisions
- Procurement and distribution of basic supplies for managing adult HIV/AIDS where needed.
- Support for personnel involved in the training, national expansion program, monitoring & evaluation and former Plus-Up sites in Anyeke Health Centre IV and Kagadi & Kiryandongo Hospitals.
- Support for pediatric HIV/AIDS training curriculum development for in-service in order to incorporate aspects of family-centered care/treatment.
- Support for data management and utilization through strengthening capacities of Baylor – Uganda, District Health Offices and targeted health facilities with computers, internet connectivity, hands-on training, in various data management programs/packages, routine data collection and analysis, with report writing.
- Routine monitoring and evaluation of the program for ARV services, bi-annual regional program review meetings, and best practice documentation and dissemination will also be covered under this program area.
- Formation & working in partnership with other actors will be important in rolling out adult ARV services and related care needs for nutrition, income generating activities, etc.
- Community mobilization on family-centered HIV/AIDS treatment and care through radio and community dialogues, etc.
- Provision of activity related incentives for rural health facility staff such as staff tea break, overtime allowance, across the facility.

Undertake quality improvement initiatives in all sites with support from HIVQUAL; a capacity building program for quality improvement in HIV care and treatment.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13248

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13248	4381.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$2,065,771
8284	4381.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$1,925,771
4381	4381.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$368,415

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$50,519

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5342.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 10139.20734.09	<b>Planned Funds:</b> \$2,535,941
<b>Activity System ID:</b> 20734	

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

In FY 2008, AIDSRelief expanded its services to four new LPTFs and three community based organizations. It also decentralized services by encouraging LPTFs to open satellite sites and outreach clinics. As of July 31, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. AIDSRelief has supported a comprehensive continuum of care for adults living with HIV, in order to enhance their quality of life throughout the entire span of their illness. The adult care and treatment component has been built on existing clinical and social services in all LPTFs. Clinically, the program continued providing adults with 1st line, alternative 1st line, and 2nd line therapies, clinical follow-up, laboratory testing (including CD4), and treatment of opportunistic infections. Social services supported consist of psychosocial and spiritual support, as well as nutrition counseling and education were available to all 55,781 HIV+ adult patients enrolled in care in FY 2008.

To get services closer to the PHAs, AIDSRelief has encouraged and supported LPTFs to open up satellite clinics and this has increased accessibility of these services to those in rural areas. All LPTFs had outreach teams led by a community nurse/clinical officer and are linked with community based volunteers, many of whom were PLWHAs on treatment. Emphasis has been placed on excellent adherence in order to achieve durable viral suppression. As a result there has been very good retention rate for patients on ART, low drug toxicity, and an average adherence rate of over 95%. The teams also provided community based and household ARV treatment support and preventative services which included education on the importance of using ITNs, basic hygiene and good nutrition. Emphasis has been put on the creation of linkages within the different services provided at the LPTFs and other service providers. The referral linkages between ANC, PMTCT and ART services have been encouraged at the LPTFs to enable HIV+ mothers, their partners and their babies to access ART services through the facilities.

AIDSRelief also continued employing a model of 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 and appropriate referral for management of opportunistic infections (OIs), as well as supply of the basic care package (ITNs, safe water, information on cotrimoxazole prophylaxis and prevention for positives). Activities were expanded to 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. The program has recognized the strong link between nutritional and Antiretroviral therapy and adherence to ART but this 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) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

By the end of FY 2008, 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 were included in this analysis, grouped into three cohorts (36, 24 and 12 months) representing the length of time they had received therapy.

In FY2009, due to projected flat-lined funding, AIDSRelief activities will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites in order to maintain 17,200 adult patients on AIDSRelief provided ARVs and 55,781 adult patients in care. Support will consist of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. A major focus will be to increase the devolution of services to alternate cadres of service providers through 'task shifting,' and networking with facilities and with other service providers including the Ministry of Health. At the LPTFs, this strategy will focus on protocols enabling nurses and clinical officers to do routine follow-up of stable patients and manage non-critical acute symptoms as well as enabling nurses and pharmacy staff to do routine medication dispensing to stable patients. This will increase service delivery, and ensure greater coordination and integration of services provided within the community. Should additional funding from the USG become available, AIDSRelief is poised to expand the services it supports to other underserved areas of Uganda to reach an additional 6300 adult patients on ARVs and 10,000 adults in care.

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, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV + patients enrolled in care in 18 LPTFs and their satellites. There will also be strengthened linkages between other health facility services, especially for PMTCT and TB

The AIDSRelief technical team will provide comprehensive training and technical assistance to 290 medical and 720 non-medical staff to increase the capacity of LPTFs to appropriately manage and monitor patients with HIV infection. This will include the recognition and management of opportunistic infections, treatment

**Activity Narrative:** 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 also establish 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.

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. 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 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 symptom monitoring, disclosure counseling, secondary prevention, and family-based testing and education.

In FY 2009, 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 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.

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 PSI and UHMG (Uganda Health Marketing Group) will be strengthened in order to increase access to ITNs 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.

Coordinated by Constella Futures, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AIDSRelief will ensure that 100% of the LPTFs use the new PMM system, IQCare, and other IT solutions that enhance data use, like IQTools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, and collect data across all program areas. This will support the program to reach and report on its patients. During the year, great efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. Staff will be given skills to analyze their own data, and use the information to carry out quality of life analyses to be able take informed clinical decisions. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services. These indicators will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcoholism. LPTFs will also be able to track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs, like malaria, and chest infections, and overall patient morbidity trends.

Through the already established CQI plans, and the "small test of change" methodology that is being used at all LPTFs, staff will be assisted in generating, collecting and using patient level outcome information to continuously assess, define gaps and improve the services they provide. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed as a team. This will enhance better understanding and ownership of the program, and indicators that enhance good clinical practice. The program will also promote these 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 also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care services. This capacity strengthening will include human resource support and management, financial management, infrastructure improvement, and strengthening of health management information systems.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13260

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13260	10139.08	HHS/Health Resources Services Administration	Catholic Relief Services	6428	5342.08	AIDSRelief	\$3,169,926
10139	10139.07	HHS/Health Resources Services Administration	Catholic Relief Services	5342	5342.07	AIDSRelief	\$2,932,296

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Malaria (PMI)

- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$2,315,674

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$72,388

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 4386.20745.09	<b>Planned Funds:</b> \$3,617,592
<b>Activity System ID:</b> 20745	



**Activity 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

In FY 2008, AIDSRelief expanded its services to four new LPTFs and three community based organizations. It also decentralized services by encouraging LPTFs to open satellite sites and outreach clinics. As of July 31, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. AIDSRelief has supported a comprehensive continuum of care for adults living with HIV, in order to enhance their quality of life throughout the entire span of their illness. The adult care and treatment component has been built on existing clinical and social services in all LPTFs. Clinically, the program continued providing adults with 1st line, alternative 1st line, and 2nd line therapies, clinical follow-up, laboratory testing (including CD4), and treatment of opportunistic infections. Social services supported consist of psychosocial and spiritual support, as well as nutrition counseling and education were available to all 55,781 HIV+ adult patients enrolled in care in FY 2008.

To get services closer to the PHAs, AIDSRelief has encouraged and supported LPTFs to open up satellite clinics and this has increased accessibility of these services to those in rural areas. All LPTFs had outreach teams led by a community nurse/clinical officer and are linked with community based volunteers, many of whom were PLWHAs on treatment. Emphasis has been placed on excellent adherence in order to achieve durable viral suppression. As a result there has been very good retention rate for patients on ART, low drug toxicity, and an average adherence rate of over 95%. The teams also provided community based and household ARV treatment support and preventative services which included education on the importance of using ITNs, basic hygiene and good nutrition. Emphasis has been put on the creation of linkages within the different services provided at the LPTFs and other service providers. The referral linkages between ANC, PMTCT and ART services have been encouraged at the LPTFs to enable HIV+ mothers, their partners and their babies to access ART services through the facilities.

AIDSRelief also continued employing a model of 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 and appropriate referral for management of opportunistic infections (OIs), as well as supply of the basic care package (ITNs, safe water, information on cotrimoxazole prophylaxis and prevention for positives). Activities were expanded to 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. The program has recognized the strong link between nutritional and Antiretroviral therapy and adherence to ART but this 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) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

By the end of FY 2008, 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 were included in this analysis, grouped into three cohorts (36, 24 and 12 months) representing the length of time they had received therapy.

In FY2009, due to projected flat-lined funding, AIDSRelief activities will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites in order to maintain 17,200 adult patients on AIDSRelief provided ARVs and 55,781 adult patients in care. Support will consist of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. A major focus will be to increase the devolution of services to alternate cadres of service providers through 'task shifting,' and networking with facilities and with other service providers including the Ministry of Health. At the LPTFs, this strategy will focus on protocols enabling nurses and clinical officers to do routine follow-up of stable patients and manage non-critical acute symptoms as well as enabling nurses and pharmacy staff to do routine medication dispensing to stable patients. This will increase service delivery, and ensure greater coordination and integration of services provided within the community. Should additional funding from the USG become available, AIDSRelief is poised to expand the services it supports to other underserved areas of Uganda to reach an additional 6300 adult patients on ARVs and 10,000 adults in care.

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, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV + patients enrolled in care in 18 LPTFs and their satellites. There will also be strengthened linkages between other health facility services, especially for PMTCT and TB.

The AIDSRelief technical team will provide comprehensive training and technical assistance to 290 medical and 720 non-medical staff to increase the capacity of LPTFs to appropriately manage and monitor patients with HIV infection. This will include the recognition and management of opportunistic infections, treatment failure, adult counseling, and psycho-social assessments. AIDSRelief will follow-up didactic training with

**Activity Narrative:** on-site clinical mentorship for clinicians and site level support for other cadres of workers. AIDSRelief will also establish 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.

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. 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 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 symptom monitoring, disclosure counseling, secondary prevention, and family-based testing and education.

In FY 2009, 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 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.

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 PSI and UHMG (Uganda Health Marketing Group) will be strengthened in order to increase access to ITNs 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.

Coordinated by Constella Futures, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AIDSRelief will ensure that 100% of the LPTFs use the new PMM system, IQCare, and other IT solutions that enhance data use, like IQTools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, and collect data across all program areas. This will support the program to reach and report on its patients. During the year, great efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. Staff will be given skills to analyze their own data, and use the information to carry out quality of life analyses to be able take informed clinical decisions. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services. These indicators will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcoholism. LPTFs will also be able to track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs, like malaria, and chest infections, and overall patient morbidity trends.

Through the already established CQI plans, and the "small test of change" methodology that is being used at all LPTFs, staff will be assisted in generating, collecting and using patient level outcome information to continuously assess, define gaps and improve the services they provide. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed as a team. This will enhance better understanding and ownership of the program, and indicators that enhance good clinical practice. The program will also promote these 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 also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care services. This capacity strengthening will include human resource support and management, financial management, infrastructure improvement, and strengthening of health management information systems.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13268

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13268	4386.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$4,686,000
8289	4386.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$4,186,630
4386	4386.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$3,286,630

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1245.09	<b>Mechanism:</b> Makerere University Walter Reed Project (MUWRP)
<b>Prime Partner:</b> Walter Reed	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Adult Treatment
<b>Budget Code:</b> HTXS	<b>Program Budget Code:</b> 09
<b>Activity ID:</b> 4507.20037.09	<b>Planned Funds:</b> \$473,820
<b>Activity System ID:</b> 20037	

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

The Adult Care and Treatment program described below continues to be part of a comprehensive program and activities do link to other program areas. Specific program activities that are included in this comprehensive program include prevention, SI, CT, laboratory, ARV drugs, and OVC services. During FY2008, MUWRP greatly expanded adult care and treatment services to the north of Kayunga District, to the rural, underserved, fishing communities of Galilyra. This was done by supporting an HIV clinic at the Galilyra Health Center III, and training local clinicians and capacity building. Two other HIV clinics, the Kayunga District Hospital and the Bbaale Health Center IV, were completely renovated during FY2008 to successfully address issues of patient flow, confidentiality, waiting times, and staff morale. MUWRP supportive supervision was expanded during FY2008 for all MUWRP supported HIV clinics, to four visits per week. This included two MUWRP supported nurses, two clinical officers, one pharmacist, and one medical officer. One primary focus of the MUWRP FY2008 adult Care and Treatment program was to train 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 treatment patients – each of the farms has already had one successful harvest and all patients have benefited regardless of the percent time they have spent working on the farms. Treatment club volunteers have also distributed over 1200 basic care packages to adult care and treatment patients and spearheaded 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. Also during FY2008, MUWRP supported the implementation of Post Exposure Prophylaxis Programs at each of the 5 HIV clinics in Kayunga for victims of rape, defilement, or any other person who has had immediate exposure to HIV and also supported 30 District clinicians in a two-week training on reproductive health. Finally, Because ART and 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 ART or OI drug stock outs.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

During FY2009, MUWRP will meet increasing adult care and treatment patient burden by expanding services to one additional health facility in Kayunga and also expand services to the District of Mukono South sub-district. The rate of adult care and treatment enrollment is rising in Kayunga due to HIV+ referrals from a house-to-house counseling and testing program which started in July 2008. Beginning in FY2009 MUWRP will partner with the remote Busana Health Center III in eastern Kayunga so this clinic can begin to provide HIV services, including adult care and treatment, to address the rising requirement for services in this district. Additional activities in Kayunga will include the renovation of two more HIV clinics in Kayunga, the Galyiria Health Center IV and the Busana Health Center III. In order to operate at capacity these clinics will need to be renovated to address issues of patient flow, confidentiality and waiting times. Also during FY2009 MUWRP intends to expand services into Mukono District in order to support the Kojja Health Center IV. The initial aims of this support will be to promote care, treatment, laboratory services and counseling and testing services for the entire sub-district of Mukono South; including supporting three surrounding health center III's for the same services via mobile VCT outreaches into the surrounding fishing communities. Presently, the only HIV service provision at Kojja is a PMTCT component including a treatment club for mothers supported by EGPAF. Mukono South sub-district has a population of 120,000 persons and using data from the Uganda sera-survey, we can expect approximately 12,000 HIV positive residents; at least 80% of these (9,600) would be HIV+ adults. Other FY2009 initiatives under this program area include: (1) partnering with AIDS Treatment Information Center (ATIC) so that District HIV clinicians in rural areas can receive a medical consultation over the phone from a HIV/AIDS specialist, (2) expansion of adult care and treatment service provision to HIV+ prisoners residing in Bulawula (3) retraining of all HIV clinic staff as the Uganda MOH has recently revised its policies on ART, and (4) support of the District HIV team to meet weekly and conduct supportive supervision to the HIV clinics monthly (this is in addition to the weekly MUWRP supportive supervision). The final new activity for FY2009 Funding will support the expansion, training, technical assistance, transportation, capacity building, remodeling and provision of commodities (including pain medication) to five HIV clinics operating in Kayunga District and expansion of comprehensive services to Mukono South sub-district.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15713

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15713	4507.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$613,757
8527	4507.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$523,787
4507	4507.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$39,655

### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$116,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$27,000

### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$2,500

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$22,000

### Education

### Water

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Prime Partner:** Makerere University Faculty of Medicine

**Funding Source:** GHCS (State)

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Treatment: Adult Treatment

---

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 4036.20768.09

**Planned Funds:** \$2,315,160

**Activity System ID:** 20768

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI, health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART), and people living with HIV receive free clinical care including ART. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komaboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are implemented in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

Currently, the MJAP Adult Care and Treatment activities are implemented at 15 outlets as listed above. By June 2008, the 15 service outlets had served over 45,000 patients cumulatively of which 37,365 were still in active care and 8,154 (48.58%) were receiving antiretroviral therapy. Of the patients on ART, 7,404 patients receive their ARV drugs from Global Fund for AIDS, TB and Malaria, and the Clinton Foundation HIV/AIDS Initiative (CHAI). The number of HIV patients in all the clinics continues to increase with the expansion of Routine HIV Testing and Counselling (RTC) in the hospitals: over 25,000 HIV infected persons were identified through RTC in FY 2008 and a good proportion were linked to care at MJAP supported sites. MJAP provides mainly adult care and treatment while pediatric patients are handled through collaborative partnerships with other providers namely e.g. PIDC, KCC, and MOH. KCC provides clinic space and drugs for management of OIs. NTLP provides TB medications and support supervision. VCT is provided by AIDS Information Centre, PMTCT under PREFA, ART under MOH-Global Fund Program, and OVC support through Ministry of Gender, Labour and Social Development. These programs are working together to ensure comprehensive care for families affected by HIV/AIDS while avoiding duplication of service.

The demand for HIV basic care and ART services is very high in all the care and treatment sites compared to the available staffing and space. The basic care and ART programs are integrated: all patients on ART receive basic care, and all patients receiving basic care are regularly evaluated for ART eligibility. The palliative basic care programs include provision of a basic care package comprising of daily cotrimoxazole for prophylaxis, insecticide treated mosquito nets, safe water vessels for safe water provision, diagnosis and treatment of opportunistic infections (OI) treatment and prophylaxis. Newly diagnosed HIV positive patients from the RTC program also receive a month's supply of cotrimoxazole prophylaxis and are provided with referrals for follow-up care in the HIV clinics. Up to 70% of HIV positive patients identified through the RTC program are ART eligible. Before patients get initiated on ART, they undergo counseling to prepare them for ART including basic facts on ART, issues of adherence, side effects, duration of treatment, among others. Patients who fulfill the eligibility criteria receive a second orientation meeting with their treatment supporter. ARVs are initiated on the third visit if the medical officer is satisfied that the patient is ready to begin therapy. Patients are seen by the adherence nurse counselor on day 0, day 15, 1 month and then monthly for counseling and ARV refills. Adherence to ARVs is monitored by self report using a visual analogue scale, ART patient cards and pill counts (patients return the bottles with any remaining pills). The program also carries out routine ART monitoring tests that include CD4+ cell count, haematology, serology and routine TB screening. Currently, the clinics get support for follow-up of patients from the home visitors and the family based care team of MJAP. In both Mulago and Mbarara ISS clinics, we estimate that about 80% of clinically eligible patients are receiving ART.

In addition to the support for ART, the program provides special attention to discordant couples at all the treatment centres with currently over 100 couples attending the special clinics. The couples are provided with psychosocial support, prevention and treatment of OIs, positive living package and disclosure support.

MJAP has trained over 800 health care providers in the provision of antiretroviral therapy and strengthened systems for ART delivery including staffing, laboratory support, and logistics and data management. By the end of FY 2008, the program expects to provide adult care and treatment services to over 70,000 individuals. Over 10,000 patients shall be supported to initiate ART at the supported sites.

#### FY09 activities

In FY 2009, MJAP will consolidate existing services; scale up to 4 new service outlets, bringing the total to 19. The location of the new clinics shall be determined based on the current demand for care and treatment services. Funds will go towards additional staffing and training of new and existing staff. A limited number of

**Activity Narrative:** staffs shall be hired with emphasis being placed on transferring the management of the current existing clinics/ services to the local government systems.

MJAP will provide care and treatment services to 85,000 HIV-infected persons with at least 38,000 being on ART (15,000 of whom will receive their ARVs from GFTAM and CHAI sources). Thirty thousand (30,000) newly- identified HIV infected persons (through the RTC program) will receive a month's supply of cotrimoxazole at the time of diagnosis before referral into care. At least 10,000 patients will be supported to initiate antiretroviral therapy. The program will reinforce adherence counseling and support, and follow-up of ART patients through modifications in the current adherence support mechanisms at all clinics. As a quality improvement strategy, patients that are stable on ART shall be moved from routine clinician visit to the pharmacy-only and nurse-only visit programs to reduce both the waiting time and need for staffing. In this arrangement, patients shall only see a clinician/doctor only once in three months while in all the other visits they are either picking their drugs from the pharmacy directly or are seen by a nurse. The program will continue to carry out routine ART monitoring tests that shall include CD4+ cell count, haematology, serology TB screening.

MJAP will strengthen prevention with positives counseling and support including HIV testing for spouses and other family members of index patients attending the HIV clinics. Many more Family clinic days will be held in order to reach out to many more patients. In all the clinics MJAP will provide comprehensive HIV/AIDS care and treatment for families including children in partnership with other programs where applicable. Pregnant mothers registered in the clinic shall be evaluated for ART eligibility and provided with ARVs in accordance with the national PMTCT guidelines. Patients with opportunistic infections shall be offered treatment and where necessary referred for further specialised care. MJAP will provide cotrimoxazole prophylaxis and other OI care, malaria diagnosis and treatment, and Population Services International (PSI) will provide safe water supplies and insecticide treated mosquito nets. The clinic based activities will be further supported by the Family-based Care team and health visitors who will conduct follow up visits to support disclosure, trace treatment defaulters, provide support on home care for HIV positive persons, test other family members and refer the HIV positive ones to the clinics for further care.

MJAP will support efforts to identify and provide care and treatment services to new HIV infected persons by extending RTC services to HC IVs in the catchment areas of the already supported regional referral hospitals. In order to achieve the above objectives, MJAP will enhance the human resource capacity in various ways. MJAP will hire and train additional and existing staff: - up to 500 health care providers will receive training in ART delivery. In collaboration with Makerere and Mbarara universities, the program will provide pre-service training to students (offering courses of bachelor of medicine and surgery, dental surgery, pharmacy degree, nursing degree and post-graduate studies) in provision of HIV care and treatment services. A total of 400 students will receive training through both lectures and practical attachment to the MJAP supported centres. To ensure sustainability, MJAP will continue to support the improvement of existing infrastructure and systems. This will include the improvement of data management and reporting to all stakeholders within the districts to MOH; 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, MJAP has recently developed and is already implementing a strategy for involvement of people living with HIV/ AIDS (PHAs) in aspects of patient care following appropriate training.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13279

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13279	4036.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$2,525,400
8319	4036.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$2,025,400
4036	4036.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,725,400



---

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$1,782,040

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism****Mechanism ID:** 1298.09**Mechanism:** HIV/AIDS Project**Prime Partner:** Mildmay International**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Treatment: Adult Treatment**Budget Code:** HTXS**Program Budget Code:** 09**Activity ID:** 4414.20801.09**Planned Funds:** \$2,599,884**Activity System ID:** 20801

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trial. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 10,822 clients received palliative care/basic health care and support (including children) under MU through 9 sites and RO through 3 sites. 437 were trained in palliative care and support. There were 1,294 new naïve adult clients (+ 15 years) receiving ARVs and 6,548 who had ever received ARVs. Two specialist clinics were started. Eye clinic was opened in November 2007 to screen and treat patients with HIV related eye conditions. 28% of the clients seen in the eye clinic are children. The community programme was introduced in February 2008. Stable adult patients are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The trainings run at MU target the management of HIV/AIDS in adults. 410 health care workers were trained in HIV/AIDS treatment. These included doctors and nurses, allied health professionals; counsellors, physiotherapists, occupational therapists, nutritionists and informal caregivers; carers of patients. Training not only focuses on the physiological processes of HIV/AIDS but also on the psychosocial and spiritual needs of patients living with HIV. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration.

During FY 2009 MU will continue providing HIV services and training activities at 12 sites of MU and 4 sites of RO. In FY 2009, 15,422 adults will receive basic health care and support; of these 6025 will be at MU, 6000 at the satellite clinics and 3397 at RO. The funds for this programme area will finance the purchase of drugs for management and prevention of OIs, along with symptom control and pain management. Family planning services will be provided at MU as part of the care and treatment. The target population is people living with HIV/AIDS in a 60-kilometre radius for TMC and population at its 12 rural sites and military populations in the catchment area of RO plus persons who left the IDP camps and settled around RO. MU will train 1500 individuals through formal courses and clinical placements. MU will also work in collaboration with PSI to make the basic care kit (including 2 mosquito nets, safe water vessel, water guard, and condoms) available to patients; MU will screen an estimated 500 HIV infected women at risk of cervical cancer using both the visual method (VIA), and the pap smear. In addition, patients will be assessed for mental illness and those found seen by a psychiatrist who runs a weekly clinic on site. In addition all patients starting ART will be assessed for CMV retinitis to prevent blindness and those found with CMV treated by a visiting ophthalmologist who runs a weekly clinic on site. Disabled (hemiplegic and paraplegic) patients in care will be provided with transport to and from their homes whenever necessary but the home visitors will also ensure that these patients receive their services at home. The patients whose homes are visited will have an opportunity to have their family members tested for HIV and those already stable in care will have their drugs and support provided at selected community sites with the help of community-based

**Activity Narrative:** volunteers (CBVs). This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. Care and treatment plus training activities will be provided at 12 sites and 4 sites at RO. MU will continue training at the Centre as well as upcountry in targeted districts. Together with Emerging Markets Group, a USAID – funded project MU will also train health practitioners in the private sector in HIV management. MU will train – individuals through formal courses and clinical placements.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13290

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13290	4414.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$4,490,301
8333	4414.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$4,490,301
4414	4414.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$3,271,807

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Budget Code:** HTXS

**Activity ID:** 4057.20880.09

**Activity System ID:** 20880

**Program Area:** Treatment: Adult Treatment

**Program Budget Code:** 09

**Planned Funds:** \$3,154,880

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

About 81,000 active adult clients were served at various service delivery venues operated by TASO Centers. In FY 2008, the TASO priorities for Adult Care & Treatment were: providing counseling services to clients and their family members; screening and treating opportunistic infections; screening and treating sexually transmitted infections (STI); providing vital information to clients (cotrimoxazole prophylaxis, safe water, nutrition, STI, FP, PMTCT); enrolling clients on cotrimoxazole prophylaxis; providing safe water vessels and promoting safe water use; providing LLITN (long lasting insecticide treated nets) and promoting malaria prevention; providing condoms to sexually active clients; conducting various courses to train service providers to provide HIV care and support. By March 2008, TASO had 19,000 adult clients accessing ART at the 11 TASO Centers nationwide (including 1,200 clients of HBAC Tororo). 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 facilities (i.e. 11 TASO Centers) and the community (i.e. clients' homes and Community Drug Distribution Points). Field Officers delivered ARV drugs to Community Drug Distribution Points and clients' homes. TASO continued supporting models that meaningfully involve PHA; the 1,000 expert clients who had been trained as Community ART Support Agents (CASA) continued playing a grassroots' support role in to ART clients in the community, these TASO trained resource persons also support clients in the community accessing treatment from other partners). The 11 Centers continued running multidisciplinary case conferences to: assess eligibility for ART initiation; assessing client readiness for ART initiation; switching 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 Centers on appointment. The system was also aimed at enhancing the quality of services through adequate preparation by service providers. TASO Centers 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 record filing/archives 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

**Activity Narrative:** models; resolving ART implementation challenges; and other key issues.

During FY 2009, 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 Centers 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 & Treatment services. The Adult Care & Treatment package will comprise: counseling for clients and family members; provision of antiretroviral therapy (ART); screening and treating opportunistic infections; pain and palliative care management, STI screening and management; promoting and providing cotrimoxazole prophylaxis, safe water, nutrition counseling, PMTCT and family planning; 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; and procurement/provision of nutritional supplements for clients. In order to reach the targeted beneficiaries, TASO will provide Adult Care & Treatment through various venues and using appropriate and proven service delivery models (TASO is a key partner in developing innovative client-friendly and community-friendly service delivery models). The TASO Centers will deliver services to clients through the 11 static outlets, clients' homes and 34 outreach clinics sites (each of the 11 TASO Centers 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. In partnership with Population Services International (PSI Uganda), TASO will target 20,000 clients to receive a basic care starter kit consisting of safe water vessels and chlorine solution (Waterguard®), LLITN for prevention of mosquito bites, cotrimoxazole prophylaxis and condoms to sexually active clients. Additionally Prevention with Positives (PWP) interventions will be provided; including partner and family-based counseling and testing, supported disclosure, STI management, PMTCT and FP services or referral, and safe sex counseling. All adult clients will have the option to access condoms, and the sexually active clients will be empowered to appreciate, access and use condoms correctly and consistently. The 80,000 clients currently on cotrimoxazole and 20,000 new clients including children will be provided with cotrimoxazole prophylaxis and Dapsone will be procured as alternative medicine for a few clients that are allergic to cotrimoxazole. TASO will target to have at least 95% of ART recipients and 75% of overall active clients accessing cotrimoxazole prophylaxis. Client sensitization on the importance of the various Care & Treatment services in improving the quality of clients' lives 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/behaviors, gender equity, women's rights and gender violence. The various TASO field teams will monitor use of Care & 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 Centers 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 arising from improved health due to ART. During FY 2009, TASO Centers will scale up cervical cancer screening for the female clients above the FY 2008 level. Clients will continue to receive ARV drugs both through the facility arm (i.e. 11 TASO Centers) 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 exploring more client-friendly service delivery models. 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 by FY 2007) and supporting the few clients with low adherence through follow-up. Gender-related challenges often impede the success of adult care and treatment services. TASO will continue addressing gender issues affecting care and 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 (QA) 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 Care & 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. The activities under this Program Area are also linked to other USG funding through USAID focusing on Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13230

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13230	4057.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$4,086,632
8361	4057.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$3,786,632
4057	4057.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$2,460,072

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 4021.21222.09

**Planned Funds:** \$362,086

**Activity System ID:** 21222



**Activity 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 grant that carries forward lessons learnt in phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts of Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based Voluntary Counseling (VCT) program, provision of basic palliative HIV care, antiretroviral therapy (ART), Prevention of Mother to Child Transmission (PMTCT), tuberculosis (TB) care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV test results are returned to these clients through program resident community counselors. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons to household members. Through the medical male circumcision service, clients seeking male circumcision service are also offered VCT. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 outreach clinics in Rakai and Lyantonde districts. These clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. Services offered include: health education, on-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, ART, HIV prevention for positives interventions, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated). The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR support, HIV-infected individuals identified through

**Activity Narrative:** MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

Progress to date:

Basic HIV care: In this financial year (FY 2008), RHSP proposed to provide basic HIV care to 5000 HIV positive clients. In this program, HIV basic care comprises of continuous health education offered on every clinic day before the clinical sessions begin. These sessions cover a wide range of health issues including PMTCT, nutritional education, family planning, drug adherence, couple VCT, and disclosure among other topics. Treatment of opportunistic infections, on-going HIV counseling, provision of HIV basic care package for prevention of diarrheal diseases and malaria. Education on prevention of domestic violence is also provided through the "Safe Homes and Respect for Everyone" (SHARE) program. In the first 6 months of this financial year, the program had enrolled 4501 HIV positive clients and 4111 were under regular care. Clients in regular care receive the basic care package and we are currently pilot testing an evaluation of the utilization of these basic care packages provided to HIV-positive clients through impromptu (unannounced) home checks. The program laboratory has the capacity to carry out various screening and monitoring tests. These include: CD4 testing, viral load chemistry tests, hematology, serology, and microbiology. Each patient enrolled for care have CD4 count testing at least 6 monthly to assess eligibility for antiretroviral therapy or monitor immunological improvement while on ART. All patients on ART have 6 monthly viral loads to assess virologic failure. In this financial year, Number of tests performed include; HIV testing: 7524 Elisa tests, 499 Western blot tests, 2510 PCR tests (of these, 1700 were from the HIV clinic and 57 were for infant diagnosis, others from other Rakai studies), 4076 CD4 counts, of which 2806 were for the HIV clinic and 457 for other health centers in the district (Lyantonde and Kitovu hospital). 5370 RPR and 401 TPHA tests for syphilis diagnosis, 310 Elisa for HSV-2 diagnosis, 20 serum CRAG and hepatitis-B tests. Laboratory support is also provided to other health units: The program currently provides CD4 count testing for HIV positive patients of Lyantonde hospital. ART: In the first 6 months of FY 2008, we initiated 305 clients onto ART, making the total cumulative number of patients on ART as of June 2008 to 1594.

In 2009, emphasis to be put on:

- Screening for Sexually transmitted infections like syphilis.
- Provision of health education at the HIV clinics and at the community level via community meetings.
- Preventive services like the basic care package, provision of condoms at both
- Treatment and prophylaxis of opportunistic infections like Tuberculosis, cryptococcal meningitis, Pneumocystis pneumonia
- Prevention of gender-based violence.
- Training of HIV care providers based at the program and those providing care at district health centers.
- On-going support and counseling at the clinics and through the resident counselors.
- Appropriate laboratory care and treatment monitoring through the central laboratory based at the Kalisizo station.
- Family involvement in HIV testing

Geographical coverage

These services are provided to Rakai and Lyantonde district and a few residents of the neighboring districts of Masaka and Mbarara, via 17 outreach/mobile clinics which operate on a bimonthly basis. The program targets all persons residing in these districts. Via community meetings, the population is encouraged to visit the clinics for HIV testing and those who turn out HIV positive are retained for HIV care. All clinics are located at already existing government health centers. This in part has reduced the stigma among our clients because the health center serves both HIV positive and negative persons.

Other non-PEPFAR support - Most of the routine viral load testing is supported by NIH-ICER.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13238

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13238	4021.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$469,023
8326	4021.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$469,023
4021	4021.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$386,705

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$279,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water      \$20,000

Program Budget Code:      10 - PDCS Care: Pediatric Care and Support

**Program Area Narrative:**

Of the estimated 940,000 people living with HIV/AIDS (PHA) in Uganda, about 130,000 are children below the age of 14 years (UNAIDS 2008). Infant mortality among children born to HIV-infected and uninfected mothers is estimated at 209 and 98 per 1,000 births respectively (Rakai Program Cohort, 2000). Without access to ART, 50% of HIV infected infants will die before their second birthday and 75% will die before their fifth birthday (UNAIDS, 2005). UNAIDS does not provide estimated national need for children requiring ART, but if one assumes 15% of the estimated total of 350,000 persons, this would be 52,500 children and infants in need of treatment.

The primary mode of transmission of HIV in children is mother-to-child-transmission (MTCT) accounting for over 95% of HIV infections in children under 12 years, and 18% (25,000) of 135,000 new HIV infections annually. Factors contributing to high MTCT rates and large numbers of HIV-positive children include: 1) high fertility rate of 6.7 children per woman; 2) the 6.5% 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 safe and affordable infant feeding options resulting in HIV transmission through breast feeding.

**Policy and guidelines**

The National Pediatric ART Committee, established in 2006, developed a pediatric HIV Ten-Point Management Plan:

1. Early diagnosis of HIV infection
2. Growth and development monitoring
3. Routine childhood immunizations and deworming for helminthes
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 available and indicated

In the absence of affordable and safe infant feeding options, exclusive breast feeding up to 6 months of age with rapid weaning is recommended for all HIV-exposed infants. Cotrimoxazole prophylaxis should be initiated at 4-6 weeks of age or first encounter with health system and continued until HIV infection can be reliably excluded. For breast-feeding exposed infants, virologic HIV testing using DNA-PCR at 4-6 weeks is recommended. 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. Indications for ART initiation vary with age. The revised National ART Guidelines (June 2008) broadened the ART eligibility criteria to include all infants under 12 months of age with a confirmed diagnosis of HIV irrespective of CD4 count or percentage.

**FY08 accomplishments**

The Uganda National Strategic Plan for HIV/AIDS 2006/7-2011/12 recognized children as an underserved population and advocated for improved support. Through PEPFAR, many partners have supported capacity building for pediatric care and treatment by training health providers, particularly in communication with children, child survival strategies, Early Infant Diagnosis (EID), and administration of complex ARV regimens. MOH has adapted the Integrated Management of Childhood Illnesses (IMCI) complementary HIV course for training primary-level health workers in pediatric HIV. MOH and partners have established regional mentors for pediatric HIV care and treatment.

The number of accredited ART sites with capacity to provide pediatric care and treatment increased from 30 in 2006 to 209 in 2008. In FY08, 11,686 children were on ART supported by PEPFAR, with a male to female ratio of 1:1. This is an increase of 2,859 children since 2007. All children in care were indirectly supported through USG inputs in national training, laboratory diagnostics, logistics systems, quality assurance and policy. However, only 9% of all persons on PEPFAR supported ART are children, a decline from 11%. This relative change in children treated can be partially attributed to the increase in the family-centered approach to care, which has identified proportionally more adults. As of June 2008, MOH reported a total of 12,577 children on ART nationally, meaning that PEPFAR supports 95% of all children on treatment. The number of children needing ART will increase with the recently revised national guidelines that recommend ART for all confirmed HIV-positive infants under 12 months. Based on the new guidelines, an additional 25,000 infants may require ART in the absence of better PMTCT interventions.

There has been progress in identifying HIV infected children. In October 2006, MOH in collaboration with partners initiated EID, which uses DNA-PCR to diagnose infant HIV infection. The EID program is linked to 214 health facilities and has conducted more than 13,500 tests using Dried Blood Spot specimens processed at 7 reference laboratories countrywide. Each district has at least one health facility able to refer or test specimens using HIV DNA-PCR. The program targets HIV exposed infants with mothers diagnosed during antenatal care or newly identified at post-natal and immunization visits. In addition, several health facilities are

implementing Provider Initiated HIV Counseling and Testing (PICT) in pediatric in- and out-patient wards with support from Baylor-Uganda, RTI, and MJAP programs.

Through the Clinton Foundation HIV/AIDS Initiative (CHAI), commodities supporting pediatric HIV diagnosis, care and treatment have been available nationally since 2006/7, greatly improving access to pediatric care. Commodities include pediatric ARVs drug formulations, laboratory reagents for HIV diagnosis in children, nutritional supplements, and cotrimoxazole. Staffing support and training were also provided to some sites. When the pediatric component of CHAI ends in 2010, it is expected that these activities will be rolled into the existing national program supported by PEPFAR and MOH-Global Fund. The USG team and the MOH will plan for this transition; otherwise it is possible that services, particularly the EID program initiated with CHAI support and procurement of costly pediatric ARV formulations, will be disrupted

Two annual national pediatric advocacy meetings were held bringing together all stakeholders. The aim of these meetings was to harmonize practices and improve coordination among providers. Family based care was piloted and adopted by several partners, thereby improving pediatric access. Counseling guidelines were revised to address HIV testing issues in children. The National HIV Care Quality Improvement (QI) program was rolled out to 220 ART sites with support from HIVQUAL and HCI. Specific pediatric indicators are being used at sites located in Northern Uganda with support from UNICEF. The plan is to scale-up evaluation of pediatric care to all ART sites.

## Challenges

1. Limited access to pediatric care: Although the number of children on ART doubled in the previous year, they comprise only 9% of the all persons on treatment, still below the MOH target of 15%. The MOH estimates that 27% of eligible children are on ART. Pediatric care is especially limited in rural areas. Major factors contributing to the limited access are:

a) Inadequate community education and mobilization for pediatric care services. Many parents and guardians are still reluctant to establish the HIV status of their children, even when children have a history of exposure. Adults in care are often unwilling to bring in children for HIV testing or may even deny them care and treatment after being diagnosed positive.

b) Human resource gaps: Shortage of health workers with skills in pediatric care remains a major challenge. Children require more physician time and therefore suffer most from understaffing. Because of these staffing shortages, fewer ART sites provide pediatric HIV/AIDS care compared to adult treatment. Although task-shifting has alleviated some human resource problems at ART sites, the technical expertise and time required for pediatric care prevents task shifting from fully addressing the shortage in pediatric health care staff.

c) Inadequate commodity supplies: Pediatric ARV regimens are more costly and complex than adult regimens. The challenge of procuring pediatric ARV formulations will increase when the Clinton Foundation donation ceases in 2010. In addition, pediatric TB drug formulations are unavailable in Uganda. Although Uganda eventually plans to relieve the ARV drug supply problems by producing its own generic drugs in partnership with Cipla and Quality Chemicals, a plant for the production of pediatric formulations has not yet been built.

d) Limited coverage of EID: Although the EID program has improved the capacity for HIV diagnosis in infants under 18 months, the number of facilities linked to the service is limited. It is estimated that only 13% of the estimated 91,000 HIV exposed infants were tested through this program in 2007. In addition, the system for sample collection, transport to the reference laboratory, sample processing and return of results (turn-around time) needs to be reviewed to improve efficiency.

2. Data gaps: The demand for pediatric care is not really known as there are no clear data on numbers of infected children, number in active care nationally, and number eligible for ART. The AIDS Indicator Survey planned for early 2009 will hopefully address this gap. Improved reporting, national program monitoring and evaluation are needed.

3. Continued MTCT: The national PMTCT program is less than optimal. There are also weak linkages between the PMTCT program and pediatric care leading to 'loss to follow-up' of HIV exposed infants, missed opportunities for HIV diagnosis and for timely initiation of treatment.

4. Adolescent sexuality: Sexuality and reproductive health needs of HIV infected adolescents are a challenge. In addition to the unmet medical needs, adolescents with HIV are a particularly vulnerable group with a wide range of psychosocial needs. Lack of child and adolescent-friendly services including reproductive health and family centered care compound the problem.

5. 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 if not addressed.

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

7. Nutrition: Alternative safe infant feeding options are lacking, increasing the risk of transmission through breast feeding. The majority of HIV infected children are malnourished; for example, up to 30% of children in the nutrition unit at Mulago National Referral Hospital are HIV infected.

In FY09, USG will continue to leverage other donor resources including the Global Fund, the Clinton Foundation, UNICEF, and others to increase the number of children receiving HIV care and ART. In FY09, 12,735 children 0-14 years old will receive antiretroviral treatment from USG-supported sites.

1. Continue 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 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. Approaches such as Provider Initiated HIV Counseling and Testing (PICT) and 'Know Your Child's Status' campaigns will be encouraged within existing HIV clinics and home-based HCT programs. USG will support the expansion of the pediatric mentoring program using regional pediatricians and experts.

2. Scale-up of Early Infant HIV Diagnosis (EID). This will involve review and possible modification of the current communication system between testing centers and care units to ensure timely delivery of results. Better communication will also minimize attrition of eligible children.

3. Referral and linkages: The USG will continue to strengthen linkages among OVC, PMTCT, EID, and pediatric HIV care and treatment services. All HIV exposed and infected children are vulnerable and/or orphaned and therefore need to be linked to ART care and OVC services.

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. Provide nutritional counseling and supplementation to eligible children and their families. The USG will establish and strengthen linkages with the NuLife program to provide therapeutic and supplemental food to nutritionally compromised children. Routine PICT 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 introduced as part of routine pediatric HIV care and support.

6. Guidelines for pediatric care recommend initiating cotrimoxazole prophylaxis from 6 weeks after birth until HIV infection is excluded after weaning. Other components of the BCP such as insecticide treated bednets, safe water systems, treatment for malaria and other OIs delay the progression to AIDS. The USG will continue to supply the BCP to mother-child pairs. To ensure continued availability of pediatric care commodities, the USG will work closely with the MOH, UN and other partners in the Global Fund development process to plan for gaps resulting from the end of Clinton Foundation support.

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4404.21232.09

**Planned Funds:** \$132,650

**Activity System ID:** 21232

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support, the Ministry of Health has trained health workers from district health facilities in comprehensive HIV/AIDS care and management of ART. Health workers trained included medical officers, clinical officers, nurses, counselors and nursing assistants who provide direct HIV care and treatment. To date over 3000 health workers have been trained in ART provision. In addition, longitudinal data management has been supported, updating, production and dissemination of ART data management tools, mentoring of staff in ART data management, supporting supervision to all accredited health facilities providing ART services including their management of longitudinal data. The MOH also led the national treatment workgroup in the review and updating of the national ART policy, treatment guidelines and training materials that have been completed. The next step will be updating of ART data management tools and reporting forms and strengthening the data management and treatment outcome system. The Care and support program has obtained support from WHO, USG, GFATM and UNICEF. In FY2008, health facilities accredited to offer ART increased from 305 to 358. 100 District TB/HIV managers from 10 districts and 60 health workers from 10 problem districts were trained in the IMCI/HIV complementary course. In addition, 24 health workers from sites with low enrolment of children into HIV care were attached to PIDC and Mildmay and post-training supervision will be carried out in 12 districts that were trained in the IMCI/HIV Complementary course. A total of 160 people comprising HMIS officers, ART district coordinators and health workers will be trained in data management and cohort analysis. In addition, data quality audits for ART will be carried out in 20 health facilities and 40 sign language instructors trained in comprehensive HIV prevention and care and sites with weak history of ART data management and reporting will be supported. Under the HIVQUAL and HCI program, the MoH had established HIV Quality of Care activities in 226 sites. The program developed an HIV Counseling and Testing module which will be piloted in ten health facilities. The HIVQUAL program initiated 20 more facilities into quality improvement, assessed and built quality management infrastructure in 130 health facilities from 40 districts, conducted 600 coaching and mentoring sessions, 10 continuous quality improvement trainings in 4 regions for total of 180 of health workers, 8 data management trainings in 4 regions for 120 data management staff, 4 regional learning network meetings, trained 120 trainers of trainees, sensitized 40 districts and 70 national stakeholders, supported data collection and reporting tools at 130 health facilities, supported 40 districts to monitor the implementation of quality improvement activities. The final draft ART treatment guidelines were produced and should be ready for dissemination.

In FY 2009, activities under this program shall continue. New and selected districts affected by staff attrition and transfers will be supported to conduct comprehensive HIV care training including ART and the IMCI Complementary HIV course. Post-training support supervisions for health facility staff from 20 districts trained in HIV care, ART and data management will be carried out two weeks after each district-level training. These support supervision visits will also contribute to the process of accreditation of newly trained facilities as ART sites. An additional 40 new health facilities will be accredited to provide ART services. An additional 40 ART sites will be involved in monitoring and evaluation including ART cohort tracking and data analysis. New sites will be trained in data management for enrolled cohorts using standardized tools. Mentoring and support supervision of existing ART sites will be carried out as part of quality improvement coaching activities. Data quality audits will be carried out as part of mentoring activities. Districts with health facilities that have low enrollment of children into HIV care will be supported to provide placements for some of their staff in Mildmay Center and the Pediatric Infectious Disease clinics. A total of 30 health facilities will be supported to improve pediatric HIV care and treatment. The program aims at strengthening districts and regional level systems to support and sustain quality improvement activities. District health teams supported by central HIVQUAL staff shall provide 600 coaching and mentoring sessions. Central HIVQUAL teams shall conduct 12 sessions of QI training for 320 health workers and train 120 additional workers in data management. The program will roll out quality improvement activities to an additional 20 facilities providing HIV care with Anti retroviral treatment. The revised ART treatment guidelines will be also disseminated to all health workers at the ART sites. In collaboration with stakeholders, the program will review quality of care indicators including HIV Counselling and testing indicators. The program will continue to implement regional learning networks to promote peer learning and sharing, coaching and mentoring, districts and regional facilities.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13296	4404.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$331,625
8343	4404.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$331,625
4404	4404.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$276,354

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 7631.09

**Mechanism:** PEPFAR/PMI Collaboration



**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 17048.21194.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21194

**Activity Narrative:** THIS ACTIVITY IS UNCHANGED FROM FY 2008.

In FY07 the Uganda President's Malaria Initiative (PMI) program under the direction of the MOH Malaria Control Program established a national electronic database to track and map the distribution of LLITNs. PMI also established four sentinel surveillance sites to collect malaria indicators in Apac which has been identified as having one of the highest malaria rates in the world, with an infectivity rate of 1564 bites/per person/per year. Additionally as reported in the Uganda AIS, Apac is located in the north-central region which has an 8.2% HIV prevalence. Given the high disease-burden of both diseases in Apac, this district is uniquely placed to provide a forum for a district-wide PMI-PEPFAR collaboration. Apac has a total population of 480,000 settled in 100,000 households and is located at the edge of the conflict region in northern Uganda making it vulnerable to all the concomitant issues.

Following the OGAC directive to program an additional \$4 million specifically for new initiatives with a focus on sexual transmission, especially discordant couples, this PEPFAR-PMI collaboration proposal will initiate a district-wide door-to-door counseling and testing program in collaboration with the current PMI activities.

In FY08 a door-to-door counseling and testing program including provision of the basic care package and referrals for care and treatment to all HIV+ individuals identified will be initiated. The PMI program will support malaria diagnosis using the same blood draws from the HIV test. In addition PMI will measure the district malaria prevalence rates and provide valuable information on the long-term impact of the two large scale PMI prevention interventions (IRS in all residences annually with support from PMI and universal coverage of LLITNs by the MOH) using the national electronic database to track the distribution of LLITNs they established in 2007 and PDAs to map all households with GIS and record household demographics and bed net use.

Through leveraging the PEPFAR and PMI initiatives in Apac with reliable data readily available to both programs the district will gain a better understanding of the population-based impact of the programs' interventions: identifying discordance, use of basic care package commodities, especially bed-net usage and, IPTp (intermittent preventive malaria treatment during pregnancy).

Finally, the performance of district-level ANC clinics will be enhanced by merging the HIV and Malaria surveillance activities including the strengthening of laboratory services in all district health center IIIs and IVs; training of health care providers; and, expansion of diagnosis and treatment of both HIV and malaria and will contribute to improved PMTCT services throughout Apac.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17048

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17048	17048.08	HHS/Centers for Disease Control & Prevention	To Be Determined	7631	7631.08	PEPFAR/PMI Collaboration	[REDACTED]

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

---

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4023.21218.09

**Planned Funds:** \$50,000

**Activity System ID:** 21218

**Activity 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 grant that carries forward lessons learnt in phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts of Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based Voluntary Counseling (VCT) program, provision of basic palliative HIV care, antiretroviral therapy (ART), Prevention of Mother to Child Transmission (PMTCT), tuberculosis (TB) care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV test results are returned to these clients through program resident community counselors. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons to household members. Through the medical male circumcision service, clients seeking male circumcision service are also offered VCT. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 outreach clinics in Rakai and Lyantonde districts. These clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. Services offered include: health education, on-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, ART, HIV prevention for positives interventions, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated). The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR support, HIV-infected individuals identified through

**Activity Narrative:** MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

RHSP provides a range of HIV care and treatment services for children ages 0-14 including: early infant diagnosis using DNA-PCR, psychosocial support, VCT, nutritional counseling and education, diagnosis and treatment of opportunistic infections, laboratory monitoring, preventive services, health education, provision of antiretroviral therapy and family counseling and testing. To date, a total of 66 HIV positive children under the age of 2 years have been screened for ART eligibility. Of these, 17 are currently receiving antiretroviral treatment. Following the new WHO guidelines for infant initiation of ART, all HIV positive infants under the age of 2 years are being initiated on ART irrespective of CD4 cell percentage. Over 196 HIV positive children aged 2-14 years have been screened for ART eligibility and 55 of these are currently on treatment. Families of HIV positive children have been provided with VCT, so as to mobilize family support for these children and ensure treatment adherence. All the HIV-positive children active in care have received the HIV basic care package, comprising of a safe water vessel and sodium hypochlorite solution for water disinfection to reduce incidence of diarrheal diseases and insecticide-impregnated bed nets, for prevention of malaria. Cotrimoxazole prophylaxis is provided to all HIV infected children and to babies born to HIV positive mothers, until HIV infection is excluded (ruled out). Laboratory screening and monitoring: All children that are not yet eligible for ART will have CD4% re-assessment performed every 3 months while those on ART have semi-annual CD4 and viral load reassessment. Other laboratory testing done include: hematology (complete blood counts), chemistry, (liver and renal function tests), and serology.

These services are provided to HIV positive children residing in Rakai and Lyantonde districts.

FY 2009 and 2010 ACTIVITIES: Emphasis areas to be addressed include:

- Expansion of the early infant diagnosis program for HIV diagnosis among infants
- Diagnosis and treatment of opportunistic infections
- Provision of daily cotrimoxazole for prophylaxis
- Mobilization of family support for the children in care
- Laboratory monitoring
- Provision of antiretroviral therapy for eligible children (including infants below 12months of age who are confirmed HIV positive irrespective of CD4 count)
- Nutritional counseling and education
- HIV preventive education and services

Other non-PEPFAR support - Most of the routine viral load testing is supported by NIH-ICER.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13234

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13234	4023.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$250,000
8328	4023.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$229,565
4023	4023.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$136,000

#### Emphasis Areas

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$12,500

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 699.09	<b>Mechanism:</b> Basic Care Package Procurement/Disemination
<b>Prime Partner:</b> Population Services International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 4400.20860.09	<b>Planned Funds:</b> \$586,000
<b>Activity System ID:</b> 20860	

**Activity Narrative:** 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 is an affiliate of PSI with operations in Uganda since 1998. The organization aims to measurably improve the health of vulnerable Ugandans, with added emphasis on rural populations. PSI utilizes evidence based social marketing and other proven techniques to educate and promote sustained behavior. PSI is committed to an effective partnership with the Ministry of Health (MOH) and supports various 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 over 900,000 Ugandans including children die annually of HIV-related opportunistic infections (OIs); in spite of sufficient evidence that supports simple interventions to prevent these OIs. Since September 2004, PSI has received PEPFAR funding through CDC. PSI Uganda has been implementing a 5 year HIV Basic Preventive Care Program (BCP) which is focused on reducing HIV-related morbidity and mortality and HIV transmission among adults and children living with HIV/AIDS (PHA). Currently, BCP includes identification of PHA through family based counseling and testing. PSI BCP services are prolonging and improving the quality of their lives by preventing OIs; and prevention with positives interventions (PWP). The PWP strives to avert HIV transmission to 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. Program implementation is supported by a multi-faceted communications campaign that educates PHAs and children on how to prevent OIs, live longer and healthier lives through the following: cotrimoxazole prophylaxis, prevention of diarrheal diseases using household water treatment and safe storage, use of insecticide treated nets (ITN) for malaria prevention, and the prevention of HIV transmission to unborn children. 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), PSI 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, which are simple for PHA and their families to implement. 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. PSI manages the procurement, packaging and distribution of all health commodities to ensure a consistent supply of the basic care starter kits and refills of the different commodities. PSI pediatric care and treatment activity has increased knowledge, access and utilization of HIV basic preventive and palliative care products and services among families with children infected with HIV/AIDS. Pediatric Palliative Care Training sessions focus on the unique needs of the children, and create an expanded awareness among health service providers and counselors, on the benefits of the basic and palliative care products and services.

During FY 2008 (October 2007 – July 2008), PSI has partnered with 151 HIV/AIDS care and support organizations in 54 districts including public and private hospitals, CBOs, FBOs, and NGOs. To date, 34 of the partner organizations are offering PMTCT services to pregnant women; while seven sites are offering specialized HIV pediatric care to children living with HIV/AIDS. Pediatric clients in rural and hard to reach areas have been prioritized through a partnership, and scale up of the BCP program to non CDC and public health facilities. PSI also worked closely with stakeholders to revise training curriculum and IEC program materials. PSI coordinated the development of technical content through collaborative efforts with the Ugandan MOH, CDC Uganda and World Health Organization (WHO) to ensure that all material are in line with the MOH strategic plan and relevant guidelines. Pediatric BCP IEC on safe water, malaria prevention, cotrimoxazole prophylaxis, and the new components of TB/HIV, nutrition in HIV, pain and symptom management were developed. The relevant approvals are being finalized this process before the IEC materials are completed and disseminated.

FY 2008 Pediatric Care and Treatment Achievements (October 1, 2007 to July 31, 2008)

Indicator (July 31, 2008)	Target	Achievement to date
Number of service outlets	5	7 (Cumulative for 3 years)
Number of pediatric PHA provided with BCP Starter kit	3,760	4,630
Total number of individuals trained to provide BCP at pediatric sites (peer educators)	75	42 (32 providers, 10 peer educators)

Since program inception in September 2004, 15,176 starter kits and 121,408 bottles of chlorine solution for water treatment have been distributed to children below the age of 18 years at the pediatric sites. One hundred and forty one (141) health service providers and 91 peer educators have been trained on BCP with focus on the unique needs of the children. From October 1, 2007 to July 31, 2008, PSI has distributed 4,630 starter kits to children living with HIV/AIDS and their families. PHA including parents, care takers of the children and adolescents have been actively involved in interpersonal communication activities at partner sites including giving health talks and participating in community sensitization on HIV/AIDS prevention and care. To support the IEC campaign, STF has developed and aired 37,198 radio messages in 8 local languages on 12 radio stations countrywide and 112 parent talk programs in 8 local languages on 8 radio stations across the regions of Uganda.

Advocacy and social support for BCP was built through aggressive involvement of the host district leadership in four annual regional stakeholder meetings. These meetings also exhibited work of all BCP stakeholders, and provided a platform for networking and linkages between the various partners.

According to the 2004/2005 HIV Sero-Behavioral survey approximately 149,000 new HIV infections occur each year in Uganda. The 2004 MOH/ACP HIV report states, that of all the HIV infections in Uganda, children less than 18 years of age contribute approximately 10% of the infection rate. With the introduction of various VCT scale up models including, family based CT and increasing the number of PHA who know their status; more people are opting to access BCP and other HIV care. BCP service provision has increased dramatically at existing PSI partner sites. This influx can help to explain why BCP targets are consistently higher; suggesting that there is an unmet need not included in the initial program projections.

**Activity Narrative:** The pediatric care and treatment activity at expanding access to cotrimoxazole prophylaxis, long lasting treated bed nets, safe water systems, pain and symptom relief, TB/HIV integration and IEC and education on nutrition to children infected with HIV/AIDS. In FY 2009, emphasis will be placed on strengthening sustainability of BCP, development and execution of a phase out plan. Activities will include:

1. It is anticipated that in FY 2009, three (3) new pediatric sites will be enrolled. For the new sites, preference will be for public facilities in hard to reach areas; such as, islands in Lake Victoria and the Karamoja region. Through existing and new sites nationwide, 3,760 starter kits containing two LLINs, a safe water vessel, filter cloth and four bottles of water treatment solution will be distributed to new pediatric clients. No new sites will be enrolled in FY 2010, since the project terminates in March 2010.
2. Replacement of bed nets and safe water vessels for 4,042 pediatric clients who received starter kits in year two (FY 2006) of program implementation will commence, 60,704 bottles of water treatment solution and 13,767 filter cloths will be distributed as refills to all old clients.
3. Other than create a parallel system of essential medicines distribution, PSI will train and support pediatric partner sites to generate timely and accurate cotrimoxazole orders to National and Joint Medical stores. This will ensure sustained availability of cotrimoxazole to the pediatric clients.
4. Plans for program sustainability include;
  - a. PSI will collaborate with the local manufacturers and other partners like Uganda Health Marketing Group. This partnership will continue to make BCP commodities available in the commercial sector. It is hoped that all these commodities will be available nationwide through sustainable channels.
  - b. BCP activities will be further scaled up through district health structures including PMTCT sites.
  - c. Trainings will be supplemented by mentorship. Added emphasis will be placed on training and mentoring all public sector trainers on BCP, in addition to the whole site trainings that are currently conducted at all BCP service outlets. Each service outlet supervisor will also be trained (or retrained) and mentored as a BCP trainer.
  - d. Refresher trainings and preliminary training for new health service providers and peer educators in preventive care and prevention with positives initiatives will continue in FY 2009
  - e. BCC will focus on sustaining BCP-related behavior change. This will be implemented by Straight Talk Foundation through development and production of radio spots, parent talk programs and radio talk shows. This will be supplemented by acquiring political support and utilizing testimonies of well known HIV authorities. Furthermore, by learning intensive interpersonal communication strategies social support, PHAs will attain social support in their communities.
  - f. PSI will maintain a regional implementing partner network and facilitate study trips with partner sites. This regional network will target unit heads and staff involved in BCP activities; to learn about each others best practices as well as improve integration of BCP activities.
5. Communicate phase out plan to partners in the second quarter of FY 2009.
 

The phase out plan will focus on:

  - a. Logistics management. PSI will build capacity of partner sites to manage BCP commodity procurement and distribution at individual sites.
  - b. The peer educators will continue to participate in routine site activities.
  - c. Distribution of IEC materials.
  - d. Updating and sharing of BCP partner sites service database.
6. Monitoring activities to track program implementation will also continue in FY 2009.
7. End of project evaluation

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13308

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13308	4400.08	HHS/Centers for Disease Control & Prevention	Population Services International	6437	699.08	Basic Care Package Procurement/Disemination	\$3,496,718
8353	4400.07	HHS/Centers for Disease Control & Prevention	Population Services International	4812	699.07	Basic Care Package Procurement/Disemination	\$3,309,093
4400	4400.06	HHS/Centers for Disease Control & Prevention	Population Services International	3341	699.06	Basic Care Package Procurement/Disemination	\$2,306,214



---

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$14,400

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4054.20876.09

**Planned Funds:** \$146,000

**Activity System ID:** 20876

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. TASO is registered with the Government of Uganda as an NGO and is categorized among HIV/AIDS NGOs with national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets implementing the TASO 2008-2012 Strategic Plan across Uganda. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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). TASO also supports 22 partner sites and 100 community-based initiatives to deliver services. About 100,000 people are index clients of the outlets; about 400,000 household members are indirect beneficiaries. The outlets reach a catchment population of about 10 million people. Over 30% of the outlets deliver services to conflict/post-conflict regions/sub-regions of Uganda (TASO pioneered HIV/AIDS intervention in the conflict/post-conflict regions/sub-regions and continues to play the flag-ship role). TASO is structured in six Directorates, namely: Program Management (in charge of program development, quality assurance and technical support), Planning & Strategic Information (in charge of monitoring and evaluation), Capacity Development (development of human resources for TASO and partners), Human Resources & Administration, Advocacy & Networking (in charge of national and global advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has infrastructure (counseling rooms, medical rooms, laboratory, drugs store, dispensary, vehicles, ICT systems, training rooms, resource centre, client Day Centre), management team, service delivery teams, operational support team and a team of expert clients (peer leaders). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. The TASO governance structure comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Centre Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies (TASO is a membership organization). TASO management and governance is done in accordance with national policies and documented organizational policies. TASO has had a successful track record in implementing PEPFAR I activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. Over 96% of the 20,000 clients accessing ART in TASO have levels of adherence to treatment of over 95%. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of core TASO work. These service models are regularly disseminated and provide a backbone for adaptation by other partners (dissemination fora include TASO experiential placement training programs focusing on sub-Saharan Africa). TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support civil society coordination; sharing resources with public health facilities in under-resourced areas (laboratory monitoring); and developing human resources for health.

This program will support the provision of comprehensive HIV/AIDS prevention, care, treatment, and related services to HIV positive adults, children and their family members. Services will include antiretroviral therapy (ART); adherence counseling; TB screening and treatment; diagnosis and treatment of opportunistic infections (OI); the basic preventive care package (BCP); prevention with positives (PWP) interventions; family-based and individual confidential HIV counseling and testing; and psycho-social support. In order not to interrupt critical services and to ensure the continuation of care and treatment, the previous implementing partner was extended for 6 months through September '07. During this time, the partner provided ART for 15,000 adults and children. The applicant for the FY'08 program will provide comprehensive services through an established country-wide network of urban and rural health facilities with the goal of continuing ART to the existing client base of 15,000, as well as provide comprehensive HIV support, prevention, care and treatment (as needed) to an additional 70,000 HIV positive individuals. A family-centered approach will be established, using the index HIV+ client to identify family members, who will receive confidential HIV counseling and testing and HIV care for those identified as seropositive. All seropositive clients and HIV+ family members will receive a Basic Preventive Care package that includes: cotrimoxazole prophylaxis; a safe water vessel and chlorine solution; insecticide treated bed nets; condoms as appropriate; educational materials; plus PWP counseling. Following national ART treatment guidelines and services criteria, each health center supported by the applicant will be staffed with trained HIV clinical and ancillary health care professionals, and will establish systems to monitor patients for ART eligibility and initiation. Those on ART will receive continuous adherence counseling and support services. PWP interventions will be an integral part of services to reduce HIV transmission to sexual partners and unborn children, including specific interventions for discordant couples. Methods to integrate prevention messages into all care and treatment services will be developed, and will be implemented by all staff. HCT services will also be offered to sexual partners who are not family members. Depending on the location of each health center, various service delivery models will be developed to facilitate access and ensure coverage of the target population; these will include facility, community, and home-based approaches, as well as outreach activities. The applicant will also develop a more robust program to provide services to conflict and post-conflict areas of Northern and North-eastern Uganda; these will include HCT at facility-based and mobile out-reach clinics.

Palliative care (PC) involves the provision of a wide range of services, counseling, and commodities, including the Basic Care Package, PWP interventions, the Client Kit, and other types of support. FY08 goals for the applicant will include expanding PC coverage to a greater number of HIV+ clients and their seropositive family members. All components of palliative care will be available, directly or through referral. Because many components of PC need not be facility based, increased efforts will be made to provide services at the community level, and to use PHA networks. Logistics, commodity procurement and human

**Activity Narrative:** resources will be emphasized. Procurement logistics will be enhanced, as described in the "ARV Drug" area activity narrative, by working within the National System for commodity procurement and distribution. Commodities that are relevant to PC include those needed for the prophylaxis, management, and screening of OIs; and components of the Basic Client Kit. The applicant will work to ensure that these commodities, drugs and diagnostics are available to meet increased needs. Health care workers will be given refresher training to improve and update their knowledge of and skills in providing palliative care. This will include training of health care providers to enhance their capacity to also provide PWP counseling. To ensure quality assurance, standardized and up-to-date guidelines of palliative care will be provided and service centers will be supported to ensure quality of service provision. Data collection and monitoring systems will be maintained and enhanced with the goal of improving patient care, meeting reporting requirements, and evaluating data to improve program planning.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13226

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13226	4054.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$730,000
8358	4054.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$565,836
4054	4054.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$565,836

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* Child Survival Activities

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 629.09

**Prime Partner:** National Medical Stores

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 12443.20818.09

**Activity System ID:** 20818

**Mechanism:** Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Care: Pediatric Care and Support

**Program Budget Code:** 10

**Planned Funds:** \$150,000

**Activity 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 health facilities throughout Uganda. NMS has developed a countrywide distribution supply chain for essential medicines and supplies; as well as providing HIV/AIDS-related Laboratory materials which are supported by PEPFAR funding. Health facilities and HIV Counseling and Testing Centers (HCT), can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. Following the national credit line for essential medicines, the Ministry of Health (MOH) provides a 20% contribution to JMS for faith-based and mission health facilities and NMS allocates the same 20% of PEPFAR funding for JMS to procure and store HIV/AIDS-related laboratory commodities.

In FY 2005, this NMS project received expansion funds, to provide an increased stock of Cotrimoxazole tablets following the national policy to prescribe all HIV + persons with daily Cotrimoxazole prophylaxis. Using this stock over the past three years, both NMS and JMS have successfully expanded their distribution to accredited treatment sites. NMS has established a frame work contract with an in-country manufacturer (long-term agreement which allows multiple shipments), to ensure distribution to the health facilities. Similarly, NMS established an updated distribution mechanism for USG implementing partners and private sector who can not procure directly; the percentage to JMS was increased from 20 to 30%. Of the 60,000 units (unit = one tin of 1,000 tablets) procured to-date, 38,000 units have been distributed to health facilities. NMS estimates, that the remaining units will be utilized by the facilities and implementing partners during the third quarter of the FY 2008 project period. The next Cotrimoxazole procurement will be delivered in-country by January 2009; for inclusion in the NMS health facility credit line, with 30% of the funds going to JMS for procurement to supply USG Implementing Partners and the private sector.

In FY 2009, the funding level will increase to \$750,000. NMS will allocate \$375,000 for procurement and distribution to national health facilities; and JMS will receive \$375,000, which is an increase from previous years' allocations (from 30 to 50%) for procurement and distribution to USG care and treatment partners and private sector facilities. These activities will continue to contribute greatly to the success of HIV care programs in Uganda as both NMS and JMS will have an expanded supply of Cotrimoxazole for HIV+ patients, and expand access by leveraging Global Fund procurements for the public sector.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13303

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13303	12443.08	HHS/Centers for Disease Control & Prevention	National Medical Stores	6435	629.08	Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services	\$750,000
12443	12443.07	HHS/Centers for Disease Control & Prevention	National Medical Stores	4810	629.07		\$600,000

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 1298.09	<b>Mechanism:</b> HIV/AIDS Project
<b>Prime Partner:</b> Mildmay International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 4419.20796.09	<b>Planned Funds:</b> \$136,000
<b>Activity System ID:</b> 20796	

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 48 clients received TB+ HIV care/treatment. There were 9 sites under MU that provided TB/HIV treatment. 254 were trained in TB/HIV treatment. Two specialist clinics were started. Eye clinic was opened in November 2007 to screen and treat patients with HIV related eye conditions. 21% of the clients seen in the eye clinic are children. The community programme was introduced in February 2008. Stable children together with their carers are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. 847 health care workers trained. These include health professionals; doctors and nurses, allied health professionals; counsellors, physiotherapists, occupational therapists, nutritionists and informal caregivers; carers of children. Training not only focuses on the physiological processes of HIV/AIDS but also on the psychosocial and spiritual needs of children living with HIV. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration. The main topics in paediatric training include communication with children, disclosure of HIV status to children, supporting children who attend school as well as the usual ART and OI training issues. The challenges in paediatric treatment and care include measurement of adherence in children on syrups, linking well children to school programmes, provision of food to the families of malnourished children and those from food-insecure families, supporting carers who are elderly and linkages to skills development and IGAs for children growing into adult hood.

During FY 2009 MU will continue providing services and providing training activities at 12 sites and 4 sites at RO. In FY 2009, 4,357 children will receive basic health care and support; of these 3000 will be at TMC, 1067 at the satellite clinics and 290 at RO. The funds for this programme area will finance the purchase of drugs for management and prevention of OIs, along with symptom control and pain management. This will be done by provision of a basic care package including Cotrimoxazole, a safewater system, ITNs and treatment of specific OIs. In addition ART will be provided to children who qualify through the MU multidisciplinary team. There will be an in patient facility with 53 bed capacity where an average of 80 children with severe symptoms and OIs will be admitted for stabilisation. As part of this children will also be provided with psychosocial support through the social workers, counsellors, the child care assistants and through the children's and adolescents support group OGMAC. The adherence will also organise follow up visits to homes and schools of selected children with adherence challenges. Children with severe dental disease related to HIV, mental conditions and eye problems related to HIV will receive services on site through these weekly special clinics. These services are provided to improve welfare of the children and also to improve adherence to treatment and care regimens as well as reducing morbidity. TMC will train

**Activity Narrative:** 1500 individuals through formal courses and clinical placements to better the paediatric care in other rural sites. TMC will also work in collaboration with PSI to make the basic care kit (including 2 mosquito nets, safe water vessel, water guard,) available to patients. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. For this work to be done a multidisciplinary team of health workers will be maintained. MU will continue training at the Centre as well as upcountry in targeted districts. Together with EMG, a USAID – funded project MU will also train health practitioners in the private sector in HIV management. MU will train – individuals through formal courses and clinical placements. The targeted group are children living with HIV and already in the programme, newly diagnosed children from the HIV testing routines at the Centre and surrounding community as well as those from the families of our established patients and the military in Mbuya.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13285

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13285	4419.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$340,000
8338	4419.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$280,000
4419	4419.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$172,000

#### Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* Child Survival Activities

Military Populations

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

**Prime Partner:** Makerere University Faculty of Medicine

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4032.20762.09

**Planned Funds:** \$73,000

**Activity System ID:** 20762



**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counselling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counselling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council - KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP currently offers pediatric clinical HIV care and treatment at only the Mbarara satellite clinics of Bwizibwera health centre-IV and Mbarara Municipal Council Clinic. The other 12 operational MJAP supported clinics have on-site pediatric care and treatment services provided in partnership with the Joint Clinical Research centre-JCRC (Mbarara ISS Clinic); Baylor College of Medicine Children's Foundation - Uganda/PIDC for Mulago Hospital and all the satellite KCC sites. In these clinics, MJAP conducts Routine HIV Testing and Counseling (RCT) in pediatric wards and refers these kids for care and treatment in existing clinics after initiating cotrimoxazole. In Mulago, MJAP is also supporting pediatric care with laboratory support for ART delivery (CD4, counts, CD4 percentages, CBC and chemistry tests.. This partnership is expected to continue in FY 2009. The MJAP pediatric care and treatment program is currently offering HIV care for HIV infected children and babies born to HIV positive mothers (exposed babies) until their HIV status is established. There are functional PMTCT programs within the MJAP affiliated satellite clinics that work in line with the MoH PMTCT guidelines. HIV diagnosis is carried out using DNA PCR for infants below 18 months and using the normal HIV antibody testing algorithm for all the children above 18 months of age. A family- based approach to care is used whereby a mother or parent is seen together with their child/children on the same clinic day by the same clinician. Under basic HIV care, all children attending HIV care receive an Insecticide Treated Mosquito Net (ITN), Cotrimoxazole for prophylaxis, multivitamin supplementation, diagnosis and management/treatment of all major HIV opportunistic infections (OIs), childhood vaccinations, provision of anti-helminthes (for de-worming), counseling and psychosocial support, growth and development monitoring, and age specific health education. Adolescents are given health education about prevention of HIV transmission i.e. 'prevention with positives'. Children enrolled in care are also offered routine HIV monitoring tests to include CD4+ cells count/percentage monitoring, hematology, serology and other related tests at regular intervals that are detailed in the National Care and Treatment standard operating procedures/ guidelines. Children in the clinic are offered basic nutritional support consisting of a pint of milk as they wait for their clinical review. Follow-up of the children is carried out with the support of the MJAP family based care (FBC) team and home visitors that regularly track these clients at home. In addition, the FBC team provides linkages to the clinics through testing of family members (including children) of index clients identified in the clinics and linking those found to be HIV infected to care and treatment. The home visitors are routinely involved in the tracking of patients lost to follow-up and those defaulting on treatment. Routine pregnancy testing using HCG tests is recommended/ offered for all women of child bearing age and with suspected pregnancy in the clinics to facilitate early prevention of vertical transmission. Among the sexually active females with amenorrhea and/or a high index of suspicion for pregnancy attending the HIV care services the HCG positive rates range between 40 to 50% of those taking the test. The ARV drugs for the pediatric care are obtained from the Uganda Ministry of health/Global fund for treatment of AIDS, Tuberculosis and Malaria; Clinton foundation HIV/AIDS initiative. MJAP supplements supplies in case of stock-outs. MJAP also collaborates with other existing HIV programs that include the AIDS Information Centre, EGPAF for PMTCT, ART under MOH-Global Fund Program, and OVC support through Ministry of Gender, Labour and Social Development. Treatment for tuberculosis is provided through the National TB and leprosy control program (NTLP) which provides the drugs and support supervision to the sites. MJAP is supporting paediatric TB diagnosis through provision of purified protein derivative (PPD) and administration needles. The different programs are working together to ensure comprehensive care for families affected by HIV/AIDS while avoiding duplication of services. MJAP trains various cadres of staff in paediatric HIV care and treatment in order to enhance their knowledge and skills in provision of quality paediatric care and treatment. In order to address the huge human resource needs and gaps for paediatric ART, MJAP in FY-2008 embarked on task-shifting and allowed lower clinic staff and persons living with HIV/AIDS (PHA) to be trained and later involved in the routine care and treatment for the patients. The PHAs are involved in the counselling, health education, peer support and other non-technical roles. Qualified PHAs have been continuously involved in

**Activity Narrative:** the routine technical activities of the clinic. To date, MJAP has trained over 60% of the health workers offering HIV care in pediatric HIV care; supported 128 children (110 in active care) to initiate and stay on antiretroviral therapy; provided basic and palliative HIV care to 234 children; provided the basic care package to 306 children and followed up 270 babies born to HIV positive mothers identified through the clinics.

In FY 09, the program will intensify efforts for early identification of HIV and early initiation of quality care and treatment for those found to be HIV positive, while also supporting activities to reduce vertical HIV transmission. Greater emphasis will be put on capacity building (human, infrastructure, and systems) for sustainable provision of quality pediatric care and treatment services. The program will continue to offer HCT for children and HIV DNA PCR tests for exposed babies as described above. Early infant diagnosis shall continue to follow the algorithm set out by the national PMTCT and Early Infant Diagnosis guidelines for Uganda. The programs in collaboration with the different partners will link all pregnant HIV positive mothers to available PMTCT services and ensure that these are followed up together with their babies. At all 18 proposed sites, MJAP shall continue to offer routine HCG/pregnancy tests to women of child-bearing age. Furthermore, the program shall further strengthen the early identification of children through counseling existing clients to have their children tested and increased campaigns for family treatment days in the clinics. In the satellite clinics, more HIV positive children and infants will be identified by extending RTC to cover vaccination points and young child clinics. The FBC team will also identify and refer more children (including OVC) who need HIV care and treatment during visits to homes of consenting index clients but also from the community based HCT component. The pediatric care and treatment services will be offered at Bwizibwera and Mbarara municipal council satellite clinics. These two clinics will be provided with additional equipments for routine monitoring. Such equipment includes those meant for monitoring growth, nutrition and other routine HIV monitoring test Using the revised WHO guidelines, all children eligible and ready to start ART will be offered ART. All children under care will be provided with all the appropriate components of pediatric and adolescent HIV care following the ten point management plan for pediatric HIV care. The program will continue to offer routine screening and treatment of all major opportunistic infections in children with emphasis on the special treatment needs. The current OI treatment drugs range will be expanded to include medicines specific for the needs of pediatric patients. In particular, cancer chemotherapy; and treatment and prophylaxis for Cryptococcal meningitis and Pneumocystis carinii pneumonia shall be strengthened. The pediatric patients in the clinic will be given Cotrimoxazole prophylaxis or Dapsone for cases unable take the former. Tuberculosis diagnosis and treatment shall be carried out in close collaboration with the NTLP as described above. In order to step up pediatric HIV care, pediatric counselors shall be recruited to address the specific needs of these patients. The clinical care team will work closely with the FBC team and identified OVC programs to address other OVC related needs. As mentioned earlier, MJAP will put greater emphasis on local capacity building for sustainable delivery of quality pediatric care and treatment services by the health facilities and community structures by 2010. In collaboration with the Faculty of Medicine of Mbarara University of Science and Technology, MJAP will train 200 students to offer home-based support to family members in the clinics. In addition, a further 200 students of both Makerere University faculty of Medicine and Mbarara university faculty of medicine shall be offered pre-service training in HIV/AIDS pediatric care as a sustainability measure. The task-shifting of provision of care and treatment will be further enhanced through the involvement and close supervision of more PHAs. Over 100 health workers and PHAs will be trained in all or parts of comprehensive pediatric HIV care. Children requiring nutritional rehabilitation will be attached to nutritional rehabilitation centers. Reproductive health services will be offered as part of PMTCT services and adolescent care. All HIV positive mothers will be trained in infant feeding. The pediatric care and treatment program of MJAP shall target the under-served populations in rural and peri-urban areas of Mbarara. Bwizibwera offers a typical rural ART clinic in a facility with limited resources and a poor population unable to afford basic health care. The program targets to provide care and treatment to 600 HIV infected children at the two clinics with at least 350 being on ART. In addition, at least 400 babies born to HIV infected mothers (HIV exposed babies) shall be followed up until a diagnostic test of sero-status is possible. All children seen in the clinics will be given milk as they wait to be seen by the clinicians.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13273

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13273	4032.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,460,000
8315	4032.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,400,000
4032	4032.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$935,587

---

**Emphasis Areas****Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$50,000

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Prime Partner:** Walter Reed

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 4506.20034.09

**Activity System ID:** 20034

**Mechanism:** Makerere University Walter  
Reed Project (MUWRP)

**USG Agency:** Department of Defense

**Program Area:** Care: Pediatric Care and  
Support

**Program Budget Code:** 10

**Planned Funds:** \$107,000

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

The Pediatric Care and 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 prevention, SI, CT, laboratory, ARV drugs, and OVC services.

During FY2008, and in partnership with Child Advocacy International (CAI), MUWRP has expanded activities of its mobile clinical/counseling follow-up program which provides home-based care and treatment to HIV+ pediatrics. CAI expanded their coverage of Kayunga District 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. CAI 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, and supplemental food. During FY2008, CAI 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 included linking families of pediatric ART patients together for group/peer counseling and psychosocial support. CAI 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 ART and the array of OI 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.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

MUWRP funding to CAI 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. However in June 2008, due to shifting priorities and budgetary constraints, CAI lost its funding from its primary partner, the UK based Elton John Foundation. Because of their excellent track record, MUWRP proposes take on full funding of CAI for activities in Kayunga. With MUWRP as its primary partner, CAI will be able to continue to provide high quality comprehensive services to HIV+ pediatrics in Kayunga in FY 2009. 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. Also during FY2009 MUWRP intends to expand services into Mukono District in order to support the Kojja Health Center IV. The initial aims of this support will be to promote care, treatment, laboratory services and counseling and testing services for the entire sub-district of Mukono South; including supporting three surrounding health center III's with the same services via mobile VCT outreaches into the surrounding fishing communities. Presently, the only HIV service provision at Kojja is a PMTCT component and a treatment club for mothers, both supported by EGPAF. Mukono South sub-district has a population of 120,000 persons and using data from the Uganda sera-survey, we can expect approximately 12,000 HIV positive residents; at least 20% of these (2,400) would be HIV+ pediatrics. Funding will support the expansion, training, technical assistance, transportation, capacity building, and provision of commodities (including pain medication) to five HIV clinics operating in Kayunga District and expansion of comprehensive services to HIV+ pediatrics to Mukono South sub-district.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15710

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15710	4506.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$435,000
8526	4506.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$317,000
4506	4506.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$134,999

### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$33,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$4,000

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

Estimated amount of funding that is planned for Education \$5,000

### Water

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 12442.20059.09

**Planned Funds:** \$480,000

**Activity System ID:** 20059

**Activity Narrative:** 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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific paediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of paediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kirudu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of paediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in paediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health.

Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where paediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these will lead to the development of many clinical best practices for paediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

By June 2008, there were 328 ART accredited sites in Uganda, most of which (60% – 70%) are urban based and mostly in central part of Uganda. Of an estimated 110,000 children living with HIV, about 50,000 require ART. However, only 11,000 are currently enrolled on ART. Baylor-Uganda is the largest provider of paediatric antiretroviral therapy (ART) in Uganda supporting provision of ART to more than 3,750 (35%) of paediatric patients countywide. Over 7,500 children and their care givers are enrolled in active care at Baylor-Uganda supported clinics (Baylor- Uganda Center of excellence, 6 satellites centres in Kampala districts, 4 regional centres in Soroti and Kasese areas and now 32 public rural health facilities. Baylor – Uganda has also spearheaded the scale-up of paediatric ART services in rural lower level health facilities (Health Centre IVs & HC IIIs) in Uganda through integration of paediatric, adolescent and family centered HIV/AIDS services within existing public health facilities. In 2008, Baylor – Uganda has integrated paediatric HIV/AIDS services in 33 health facilities and through this initiative more than 1,200 and 305 children have been enrolled in active HIV/AIDS care and ART respectively within three months period. This demonstrates immense potential for patient recruitment, but also shows the opportunity to increase equitable access to HIV/AIDS care and treatment. However, our initial ART Site Preparedness Assessment showed gaps in capacities of these lower level health facilities to initiate and sustain paediatric HIV/AIDS services in the area of infrastructure improvements; number, skills and motivation of personnel, pharmacy and logistics management, laboratory support, data management & use, support supervision, etc. Population Services International provides support to Baylor – Uganda for basic care services for people living with HIV/AIDS (PHAs).

In FY2009, Baylor – Uganda will continue to support paediatric HIV/AIDS care/ARV services at the Baylor-Uganda Center of Excellence (COE), Satellite clinics & rural health facilities. The following will be the key activities to be implemented over this period:

**Activity Narrative:**

- Provision of ART services to eligible children, adolescents and their family members and continual clinical and laboratory monitoring of those in HIV/AIDS care, including those ART.
- Prevention & management of opportunistic infections (excluding TB), malaria, diarrhea, pain & symptom relief, nutritional support, etc.
- Procurement and distribution of pharmaceuticals (non-ARVs), basic care package (Insecticide Treated Mosquito Nets (ITNs), safe water vessels, etc) to all supported sites, and support to the Acute Care Unit of Mulago Hospital,
- Training various cadres of staffs in pediatric HIV/AIDS management, Pediatric HIV/AIDS Counseling, Home based Care, etc. through didactic, attachment and on-site mentorship. More than 600 health professionals will be trained.
- Continuous provision of technical support to rural health facilities through on-site mentorship (at least for 3 consecutive months to develop systems and competencies of trained staff) and routine support supervision & monitoring.
- Minor infrastructure improvements such as renovations, painting to make service areas child-friendly, building of tents as waiting space for facilities without such provisions
- Support for personnel involved in the training, national expansion program, monitoring & evaluation and former Plus-Up sites in Anyeke Health Centre IV and Kagadi & Kiryandongo Hospitals.
- Support for pediatric HIV/AIDS training curriculum development for in-service training
- Support for data management and utilization through strengthening capacities of Baylor – Uganda, District Health Offices and targeted health facilities with computers, internet connectivity, hands-on training, in various data management programs/packages, routine data collection and analysis, with report writing.
- Routine monitoring and evaluation of the program for ARV services, bi-annual regional and program review meetings, best practice documentation and dissemination will also be covered under this program area.
- Support for human resources such as team building, effective executive training, finance for non-finance managers, and human resources information system,
- Formation & support to partners will be important in rolling out pediatric ARV services and related care needs for nutrition, education, OVC issues, etc.
- Administrative support and IT maintenance
- Community mobilization on pediatric HIV/AIDS through radio and community dialogues, etc.
- Site assessment for additional 32 facilities for integration of paediatric HIV/AIDS services.
- Provision of activity related incentives for rural health facility staff such as staff tea break, overtime allowance, across the facility.

Undertake quality improvement initiatives in all sites with support from HIVQUAL; a capacity building program for quality improvement in HIV care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13258

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13258	12442.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$600,000
12442	12442.07	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	4798	1186.07	Pediatric Infectious Disease Clinic	\$600,000



## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$30,000

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 4395.20740.09	<b>Planned Funds:</b> \$74,000
<b>Activity System ID:</b> 20740	

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, their families, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have increased access to Antiretroviral Therapy (ART) and quality comprehensive medical care. AIDSRelief (AR) is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the prime agency, the Institute of Human Virology (IHV) of the University of Maryland School of Medicine, Constella Futures Group (CF), Catholic Medical Mission Board and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed across Uganda in some of the most underserved and rural areas. These include St. Mary's Lacor, St Joseph Kitgum, Kalongo Hospital, Aber Hospital and Amai Hospital in Northern Uganda; Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Villa Maria Hospital and Nkozi Hospital in Central Uganda; Family Hope Center Jinja and Nyenga Hospital in Eastern Uganda; Virika Hospital, Kabarole Hospital, Bushenyi Medical Center - Katungu, KCRC – Bushenyi, Kyamuhunga Comboni Hospital, Kasanga Health Centre in Western Uganda. In order to get services closer to the communities served, AIDSRelief supports devolution of services to satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

As of July 31, 2008, AR in Uganda was providing care and support to 5144 pediatric patients <18years, and ART to 1726 patients <15 years. We maintained and supported 18 LPTFs and their satellites providing care and treatment to adults and children and a number LPTFs expanded and decentralized their services by opening satellites and outreach clinics. Specific pediatric focused sessions occurred at the various partner forums; topics covered were Adult and Pediatric ARV provision with a focus on switching to second line therapy; prevention of transmission of HIV from mothers to their infants; TB and the integration of TB and HIV care and treatment services. AR also provided training in pediatric counseling to all LPTFs using a newly developed curriculum produced in partnership with the African Network for Caring for Children with AIDS. Subsequent to this training, LPTFs have established child friendly corners, organized family treatment days and formed child support groups. Barriers to disclosure to children which had been a difficult issue for health workers have been overcome. The hallmark of the model is to provide a continuum of care from health facility to community supported by ongoing on-site mentorship/preceptorship for all cadres of staff at supported LPTFs. By the end FY 2008 the AR Technical team will have made an average of one weekly visit to each LPTF/quarter. Additional technical support visits will have been made to all LPTFs focusing on the areas of pediatric care and PMTCT, TB/HIV service integration and pediatric psycho-social support. The program has recognized the strong link between nutritional inputs, ART and adherence but this remains a significant challenge. LPTFs have been encouraged to link with other organizations to able to provide food, especially for severely malnourished patients. Training and guidance (national guidelines in nutrition and HIV/AIDS) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

In FY 2009, AR will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites with the goal of maintaining 2800 pediatric patients on ART (16%) and 7,839 pediatric patients in care and support through the provision of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. In FY2009, AR proposes to expand its services to bring more 2500 children in care, and 750 children on ART and continue to support a comprehensive and integrated continuum of care for HIV infected patients building on existing services at the LPTFs to provide psychosocial and counseling support, clinical follow-up, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV+ patients including 7,839 pediatric patients enrolled in care and 20000 patients including 2800 children on ARVs in 18 LPTFs and their satellites. In many of the regions supported by AR, access to pediatric care and treatment services is limited. AR will bring infants and children into care and treatment as an area of targeted expansion and will ensure integration and linkages between ANC, Labor and Delivery Services, MCH and Immunization services to identify and enhance the follow-up of HIV infected mothers and their exposed children. AR will maintain linkages with JCRC and other groups, who can provide early infant diagnosis so that all HIV exposed infants can be diagnosed in a timely manner, receive their results and be referred for comprehensive HIV care. Strengthening a provider initiated testing in out and inpatient pediatric services will also identify more HIV infected children 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 and are documented negative and later they will continue to access services through the OVC program up to the age of 5 years. In an effort to ensure that all children and their families have access to the BCP, linkages with organizations such as PSI and UHMG will be strengthened. AR 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 AR supported facilities receive comprehensive age appropriate psycho-social counseling and treatment and adherence support, provide training and technical assistance to all service providers in the area of pediatric psycho-social counseling. Task shifting to maximize human resources will be emphasized at facility and community levels, focusing 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, we 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 the model of providing integrated services to families at the community by inter-linking facility based health providers and community health workers and volunteers. Currently, AR provides 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 in their communities. 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. They also promote family based care through symptom monitoring, disclosure counseling, secondary prevention, and family based testing and education. In addition, the LPTFs'

**Activity Narrative:** community volunteers will be used as resources to support patients on therapy, disseminate HIV care and prevention literacy. AR will adapt existing, locally appropriate IEC and BCC materials, identify gaps in these media and develop materials as needed to be used by HCWs and community volunteers. Education on the importance of using ITNs, basic hygiene and good nutrition will be provided at household level and to communities. AR will assist LPTF networks with PLHA groups serving as volunteers in the community to strengthen adherence programs. We will support 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. Linkages with organizations such as PSI and AFFORD will be strengthened in order to increase access to ITNs and clean water. 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, the program will continue to ensure that all involved cadres of service providers have the capacity to provide age appropriate services to children. To accomplish this, the technical team, 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. AR will provide training in pediatric counseling and will strengthen LPTF staff capacity to develop community based psycho-social assessments. AR 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 2 partners' forums will complement LPTF's staff training, allow experience sharing and reinforce knowledge and skill transfer from AIDSRelief technical staff. Coordinated by CF, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AR will ensure that 100% of the LPTFs use the new PMM system, IQ Care, and other IT solutions that enhance data use, like IQ Tools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, thus support the program to reach and report on its patients. During the year, efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services which will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcohol intake; track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs. The program will maximize tracking of activities that lead to scale up of pediatric care and treatment. Documenting and reporting on enrolled children, followed up by age group, treatment regimens, and those receiving the basic care package. Through the already established CQI plans, and the "small tests of change" methodology that is being used at all LPTFs, staff will be able to identify patient management gaps, and decide how and when these will be addressed. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed. The program will also promote these 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. We will also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively. In addition, AIDSRelief will initiate a CQI process in which LPTFs will be assisted in generating, collecting and using patient level outcome information to continuously assess and improve the services they provide. 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 continuous delivery of quality HIV care and treatment, and 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY 2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions, and focus on its relationship with indigenous organizations such as the UCMB and UPMB to build their institutional capacity to support LPTFs. AR will continue to strengthen the health system management of LPTFs, conduct biannual finance and compliance trainings and program finance staff will carry out regular site visits to provide technical assistance, and to set up appropriate cost accounting systems.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13263

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13263	4395.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$370,000
8292	4395.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$200,000
4395	4395.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$110,362

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

\* TB

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 21886.09

**Planned Funds:** ██████████

**Activity System ID:** 21886

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening [REDACTED]

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 4365.21716.09

**Activity System ID:** 21716

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Pediatric Care and Support

**Program Budget Code:** 10

**Planned Funds:** [REDACTED]

**Activity Narrative:** The number of children living with HIV and AIDS in Uganda is on the increase. An estimated 200,000 children are living with HIV and another 25,000 get infected annually. Currently 11,000 children are accessing treatment, representing only 22% of all those in need. The need for pediatric care and treatment is enormous. However, human resource constraints, poor accessibility to services and limited pediatric care skills have in combination limited wide-scale accessibility to pediatric AIDS care and treatment. 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14210

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14210	4365.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8424	4365.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4365	4365.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 3340.09

**Mechanism:** AFFORD

**Prime Partner:** Johns Hopkins University  
Center for Communication  
Programs

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and  
Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4409.21737.09

**Planned Funds:** \$460,000

**Activity System ID:** 21737



## Activity Narrative: INTRODUCTION

The AFFORD Health Marketing Initiative (AFFORD) is a cooperative agreement awarded to the Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs in October 2005. AFFORD has the following objectives:

1) Increase accessibility and affordability of HIV/AIDS, reproductive health, child survival and malaria products and services for Ugandans using innovative private sector approaches; 2) Enhance knowledge, and correct use of HIV/FP/CS/Malaria products and services to encourage and sustain healthy behaviours and lifestyles; 3) Strengthen/establish indigenous organization(s) for sustainable and self sufficient delivery of key health marketing functions, including product distribution and promotion. AFFORD is a consortium of 6 organizations, three international and three local. All 6 consortium members have contributed to the creation of an indigenous organization, the Uganda Health Marketing Group (UHMG), and are building the required skills and capacity to continue in the footsteps of AFFORD when the project comes to an end. UHMG is now incorporated as a not for profit company and is working alongside other consortium partners. UHMG continues to build its technical, managerial and financial capacity to effectively deliver the objectives of AFFORD now and in the future.

AFFORD has worked through the private sector to provide quality palliative care products and services to PLHAs including provision of counseling and referral services for clients. In 2007/8 AFFORD developed a network of 100 private clinics referred to as the Good Life clinics that offer comprehensive service in palliative care for individuals and families. In addition, AFFORD's wide network of other clinics, midwiferies, pharmacies and drug shops across Uganda supports the intervention with information and carefully coordinated referrals. The numerous communication channels developed are utilized in the promotion of these services. Through this intervention the private sector is increasingly contributing its share to care for PLHAs.

## PROGRESS TO DATE

In FY 2008, AFFORD through its 510 private clinics providing palliative care the project reached 100,962 adult PLHAs with services and products. Over the years AFFORD has observed that demand for palliative care services for children from PLHA families has been progressively increasing. Indeed family members, care givers and children of PLHAs have received palliative care services from AFFORD supported clinics and used palliative care products provided by these 510 clinics. Treatment of opportunistic infections has also without doubt brought new hope and opportunities to individuals, families, and care givers of PLHAs. As PLHAs regain their health and strength, they are in a position to change the predominant attitude of the existing services in the private sector.

### Health Maintenance Products and OI Drugs

AFFORD has developed products that are being promoted to PLHAs for palliative care. Specific products like Cotrimoxazole, Aquasafe water purification tablets, Restors low osmolarity ORS, Zinkid (Zinc treatment for diarrhea in children under five) and long lasting Insecticide treated Mosquito nets (LLINs) are particularly promoted for pediatric care of children living with HIV. All these products in distribution are available on the market and in our supported clinics at subsidized prices.

### 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.

The Good Life campaign launched with The Good Life! Show, a highly popular TV, radio and experiential game show that uses edutainment to increase knowledge, facilitate couple communication, promote healthy behaviors, and increase demand for products and services. Areas of HIV focus included palliative care for PLHAs (both adults and children), risk perception, condom use, HIV testing, disclosure, and PMTCT. In FY 2008, 24 episodes were broadcast on 3 TV stations, 20 radio stations in 5 languages and appeared in 120 locations countywide through the experiential road shows. The experiential road shows were further refined to enhance interpersonal communication and resulted in the development of the "four tent" model. Using this approach, fewer people gather under a tent to receive messages and are able to ask pertinent questions which they otherwise would not have been able to ask.

## FY 2009 ACTIVITIES – Reaching 12,000 children with care and treatment

### Pediatric care and support

AFFORD's approach in the past years has targeted families and individuals with palliative care and support for PLHAs. In FY2009 the project will expand its care and support activities to capture more children living with HIV who require palliative care services and products. PLHAs accessing services from these clinics will be used as index persons to link service providers to their families. AFFORD will invest in building capacities of participating private clinics and enhance skills of providers so that they can better deliver quality palliative care services for HIV positive children and young people below 17 years of age. As an entry point into pediatric palliative care, participating clinics will be trained in dry blood spot (DBS-PCR) testing for children.

Specifically AFFORD will be increasing the number of clinics in its Good Life network from 100 to 200 in 20 districts. The staff of the clinics will be trained in offering pediatric care for children living with HIV.

In FY2009, AFFORD through its partners and the Good Life Clinics will:

#### a) Strengthen skills of health workers in infant diagnosis of HIV

Being aware that early infant diagnosis can serve as the bridge between prevention care and treatment, AFFORD will train health workers in private clinics to incorporate collection of dried blood spot (DBS) and which will then be sent to regional hospitals and JCRC TREAT centers for HIV testing. Along side DBS will be conventional HIV testing services for young people between 14-17 years of age will be continued.

#### b) Increase access to cotrimoxazole prophylaxis, safe water, diarrhea management and malaria prevention interventions for children:

Prevention of opportunistic infections will be a critical component of pediatric care. Children with HIV infection are susceptible to co-infection like tuberculosis, serious and recurrent pneumonia, meningitis, malaria and diarrhea. Out interventions will focus on promoting cotrimoxazole prophylaxis, prevention of diarrhea using water purification tablets (Aquasafe) and vessel and reducing severity and frequency of

**Activity Narrative:** diarrhea episodes using Restors and Zinkid, support distribution of LLINs to children and PLHA household to reduce risk of malaria. In addition we will support and link care givers to immunizations programs in their localities so that HIV positive children receive their routine immunization. Health workers will be trained to provide routine follow to infected children.

c) Nutritional care:

Poor nutrition among HIV infected children weakens the immune system and exposes children to more severe opportunistic infections. They are further at risk because of mal-absorption of nutrients, increased metabolism due to infections and poor feeding habits. AFFORD will through the Good life clinics conduct nutrition training for health workers who in turn through counseling and interpersonal communication will pass on this important information to care givers of affected children. Care givers of these children will also be linked to other implementing partners with nutrition and home based care programs. We will develop nutrition job aids and other reference materials for both health workers and families of infected children. An estimated number of 400 health workers will be trained to offer this specialized care. To support providers to effectively take on this expanded role, AFFORD will provide job aids and support materials for providers and client information on pediatric AIDS care.

Through the various channels mentioned above the project expects to reach about 4,000 children under two years, 5000 between 2 and 14years and 3,000 between 14 and 17 years.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14222

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14222	4409.08	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	6743	3340.08	Health Comm Partnership; AFFORD	\$2,300,000
8440	4409.07	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	4841	3340.07	Health Comm Partnership; AFFORD	\$2,000,000
4409	4409.06	U.S. Agency for International Development	Johns Hopkins University Center for Communication Programs	3340	3340.06	AFFORD	\$2,000,000

### Emphasis Areas

Health-related Wraparound Programs

\* Child Survival Activities

\* Malaria (PMI)

Refugees/Internally Displaced Persons

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$80,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 9320.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 21469.21770.09

**Activity System ID:** 21770

**Mechanism:** Community-based Care and Support/TASO Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Pediatric Care and Support

**Program Budget Code:** 10

**Planned Funds:** ██████████

**Activity Narrative:** This is follow-on to USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to Government of Uganda and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting a large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built the technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated the capacity to manage USAID programs as prime partners.

In FY 2007 USG has reached more than 80,000 clients (adult and children) with HIV/AIDS care and support services through TASO.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from a sole sourcing or subgrant approach to a direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs.

USAID will use this proposed mechanism to support pediatrics HIV/AIDS care and support services through civil society, public health and community outreach structures in the proposed geographic areas. Services will include management of Opportunistic Infections (OIs); increased access to Cotrimoxazole preventive therapy and other basic care products; pain and symptom relief; nutrition assessment and counseling; routine monitoring for treatment eligibility, psychosocial support; support adherence to OIs and ART; and linkage to other wraparound services; including nutrition, and livelihood support.

Through this mechanism USAID will implement specific activities to addresses challenges for increasing access to HIV/AIDS care and treatment among children by implementing approaches for identifying HIV exposed infants and referral for early infant diagnosis; counseling and testing for at-risk children adolescents; increasing linkage with OVC services, improved reporting and data quality on pediatrics care; improved linkage between PMTCT and pediatric care and treatment and linkage with routine child health services including immunization. Through this mechanism USAID intends to reach an estimated 4,000 children and adolescents with comprehensive HIV/AIDS care and support services. The mechanism also builds the technical and management capacity of indigenous organizations that would participate in program implementation as prime and sub partners.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21469

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21469	21469.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$1,954,780

### Emphasis Areas

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Table 3.3.10: Activities by Funding Mechanism

**Mechanism ID:** 7207.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 16008.21546.09

**Activity System ID:** 21546

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Pediatric Care and Support

**Program Budget Code:** 10

**Planned Funds:** [REDACTED]

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive, and on the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. USAID will award the new Cooperative Agreement by March 2009. This will ensure smooth transition between the current JCRC program and the TBD mechanism.

In FY 2009 the major focus of the activity will be to ensure continuity of life saving care and treatment services, smooth transition and capacity building in the 11 regional referral hospitals and expansion of district wide HIV/AIDS care and treatment services in 40 facilities located in the 11 districts hosting the regional referral hospitals.

Specific activities will include: training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis (TB) and HIV. The program will train physicians and non-physicians to provide Pediatric care and treatment services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, utilization of pediatric care and treatment services, growth monitoring, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for pediatric HIV-positive patients and linkages to basic preventive package and wrap-around services.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites, the program will support infrastructure development for pediatric care and treatment services and build capacity of the Directorate of Health Services to scale-up linkages between PMTCT and pediatric care and treatment in the district. It is estimated that a total of 11,000 children will receive care and 5,000 will be initiated on treatment.

Critical emerging issues like adherence, surveillance for resistance, Infant Diagnosis using DNA-PCR and screening of patients under palliative care for ART eligibility will be supported. The program will provide financial support in form of grants to Civil society organizations and Networks of PHAs to carry out activities that support improved ART literacy, adherence, patient tracking, prevention with positives and linkages to wrap around services.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women and, linkages between pregnant women and pediatric care are strengthened. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16008

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16008	16008.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$340,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Mechanism:** STAR-EC

---

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 21145.21577.09

**Activity System ID:** 21577

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Care: Pediatric Care and  
Support

**Program Budget Code:** 10

**Planned Funds:** \$136,000

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, adult care and treatment, TB/HIV, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. . This activity will expand to other underserved districts in subsequent years.

Significant progress has been made in the area of pediatrics HIV/AIDS care and treatment. There are nine laboratories nationwide have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs have made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal linkage to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9220.09	<b>Mechanism:</b> TBD - HCT/AIC Follow on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 21470.21572.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21572	

**Activity Narrative:** This activity is an on-going program related to the CSF/Deloitte and Touche HIV Counseling and Testing program that was approved in COP 08 implemented by a national indigenous organization contributing towards the national goal of scaling up HIV counselling and testing services in Uganda. The goal of this program is to support the MOH, districts, private sector; and Community based Organizations (CBOs)/ Non-governmental organizations (NGOs) to scale up provision of integrated HCT services at the Regional HCT Centers of Excellence, public, private, and CBO/NGO/FBO HCT sites. This program will establish Regional HCT Centers of Excellence and scale up HCT services to cover all Regional referral hospitals, all District hospitals, all private hospitals, and all health centers up to H/C II sites that are not covered by the USAID funded District based program and other PEPFRAR HCT implementing partners. In addition, the program will establish HCT outreaches to the communities in collaboration with existing HCT service providers and CBOs in order to increase access to most at risk populations and remote areas. Outreach activities will include those held in schools, fishing landing sites, military/police establishments, mobile populations including internally displaced persons (IDPs), truck drivers, institutions of higher learning and People with Disabilities. The Regional HCT Centers of Excellence will be a focus point for coordination of M&E systems, Operational research, External quality assurance, training and mentoring of other HCT service providers within the health system in accordance with national and international guidelines.

As a continuation of the FY 2008 activities, HCT services will be provided as an integrated service to HIV/AIDS care, treatment and support services for both HIV exposed or infected children and their families at the Regional HCT Centers of Excellence and other static sites. This will entail provision of 1) Age-appropriate HCT services using a family-centered approach. 2) Cotrimoxazole prophylaxis, 3) treatment of opportunistic infections and co-morbidities 4) assessment and management of pain and other symptoms, 5) routine clinical monitoring, 6) psychological and spiritual support 7) nutritional assessment and support, 8) safe water interventions, 9) malaria prevention interventions, and 10) linkages to child survival interventions including immunizations, growth and development monitoring. HIV positive children requiring HAART will be referred to existing ART service providers.

Persons living with HIV/AIDS (PHA) networks, youth friendly services, couple HCT services and post-test clubs will be enhanced to strengthen referral linkages to prevention, care, treatment, and support. In the outreach sites and mobile clinics, HIV+ clients will receive the first dose of Cotrimoxazole for one month and additional referral information for further care and treatment services.

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 at improving quality of life of PHAs. The families of the HIV infected or exposed children will be encouraged to mobilize other family members to access HCT and to identify infected or affected children that require ART and other care and support services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21470

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21470	21470.08	U.S. Agency for International Development	To Be Determined	9220	9220.08	TBD/HCT	

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning

Military Populations

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 1258.09

**Prime Partner:** Family Health International

**Funding Source:** GHCS (State)

**Budget Code:** PDCS

**Activity ID:** 4510.21762.09

**Activity System ID:** 21762

**Mechanism:** Roads to a Healthy Future/ROADS II-SafeTStop Project

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: Pediatric Care and Support

**Program Budget Code:** 10

**Planned Funds:** \$110,000

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these sites, truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. The number of children under 18 reached with care and the number of children under 15 being treated with ART remain low compared to adult service provision.

Since launching SafeTStop in Busia, Malaba and Katuna, ROADS has reached 4,100 people with palliative care services (January 2006-March 2008), focusing on nutrition, hygiene, basic medical care, counseling on positive living, prevention for positives, referral to clinical services, pain management, and provision of such non-clinical services as psychosocial and spiritual support. ROADS has trained 375 individuals to provide palliative care. Note that in FY 2008 we did not implement treatment programming though we referred and generated uptake for treatment; however, we propose treatment targets in FY 2009 and FY 2010.

For FY 2008, ROADS did not implement pediatric care, but did identify 74 HIV-exposed children through the OVC Katuna cluster, and linked with the Joint Clinical Research Centre at Kabale District Hospital to access care, support and treatment for these children. Additional non-clinical services such as psycho-social, spiritual and nutrition were also provided.

In FY 2009 the project will extend palliative care to children in Busia, Malaba and Katuna. In FY 2009, the project will reach 430 children under 18 (207 males and 223 females) with care through 60 service outlets; in FY 2010 we will reach 495 children under 18 (239 males and 256 females) with care through 60 outlets. We will train 300 individuals to provide pediatric care in FY 2009 and 300 in 2010.

We will train home-based and OVC caregivers, who are primarily lay counselors, to take a more family-centered approach to home-based care visits to inquire about the HIV status of family members, leading to improved early infant diagnosis (EID) and treatment, improved detection of pregnant mothers who fall through the MoH facility screening, improved detection of breast-feeding mothers and improved follow up of mother-infant pairs. The caregivers will also be equipped with additional skills to enable them to provide ongoing counseling to children and adolescents living with HIV. The project will provide a comprehensive package of care services including access to the basic care package that includes safe water and LLITNs, nutritional assessment and counseling as well as support through targeted food supplementation and ongoing counseling to children and adolescents living with HIV. We will broaden the dialogue in couple counseling for CT to ask about other family members. The project will also promote PMTCT through community campaigns and ROADS clusters and advocate for an opt-out approach, hence intensifying HIV prevention through pediatric prevention and using PMTCT as an entry point into a comprehensive package of HIV prevention, care, support and treatment services for entire families affected by HIV/AIDS.

Our partner Jhpiego will build the skills of clinicians to improve their capacity to diagnose and manage pediatric AIDS cases, including providing them with client-provider materials and job aid references that define comprehensive approaches to clinical care for HIV positive children. We will link with ECSA-HC and the Regional Centre for Quality Health Care (RCQHC) to harness support for regional activities that promote HIV prevention, care and treatment for infants and children affected by HIV/AIDS. The project will increase the provision of pediatric counseling and testing (CT) at all possible entry points: outpatient departments at the local health facilities, maternal and child health (MCH) clinics and under five clinics (immunization and growth monitoring settings), as well as for HIV-exposed babies and children with TB. Given the shortage of human resources at facility level, health care workers will work together with community volunteers (home based care providers, etc.) to improve HIV testing in terms of number and quality of testing and counseling through provider-initiated counseling and testing (PICT) for children. The project will implement the opt-out approach in all the settings described above as well as through other community forums including HIV counseling and testing days focusing on children. The project will also strengthen the referral system between the communities and health facilities. Improved identification of HIV-exposed children will be achieved by improving the link between ANC and labor delivery wards with under 5 clinics, eg. introduction of mother-baby passport and strengthening follow up of mother-baby pairs through the postnatal clinics and well-baby clinics to facilitate HIV testing at six weeks using DNA PCR and initiation of co-trimoxazole prophylaxis.

The project will strengthen the health facilities' capacity to address OIs in children including nutrition counseling and growth monitoring, and HIV/AIDS education for care givers. The project will coordinate exchange visits (study tours) between sites for facility staff involved in pediatric care and will also provide consistent coaching and mentoring linked to the district hospitals. Facility and community care providers will be exposed to national and regional meetings to strengthen their skills in HIV prevention, care and treatment for infants and children affected by HIV/AIDS. We will work closely with the district hospitals closest to the SafeTStop towns to improve the monitoring process alongside provision of facilitative supervision to sites, thereby improving provider performance and motivation as well as ensuring quality of care. The project will also ensure that the local health facilities within our catchment area are linked into the District health management information system by providing the necessary infrastructure and capacity building.

**Activity Narrative:** Targeted local health facilities are Busia, Katuna and Malaba (Busia HC IV, Malaba HC III, Kamuganguzi HC 3, Kyasano HC II) and we will strengthen linkages between the community, health centers and district hospitals at Kabale and Tororo as well as Rubaya HC IV (Katuna), Mukujju HC IV (Malaba) and Masafu hospital. The ROADS PLHA and OVC clusters specifically will serve as an avenue to promote HIV testing for children and pediatric care services at facility and community level.

The project will build on existing linkages with other USG funded partners such as JCRC, TASO and others to support pediatric care and access to ART.

**SUSTAINABILITY:** Almost all partners on the project are local entities that exist without external funding, including private and most public outlets that offer HIV care and support services. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project, including those which can provide community-based care and support, were established without outside assistance. These will continue functioning over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

**EXPANSION SITES:** Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DRC; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14194

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14194	4510.08	U.S. Agency for International Development	Family Health International	6736	1258.08	ROADS - SafeTstop Project	\$550,000
8418	4510.07	U.S. Agency for International Development	Family Health International	4833	1258.07	Northern Corridor Program/Uganda Section	\$525,000
4510	4510.06	U.S. Agency for International Development	Family Health International	3366	1258.06	Northern Corridor Program/Uganda Section	\$75,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$110,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.10: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 690.09	<b>Mechanism:</b> N/A
<b>Prime Partner:</b> US Department of Defense	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 26465.09	<b>Planned Funds:</b> \$115,200
<b>Activity System ID:</b> 26465	

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members. AIDS and war continue to be the topmost causes of death among UPDF personnel and their families. As a result, the Uganda Peoples Defense Forces has a large burden of orphans that are potentially infected by HIV, in addition to children in intact families. PEPFAR funding for a UPDF OVC program was initiated in 2008, and linkages between the OVC program and referral to for Pediatric Care and Treatment of infected children, will be a program priority. Additionally, as the PMTCT program is strengthened with PEPFAR funding, to include early infant diagnosis (EID), there will be an increased demand for Pediatric HIV clinical services.

With PEPFAR support, 8 military clinic sites now provide ART and HIV care services. UPDF continues to have challenges due to a lack of trained clinical staff, particularly in Pediatric management of HIV, and inadequate laboratory diagnostics for OIs and co-infections. These inadequacies are being systematically addressed via the support from the USG, concentrating on the Kampala based Bombo military hospital, with the largest population of HIV patients, with expansion to military medical facilities in Nakasongola, Wakiso, and Gulu. Drugs for OI prophylaxis and treatment are being procured for these sites. Clinical training for doctors, nurses and clinical officers, particularly through the Infectious Diseases Institute, Kampala has been an area of emphasis. This will be expanded to MildMay for Pediatric specific training, with a goal of training clinical staff in managing pediatric HIV infected patients at each of the 8 ART sites. Access to the Basic Health Care Package (impregnated mosquito nets, safe water vessel, cotrimoxazole) has been incorporated into the UPDF HIV clinics.

ART services are in place at 8 UPDF clinics and hospitals, with > 4,000 HIV infected patients, including children receiving ART of which 579 are children 0-17 years. With the intensified linkages to the OVC, PMTCT, and discordant couple counseling programs, the number will increase. The Uganda MOH guidelines for care of pediatric patients are being disseminated to all the ART sites. A Pediatric technical consultant for the UPDF will be initiating an overall strategy in Pediatric Care and Treatment, to include assessment of appropriate ART formulation availability and training for health care providers.

**ACTIVITY UNCHANGED FROM FY 2008**

Pediatric HIV care and treatment services will be integrated into services offered at all the UPDF ART centres. UPDF will continue to sensitize the community about pediatric HIV care and treatment services, linking children of HIV positive mothers to Early infant diagnosis service provision centres and provide ongoing counseling support and management of OIs among children already in care. Health care workers will be trained to equip them with skills in pediatric HIV care and treatment. UPDF will continue to distribute the MoH pediatric HIV care and treatment guidelines to reach all healthcare workers involved in the management of children and adolescents with HIV/AIDS. Community volunteers will be supported to make home based follow-up of who default on clinic appointments in their families and provide adherence support.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 3166.09

**Mechanism:** Expanding the Role of Networks of People Living with HIV/AIDS in Uganda

**Prime Partner:** International HIV/AIDS Alliance

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 4695.24484.09

**Planned Funds:** \$128,000

**Activity System ID:** 24484



**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008 the project has 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 such as family planning and broader reproductive issues. The project has trained 839 Network Support Agents (NSAs) who have been seconded to 416 Health centers across the 40 districts of operation. A total of 29 consortiums of PHA groups have been formed at Health Sub district level to participate in the delivery of HIV-related services. The NSA and the PHA groups have carried out ART education, ART adherence counseling and they have followed up clients in their homes to support patients with drug adherence and general welfare. As a result, a total of 238,800 individuals were reached with ART education, 40,434 reached with follow up counseling, 31,242 reached through home visits. In addition, through the project, the Alliance has linked the PHA groups with PSI which has provided basic care kits that prevent opportunistic infections like safe water vessels, insecticide treated nets and pharmaceuticals. Working in partnership with NuLIFE, the program is training NSA in integration of nutrition in care and support programs for PHA. A total of 580 NSA have been trained.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

In FY 2009, the project will consolidate activities in the 40 districts. An additional 100 consortiums of PHA groups will be formed and supported financially and technically to strengthen care and treatment support provision to their members and other PHAs identified in the community. The groups will therefore carry out home visits, couple counseling and support for disclosure and ART adherence counseling. 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. The project will also continue supporting post test clubs because they facilitate transition from counseling and testing to care, treatment and prevention services. The project has specifically targeted Post Test Clubs (PTCs) comprised of military populations in order to extend care and support services to this key population.

As members of the PLHIV groups, the trained NSAs in addition to undertaking activities outlined above, will play a critical role in mobilization of PHAs, making referrals to health facilities and creating linkages between the clients and the PHA group for continued care and support. As the number of people accessing HIV/AIDS related services increases, the importance of ensuring quality services and drug adherence remain critical. The presence of the NSAs at the health facilities makes this possible and the Alliance proposes to lobby the Ministry of Health to integrate the NSAs into the formal district health care delivery system since they provide an alternative source of manpower for health care.

Gender norms and practices are a barrier to people accessing care and support services. The project plans to 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 Project plans to strengthen Prevention for Positive programs in order to provide PHAs with the skills they need to take control over the disease in their lives. Working closely with SCOT (Strengthening Counselor Training Program), the project will build the capacity of PHA groups to provide patient education, conduct behavioral counseling and to support patients develop personal prevention strategies. IEC materials will also be provided to reinforce education on prevention for PHAs within the continuum of care. The PHA groups will also be supported to conduct "HIV stops with Me" campaigns in order to reduce stigma associated with HIV.

As part of the capacity building process of the PHA groups, the project plans to continue supporting refurbishment of Common Facility Centers. These centers provide space for people living with HIV to meet regularly for peer support and shared learning, and to conduct health education programs for the community members. The centers will also house vocational training workshops, provide space for setting up demonstration gardens and act as a reference point for the groups.

The project will continue to partner with PSI and other malaria control partners to provide basic care commodities to the PHAs and their families. Commodities include mosquito nets, water vessels and pharmaceuticals. The partnership with NULIFE will be expanded to cover 12 new districts in Mid Western Uganda that have not been covered in FY 2008 as well as increase capacities of groups to conduct nutritional assessments, carry out nutrition counseling and education. The project will also facilitate

**Activity Narrative:** linkages of PHA groups to Government programs like NAADS and other existing agricultural programs to provide skills in vegetable growing and horticulture for purposes of improving nutrition. The community engagement strategy will continue to be employed to further link PHA groups to other organizations providing wrap around services e.g. family planning, reproductive health, supplementary feeding, livelihood programs and water and sanitation programs.

The project proposes to strengthen the link between the groups and the local government at district and county levels and hence ensure that the local government provides leadership, technical support and mobilizes resources for PLHIV groups and networks in order to sustain care and support programs beyond the project life. The Alliance will therefore provide technical assistance to local governments to institutionalize the network model and strengthen capacity of PHA groups' to leverage local resources.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15634

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15634	4695.08	U.S. Agency for International Development	International HIV/AIDS Alliance	6738	3166.08	Expanding the Role of Networks of People Living with HIV/AIDS in Uganda	\$1,200,000
8465	4695.07	U.S. Agency for International Development	International HIV/AIDS Alliance	4851	3166.07	Expanding the role of People Living with HIV/AIDS Networks	\$1,000,000
4695	4695.06	U.S. Agency for International Development	International HIV/AIDS Alliance	3166	3166.06	PHA Network	\$580,000

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 4961.09

**Mechanism:** TBD/Drug Logistics

---

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and  
Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 23926.09

**Planned Funds:** ██████████

**Activity System ID:** 23926

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to PMTCT, ARV drugs, Adult Care and Treatment, Pediatric Care, Counseling and Testing, Laboratory Infrastructure, TB/HIV.

In FY 2008, the SCMS project provided procurement services and technical assistance to the Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), and UPHOLD (now ended) to improve the availability and management of ARV drugs in their sites. SCMS also provided funds to the MOH for emergency ARV procurements. To-date, a total of \$1,795,000 of ARVs and related commodities has been procured through SCMS for these partners. SCMS will also procure ARVs for EGPAF. NUMAT, in partnership with SCMS, established logistic management systems and procedures for ARV supply in its ART sites and a working arrangement was developed with Joint Medical Stores, a central warehouse for FBOs and other private sector organizations, to deliver to the partner sites based upon requisition. NUMAT technical officers trained and mentored ART teams in logistics management to ensure smooth system performance and logistics tools and materials adopted from MOH formats were distributed to the ART sites to ensure proper reporting of drug consumption. During the period, two cycles were delivered of first and second line adult ARV formulations for 17 existing ART sites and later for 6 additional newly accredited ART sites in the nine districts. Gaps in pediatric support were identified, which led to negotiations with Baylor Children College (Uganda) to provide the ART clinics with ARV formulations for young children. The choices of ARV drugs selected by the program were determined by the current GoU ARV policy that took into consideration efficacy, adverse effect profile, and pill burden. The ARV drugs selected also took into consideration needs of the clients gaining entry through the other program areas of PMTCT and TB.

SCMS also procured ARVs and drugs for opportunistic infections for the IRCU program. Technical staff have been trained in forecasting drug needs for the program and on the ARV logistics management system. A computerized logistics management information system was installed using standard software to track consumption and stock levels at the individual sites. Thirteen implementing sites are currently submitting bimonthly ARV drug reports and orders to the IRCU Logistics Officer. The partnership with SCMS and JMS has been successful to date and has guaranteed steady availability of ARVs at all IRCU supported sites. In addition, as a result of this partnership, IRCU has been able to procure quality ARVs at the most competitive rates available on the market, guaranteeing that its clients are accessing quality products and, with the savings, enabling the program to recruit more ART clients.

At the national level, SCMS provided technical assistance to the MOH to forecast and quantify the country's ARV needs, coordinate procurement with donors, and train new district and new ART site staff on logistics management and reporting. SCMS also assisted in support supervision activities at district level to improve facility level performance. Specific achievements include 683 health workers country-wide trained on the redesigned MOH ART logistics management system, 28 MOH regional pharmacists and senior dispensers trained on management of ART logistics activities, and 92 health workers from 38 newly accredited ART sites trained on the logistics management system. The SCMS supervisory team visited a total of 174 ART sites to monitor performance and provide on-the-job support to health workers charged with logistics management. Efforts to harmonize ARV procurement among PEPFAR partners and communicate supply issues continued through various technical working groups and technical support was provided to the GFTAM third party procurement agent (WHO/UNICEF). In FY08, technical assistance was provided to JMS to completely overhaul its warehousing and inventory management system including installation and training in the new warehouse management information system (MACS) and the financial system (SAGE) software. Support was also provided to NMS to assess its warehousing and inventory management system, the recommendations of which were endorsed by the NMS Board of Directors.

The new procurement mechanism will provide technical assistance to national and district-level PEPFAR partners on commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job

**Activity Narrative:** training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submitting timely reports to keep the supplies flowing. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution from district stores to health centers in selected districts.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.10: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7253.09	<b>Mechanism:</b> TBD - Districts South-Southwest
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 21590.24026.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 24026	

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, adult care and treatment, TB/HIV, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY09, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. . This activity will expand to other underserved districts in subsequent years.

Significant progress has been made in the area of pediatrics HIV/AIDS care and treatment. There are nine laboratories nationwide have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs has made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal linkage to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21590

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21590	21590.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	■

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development ■

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 7257.09	<b>Mechanism:</b> Health Care Improvement Project - HCI/NuLife
<b>Prime Partner:</b> University Research Corporation, LLC	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 23929.09	<b>Planned Funds:</b> \$150,000
<b>Activity System ID:</b> 23929	

**Activity Narrative: Activity Narrative (Pediatric)**

The Food and Nutrition Intervention for Uganda –(NuLife) is being implemented by University Research Co., LLC (URC) to support to Ministry of Health (MOH), CBOs/NGOs, Networks of People Living with HIV/AIDS and USG implementing partners to integrate and expand food and nutrition into HIV/AIDS prevention, care and treatment programs. The focus of the program is to increase the utilization, adherence to and efficacy of anti-retroviral treatment (ART) and improving the nutritional and health status of PLHIV. The program's three primary objectives include: 1) provision of technical and financial support to the MOH, CBOs/NGOs, PLHIV Networks, USG partners to integrate food and nutrition interventions in HIV and AIDS prevention, care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable RUTF made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities. The program will provide targeted food and nutrition support that includes food supplements for vulnerable groups including OVCs, HIV-positive pregnant and lactating mothers and those with mild-to-moderate malnutrition, therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants. During FY 2008, NuLife has established collaboration mechanisms with MOH through establishment of a Sub-Committee on Nutrition (SCN) and provided technical assistance in drafting the National Nutrition and HIV and TB Strategy (2008-2010). NuLife has reviewed both national and international guidelines, training curricula, educational materials and other documents related to food and nutrition for PLHIV; supported the updating and expansion of the National Infant and Young Child Feeding (IYCF) Guidelines and the development of related counseling tools and other job aids. It has facilitated a critical review of the draft National Guidelines on the Integrated Management of Acute Malnutrition (IMAM). Through the Health Care Improvement Project (HCI), NuLife secured a position for a nutritionist on the Core Team at the national level and expanded the role of the current HCI-supported Quality Improvement (QI) collaborative teams to include a nutrition focal person at each level. Through regular HCI learning sessions, a total of 223 health workers from 120 ART facilities were sensitized in the basics of integrating food and nutrition in health facilities. Working with the IHAA and the Northern Uganda Malaria and HIV/AIDS TB (NUMAT) program, 605 network support agents (NSAs) and 100-health facility in charges from 36 districts received an initial orientation and package of educational materials on the special food and nutrition needs of PLHIV. A Geographic Information System (GIS) was established for use in prioritizing areas of operation, program planning and visual reporting; 32 phase one priority sites across 29 districts were selected and a community mobilization strategy was developed. The specifications for the production of a local RUTF were developed and the identification and selection process for a Ugandan manufacturer was completed.

During FY2009, NuLife will build on and consolidate its FY2008 achievements as it expands its technical and financial support for HIV-related food and nutrition interventions. Specific to Adult Care and Treatment programming, Under the framework of the National Strategy for Nutrition and HIV and TB (2008-2010), NuLife will support training of both facility and community health staff in 32 Phase One and 45 Phase Two sites participating communities related to 1) nutrition and HIV/AIDS for Adult Care and Treatment programs, including nutritional assessment, counseling, forecasting of RUTF, and food by prescription (FBP); 2) Integrated Management of Acute Malnutrition (IMAM) in the context of HIV/AIDS; and Community Mobilization for Behavior Change related to nutrition and HIV. Support materials will include: a) a counseling materials for use with PLHIV, b) patient take home flyers; c) training materials and d) equipment. NuLife will greatly support the capacity building effort of the MoH and other partner for integration of nutrition care and support within adult care and treatment services by training a core national team of 100 trainers drawn from a pool national and regional level nutrition experts. The trainers will in turn train health workers, community based volunteers and district teams in IMAM, FBP guidelines and community mobilization. Working through the Health Care improvement (HCI) program and USG partners, NuLife will select at least 12 health workers from each district and regional health facilities and 8 health workers from each HCIV including members from the quality improvement (QI) ART teams, in the provision of food and nutrition care and support (nutrition counseling, assessment and food by prescription) services. A total of 1600 health workers from Phase One and Two health facilities and participating communities will be trained. 654 community health workers will be trained under the NuLife community mobilization model and through partnership with IHAA, EGPAF, NUMAT and other USG implementing partners.

USG Partner Coordination: The program will focus collaborative efforts with USG partners implementing Adult Care and Treatment programs in the selection of health care providers to be trained. Some of the major Adult Care and Treatment partners will include JCRC, TASO, International HIV AIDS Alliance, NUMAT, CRS/AIDSRelief, where programming overlaps with the 32 NuLife Phase One Sites and 45 Phase Two Sites. Adult patients participating in programs supported by USG partners will also be able to access food and nutritional care and support counseling services.

MOH/Quality of Care Initiative (QoCI): NuLife is collaborating closely with the MOH/Quality of Care Initiative in the introduction of food and nutrition interventions in health facilities providing ART throughout the country. The mechanisms through which NuLife will collaborate with the national QoCI including support for the participation of selected nutritionists or nutrition focal persons in the national-level Core Team (made up of technical staff from MOH, URC/HCI staff and key USG HIV care and treatment partners), the Regional Coordinator Teams (5-6 member); and the District Quality Improvement (QI) Teams. During FY2009, NuLife will introduce food and nutrition interventions in selected HCI sites through training in priority areas during learning sessions, and will provide follow-up through monthly supervision or coaching visits to Phase One and Phase Two Sites. Under the HCI model for sustainability purposes, the district QI teams are assuming the roles of the Regional Coordinator Teams in the supervision and support to participating health facilities in relation to implementation of ART guidelines, data collection and management, and improving the quality of care and services. NuLife has worked with the HCI program to strategically start with districts where there is a presence of URC- supported facilities and orienting the districts in food and nutrition interventions for PLHAs. A total of 246 staff from DHT teams will trained to provide support supervision to health facilities supported by NuLife.

Community level: Community mobilization will be used as a strategy towards creating demand for comprehensive food and nutrition services for PLHIV, mobilizing internal resources to the response, reaching the most vulnerable within the catchment area, and addressing the underlying causes of malnutrition. Approximately 400 network support agents and peer counselors from communities within the catchment area of the 32 Phase One and 45 phase Two facilities will be trained and supported by district and health facility-based teams to integrate food and nutrition interventions for PLHIV. Using the Community



**Activity Narrative:** Action Cycles (CACs) approach, NuLife will work with USG partners to initiate relationships with existing community based groups (volunteer networks, family support groups, and community leaders) to promote good nutrition practices. Other support activities will be identification and follow up of malnourished cases within the catchment area. For each of the ART QI teams at the 32 Phase One and possibly 45 phase Two, at least 2 people from the community groups will be seconded to the QI team whose roles will be to coordinate the community component and linking the community with the health facility. At the sub-county level, a community core group (CCGs) of 4-5 persons will be formed to provide overall coordination of activities at the sub-county level including development and implementation of community action plans for food and nutrition. Trained volunteers will primarily identify and follow up malnourished PLHIV children using the mid upper arm circumference (MUAC) and simple criteria of danger signs to determine those in need of referral. Working with ACDI/VOCA and other partners, like World Vision, WFP, LWF, linkages will be made to programs that provide supplementary feeding, food assistance and livelihood assistance programs for households of PLHIV.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

#### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* Safe Motherhood

Refugees/Internally Displaced Persons

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$70,000

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery      \$35,000

#### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities      \$45,000

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**Prime Partner:** Management Sciences for Health

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 15721.24016.09

**Planned Funds:** \$136,000

**Activity System ID:** 24016

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric, TB/HIV, ARV drugs and laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

Significant progress has been made in the area of pediatric HIV/AIDS care and treatment. There are nine laboratories nationwide that have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs have made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal access to laboratory services, and suboptimal linkages to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build an effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15721

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15721	15721.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7156.09	<b>Mechanism:</b> NUMAT
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 24047.09	<b>Planned Funds:</b> \$200,000
<b>Activity System ID:</b> 24047	

**Activity Narrative:** This activity also relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

In FY2008 only 127 children in NUMAT supported facilities were on ART, of these only 9 were below 2 years of age. Health workers considered pediatric treatment, care and support complicated and preferred to refer the children to bigger hospitals for specialist management. HIV led many children to be orphaned while others were additionally ill. This caused the children to loose out on appropriate screening, prevention and treatment of malaria, parasitic infestations, malnutrition and other childhood diseases. NUMAT embarked on rigorous capacity building for the health workers at the supported health facilities. The trainings covered ART, palliative care and various aspects of pediatric psychosocial support. 36 health workers were trained in comprehensive pediatric care and treatment. 96 health workers also trained in pain and symptom management for HIV patients and management of OI's whose benefits were cross cutting addressing treatment and care in both adults and children. Up to 660 children were also offered free CD4 and full blood count testing as part of the process of scaling up access and quality of ART in the supported sites. Early infant diagnosis was also supported in 10 sites. All these efforts led up to 40 percent of tested infants and children found eligible. While NUMAT planned and procured Adult ARV formulations for some of the older children. Meanwhile the need for pediatric formulations for the younger children led to negotiations with Baylor Children's College Uganda who could additionally impart best practices and clinical skills in paediatric care to the health workers in the supported sites.

During the same period 750 home based care providers from the nine districts were trained to support HIV positive children in the community by monitoring their health status, monitoring ART adherence, offering them on going counseling and identifying economical, social, educational and psychological effects of HIV /AIDS on the children so that they could be referred for appropriate care. The project also mobilized and trained 103 PHA volunteers to work as Network support agents (NSA) in 45 health facilities. In addition to their cardinal role of linking fellow PHAs and family members to community and health facility- based care and treatment services, NSAs also supported children with counseling, community based care and support.

#### ACTIVITY UNCHANGED FROM FY 2008

In FY 2009, NUMAT will scale up paediatric care and treatment activities through coordination with MOH, district local governments, other agencies and communities. More HIV affected children including those actually HIV positive will benefit from an increase in the number of Health facilities able to provide holistic paediatric care. This will be made possible as MOH supports NUMAT led site assessments and subsequently accredits suitable ART sites. By the end of the period NUMAT will have supported up to 30 accredited sites.

Some of these sites will be "model sites" - hard to reach and high risk communities targeted by NUMAT with an aim of increasing access and quality of holistic treatment and care for children and their families. The model site concept is a synchronised effort by all the different NUMAT program areas providing holistic clinical and community based support for children in, transit IDP camps, fishing villages, military camps and other environments that increase their vulnerabilities to HIV, malaria and Tuberculosis.

NUMAT has signed an MOU with Baylor Children's College Uganda (BCCU) forging a partnership with an objective of promoting skills of health workers in paediatric care through pedagogic and on site mentorship in all aspects of Pediatric HIV treatment, care and psychosocial support with particular consideration for disclosure and promoting life skills in children, adolescents and their caregivers affected by HIV. BCCU will also supply pediatric formulations for children less than 5 years of age. Comprehensive paediatric care will also encompass growth monitoring, and management of childhood diseases. Other routine support for child health for instance, nutritional assessments of anthropometric status, immunisation, provision of promulti-micronutrient supplements, therapeutic or supplementary feeding support for clinically malnourished patients, infant feeding support will be promoted. NUMAT will support PHA networks and other groups that provide psychosocial and wrap around support for children, adolescents, caregivers and families. Additionally, NUMAT will make use of home visitors coordinated by Community care coalitions (CCCs) that will provide Community based ARV adherence monitoring and follow up for the children.

CD4 and full blood count testing at all the NUMAT supported sites will continue albeit at a larger scale than in PY2. A total of 21,880 CD4 tests and about 600 full hemogram tests will be offered to both children and adults requiring the test through AIC and CNAPSIS. This is an increase from 4800 CD4 tests offered in the last FY. NUMAT has supported capacity building as regards CD4 testing by conducting training for health workers in HIV care, by on site mentoring focusing on CD4 utilization.

Linkages with other program areas including the PMTCT program will be strengthened. Early Infant Diagnosis will be scaled up by training health workers in dry blood spot collection and communities will be sensitised to link children with essential HIV clinical services. Communities will also be encouraged to link HIV affected children to wrap around services including food, material, and educational support. Referral networks involving PHA groups, health facilities, NGOS, CBOs and Community Care Coalitions (CCC) will allow the expansion of access to these services. The health visitors shall continue to monitor the health status of children in their homes; monitor ARV adherence, identify economic social, educational and psychosocial effects of HIV and AIDS on children and refer them for the wrap around services. Collaboration with other USG supported programmes like PSI, IRCU, AFFORD, IHAA, NuLife to exploit initiatives will additionally expand and improve care and support for children. Benefits would include promotion of prevention & care packages including Cotrimoxazole prophylaxis for opportunistic infections (OIs), ITNs, and additional psychosocial support.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* Child Survival Activities

\* Family Planning

\* Malaria (PMI)

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$40,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.10: Activities by Funding Mechanism**

**Mechanism ID:** 5740.09

**Mechanism:** Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: Pediatric Care and Support

**Budget Code:** PDCS

**Program Budget Code:** 10

**Activity ID:** 26673.09

**Planned Funds:** \$45,900

**Activity System ID:** 26673

**Activity Narrative:** Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a Liaison office in Kampala. ICOBI's vision is "a healthy and prosperous rural population" and its mission is to improve the quality of life of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely: Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple~S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project (NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing in Bushenyi district (October 2004-June 2007). With funding from CDC/PEPFAR,ICOBI was able to offer HBVCT to about 270,000 adults and children, about 12,000 PHA's were identified and provided with the basic care package in collaboration with Bushenyi district health office. Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID (on going in Bushenyi district); and recently April 2008; OVC Care & support with funding from NPI/USAID for Mbarara and Bushenyi district. ICOBI received a notice of ward on 30th June 2008 from CDC to implement a program entitled "Provision of Full Access Home based confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda". ICOBI HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013. The program will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region in Uganda. The goal of the program is to provide 100% Full access Home Based HIV confidential Counseling and Testing services to all adults and at risk children residing in the six districts in five years. The program will provide preventive basic care and support to all identified HIV infected individuals and their families in five years. Currently we are in preparatory stages of identifying, recruiting and training staff, procurement of equipment, materials, services and opening of project offices for the program. ICOBI is still waiting for the final approval of the work plan and budget after responding to technical review comments from CDC and hopes to start actual implementation of the HBCT in homes and communities at the end of September 2008.

The prevalence of HIV infection in the Central region/districts of Mubende, Mityana, Luwero and Nakaseke is about 10%. 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 program and 10% of these about 1,500 HIV infected children will be identified during HBCT in the four districts by the counseling and testing teams. We shall also identify about 100 HIV infected pregnant mothers who will be referred to health center 4 and hospitals for preventive services provided by PMTCT programs by respective district health systems and other providers and about 200 infants and children born to HIV infected mothers of six weeks to 18 months will also be identified during HBCT in the four districts.

The counseling teams will collect blood samples from the children and submit them to centers carrying out HIV DNA PCR virologic tests to confirm HIV infection (enhance early infant diagnosis). All HIV exposed children <2 years will be referred to health units for immunization as well as growth and development monitoring and promotion. The children 2 to 14 years born to HIV infected mothers or having any other potential risk of HIV infection will have HIV counseling and tested using the three tier test algorithm. ICOBI counseling and testing teams will refer all children infected with HIV using referral forms to health units (hospitals and health center Fours) and other service providers offering pediatric HIV care and treatment. Pediatric care and treatment is offered at hospitals and health center 4s in the districts. In the four districts the services are offered at about 10 centers (both public and private).

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. With the help of CDC and PSI we will procure these commodities deliver these commodities to referral centers/health units and the health workers will provide the HIV infected clients with basic care commodities. Cotrimoxazole will be initiated at 190 health centers (includes hospitals, health center4s, health center3s and health center 2) 55 health centers in Mubende, 53 health centers in Mityana 61 health centers in Luwero, and 21 health centers in Nakaseke district. This will be replenished at the health centers or in the community by resident parish mobilisers/community volunteers (drug distributors/peer educators). Bed nets and safe water vessels including water guard refills will be supplied by the 295 resident parish mobilisers in collaboration with the village health teams and health workers at health center 3 and 2.

In order to ensure success of this program, health workers (doctors, midwives, nurses, health educators etc) at health center 4 and hospital level and all HBCT counselors and laboratory assistants will be trained in paediatric HIV care and treatment, paediatric 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. Further more to ensure that the HIV+ children receive paediatric care and treatment; priority is given to collaboration with other institutions offering paediatric care like JCRC that can provide services related to ART eligibility assessment, existing, OVC programs and strengthening of the Mubende, Mityana, Luwero and Nakaseke districts health systems at hospital level and health center levels. The existing 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 increased numbers of clients visiting hospitals and sub district hospitals that are accredited to offer paediatric care and treatment (ART). The program will give logistical support within the districts (stipend for staff) to handle the HIV 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 the family. Funds under this activity will be used for procurement of commodities, community mobilization and sensitization of parental groups, training of health workers, HBCT counselors and laboratory assistants, community volunteers in paediatric counseling, home care for the HIV positive

**Activity Narrative:** children and for supporting the districts' health system in handling and tracking HIV infected children referred for care.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

Program Budget Code: 11 - PDTX Treatment: Pediatric Treatment

**Total Planned Funding for Program Budget Code: \$10,913,291**

**Table 3.3.11: Activities by Funding Mechansim**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 27128.09

**Planned Funds:** \$319,190

**Activity System ID:** 27128

**Activity Narrative:** This is not a new activity, but a continuation of Activity Number 4407.08

The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support, the Ministry of Health has trained health workers from district health facilities in comprehensive HIV/AIDS care and management of ART. Health workers trained included medical officers, clinical officers, nurses, counselors and nursing assistants who provide direct HIV care and treatment. To-date over 3000 health workers have been trained in ART provision. In addition, longitudinal data management has been supported, updating, production and dissemination of ART data management tools, mentoring of staff in ART data management, supporting supervision to all accredited health facilities providing ART services including their management of longitudinal data. The MOH also led the national treatment workgroup in the review and updating of the national ART policy, treatment guidelines and training materials that have been completed. The next step will be updating of ART data management tools and reporting forms and strengthening the data management and treatment outcome system. The Care and support program has obtained support from WHO, USG, GFATM and UNICEF. In FY2008, health facilities accredited to offer ART increased from 305 to 358. 100 District TB/HIV managers from 10 districts and 60 health workers from 10 problem districts were trained in the IMCI/HIV complementary course. In addition, 24 health workers from sites with low enrolment of children into HIV care were attached to PIDC and Mildmay and post-training supervision will be carried out in 12 districts that were trained in the IMCI/HIV Complementary course. A total of 160 people comprising HMIS officers, ART district coordinators and health workers will be trained in data management and cohort analysis. In addition, data quality audits for ART will be carried out in 20 health facilities and 40 sign language instructors trained in comprehensive HIV prevention and care and sites with weak history of ART data management and reporting will be supported. Under the HIVQUAL and HCI program, the MoH had established HIV Quality of Care activities in 226 sites. The program developed an HIV Counseling and Testing module which will be piloted in ten health facilities. The HIVQUAL program initiated 20 more facilities into quality improvement, assessed and built quality management infrastructure in 130 health facilities from 40 districts, conducted 600 coaching and mentoring sessions, 10 continuous quality improvement trainings in 4 regions for total of 180 of health workers, 8 data management trainings in 4 regions for 120 data management staff, 4 regional learning network meetings, trained 120 trainers of trainees, sensitized 40 districts and 70 national stakeholders, supported data collection and reporting tools at 130 health facilities, supported 40 districts to monitor the implementation of quality improvement activities. The final draft ART treatment guidelines were produced and should be ready for dissemination.

In FY 2009, activities under this program shall continue. New and selected districts affected by staff attrition and transfers will be supported to conduct comprehensive HIV care training including ART and the IMCI Complementary HIV course. Post-training support supervisions for health facility staff from 20 districts trained in HIV care, ART and data management will be carried out two weeks after each district-level training. These support supervision visits will also contribute to the process of accreditation of newly trained facilities as ART sites. An additional 40 new health facilities will be accredited to provide ART services. An additional 40 ART sites will be involved in monitoring and evaluation including ART cohort tracking and data analysis. New sites will be trained in data management for enrolled cohorts using standardized tools. Mentoring and support supervision of existing ART sites will be carried out as part of quality improvement coaching activities. Data quality audits will be carried out as part of mentoring activities. Districts with health facilities that have low enrollment of children into HIV care will be supported to provide placements for some of their staff in Mildmay Center and the Pediatric Infectious Disease clinics. A total of 30 health facilities will be supported to improve pediatric HIV care and treatment. The program aims at strengthening districts and regional level systems to support and sustain quality improvement activities. District health teams supported by central HIVQUAL staff shall provide 600 coaching and mentoring sessions. Central HIVQUAL teams shall conduct 12 sessions of QI training for 320 health workers and train 120 additional workers in data management. The program will roll out quality improvement activities to an additional 20 facilities providing HIV care with Anti retroviral treatment. The revised ART treatment guidelines will be also be disseminated to all health workers at the ART sites. In collaboration with stakeholders, the program will review quality of care indicators including HIV Counseling and testing indicators. The program will continue to implement regional learning networks to promote peer learning and sharing, coaching and mentoring, districts and regional facilities.



**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 690.09

**Prime Partner:** US Department of Defense

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 26467.09

**Activity System ID:** 26467

**Mechanism:** N/A

**USG Agency:** Department of Defense

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$48,250

**Activity Narrative:** 1. Activity Narrative – The UPDF is Uganda’s national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF’s AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members. AIDS and war continue to be the topmost causes of death among UPDF personnel and their families. As a result, the Uganda Peoples Defense Forces has a large burden of orphans that are potentially infected by HIV, in addition to children in intact families. PEPFAR funding for a UPDF OVC program was initiated in 2008, and linkages between the OVC program and referral to for Pediatric Care and Treatment of infected children, will be a program priority. Additionally, as the PMTCT program is strengthened with PEFAR funding, to include early infant diagnosis (EID), there will be an increased demand for Pediatric HIV clinical services.

With PEPFAR support, 8 military clinic sites now provide ART and HIV care services. UPDF continues to have challenges due to a lack of trained clinical staff, particularly in Pediatric management of HIV, and inadequate laboratory diagnostics for OIs and co-infections. These inadequacies are being systematically addressed via the support from the USG, concentrating on the Kampala based Bombo military hospital, with the largest population of HIV patients, with expansion to military medical facilities in Nakasongola, Wakiso, and Gulu. Drugs for OI prophylaxis and treatment are being procured for these sites. Clinical training for doctors, nurses and clinical officers, particularly through the Infectious Diseases Institute, Kampala has been an area of emphasis. This will be expanded to MildMay for Pediatric specific training, with a goal of training clinical staff in managing pediatric HIV infected patients at each of the 8 ART sites. Access to the Basic Health Care Package (impregnated mosquito nets, safe water vessel, cotrimoxazole) has been incorporated into the UPDF HIV clinics.

2. Progress to-date. ART services are in place at 8 UPDF clinics and hospitals, with > 4,000 HIV infected patients, including children receiving ART of which 579 are children 0-17 years. With the intensified linkages to the OVC, PMTCT, and discordant couple counseling programs, the number will increase. The Uganda MOH guidelines for care of pediatric patients are being disseminated to all the ART sites. A Pediatric technical consultant for the UPDF will be initiating an overall strategy in Pediatric Care and Treatment, to include assessment of appropriate ART formulation availability and training for health care providers.

3. Planned activities for FY 2009. **ACTIVITY UNCHANGED FROM FY 2008**  
Paediatric HIV care and treatment services will be integrated into services offered at all the UPDF ART centres. UPDF will continue to sensitize the community about paediatric HIV care and treatment services, linking children of HIV positive mothers to Early infant diagnosis service provision centres and provide ongoing counseling support and management of OIs among children already in care. Health care workers will be trained to equip them with skills in pediatric HIV care and treatment. UPDF will continue to distribute the MoH pediatric HIV care and treatment guidelines to reach all healthcare workers involved in the management of children and adolescents with HIV/AIDS. Community volunteers will be supported to make home based follow-up of who default on clinic appointments in their families and provide adherence support. Children will be provided with cotrimoxazole prophylaxis, bed nets and safe water vessels.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

Military Populations

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.11: Activities by Funding Mechanism****Mechanism ID:** 9833.09**Prime Partner:** Johns Hopkins University  
Center for Communication  
Programs**Funding Source:** GHCS (State)**Budget Code:** PDTX**Activity ID:** 23765.09**Activity System ID:** 23765**Mechanism:** Health Communication  
Partnership**USG Agency:** U.S. Agency for International  
Development**Program Area:** Treatment: Pediatric Treatment**Program Budget Code:** 11**Planned Funds:** \$434,250

**Activity Narrative:** This activity is a continuation from the FY 2008 pediatrics training and curriculum development activity through the Regional Center of Quality of Health Care (RCQHC). In an effort to limit the number of management units and to effectively utilize complementary competencies of existing partners, USAID has made a decision to implement this activity through an existing mechanism with the Johns Hopkins University Center for Communication Programs (JHUCCP). RCQHC will be the main sub partner responsible for providing the clinical content and implementing the clinical care and treatment aspect of the program. The prime, JHUCCP will be responsible for developing the curriculum and for technical content for the pediatric counseling. Both partners have credible experience in the area of curriculum, training and education materials development which is a significant portfolio under this activity.

The program will also draw on the regional experiences of RCQHC with the Africa Network for Care and Children with AIDS (ANECCA). The RCQHC HIV/AIDS program has access to experts in pediatric AIDS through this Network. This includes 300 individuals of whom 29 are senior pediatricians currently involved in providing services to children and families affected by HIV/AIDS in all regions of the country. The ANECCA network members have extensive experience in clinical care, treatment and psychosocial support for pediatric AIDS. The Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs that was awarded in July 2007. Its purpose is to provide communication support to the Government of Uganda, PEPFAR and other USAID health programs, and to strengthen capacity for strategic, evidence-based HIV/AIDS and health communication in Uganda. HCP has been very successful in providing communication support across several program areas and its end date is being extended through 2012.

HCP has been providing technical assistance to the Joint Clinical Research Center (JCRC), the Ministry of Health, and other HIV/AIDS treatment partners to improve the quality of ART client education and adherence counseling, provide public education about ART, increase the uptake of HIV services among children with HIV/AIDS, and reduce stigma and discrimination against people living with HIV/AIDS. In FY 2007 and 2008, HCP assisted JCRC to launch a pediatric ART campaign focused on caregivers of children at-risk of HIV, HIV positive adolescents on ART, and caregivers of children on ART. The multi-channel campaign aimed at motivating caregivers to take their children for HIV testing and, for those who are positive, start them on ART and maintain adherence to medication. HCP supported JCRC to conduct outreach counseling and testing for over 2,200 children and their caretakers in Kampala, and to develop and disseminate support materials for use by caretakers and health workers when counseling HIV positive children.

This activity will address some key gaps in pediatric HIV/AIDS treatment that has been identified by the Uganda Ministry of Health (MOH) and USG; and supports PEPFAR and National targets that at least 15% of ART patients should be children.

Challenges related to pediatric services include: high cost of pediatric ARVs, inadequate skills, and limited resources for diagnosis of HIV in children. The roll out of pediatric HIV/AIDS care and treatment to lower level facilities is hampered by a lack of adequate counseling and clinical skills among health workers and suboptimal access to laboratory services and linkages to services.

This activity will address key gaps in health workers skills by developing and/or strengthening pediatric treatment and counseling training, curricula and practical job aides including comic books for child literacy. The implementing partner will also support the MoH in training regional and district training of trainers (ToTs) and resource persons; train technical staff of partners with clinical mentoring responsibilities and also health workers delivering services in lower level facilities (HCIV level)

The proposed activity will coordinate with the MoH pediatric ART technical working group, Joint Clinical Research Center (JCRC), Mildmay, TASO SCOT, Pediatric Infectious Disease Clinic (PIDC) and other key players in developing such materials.

The activity has clear and well defined deliverables including:

- 1) Develop and disseminate policy/guidelines, training curriculum and standards on pediatric counseling, education, care and treatment, building on existing guidelines and protocols produced by other partners; Print and disseminate simplified job aides including ARV and CTX dose charts, counseling aides, child counseling cards and IEC materials;
- 2) Develop a training curriculum for people living with HIV/AIDS, network support agents and OVC providers on community mobilization for increased utilization of pediatric care and treatment services;
- 3) Work with OVC partners to develop, print and disseminate simplified tools and job aides for linking OVC programs with pediatric HIV/AIDS counseling, care and treatment;
- 4) Dissemination of best practices and lessons learnt in Uganda and within the region through publications (biannual news letter);
- 5) Support national pediatrics HIV/AIDS conference (FY 2009 and FY 2010);
- 6) Develop, print and disseminate training curriculum on pediatric referral, care and treatment services utilization and community mobilization for PHA network support agents and community volunteer;
- 7) Develop education materials for children (e.g. comic books) on HIV, ART, and adherence; and
- 8) Build human resource capacity by training regional and selected district teams who would be champions in leading expansion and quality improvement in pediatric care; Over 2,000 health workers ranging from physicians, nurses, counselors, community health workers and expert clients will be trained during FY 2009 and 2010.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 21645.24018.09

**Activity System ID:** 24018

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$411,733

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, pediatric, TB/HIV, ARV drugs and laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

Significant progress has been made in the area of pediatric HIV/AIDS care and treatment. There are nine laboratories nationwide that have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs have made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal access to laboratory services, and suboptimal linkages to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build an effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21645

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21645	21645.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7253.09	<b>Mechanism:</b> TBD - Districts South-Southwest
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 22499.24028.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 24028	

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, adult care and treatment, TB/HIV, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

Significant progress has been made in the area of pediatrics HIV/AIDS care and treatment. There are nine laboratories nationwide that have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs have made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal linkage to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 22499



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
22499	22499.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3444.09	<b>Mechanism:</b> HIVQUAL
<b>Prime Partner:</b> New York AIDS Institute	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 9137.24819.09	<b>Planned Funds:</b> \$96,500
<b>Activity System ID:</b> 24819	

**Activity Narrative:** The HIVQUAL Program in Uganda (HIVQUAL-U) is implemented under the leadership of the Ministry of Health (MoH) in close collaboration with CDC-Uganda for program management and technical support. This activity compliments other quality monitoring (QM) activities supported by WHO, UNICEF and the USG in Uganda. QM in Uganda is focused on facility level data collection, data management and building capacity for quality management activities at the clinic level. These activities feed directly into the MoH QM priority areas of quality assurance, monitoring and evaluation.

Facilities implementing HIVQUAL-U are selected through a coordinated planning approach led by MOH to minimize duplication with other partners. Indicators measured through HIVQUAL-U include: continuity of HIV care, access to antiretroviral therapy (ART), CD4 monitoring, TB screening, HIV prevention education, adherence assessment and cotrimoxazole prophylaxis. Documentation systems are enhanced through these activities; leading to the development of tracking systems that improve clinical monitoring of patients and retention in care.

Facility-specific data is aggregated, to provide population-level performance reports that indicate priorities for national and regional quality improvement activities. Both internal and external factors influencing the quality of care in a negative manner are identified and where possible improved; the former within the clinic and the latter by raising issues to the MOH HIVQUAL-U team. HIVQUAL-U provides special support to regional and district networks of providers who are engaged in quality improvement (QI) activities thus fostering coordinated approaches to address challenges unique to each region, including: human resource shortages, coordination of care among multiple agencies and donors, and community follow-up and adherence services.

In the previous year, pediatric care and treatment indicators were introduced to an additional 20 public and Non Governmental Organizations (NGO) ART sites in collaboration with UNICEF in Northern Uganda. In addition, the second round of data collection was completed and a report issued. Several QI trainings were completed in addition to a training-of-trainers (TOT) program.

In FY 2009, HIVQUAL-U will expand upon its work initiated in FY 2006 thru FY 2008; from 20 facilities in 2006 to 130 facilities in 2009 (currently 110 facilities are active). In collaboration with UNICEF, pediatric indicators were developed to measure growth monitoring, provision of bed-nets and referrals from PMTCT programs. The specific emphasis of this activity is based at the clinic-level, where HIVQUAL-U is adapting methods of quality improvement (QI) to each organization's particular systems and capacities. An expansion of this project will occur in 20 new health facilities; the QI will consist of monitoring both pediatric care and treatment indicators, in addition to the adult indicators. Provider meetings will be held to share best practices and QI strategies.

HIVQUAL-U team will also lead coaching and mentoring sessions for indigenous partner organizations (e.g. TASO, Mildmay), as well as international consortium partners (e.g. AIDS Relief) to promote the development of their agency-wide QM programs. Sponsorship by district health officers will be encouraged. HIVQUAL-U and its Ugandan partners will be providing additional QI training to adult and pediatric providers. Similarly, TOT programs will work with health training organizations to expand the capacity of QI trainers within Uganda. The U.S. HIVQUAL team will continue to mentor the HIVQUAL-U team to strengthen the following skills: 1) to oversee quality management programmatic activities, 2) evaluate the progress of the HIVQUAL-U program and 3) recommend growth and improvement activities to the HIVQUAL-U team. A Pilot of HIVQUAL in PMTCT programs will continue during this year. The data collected from participating pilot sites, will generate performance data reports. These QI project reports will include comparative analyses and indicators will be refined for data collection in consultation with MOH and key stakeholders.

John Snow Inc. (JSI) has been contracted to evaluate the work of HIVQUAL-International (HRI). JSI will also assess if HRI is achieving its desired goals of building capacity for quality management. The JSI team will meet with key stakeholders to interview them about the work of HIVQUAL and also visit several participating sites. HIVQUAL-U is expected to reach 130 sites that offer PMTCT, pediatric, adult care and treatment services Travel support for key staff in the Ministry of Health to participate in an international QI conference has been allocated; the conference will further educate the staff, in the methods and theory of QI which are not available in Uganda.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13306

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13306	9137.08	HHS/Health Resources Services Administration	New York AIDS Institute	6436	3444.08	HIVQUAL	\$500,000
9137	9137.07	HHS/Health Resources Services Administration	New York AIDS Institute	4811	3444.07	HIVQUAL	\$500,000

**Emphasis Areas**

Health-related Wraparound Programs

\* Child Survival Activities

\* TB

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.11: Activities by Funding Mechanism****Mechanism ID:** 9221.09**Prime Partner:** John Snow, Inc.**Funding Source:** GHCS (State)**Budget Code:** PDTX**Activity ID:** 24377.09**Activity System ID:** 24377**Mechanism:** STAR-EC**USG Agency:** U.S. Agency for International Development**Program Area:** Treatment: Pediatric Treatment**Program Budget Code:** 11**Planned Funds:** \$411,926

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, adult care and treatment, TB/HIV, ARV drugs, laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to six districts in the East Central region of Uganda including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba. Whereas these districts are estimated to have more than 74,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

Significant progress has been made in the area of pediatrics HIV/AIDS care and treatment. There are nine laboratories nationwide have the capacity of conducting DNA-PCR for early infant diagnosis; the number of sites providing pediatric ARV services has increased from 30 to 147 over the last 12 months and an estimated 12,000 children are currently on ART.

Despite progress Pediatric HIV/AIDS treatment has been identified as a major gap and area of focus by the Uganda MoH and USG. The national and PEPFAR target is that 15% of ART patients should be children. Data from PEPFAR and MoH shows that children constitute only 11% of those on treatment.

Likewise access to pre-ART care is suboptimal and associated with high levels of drop out.

Some programs have made significant progress of increasing access of children to HIV care and treatment. Some of the best practices include: integration of ART and PMTCT services; assessment of infants and children for ART eligibility in every clinic visit; routine counseling adults on bring 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. This activity will support districts and health facilities 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, suboptimal linkage to services. This activity will build the skills of health workers on pediatric care, and treatment through didactic and on job trainings, clinical mentoring and availing simplified tools and aides.

This activity will closely work with the JCRC follow-on and other relevant partners to support districts and health facilities to build effective mechanism for transferring samples for DNA-PCR, CD4, viral load and other advanced laboratory test.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish 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

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 10444.09

**Prime Partner:** University Research Corporation, LLC

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 15773.24380.09

**Activity System ID:** 24380

**Mechanism:** HCI (Health Care Improvement Project)

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$521,100

**Activity Narrative:** The Health Care Improvement (HCI) Project provides technical support to the Ministry of Health (MOH) Quality of Care (QoC) Initiative in HIV/AIDS using a quality improvement (QI) approach to ensure the quality of service delivery and ART provision. In 2 years, HCI has established a structure for sustainable QI in 120 health facilities. The project started in 2006 with 57 sites in all 12 regions and spread to an additional 32 sites in 2007 and 31 sites in 2008. A Core Team at the national level and 60 Regional Coordinators trained and coached facility-level teams in QI methodologies. Site QI teams are made up of representatives from HIV/ART clinics, related services such as PMTCT/ANC, TB, family planning and laboratory services and community and PLHIV representatives. Teams are trained to assess the quality of their services through monthly collection of data and to take steps for developing, testing and implementing improvements in their system of care. HCI supports sites through training in QI, monthly on-site coaching and 'Learning Sessions' in which facility-level QI teams have the opportunity to share best practices from their sites and receive focused training, such as changes in MOH policy. HCI contributes to Adult and Pediatric Care and Treatment by working with sites to improve the quality of services provided and to develop best practices which are shared with other sites.

#### FY 2008 Results

As of July 2008, HCI trained 280 providers to deliver ART services; 328 providers on HIV-related institutional capacity building; 280 providers on treatment for TB to HIV infected individuals; and held 5 Learning Sessions (LS) in which providers were trained on QI approaches and methods, the application of chronic care model in HIV, MOH policies, clinical updates on aspects of adult and pediatric ART and HIV care, logistics management, and use of MOH patient monitoring, cohort analysis and reporting tools. HCI supported 540 site visits to provide follow-up coaching in these areas. In June 2008, HCI graduated the 57 sites which began in 2006. These sites have shown the ability to collect and utilize data on a regular basis, implement QI activities with minimal supervision, sustain improvements and assist other facilities in QI. Following up on an assessment conducted in June 2007, HCI held a laboratory training session in collaboration with Central Public Health Laboratories (CPHL) for a lab representative from 85 sites in January 2008 to introduce QI principles and encourage lab participation on the QI team.

QI site teams have introduced changes to improve record keeping, filing and retrieval systems, documentation and use of MOH patient monitoring tools, and timely reporting to MOH and procurement requests. HCI sites have a higher average of timely correct reporting to the MOH than the national average. They have implemented changes such as providing continuous medical education sessions for facility staff; introducing triage systems to streamline visits and reduce waiting time; task shifting of care between staff or to lower level facilities; including clients in peer counseling; improving referral systems and integration with TB, FP and PMTCT services; dispensing commodities such as ARVs and family planning (FP) within ART clinic instead of the pharmacy; organizing the provision of TB and HIV treatment in the same clinic or on the same day; and linking with community based health workers to follow up clients on TB/ART co-treatment. QI teams created links with pediatric services to improve referrals of dry blood spot samples for DNA-PCR for early infant diagnosis; coordinate with outreach workers to improve case finding and follow-up of exposed infants; schedule the same appointment dates for children and parents/caretakers; provide Septrin prophylaxis at PMTCT clinic; assess for ART eligibility and increase initiation on ART; and introduce specific clinic days for children. HCI sites have achieved the following results: 45% of sites have reached an ARV adherence level of 95% or more in at least 95% of their patients; 69% of sites are assessing 95% or more of their patients for ART eligibility at every clinic visit; 71% of sites are prescribing Septrin prophylaxis to 95% or more of their patients at every clinic visit; 66% of sites are screening 95% or more of HIV patients for active TB at every clinic visit; 96% of sites are referring 95% or more of HIV patients identified with active TB for TB treatment; 71% of sites are assessing 95% or more of infants and children for ART eligibility at every clinic visit; and 47% of sites are conducting CD4 tests for their clients every six months for 50% or more of their clients.

#### FY 2009 Activities

HCI will continue activities to improve HIV care and ART in 114 of its original 120 sites. As HIVQUAL and HCI overlapped in some sites, the two projects have agreed to divide follow-up; 6 will now be HIVQUAL sites. HCI will follow up 51 of the 57 graduated sites through quarterly coaching visits. The remaining 63 sites will be supported through monthly coaching visits. HCI will conduct 3 Learning Sessions for these groups and plans to graduate the all sites by the end of FY 2009. Learning sessions are an opportunity to provide targeted training on areas of ART service delivery which are found to be weak during site visits. Approximately 575 site visits are planned for the 114 continuing HCI sites, which consist of 1 national referral hospital, 6 regional referral hospitals, 53 general/district hospitals, 48 health center IVs, 5 health center IIIs, and 1 health center II. Sites are located in 66 districts distributed throughout 12 regions of Uganda.

The primary focus of technical assistance will shift from facilities to District Health Teams (DHT). HCI aims to further spread ART care in both breadth and depth through expanding to new sites and building capacity at the district level. The goal is to sustain and institutionalize a culture of continuous improvement in the DHT. HCI will build capacity of DHTs to coach teams to plan, manage, monitor and spread QI activities in HIV/AIDS in their districts. In addition to the DHTs, HCI will build capacity of other institutions to support the DHTs including health sub-district managers, key staff from district hospitals, and representatives from NGO clinics and CBOs. HCI will have up to four phases of implementation over 3.5 years with each phase including between 15 and 30 districts. Each phase is expected to last 1.5 – 2 years with 6 to 9 months between the start of each phase. The first two phases will begin in FY 2009. Each district coaching team will work with 2 to 3 facilities consisting of current HCI and new sites. HCI will support the DHTs through coaching visits for the first three months followed by quarterly visits. HCI, Core Team and Regional Team members will work with DHTs to conduct QI trainings at new sites. The DHTs will in turn support sites to implement improvement changes and monitor their progress. DHTs will have the opportunity to share their experiences in implementing QI activities and on the progress of their sites in improving the quality of HIV services in learning sessions every 4 to 6 months. These activities will develop the management and leadership capacity at the district level and within sites as they learn to monitor the quality of their services, take action to improve them and expand to other health areas. HCI will continue to spread the best practices mentioned in FY 2008 Results in adult and pediatric care and treatment within its current and new sites. We will also build DHT capacity to manage the health care teams to improve their engagement and

**Activity Narrative:** productivity. Specific activities planned include 3 Learning Sessions (LS) for Phase I districts, 1 4-day training on HIV care and ART for District Managers for each Phase, 1 Stakeholders' Meeting for Phase II districts, 1 LS for Phase II districts, on-site training in QI for 60 new sites, and around 120 district coaching visits during which HCI, Core Team, and Regional Coordinators will conduct close to 350 facility visits with DHTs. QI training at LSs and on-site at facilities provides the DHTs and site team members with the tools they need to analyze gaps in service and take steps to test possible solutions to improve ART service provision and develop more effective and efficient work processes within existing resources. HCI will introduce a framework on the quality of ART services to address quality gaps in access, retention and wellness to improve service outcomes and universal access. HCI will build capacity of DHTs and site teams to monitor the proportion of PLHIV eligible for ART who actually receive ART, proportion of PLHIV who are started ART and are still on therapy at any given time and the proportion of PLHIV who are currently on therapy and have good clinical outcomes. Districts and facilities will be encouraged to develop strategies for chronic care management to provide their clients with self management support and links to community support. HCI will work with sites in monitoring ART drug resistance through early warning indicators indentified with MOH, such as measures of declining clinical outcomes. HCI supports MOH M&E activities by collecting and using data to inform facility QI activities, review progress at coaching visits and aggregate indicators to determine quality of the national ART program. We will continue to assist the MOH by training sites in the use of the pre-ART and ART cards, cohort analysis, logistics requisition, and reporting data. HCI plans to conduct small operations research studies to assist the MOH in the implementation of ART programs through investigating factors affecting loss to follow-up and referrals of PMTCT mothers and infants following delivery and comparing of adherence rates in facility-based and home-based care programs.

For the DHT capacity building activities there will be 15 districts in Phase I and 20 districts in Phase II distributed in 12 regions. All Phase I and II districts will be from the current 66 HCI districts. HCI will add at least 60 new sites which will be a mix of Health Center IVs and IIIs. HCI's target population is all HIV positive adults and children and exposed children who are in need of and receiving ART services. HCI reaches this population through working with QI teams consisting of health care providers, outreach workers, and expert clients to improve the quality of services at the clinic including improved screening, referral systems with other services such as VCT/RCT, PMTCT and TB, and connections with outreach workers, such as Network Support Agents, at the facility and district level.

In partnership with Business PART Project, HCI included four private for profit (PFP) facilities in the 32 sites which started in 2007. HCI has conducted a quality assessment in 30 PFP sites and will use the assessment findings and recommendations, such as improving record keeping, follow-up of patients, and referral systems, to develop a strategy for QI in ART for PFP sites. DHTs will be encouraged to support a PFP site within its catchment area. HCI will partner with HIPS project to support additional PFP sites. HCI will also draw on existing partnerships with IDI, Mildmay, SCMS, and NMS to find opportunities that will support PFP sites in technical area and logistics systems training.

HCI will continue our work in improving laboratory processes such as referrals for samples, adherence to MOH laboratory standard operating procedures (SOP) and reducing supply stock outs through participation of lab representatives on QI teams and experience sharing at learning sessions. Lab Regional Coordinators in all 12 regions provide feedback to lab personnel during regular coaching visits. HCI is working together with the MOH and Core Team representative from CPHL on activities including development and distribution of policy documents, feedback on lab logistics problems, and the status of major equipment at facilities. Each district coaching team will include a representative of lab management and will be encouraged to improve adherence to lab SOP and referrals.

#### Partner Collaboration

NuLife will be utilizing the existing HCI structure to roll-out activities related to nutrition and HIV, specifically nutritional assessment/counseling and prescription of RUTF as needed, infant feeding in the context of HIV, and integrated management of acute malnutrition in selected HCI facilities. A nutritionist will be added to the Core Team and nutrition focal persons will be added to Regional Teams, District QI teams and site QI teams. Nulife will introduce food and nutrition interventions through HCI Learning Sessions with follow-up during monthly and quarterly coaching visits.

HCI will continue to maximize its program's impact through close partnerships with other USG-funded projects, such as NUMAT and other projects working at the district level, to coordinate activities and leverage funding. HIVQUAL and HCI are coordinating activities to maximize the impact of QI activities by covering different facilities; harmonizing indicators and data collection processes where possible; and ensuring that DHTs can coach for all sites. HCI will coordinate with the MOH, IDI and Mildmay to prepare and conduct trainings on HIV care and ART for district managers. HCI coaches will refer public, NGO and PFP facilities to IDI and Mildmay for HIV/AIDS and lab trainings. HCI will provide monthly feedback from sites on the availability of logistics (ARVs, HIV testing kits, patient monitoring tools) to NMS and SCMS. HCI will coordinate with FHI and EngenderHealth to disseminate FP and HIV integration best practices during LSs and coaching visits. HCI will strengthen partnership with institutions involved in TB/HIV care integration such as WHO, MOH Makerere-Mbarara Joints AIDS Program, National Tuberculosis and Leprosy Programme, and TB CAP. HCI will partner with PIDC and JCRC for CD4 testing and DNA-PCR tests and with EGPAF to review and develop training materials on pediatric treatment and care. Most of the partners listed are members of the Core Team and will continue to participate in monthly review meetings and as needed participate in coaching visits and LSs to provide training, policy updates and solutions to problems at regional, district and facilities levels.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15773

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15773	15773.08	U.S. Agency for International Development	University Research Corporation, LLC	7257	7257.08	HCI (Health Care Improvement Project)	\$2,700,000

**Emphasis Areas**

Health-related Wraparound Programs

- \* Family Planning
- \* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3166.09	<b>Mechanism:</b> Expanding the Role of Networks of People Living with HIV/AIDS in Uganda
<b>Prime Partner:</b> International HIV/AIDS Alliance	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 25047.09	<b>Planned Funds:</b> \$231,600
<b>Activity System ID:</b> 25047	



**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008 the project has 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 such as family planning and broader reproductive issues. The project has trained 839 Network Support Agents (NSAs) who have been seconded to 416 Health centers across the 40 districts of operation. A total of 29 consortiums of PHA groups have been formed at Health Sub district level to participate in the delivery of HIV-related services. The NSA and the PHA groups have carried out ART education, ART adherence counseling and they have followed up clients in their homes to support patients with drug adherence and general welfare. As a result, a total of 238,800 individuals were reached with ART education, 40,434 reached with follow up counseling, 31,242 reached through home visits. In addition, through the project, the Alliance has linked the PHA groups with PSI which has provided basic care kits that prevent opportunistic infections like safe water vessels, insecticide treated nets and pharmaceuticals. Working in partnership with NuLIFE, the program is training NSA in integration of nutrition in care and support programs for PHA. A total of 580 NSA have been trained.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

In FY 2009, the project will consolidate activities in the 40 districts. An additional 100 consortiums of PHA groups will be formed and supported financially and technically to strengthen care and treatment support provision to their members and other PHAs identified in the community. The groups will therefore carry out home visits, couple counseling and support for disclosure and ART adherence counseling. 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. The project will also continue supporting post test clubs because they facilitate transition from counseling and testing to care, treatment and prevention services. The project has specifically targeted Post Test Clubs (PTCs) comprised of military populations in order to extend care and support services to this key population.

As members of the PLHIV groups, the trained NSAs in addition to undertaking activities outlined above, will play a critical role in mobilization of PHAs, making referrals to health facilities and creating linkages between the clients and the PHA group for continued care and support. As the number of people accessing HIV/AIDS related services increases, the importance of ensuring quality services and drug adherence remain critical. The presence of the NSAs at the health facilities makes this possible and the Alliance proposes to lobby the Ministry of Health to integrate the NSAs into the formal district health care delivery system since they provide an alternative source of manpower for health care.

Gender norms and practices are a barrier to people accessing care and support services. The project plans to 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 Project plans to strengthen Prevention for Positive programs in order to provide PHAs with the skills they need to take control over the disease in their lives. Working closely with SCOT (Strengthening Counselor Training Program), the project will build the capacity of PHA groups to provide patient education, conduct behavioral counseling and to support patients develop personal prevention strategies. IEC materials will also be provided to reinforce education on prevention for PHAs within the continuum of care. The PHA groups will also be supported to conduct "HIV stops with Me" campaigns in order to reduce stigma associated with HIV.

As part of the capacity building process of the PHA groups, the project plans to continue supporting refurbishment of Common Facility Centers. These centers provide space for people living with HIV to meet regularly for peer support and shared learning, and to conduct health education programs for the community members. The centers will also house vocational training workshops, provide space for setting up demonstration gardens and act as a reference point for the groups.

The project will continue to partner with PSI and other malaria control partners to provide basic care commodities to the PHAs and their families. Commodities include mosquito nets, water vessels and pharmaceuticals. The partnership with NULIFE will be expanded to cover 12 new districts in Mid Western Uganda that have not been covered in FY 2008 as well as increase capacities of groups to conduct nutritional assessments, carry out nutrition counseling and education. The project will also facilitate

**Activity Narrative:** linkages of PHA groups to Government programs like NAADS and other existing agricultural programs to provide skills in vegetable growing and horticulture for purposes of improving nutrition. The community engagement strategy will continue to be employed to further link PHA groups to other organizations providing wrap around services e.g. family planning, reproductive health, supplementary feeding, livelihood programs and water and sanitation programs.

The project proposes to strengthen the link between the groups and the local government at district and county levels and hence ensure that the local government provides leadership, technical support and mobilizes resources for PLHIV groups and networks in order to sustain care and support programs beyond the project life. The Alliance will therefore provide technical assistance to local governments to institutionalize the network model and strengthen capacity of PHA groups' to leverage local resources.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 15791.21552.09

**Planned Funds:** ██████████

**Activity System ID:** 21552

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive, and on the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. USAID will award the new Cooperative Agreement by March 2009. This will ensure smooth transition between the current JCRC program and the TBD mechanism.

In FY 2009 the major focus of the activity will be to ensure continuity of life saving care and treatment services, smooth transition and capacity building in the 11 regional referral hospitals and expansion of district wide HIV/AIDS care and treatment services in 40 facilities located in the 11 districts hosting the regional referral hospitals. Specific activities will include: training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis(TB) and HIV. The program will train physicians and non-physicians to provide Pediatric care and treatment services. The program will also support groups of People Living with HIV/AIDS (PHAs) to provide services as expert clients in the health facilities and in the community. PHAs will facilitate referrals and linkages between facility-based and community-based care, utilization of pediatric care and treatment services, growth monitoring, food and nutrition support, support for adherence to anti-retrovirals (ARVs), counseling for pediatric HIV-positive patients and linkages to basic preventive package and wrap-around services.

In the selected 11 focus districts, 11 regional referral hospitals and over 40 sites, the program will support infrastructure development for pediatric care and treatment services and build capacity of the Directorate of Health Services to scale-up linkages between PMTCT and pediatric care and treatment in the district. It is estimated that a total of 11,000 children will receive care and 5,000 will be initiated on treatment.

Critical emerging issues like adherence, surveillance for resistance, Infant Diagnosis using DNA-PCR and screening of patients under palliative care for ART eligibility will be supported. The program will provide financial support in form of grants to Civil society organizations and Networks of PHAs to carry out activities that support improved ART literacy, adherence, patient tracking, prevention with positives and linkages to wrap around services.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women and, linkages between pregnant women and pediatric care are strengthened. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15791

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15791	15791.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$4,800,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 21887.09

**Activity System ID:** 21887

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** [REDACTED]

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 7257.09

**Mechanism:** Health Care Improvement Project - HCI/NuLife

---

**Prime Partner:** University Research Corporation, LLC

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 15773.21781.09

**Activity System ID:** 21781

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$183,350

**Activity Narrative: Activity Narrative (Pediatric)**

The Food and Nutrition Intervention for Uganda –(NuLife) is being implemented by University Research Co., LLC (URC) to support to Ministry of Health (MOH), CBOs/NGOs, Networks of People Living with HIV/AIDS and USG implementing partners to integrate and expand food and nutrition into HIV/AIDS prevention, care and treatment programs. The focus of the program is to increase the utilization, adherence to and efficacy of anti-retroviral treatment (ART) and improving the nutritional and health status of PLHIV. The program's three primary objectives include: 1) provision of technical and financial support to the MOH, CBOs/NGOs, PLHIV Networks, USG partners to integrate food and nutrition interventions in HIV and AIDS prevention, care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable RUTF made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities. The program will provide targeted food and nutrition support that includes food supplements for vulnerable groups including OVCs, HIV-positive pregnant and lactating mothers and those with mild-to-moderate malnutrition, therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants. During FY 2008, NuLife has established collaboration mechanisms with MOH through establishment of a Sub-Committee on Nutrition (SCN) and provided technical assistance in drafting the National Nutrition and HIV and TB Strategy (2008-2010). NuLife has reviewed both national and international guidelines, training curricula, educational materials and other documents related to food and nutrition for PLHIV; supported the updating and expansion of the National Infant and Young Child Feeding (IYCF) Guidelines and the development of related counseling tools and other job aids. It has facilitated a critical review of the draft National Guidelines on the Integrated Management of Acute Malnutrition (IMAM). Through the Health Care Improvement Project (HCI), NuLife secured a position for a nutritionist on the Core Team at the national level and expanded the role of the current HCI-supported Quality Improvement (QI) collaborative teams to include a nutrition focal person at each level. Through regular HCI learning sessions, a total of 223 health workers from 120 ART facilities were sensitized in the basics of integrating food and nutrition in health facilities. Working with the IHAA and the Northern Uganda Malaria and HIV/AIDS TB (NUMAT) program, 605 network support agents (NSAs) and 100-health facility in charges from 36 districts received an initial orientation and package of educational materials on the special food and nutrition needs of PLHIV. A Geographic Information System (GIS) was established for use in prioritizing areas of operation, program planning and visual reporting; 32 phase one priority sites across 29 districts were selected and a community mobilization strategy was developed. The specifications for the production of a local RUTF were developed and the identification and selection process for a Ugandan manufacturer was completed.

During FY2009, NuLife will build on and consolidate its FY2008 achievements as it expands its technical and financial support for HIV-related food and nutrition interventions. Specific to Adult Care and Treatment programming, Under the framework of the National Strategy for Nutrition and HIV and TB (2008-2010), NuLife will support training of both facility and community health staff in 32 Phase One and 45 Phase Two sites participating communities related to 1) nutrition and HIV/AIDS for Adult Care and Treatment programs, including nutritional assessment, counseling, forecasting of RUTF, and food by prescription (FBP); 2) Integrated Management of Acute Malnutrition (IMAM) in the context of HIV/AIDS; and Community Mobilization for Behavior Change related to nutrition and HIV. Support materials will include: a) a counseling materials for use with PLHIV, b) patient take home flyers; c) training materials and d) equipment. NuLife will greatly support the capacity building effort of the MoH and other partner for integration of nutrition care and support within adult care and treatment services by training a core national team of 100 trainers drawn from a pool national and regional level nutrition experts. The trainers will in turn train health workers, community based volunteers and district teams in IMAM, FBP guidelines and community mobilization. Working through the Health Care improvement (HCI) program and USG partners, NuLife will select at least 12 health workers from each district and regional health facilities and 8 health workers from each HCIV including members from the quality improvement (QI) ART teams, in the provision of food and nutrition care and support (nutrition counseling, assessment and food by prescription) services. A total of 1600 health workers from Phase One and Two health facilities and participating communities will be trained. 654 community health workers will be trained under the NuLife community mobilization model and through partnership with IHAA, EGPAF, NUMAT and other USG implementing partners.

USG Partner Coordination: The program will focus collaborative efforts with USG partners implementing Adult Care and Treatment programs in the selection of health care providers to be trained. Some of the major Adult Care and Treatment partners will include JCRC, TASO, International HIV AIDS Alliance, NUMAT, CRS/AIDSRelief, where programming overlaps with the 32 NuLife Phase One Sites and 45 Phase Two Sites. Adult patients participating in programs supported by USG partners will also be able to access food and nutritional care and support counseling services.

MOH/Quality of Care Initiative (QoCI): NuLife is collaborating closely with the MOH/Quality of Care Initiative in the introduction of food and nutrition interventions in health facilities providing ART throughout the country. The mechanisms through which NuLife will collaborate with the national QoCI including support for the participation of selected nutritionists or nutrition focal persons in the national-level Core Team (made up of technical staff from MOH, URC/HCI staff and key USG HIV care and treatment partners), the Regional Coordinator Teams (5-6 member); and the District Quality Improvement (QI) Teams. During FY2009, NuLife will introduce food and nutrition interventions in selected HCI sites through training in priority areas during learning sessions, and will provide follow-up through monthly supervision or coaching visits to Phase One and Phase Two Sites. Under the HCI model for sustainability purposes, the district QI teams are assuming the roles of the Regional Coordinator Teams in the supervision and support to participating health facilities in relation to implementation of ART guidelines, data collection and management, and improving the quality of care and services. NuLife has worked with the HCI program to strategically start with districts where there is a presence of URC-supported facilities and orienting the districts in food and nutrition interventions for PLHAs. A total of 246 staff from DHT teams will trained to provide support supervision to health facilities supported by NuLife.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15773

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15773	15773.08	U.S. Agency for International Development	University Research Corporation, LLC	7257	7257.08	HCI (Health Care Improvement Project)	\$2,700,000

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* Safe Motherhood

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$70,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$50,000

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$40,000

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 4687.21719.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21719



---

**Activity Narrative:** Activity Narrative:

The number of children living with HIV and AIDS in Uganda is on the increase. An estimated 200,000 children are living with HIV and another 25,000 get infected annually. Currently 11,000 children are accessing treatment, representing only 22% of all those in need. The need for pediatric care and treatment is enormous. However, human resource constraints, poor accessibility to services and limited pediatric care skills have in combination limited wide-scale accessibility to pediatric AIDS care and treatment. 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14211

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14211	4687.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,000,000
8428	4687.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,000,000
4687	4687.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$100,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 15487.21729.09

**Activity System ID:** 21729

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$154,400

**Activity Narrative:** This activity also relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

In FY2008 only 127 children in NUMAT supported facilities were on ART, of these only 9 were below 2 years of age. Health workers considered pediatric treatment, care and support complicated and preferred to refer the children to bigger hospitals for specialist management. HIV led many children to be orphaned while others were additionally ill. This caused the children to loose out on appropriate screening, prevention and treatment of malaria, parasitic infestations, malnutrition and other childhood diseases. NUMAT embarked on rigorous capacity building for the health workers at the supported health facilities. The trainings covered ART, palliative care and various aspects of pediatric psychosocial support. 36 health workers were trained in comprehensive pediatric care and treatment. 96 health workers also trained in pain and symptom management for HIV patients and management of OI's whose benefits were cross cutting addressing treatment and care in both adults and children. Up to 660 children were also offered free CD4 and full blood count testing as part of the process of scaling up access and quality of ART in the supported sites. Early infant diagnosis was also supported in 10 sites. All these efforts led up to 40 percent of tested infants and children found eligible. While NUMAT planned and procured Adult ARV formulations for some of the older children. Meanwhile the need for pediatric formulations for the younger children led to negotiations with Baylor Children's College Uganda who could additionally impart best practices and clinical skills in paediatric care to the health workers in the supported sites.

During the same period 750 home based care providers from the nine districts were trained to support HIV positive children in the community by monitoring their health status, monitoring ART adherence, offering them on going counseling and identifying economical, social, educational and psychological effects of HIV /AIDS on the children so that they could be referred for appropriate care. The project also mobilized and trained 103 PHA volunteers to work as Network support agents (NSA) in 45 health facilities. In addition to their cardinal role of linking fellow PHAs and family members to community and health facility- based care and treatment services, NSAs also supported children with counseling, community based care and support.

#### ACTIVITY UNCHANGED FROM FY 2008

In FY 2009, NUMAT will scale up paediatric care and treatment activities through coordination with MOH, district local governments, other agencies and communities. More HIV affected children including those actually HIV positive will benefit from an increase in the number of Health facilities able to provide holistic paediatric care. This will be made possible as MOH supports NUMAT led site assessments and subsequently accredits suitable ART sites. By the end of the period NUMAT will have supported up to 30 accredited sites.

Some of these sites will be "model sites" - hard to reach and high risk communities targeted by NUMAT with an aim of increasing access and quality of holistic treatment and care for children and their families. The model site concept is a synchronised effort by all the different NUMAT program areas providing holistic clinical and community based support for children in, transit IDP camps, fishing villages, military camps and other environments that increase their vulnerabilities to HIV, malaria and Tuberculosis.

NUMAT has signed an MOU with Baylor Children's College Uganda (BCCU) forging a partnership with an objective of promoting skills of health workers in paediatric care through pedagogic and on site mentorship in all aspects of Pediatric HIV treatment, care and psychosocial support with particular consideration for disclosure and promoting life skills in children, adolescents and their caregivers affected by HIV. BCCU will also supply pediatric formulations for children less than 5 years of age. Comprehensive paediatric care will also encompass growth monitoring, and management of childhood diseases. Other routine support for child health for instance, nutritional assessments of anthropometric status, immunisation, provision of promulti-micronutrient supplements, therapeutic or supplementary feeding support for clinically malnourished patients, infant feeding support will be promoted. NUMAT will support PHA networks and other groups that provide psychosocial and wrap around support for children, adolescents, caregivers and families. Additionally, NUMAT will make use of home visitors coordinated by Community care coalitions (CCCs) that will provide Community based ARV adherence monitoring and follow up for the children.

CD4 and full blood count testing at all the NUMAT supported sites will continue albeit at a larger scale than in PY2. A total of 21,880 CD4 tests and about 600 full hemogram tests will be offered to both children and adults requiring the test through AIC and CNAPSIS. This is an increase from 4800 CD4 tests offered in the last FY. NUMAT has supported capacity building as regards CD4 testing by conducting training for health workers in HIV care, by on site mentoring focusing on CD4 utilization.

Linkages with other program areas including the PMTCT program will be strengthened. Early Infant Diagnosis will be scaled up by training health workers in dry blood spot collection and communities will be sensitised to link children with essential HIV clinical services. Communities will also be encouraged to link HIV affected children to wrap around services including food, material, and educational support. Referral networks involving PHA groups, health facilities, NGOs, CBOs and Community Care Coalitions (CCC) will allow the expansion of access to these services. The health visitors shall continue to monitor the health status of children in their homes; monitor ARV adherence, identify economic social, educational and psychosocial effects of HIV and AIDS on children and refer them for the wrap around services. Collaboration with other USG supported programmes like PSI, IRCU, AFFORD, IHAA, NuLife to exploit initiatives will additionally expand and improve care and support for children. Benefits would include promotion of prevention & care packages including Cotrimoxazole prophylaxis for opportunistic infections (OIs), ITNs, and additional psychosocial support.

**Activity Narrative:**  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 15487

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15487	15487.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$1,100,000

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* Safe Motherhood

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$25,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 12489.21816.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21816	

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to PMTCT, ARV drugs, Adult Care and Treatment, Pediatric Care, Counseling and Testing, Laboratory Infrastructure, TB/HIV.

In FY 2008, the SCMS project provided procurement services and technical assistance to the Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), and UPHOLD (now ended) to improve the availability and management of ARV drugs in their sites. SCMS also provided funds to the MOH for emergency ARV procurements. To-date, a total of \$1,795,000 of ARVs and related commodities has been procured through SCMS for these partners. SCMS will also procure ARVs for EGPAF. NUMAT, in partnership with SCMS, established logistic management systems and procedures for ARV supply in its ART sites and a working arrangement was developed with Joint Medical Stores, a central warehouse for FBOs and other private sector organizations, to deliver to the partner sites based upon requisition. NUMAT technical officers trained and mentored ART teams in logistics management to ensure smooth system performance and logistics tools and materials adopted from MOH formats were distributed to the ART sites to ensure proper reporting of drug consumption. During the period, two cycles were delivered of first and second line adult ARV formulations for 17 existing ART sites and later for 6 additional newly accredited ART sites in the nine districts. Gaps in pediatric support were identified, which led to negotiations with Baylor Children College (Uganda) to provide the ART clinics with ARV formulations for young children. The choices of ARV drugs selected by the program were determined by the current GoU ARV policy that took into consideration efficacy, adverse effect profile, and pill burden. The ARV drugs selected also took into consideration needs of the clients gaining entry through the other program areas of PMTCT and TB.

SCMS also procured ARVs and drugs for opportunistic infections for the IRCU program. Technical staff have been trained in forecasting drug needs for the program and on the ARV logistics management system. A computerized logistics management information system was installed using standard software to track consumption and stock levels at the individual sites. Thirteen implementing sites are currently submitting bimonthly ARV drug reports and orders to the IRCU Logistics Officer. The partnership with SCMS and JMS has been successful to date and has guaranteed steady availability of ARVs at all IRCU supported sites. In addition, as a result of this partnership, IRCU has been able to procure quality ARVs at the most competitive rates available on the market, guaranteeing that its clients are accessing quality products and, with the savings, enabling the program to recruit more ART clients.

At the national level, SCMS provided technical assistance to the MOH to forecast and quantify the country's ARV needs, coordinate procurement with donors, and train new district and new ART site staff on logistics management and reporting. SCMS also assisted in support supervision activities at district level to improve facility level performance. Specific achievements include 683 health workers country-wide trained on the redesigned MOH ART logistics management system, 28 MOH regional pharmacists and senior dispensers trained on management of ART logistics activities, and 92 health workers from 38 newly accredited ART sites trained on the logistics management system. The SCMS supervisory team visited a total of 174 ART sites to monitor performance and provide on-the-job support to health workers charged with logistics management. Efforts to harmonize ARV procurement among PEPFAR partners and communicate supply issues continued through various technical working groups and technical support was provided to the GFTAM third party procurement agent (WHO/UNICEF). In FY08, technical assistance was provided to JMS to completely overhaul its warehousing and inventory management system including installation and training in the new warehouse management information system (MACS) and the financial system (SAGE) software. Support was also provided to NMS to assess its warehousing and inventory management system, the recommendations of which were endorsed by the NMS Board of Directors.

The new procurement mechanism will provide technical assistance to national and district-level PEPFAR partners on commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job

**Activity Narrative:** training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submitting timely reports to keep the supplies flowing. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution from district stores to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14235

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14235	12489.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$300,000
12489	12489.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$300,000

**Table 3.3.11: Activities by Funding Mechansim**

**Mechanism ID:** 9832.09

**Mechanism:** Western Region / PMTCT

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 15921.22931.09

**Planned Funds:** ██████████

**Activity System ID:** 22931

## Activity Narrative: Introduction

This narrative is a component of other EGPAF activities that include PMTCT supported through USG funding. EGPAF also supports treatment services at 5 sites using private funds donated through the Abbott Fund. The Elizabeth Glaser Pediatric AIDS Foundation (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. The Foundation directly supports programs in 27 districts to provide HIV counseling and testing, ARV prophylaxis, HAART, psychosocial support, community mobilization, training, adequate counselor and laboratory technician staff, upgraded laboratory facilities and counseling rooms, management information systems and strengthened MCH/FP services. The Foundation's staff provides technical support to the district programs and by participating in MOH technical committees such as pediatric ART and PMTCT. The Foundation works closely with the Uganda MOH and other PMTCT and treatment partners in Uganda including SCMS, JCRC, Uganda Cares, AIM, UPHOLD and UNICEF to coordinate support and maximize coverage of PMTCT and HIV treatment services.

## Progress and Achievements

The Foundation has worked directly or in partnership with other USG implementing partners to provide comprehensive care and treatment services within the 363 EGPAF PMTCT service outlets. Over the last 6 months, EGPAF is directly supporting care and treatment services to 17 service outlets that are not supported by a PEPFAR Implementing partners. This development has increased access to critical antiretroviral therapy for individuals identified through PMTCT. 1254 HIV positive clients received care and treatment services in the 17 service outlets of which, 3.2% were children. Peer educators have been introduced at 41 sites to strengthen follow-up patient care by taking over less skilled tasks from the already overburdened health workers. The Foundation's comprehensive family care model includes community level linkages to increase identification of HIV exposed children and their families, PMTCT services, care and treatment with an emphasis on pediatric care and an innovative psychosocial support effort that includes children's support groups. By providing support for care and treatment, the Foundation will continue to integrate affordable, family-based quality HIV/AIDS care and ART services into health care facilities through ensuring that a continuum of services is available and accessible: from PMTCT, to care and treatment, to psychosocial support via a Family Care Model.

## FY 2009 Activities

Activity Objective: Scale up model Family focused HIV Care Clinics within MOH Health Centers and directly enroll HIV-positive mothers and family members in HIV comprehensive care including treatment. Key activities: 1) HIV care and treatment activities. During the past year, the Foundation initiated Care and Treatment support to 20 health centers bringing urgently needed ARVs to the primary care level. Building on the success of the initial roll out, the Foundation will scale up a family centered model of care and treatment with an emphasis on pediatric care to an additional 15 health centers. The Foundation will provide training and technical support to address logistical challenges especially quantification/forecasting and distribution of ARVs. This will develop the services providers' capacity, and ensure regular supplies of ARVs and other needs. Quality improvement systems will be strengthened through the standardization of operating procedures and improvement of data management systems. As a result at least 15,000 individuals will be enrolled in HIV comprehensive care and 3,000 will be initiated on ART by the end of FY08. HIV counseling and testing will cover both outpatient and inpatient wards at the selected health facilities as well as the surrounding communities. TB clinics will be specifically targeted for routine HIV counseling and testing. The possibility of providing HIV care and treatment within the TB will also be explored. As stock outs of important medications have unfortunately been a common occurrence, the Foundation will purchase ARVs to provide a backup supply and avoid stock outs. A major component of expansion activities will be ensuring that quality laboratory services are available in each center providing ART. Referral laboratory services will be utilized for the monitoring of patients receiving HIV care and treatment. Where possible the Foundation will explore the possibility of improving and equipping laboratory facilities (especially at district hospitals) for optimal patient care. Each site will be assessed and needed upgrades in these areas will be developed. 2) Improve access to pediatric treatment. Capacity building activities to promote pediatric HIV/AIDS care will continue to be addressed during FY09. The clinical mentorship program to support pediatric HIV/AIDS care will be expanded to include a focus on pediatric nursing/counseling. The training activities will strengthen skills of lower level facility personnel to provide pediatric ART through a training package developed with the MOH Child Health Department, comprising of pediatric counseling, modified IMCI (HIV) and early infant HIV diagnosis components. This is aimed at equipping service providers with knowledge and skills to identify HIV-infected children and offer pediatric HIV/AIDS care. 3) Involving People Living with HIV/AIDS. PLWHA networks will be supported to facilitate clinical care at 40 health facilities. The programs based on the peer educator concept will utilize focal support group members in these activities. The scope of work will be site specific but will include activities such as streamlining client flow, directing clients to the different departments, health education, and registration of clients in MCH, and supplementing counseling sessions through live testimonies. The PLWHAs will be enabled to carry out home visit activities to the PMTCT and ART clients, community mobilization and sensitization. These activities aim to improve follow up of PMTCT clients at the facilities. Family support groups will continue to form a critical avenue for the provision of psychosocial support to families infected and affected by HIV/AIDS. The recently launched Ariel Clubs guidelines have formalized approaches to providing psychosocial services to HIV infected children through child focused support groups. 4) Longitudinal follow-up of HIV-positive mothers within MCH including during well-child visits. HIV care and treatment services will be strengthened through the development of mechanisms to offer continuum of care to HIV-positive mothers and their families. EGPAF will scale up Early Infant Diagnosis by expanding access to DNA PCR testing and routine HIV counseling and testing at key pediatric service points within the health facilities. Collaboration and coordination with partner organizations supporting HCT will enable expanded access to routine HIV testing. Capacity building initiatives for this activity will emphasize care for the HIV exposed infant alongside its mother and other family members. The provision of care and support services to eligible individuals has been shown to improve the uptake of all other PMTCT services. Capacity will be built to support the scale up of the program for early infant diagnosis of HIV. Focus will be directed at strengthening the enrollment of identified HIV-exposed and infected infants into continuum of care programs. Standardized operating protocols and job aides will be developed as part of

**Activity Narrative:** this effort. Following the successful involvement, PLWHA networks in the provision of HIV care at five-health center IVs the Foundation rolled out this initiative to 41 sites. The integration of peer mothers and fathers (drawn from the Family Support Groups) into the regular HIV/AIDS services at health facilities will be expanded to support the follow up of the mother-baby pair in the community. The provision of peer counseling to parents of HIV exposed infants and guiding them through the various services on offer at the health facility has reduced loss to follow up of identified HIV exposed infants. HIV infected families will roll out use of revised infant feeding materials to support the adoption of safe infant feeding practices. 5) Training activities will reflect the integral nature of the HIV/AIDS care with a bias towards family based care of HIV. Crucial knowledge and skills in ART compliance and adherence monitoring will be included in the training activities. The capacity of teams at health sub district/district/regional levels will further be built by involving all the trained trainers in supervisory roles. The Foundation will continue to conduct Continuing Medical Education (CME) approach and using the mentoring approach from five regional hospitals in order to reinforce skills development among health facility staff with the goal of improving program uptake. The technical development of MOH staff in the supported districts will ensure sustainable capacity for program implementation. Overall, the Foundation will train up to 600 health workers during FY09 in both PMTCT and ART services with the focus primarily targeting health workers in the Maternal and Child Health departments in the remaining Health Center IIIs in supported districts. Clinicians, nursing/midwifery and laboratory staff will be trained as integrated teams for HIV/AIDS patient care. Training activities will reflect the expanded nature of the PMTCT program with a strong bias towards integrating preventive and treatment aspects of HIV/AIDS. Special emphasis will be made towards increasing the use of more efficacious (combination) regimen for PMTCT and the repackaging of oral ARV medications for HIV exposed infants. 6) Monitoring and Evaluation Plan: The Foundation will continue to support the MOH's M&E network through the provision of evaluation reports on key PMTCT and HIV care and treatment indicators. Field support 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. 7)Nutrition Support: The Foundation will in collaboration with the NuLife Project initiate a therapeutic feeding program in 20 EGPAF supported districts. This will also involve the development of resource materials like job aides, pamphlets for infant feeding and nutrition of pregnant women. 8)The Foundation will work to ensure that sites provide quality clinical care services. Antiretroviral treatment will be provided in accordance with Uganda treatment guidelines and the procurement and ARV distribution will utilize the MOH systems. Collaboration will be sought from other USAID funded programs e.g. QAP to design quality improvement interventions of HIV care and treatment and provide ongoing technical guidance in this critical area. Develop and implement SOPs and strengthen outreach to assure that (75%) of exposed infants receive CTX prophylaxis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15921

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15921	15921.08	U.S. Agency for International Development	Elizabeth Glaser Pediatric AIDS Foundation	6734	6159.08	EGPAF	\$2,039,364



### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* Family Planning

- \* Malaria (PMI)

Refugees/Internally Displaced Persons

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 1290.09

**Prime Partner:** Catholic Relief Services

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Activity ID:** 4386.20746.09

**Activity System ID:** 20746

**Mechanism:** AIDSRelief

**USG Agency:** HHS/Health Resources  
Services Administration

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

**Planned Funds:** \$904,398

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, their families, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have increased access to Antiretroviral Therapy (ART) and quality comprehensive medical care. AIDSRelief (AR) is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the prime agency, the Institute of Human Virology (IHV) of the University of Maryland School of Medicine, Constella Futures Group (CF), Catholic Medical Mission Board and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed across Uganda in some of the most underserved and rural areas. These include St. Mary's Lacor, St Joseph Kitgum, Kalongo Hospital, Aber Hospital and Amai Hospital in Northern Uganda; Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Villa Maria Hospital and Nkozi Hospital in Central Uganda; Family Hope Center Jinja and Nyenga Hospital in Eastern Uganda; Virika Hospital, Kabarole Hospital, Bushenyi Medical Center - Katungu, KCRC – Bushenyi, Kyamuhunga Comboni Hospital, Kasanga Health Centre in Western Uganda. In order to get services closer to the communities served, AIDSRelief supports devolution of services to satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

As of July 31, 2008, AR in Uganda was providing care and support to 5144 pediatric patients <18years, and ART to 1726 patients <15 years. We maintained and supported 18 LPTFs and their satellites providing care and treatment to adults and children and a number LPTFs expanded and decentralized their services by opening satellites and outreach clinics. Specific pediatric focused sessions occurred at the various partner forums; topics covered were Adult and Pediatric ARV provision with a focus on switching to second line therapy; prevention of transmission of HIV from mothers to their infants; TB and the integration of TB and HIV care and treatment services. AR also provided training in pediatric counseling to all LPTFs using a newly developed curriculum produced in partnership with the African Network for Caring for Children with AIDS. Subsequent to this training, LPTFs have established child friendly corners, organized family treatment days and formed child support groups. Barriers to disclosure to children which had been a difficult issue for health workers have been overcome. The hallmark of the model is to provide a continuum of care from health facility to community supported by ongoing on-site mentorship/preceptorship for all cadres of staff at supported LPTFs. By the end FY 2008 the AR Technical team will have made an average of one weekly visit to each LPTF/quarter. Additional technical support visits will have been made to all LPTFs focusing on the areas of pediatric care and PMTCT, TB/HIV service integration and pediatric psycho-social support. The program has recognized the strong link between nutritional inputs, ART and adherence but this remains a significant challenge. LPTFs have been encouraged to link with other organizations to able to provide food, especially for severely malnourished patients. Training and guidance (national guidelines in nutrition and HIV/AIDS) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

In FY 2009, AR will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites with the goal of maintaining 2800 pediatric patients on ART (16%) and 7,839 pediatric patients in care and support through the provision of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. In FY2009, AR proposes to expand its services to bring more 2500 children in care, and 750 children on ART and continue to support a comprehensive and integrated continuum of care for HIV infected patients building on existing services at the LPTFs to provide psychosocial and counseling support, clinical follow-up, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV+ patients including 7,839 pediatric patients enrolled in care and 20000 patients including 2800 children on ARVs in 18 LPTFs and their satellites. In many of the regions supported by AR, access to pediatric care and treatment services is limited. AR will bring infants and children into care and treatment as an area of targeted expansion and will ensure integration and linkages between ANC, Labor and Delivery Services, MCH and Immunization services to identify and enhance the follow-up of HIV infected mothers and their exposed children. AR will maintain linkages with JCRC and other groups, who can provide early infant diagnosis so that all HIV exposed infants can be diagnosed in a timely manner, receive their results and be referred for comprehensive HIV care. Strengthening a provider initiated testing in out and inpatient pediatric services will also identify more HIV infected children 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 and are documented negative and later they will continue to access services through the OVC program up to the age of 5 years. In an effort to ensure that all children and their families have access to the BCP, linkages with organizations such as PSI and UHMG will be strengthened. AR 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 AR supported facilities receive comprehensive age appropriate psycho-social counseling and treatment and adherence support, provide training and technical assistance to all service providers in the area of pediatric psycho-social counseling. Task shifting to maximize human resources will be emphasized at facility and community levels, focusing 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, we 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 the model of providing integrated services to families at the community by inter-linking facility based health providers and community health workers and volunteers. Currently, AR provides 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 in their communities. 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. They also promote family based care through symptom monitoring, disclosure counseling, secondary prevention, and family based testing and education. In addition, the LPTFs'

**Activity Narrative:** community volunteers will be used as resources to support patients on therapy, disseminate HIV care and prevention literacy. AR will adapt existing, locally appropriate IEC and BCC materials, identify gaps in these media and develop materials as needed to be used by HCWs and community volunteers. Education on the importance of using ITNs, basic hygiene and good nutrition will be provided at household level and to communities. AR will assist LPTF networks with PLHA groups serving as volunteers in the community to strengthen adherence programs. We will support 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. Linkages with organizations such as PSI and AFFORD will be strengthened in order to increase access to ITNs and clean water. 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, the program will continue to ensure that all involved cadres of service providers have the capacity to provide age appropriate services to children. To accomplish this, the technical team, 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. AR will provide training in pediatric counseling and will strengthen LPTF staff capacity to develop community based psycho-social assessments. AR 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 2 partners' forums will complement LPTF's staff training, allow experience sharing and reinforce knowledge and skill transfer from AIDSRelief technical staff. Coordinated by CF, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AR will ensure that 100% of the LPTFs use the new PMM system, IQ Care, and other IT solutions that enhance data use, like IQ Tools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, thus support the program to reach and report on its patients. During the year, efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services which will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcohol intake; track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs. The program will maximize tracking of activities that lead to scale up of pediatric care and treatment. Documenting and reporting on enrolled children, followed up by age group, treatment regimens, and those receiving the basic care package. Through the already established CQI plans, and the "small tests of change" methodology that is being used at all LPTFs, staff will be able to identify patient management gaps, and decide how and when these will be addressed. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed. The program will also promote these 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. We will also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively. In addition, AIDSRelief will initiate a CQI process in which LPTFs will be assisted in generating, collecting and using patient level outcome information to continuously assess and improve the services they provide. 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 continuous delivery of quality HIV care and treatment, and 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY 2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions, and focus on its relationship with indigenous organizations such as the UCMB and UPMB to build their institutional capacity to support LPTFs. AR will continue to strengthen the health system management of LPTFs, conduct biannual finance and compliance trainings and program finance staff will carry out regular site visits to provide technical assistance, and to set up appropriate cost accounting systems.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13268

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13268	4386.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$4,686,000
8289	4386.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$4,186,630
4386	4386.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$3,286,630

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.11: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5342.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 10139.20735.09	<b>Planned Funds:</b> \$633,985
<b>Activity System ID:</b> 20735	

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, their families, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have increased access to Antiretroviral Therapy (ART) and quality comprehensive medical care. AIDSRelief (AR) is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the prime agency, the Institute of Human Virology (IHV) of the University of Maryland School of Medicine, Constella Futures Group (CF), Catholic Medical Mission Board and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed across Uganda in some of the most underserved and rural areas. These include St. Mary's Lacor, St Joseph Kitgum, Kalongo Hospital, Aber Hospital and Amai Hospital in Northern Uganda; Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Villa Maria Hospital and Nkozi Hospital in Central Uganda; Family Hope Center Jinja and Nyenga Hospital in Eastern Uganda; Virika Hospital, Kabarole Hospital, Bushenyi Medical Center - Katungu, KCRC – Bushenyi, Kyamuhunga Comboni Hospital, Kasanga Health Centre in Western Uganda. In order to get services closer to the communities served, AIDSRelief supports devolution of services to satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFS.

As of July 31, 2008, AR in Uganda was providing care and support to 5144 pediatric patients <18years, and ART to 1726 patients <15 years. We maintained and supported 18 LPTFs and their satellites providing care and treatment to adults and children and a number LPTFs expanded and decentralized their services by opening satellites and outreach clinics. Specific pediatric focused sessions occurred at the various partner forums; topics covered were Adult and Pediatric ARV provision with a focus on switching to second line therapy; prevention of transmission of HIV from mothers to their infants; TB and the integration of TB and HIV care and treatment services. AR also provided training in pediatric counseling to all LPTFs using a newly developed curriculum produced in partnership with the African Network for Caring for Children with AIDS. Subsequent to this training, LPTFs have established child friendly corners, organized family treatment days and formed child support groups. Barriers to disclosure to children which had been a difficult issue for health workers have been overcome. The hallmark of the model is to provide a continuum of care from health facility to community supported by ongoing on-site mentorship/preceptorship for all cadres of staff at supported LPTFs. By the end FY 2008 the AR Technical team will have made an average of one weekly visit to each LPTF/quarter. Additional technical support visits will have been made to all LPTFs focusing on the areas of pediatric care and PMTCT, TB/HIV service integration and pediatric psycho-social support. The program has recognized the strong link between nutritional inputs, ART and adherence but this remains a significant challenge. LPTFs have been encouraged to link with other organizations to able to provide food, especially for severely malnourished patients. Training and guidance (national guidelines in nutrition and HIV/AIDS) was provided to staff at LPTFs so that they could conduct nutritional assessment, education and counseling at community and clinical levels.

In FY 2009, AR will concentrate on consolidating the quality of services provided at existing LPTFs and satellite sites with the goal of maintaining 2800 pediatric patients on ART (16%) and 7,839 pediatric patients in care and support through the provision of ARVs, OI drugs, laboratory supplies and technical assistance to the LPTFs. In FY2009, AR proposes to expand its services to bring more 2500 children in care, and 750 children on ART and continue to support a comprehensive and integrated continuum of care for HIV infected patients building on existing services at the LPTFs to provide psychosocial and counseling support, clinical follow-up, laboratory testing (including CD4), treatment of opportunistic infections and nutrition counseling and education for the 55,781 HIV+ patients including 7,839 pediatric patients enrolled in care and 20000 patients including 2800 children on ARVs in 18 LPTFs and their satellites. In many of the regions supported by AR, access to pediatric care and treatment services is limited. AR will bring infants and children into care and treatment as an area of targeted expansion and will ensure integration and linkages between ANC, Labor and Delivery Services, MCH and Immunization services to identify and enhance the follow-up of HIV infected mothers and their exposed children. AR will maintain linkages with JCRC and other groups, who can provide early infant diagnosis so that all HIV exposed infants can be diagnosed in a timely manner, receive their results and be referred for comprehensive HIV care. Strengthening a provider initiated testing in out and inpatient pediatric services will also identify more HIV infected children 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 and are documented negative and later they will continue to access services through the OVC program up to the age of 5 years. In an effort to ensure that all children and their families have access to the BCP, linkages with organizations such as PSI and UHMG will be strengthened. AR 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 AR supported facilities receive comprehensive age appropriate psycho-social counseling and treatment and adherence support, provide training and technical assistance to all service providers in the area of pediatric psycho-social counseling. Task shifting to maximize human resources will be emphasized at facility and community levels, focusing 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, we 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 the model of providing integrated services to families at the community by inter-linking facility based health providers and community health workers and volunteers. Currently, AR provides 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 in their communities. 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. They also promote family based care through symptom monitoring, disclosure counseling, secondary prevention, and family based testing and education. In addition, the LPTFs'

**Activity Narrative:** community volunteers will be used as resources to support patients on therapy, disseminate HIV care and prevention literacy. AR will adapt existing, locally appropriate IEC and BCC materials, identify gaps in these media and develop materials as needed to be used by HCWs and community volunteers. Education on the importance of using ITNs, basic hygiene and good nutrition will be provided at household level and to communities. AR will assist LPTF networks with PLHA groups serving as volunteers in the community to strengthen adherence programs. We will support 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. Linkages with organizations such as PSI and AFFORD will be strengthened in order to increase access to ITNs and clean water. 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, the program will continue to ensure that all involved cadres of service providers have the capacity to provide age appropriate services to children. To accomplish this, the technical team, 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. AR will provide training in pediatric counseling and will strengthen LPTF staff capacity to develop community based psycho-social assessments. AR 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 2 partners' forums will complement LPTF's staff training, allow experience sharing and reinforce knowledge and skill transfer from AIDSRelief technical staff. Coordinated by CF, 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 project Local Partner Treatment Facilities (LPTFs). In FY 2009, AR will ensure that 100% of the LPTFs use the new PMM system, IQ Care, and other IT solutions that enhance data use, like IQ Tools. It will also ensure that LPTFs collect and enter their data in real time, maintain clean, valid databases, thus support the program to reach and report on its patients. During the year, efforts will be put on ensuring that outreach/satellite information is collected and integrated with that from the center. On-site training will be given to LPTF clinical and M&E staff focusing on data analysis and use. The program will collect data on various clinical indicators that will enable clinicians provide improved care and treatment services which will include: CD4, WHO stage, BMI, history and active TB, previous exposure to ARVs, and risky social behaviors like alcohol intake; track and report on patients accessing the basic care package (ITNs, safe water, Cotrimoxazole) so that this information is linked to prevalence and or incidence of certain OIs. The program will maximize tracking of activities that lead to scale up of pediatric care and treatment. Documenting and reporting on enrolled children, followed up by age group, treatment regimens, and those receiving the basic care package. Through the already established CQI plans, and the "small tests of change" methodology that is being used at all LPTFs, staff will be able to identify patient management gaps, and decide how and when these will be addressed. Through the monthly multi-disciplinary meetings at LPTFs, cross cutting issues on patient management will be discussed, and strategies to improve the program developed. The program will also promote these 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. We will also conduct a QA/QI process with a sample of patients, to evaluate the program by relating patient level outcome measures, viral suppression rates, adherence and treatment support models to program level characteristics at each LPTF. In FY 2009 this process will involve over 2000 patients from 18 LPTFs who would have been on therapy for 48, 36, 24 and 12 months respectively. In addition, AIDSRelief will initiate a CQI process in which LPTFs will be assisted in generating, collecting and using patient level outcome information to continuously assess and improve the services they provide. 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 continuous delivery of quality HIV care and treatment, and 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY 2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions, and focus on its relationship with indigenous organizations such as the UCMB and UPMB to build their institutional capacity to support LPTFs. AR will continue to strengthen the health system management of LPTFs, conduct biannual finance and compliance trainings and program finance staff will carry out regular site visits to provide technical assistance, and to set up appropriate cost accounting systems.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13260

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13260	10139.08	HHS/Health Resources Services Administration	Catholic Relief Services	6428	5342.08	AIDSRelief	\$3,169,926
10139	10139.07	HHS/Health Resources Services Administration	Catholic Relief Services	5342	5342.07	AIDSRelief	\$2,932,296

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$271,459

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$9,872

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 4381.20065.09

**Planned Funds:** \$398,694

**Activity System ID:** 20065

**Activity Narrative: ACTIVITY UNCHANGED FROM FY 2008**

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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and is due to open in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 250 children and adults on ART; and Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider of pediatric ART services in Uganda. By June 2008, 4,918 children (0 – 14 years) and 1,254 adults (15+ years) were directly receiving ART from Baylor – Uganda sites, and indirectly 281 children were on ART through the supported 32 upcountry public health facilities. An additional 4,240 adults are being served indirectly from the upcountry public health facilities with drugs for OI management, systems strengthening, etc. In total, 6,330 children and 3,122 adults in were receiving HIV/AIDS related care & support (this includes those on ART) from her direct services delivery sites; while it had 13,647 adults and 1223 children in care from the indirectly supported upcountry sites. From direct services delivery sites, HIV positive child is used as the index of entry and basis for testing care givers & other family members. Depending on HIV test result, the adults are appropriately enrolled into HIV/AIDS prevention, care &/or treatment. Baylor – Uganda uses two services delivery modes:

(a)direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC); 4 Regional Centres of Excellences (COEs) in Soroti (Lwala Hospital & Kaberamaido HCIV) and Kasese (Kilmebe Mines & Bwera Hospitals) areas; and six satellite clinics [Naguru, Kirudu, Kawempe and Kitebi Kampala City Council – KCC clinics; Kanyanya TASO Centre and Post Natal Clinic at Mulago Hospital] run as family care consortium with KCC and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI), Mulago-Mbarara Joint AIDS Program (MJAP) and The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. This 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)Baylor – Uganda provides indirect services through integration of pediatric and family-centered HIV/AIDS services into existing ART accredited public health facilities in upcountry parts of Uganda. Within 3 months period of the first project year, Baylor – Uganda has supported 33 public health facilities (32 upcountry & 1 Kampala satellite clinic – Kitebi HCIV) to integrate paediatric HIV/AIDS services, and plans to roll out in additional 100 facilities over the remaining 4 years. From the 32 upcountry health facilities already covered, 104 children (0 – 14 years) and 1,200 (adults & children) were enrolled on ART and HIV/AIDS care respectively within the 3 months.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, using multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics & Child Health. Since January 2008, the training program uses a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and tied to (3) implementation of work plan that includes enrollment of at least 5 children into HIV/AIDS care or treatment. By June 30, 2008, 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively. Continuing Medical Education programs are offered weekly at COE & monthly at Satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and their District Health Offices is on-going based on the national Health Management Information System (HMIS). In October 2008, the COE will roll out Electronic Real Time Medical records and with support of CDC, we plan to modify and roll it out to the targeted health facilities over the project period. We hope these will lead to development of paediatric HIV/AIDS database in Uganda.

**Progress to-date and outline activities and achievements**

By June 2008, there were 328 ART accredited sites (60 – 70% in central part) in Uganda, only 110 of which had integrated paediatric HIV/AIDS services. Within 3 months of CDC support in 2008, Baylor – Uganda has integrated paediatric and adolescent HIV/AIDS treatment and care in 33 health facilities (1 Satellite clinic and 32 upcountry health facilities: hospitals, Health Centre IV and Health Centre III), giving Baylor – Uganda a coverage share of 39%. Of an estimated 110,000 children living with HIV, about 50,000 require ART. Yet only 11,000 are currently enrolled on ART. Of those children on ART, 4,918 children (0 – 14 years) and 1,254 adults (15+ years) were directly receiving ART from Baylor – Uganda sites, making Baylor – Uganda the single largest provider of paediatric ART (44.7%). Indirectly Baylor – Uganda supported 281 children on ART through the 32 upcountry public health facilities. In total, 6,330 children and 3,122 adults were receiving HIV/AIDS related care & support (this includes those on ART) from Baylor – Uganda's direct services delivery sites; while 13,647 adults and 1223 children were receiving care from the indirectly supported upcountry sites. From direct services delivery sites, HIV positive child is used as the index of entry and basis for testing care givers & other family members.



**Activity Narrative:** This rapid enrollment in upcountry sites and the high unmet need for treatment in children demonstrate potential for patient recruitment and show the opportunities to increase equitable access to HIV/AIDS care and treatment. However, our initial ART Site Preparedness Assessment showed gaps in capacities of these lower level health facilities to initiate and sustain pediatric HIV/AIDS services. Gaps were in the area of infrastructure; number, skills and motivation of personnel, pharmacy & logistics management, laboratory support, data management & use, support supervision, etc. Population Services International provides support to Baylor – Uganda for basic care services for PHAs.

**FY 2009 activities**

In FY2009, Baylor – Uganda will continue to support pediatric HIV/AIDS care/ARV services at the Baylor-Uganda Center of Excellence (COE), 6 Satellite clinics & 4 Regional COEs, 32 upcountry health facilities and 10 new upcountry facilities to be initiated in FY2009. We plan for 10% increase in each of the services to be provided. The following will be the key activities to be implemented over this period:

**ACTIVITY UNCHANGED FROM FY 2008**

- oProvision of ART services to eligible children, adolescents and their family members and continual clinical and laboratory monitoring of those in HIV/AIDS care, including those ART.
- oPrevention & management of opportunistic infections (excluding TB), malaria, diarrhea, pain & symptom relief, nutritional support, etc.
- oProcurement and distribution of pharmaceuticals (non-ARVs), basic care package (ITNs, safe water vessels, etc) to all supported sites, Acute Care Unit of Mulago Hospital,
- oTraining various cadre of staffs in pediatric HIV/AIDS management, Pediatric HIV/AIDS Counseling, Home based Care, etc. through didactic, attachment and on-site mentorship. More than 600 health professionals will be trained.
- oContinuous provision of technical support to rural health facilities through on-site mentorship (at least for 3 consecutive months to develop systems and competencies of trained staff) and routine support supervision & monitoring.
- oMinor infrastructure improvements such as renovations, painting to make service areas child-friendly, building of tents as waiting space for facilities without such provisions
- oProcurement and distribution of at least 2 sets of medical equipment; and supplies for managing pediatric HIV/AIDS
- oSupport for personnel involved in the training, national expansion program, monitoring & evaluation.
- oSupport for in-service pediatric HIV/AIDS training curriculum development to incorporate aspects of family-centered care/treatment.
- oSupport for data management and utilization through strengthening capacities of Baylor – Uganda, District Health Offices and targeted health facilities with computers, internet connectivity, hands-on training, in various data management programs/packages, routine data collection and analysis, with report writing.
- oRoutine monitoring and evaluation of the program for ARV services, bi-annual regional an program review meetings, best practice documentation and dissemination will also be covered under this program area.
- oSupport for human resources such as team building, effective executive training, finance for non-finance managers, and human resources information system,
- oFormation & support to partners will be important in rolling our pediatric ARV services and related care needs for nutrition, education, OVC issues, etc.
- oAdministrative support and IT maintenance
- oCommunity mobilization on pediatric HIV/AIDS through radio and community dialogues, etc.
- oSite assessment site initiation and continuous support for additional 10 facilities for integration of paediatric HIV/AIDS services.
- oProvision of activity related incentives for rural health facility staff such as staff tea break, overtime allowance, across the facility.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

Undertake quality improvement in all sites with support from HIVQUAL; a capacity building program for quality improvement in HIV care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13248

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13248	4381.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$2,065,771
8284	4381.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$1,925,771
4381	4381.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$368,415

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$982,500

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Mechanism:** Makerere University Walter Reed Project (MUWRP)

**Prime Partner:** Walter Reed  
**Funding Source:** GHCS (State)  
**Budget Code:** PDTX  
**Activity ID:** 4507.20038.09

**USG Agency:** Department of Defense  
**Program Area:** Treatment: Pediatric Treatment  
**Program Budget Code:** 11  
**Planned Funds:** \$118,455

**Activity System ID:** 20038

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

The Pediatric Care and 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 prevention, SI, CT, laboratory, ARV drugs, and OVC services.

During FY2008, and in partnership with Child Advocacy International (CAI), MUWRP has expanded activities of its mobile clinical/counseling follow-up program which provides home-based care and treatment to HIV+ pediatrics. CAI expanded their coverage of Kayunga District 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. CAI 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, and supplemental food. During FY2008, CAI 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 included linking families of pediatric ART patients together for group/peer counseling and psychosocial support. CAI 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 ART and the array of OI 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.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

MUWRP funding to CAI 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. However in June 2008, due to shifting priorities and budgetary constraints, CAI lost its funding from its primary partner, the UK based Elton John Foundation. Because of their excellent track record, MUWRP proposes take on full funding of CAI for activities in Kayunga. With MUWRP as its primary partner, CAI will be able to continue to provide high quality comprehensive services to HIV+ pediatrics in Kayunga in FY 2009. 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. Also during FY2009 MUWRP intends to expand services into Mukono District in order to support the Kojja Health Center IV. The initial aims of this support will be to promote care, treatment, laboratory services and counseling and testing services for the entire sub-district of Mukono South; including supporting three surrounding health center III's with the same services via mobile VCT outreaches into the surrounding fishing communities. Presently, the only HIV service provision at Kojja is a PMTCT component and a treatment club for mothers, both supported by EGPAF. Mukono South sub-district has a population of 120,000 persons and using data from the Uganda sera-survey, we can expect approximately 12,000 HIV positive residents; at least 20% of these (2,400) would be HIV+ pediatrics. Funding will support the expansion, training, technical assistance, transportation, capacity building, and provision of commodities (including pain medication) to five HIV clinics operating in Kayunga District and expansion of comprehensive services to HIV+ pediatrics to Mukono South sub-district.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15713

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15713	4507.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$613,757
8527	4507.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$523,787
4507	4507.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$39,655

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$33,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$4,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

Estimated amount of funding that is planned for Education \$5,000

**Water**

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Prime Partner:** Makerere University Faculty of Medicine

**Funding Source:** GHCS (State)

**Budget Code:** PDTX

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Treatment: Pediatric Treatment

**Program Budget Code:** 11

---

**Activity ID:** 4036.20769.09

**Planned Funds:** \$121,851

**Activity System ID:** 20769

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counselling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counselling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP currently offers pediatric clinical HIV care and treatment at only the Mbarara satellite clinics of Bwizibwera health centre-IV and Mbarara Municipal Council Clinic. The other 12 operational MJAP supported clinics have on-site pediatric care and treatment services provided in partnership with the Joint Clinical Research centre-JCRC (Mbarara ISS Clinic); Baylor College of Medicine Children's Foundation - Uganda/PIDC for Mulago Hospital and all the satellite KCC sites. In these clinics, MJAP conducts Routine HIV Testing and Counseling (RCT) in pediatric wards and refers these kids for care and treatment in existing clinics after initiating cotrimoxazole. In Mulago, MJAP is also supporting pediatric care with laboratory support for ART delivery (CD4, counts, CD4 percentages, CBC and chemistry tests.. This partnership is expected to continue in FY 2009. The MJAP pediatric care and treatment program is currently offering HIV care for HIV infected children and babies born to HIV positive mothers (exposed babies) until their HIV status is established. There are functional PMTCT programs within the MJAP affiliated satellite clinics that work in line with the MoH PMTCT guidelines. HIV diagnosis is carried out using DNA PCR for infants below 18 months and using the normal HIV antibody testing algorithm for all the children above 18 months of age. A family- based approach to care is used whereby a mother or parent is seen together with their child/children on the same clinic day by the same clinician. Under basic HIV care, all children attending HIV care receive an Insecticide Treated Mosquito Net (ITN), Cotrimoxazole for prophylaxis, multivitamin supplementation, diagnosis and management/treatment of all major HIV opportunistic infections (OIs), childhood vaccinations, provision of anti-helminthes (for de-worming), counseling and psychosocial support, growth and development monitoring, and age specific health education. Adolescents are given health education about prevention of HIV transmission i.e. 'prevention with positives'. Children enrolled in care are also offered routine HIV monitoring tests to include CD4+ cells count/percentage monitoring, hematology, serology and other related tests at regular intervals that are detailed in the National Care and Treatment standard operating procedures/ guidelines. Children in the clinic are offered basic nutritional support consisting of a pint of milk as they wait for their clinical review. Follow-up of the children is carried out with the support of the MJAP family based care (FBC) team and home visitors that regularly track these clients at home. In addition, the FBC team provides linkages to the clinics through testing of family members (including children) of index clients identified in the clinics and linking those found to be HIV infected to care and treatment. The home visitors are routinely involved in the tracking of patients lost to follow-up and those defaulting on treatment. Routine pregnancy testing using HCG tests is recommended/ offered for all women of child bearing age and with suspected pregnancy in the clinics to facilitate early prevention of vertical transmission. Among the sexually active females with amenorrhea and/or a high index of suspicion for pregnancy attending the HIV care services the HCG positive rates range between 40 to 50% of those taking the test. The ARV drugs for the pediatric care are obtained from the Uganda Ministry of health/Global fund for treatment of AIDS, Tuberculosis and Malaria; Clinton foundation HIV/AIDS initiative. MJAP supplements supplies in case of stock-outs. MJAP also collaborates with other existing HIV programs that include the AIDS Information Centre, EGPAF for PMTCT, ART under MOH-Global Fund Program, and OVC support through Ministry of Gender, Labour and Social Development. Treatment for tuberculosis is provided through the National TB and leprosy control program (NTLP) which provides the drugs and support supervision to the sites. MJAP is supporting paediatric TB diagnosis through provision of purified protein derivative (PPD) and administration needles. The different programs are working together to ensure comprehensive care for families affected by HIV/AIDS while avoiding duplication of services. MJAP trains various cadres of staff in paediatric HIV care and treatment in order to enhance their knowledge and skills in provision of quality paediatric care and treatment. In order to address the huge human resource needs and gaps for paediatric ART, MJAP in FY-2008 embarked on task-shifting and allowed lower clinic staff and persons living with HIV/AIDS (PHA) to be trained and later involved in the routine care and treatment for the patients. The PHAs are involved in the counselling, health education, peer support and other non-technical roles. Qualified PHAs have been continuously involved in

**Activity Narrative:** the routine technical activities of the clinic. To date, MJAP has trained over 60% of the health workers offering HIV care in pediatric HIV care; supported 128 children (110 in active care) to initiate and stay on antiretroviral therapy; provided basic and palliative HIV care to 234 children; provided the basic care package to 306 children and followed up 270 babies born to HIV positive mothers identified through the clinics.

In FY 09, the program will intensify efforts for early identification of HIV and early initiation of quality care and treatment for those found to be HIV positive, while also supporting activities to reduce vertical HIV transmission. Greater emphasis will be put on capacity building (human, infrastructure, and systems) for sustainable provision of quality pediatric care and treatment services. The program will continue to offer HCT for children and HIV DNA PCR tests for exposed babies as described above. Early infant diagnosis shall continue to follow the algorithm set out by the national PMTCT and Early Infant Diagnosis guidelines for Uganda. The programs in collaboration with the different partners will link all pregnant HIV positive mothers to available PMTCT services and ensure that these are followed up together with their babies. At all 18 proposed sites, MJAP shall continue to offer routine HCG/pregnancy tests to women of child-bearing age. Furthermore, the program shall further strengthen the early identification of children through counseling existing clients to have their children tested and increased campaigns for family treatment days in the clinics. In the satellite clinics, more HIV positive children and infants will be identified by extending RTC to cover vaccination points and young child clinics. The FBC team will also identify and refer more children (including OVC) who need HIV care and treatment during visits to homes of consenting index clients but also from the community based HCT component. The pediatric care and treatment services will be offered at Bwizibwera and Mbarara municipal council satellite clinics. These two clinics will be provided with additional equipments for routine monitoring. Such equipment includes those meant for monitoring growth, nutrition and other routine HIV monitoring test Using the revised WHO guidelines, all children eligible and ready to start ART will be offered ART. All children under care will be provided with all the appropriate components of pediatric and adolescent HIV care following the ten point management plan for pediatric HIV care. The program will continue to offer routine screening and treatment of all major opportunistic infections in children with emphasis on the special treatment needs. The current OI treatment drugs range will be expanded to include medicines specific for the needs of pediatric patients. In particular, cancer chemotherapy; and treatment and prophylaxis for Cryptococcal meningitis and Pneumocystis carinii pneumonia shall be strengthened. The pediatric patients in the clinic will be given Cotrimoxazole prophylaxis or Dapsone for cases unable take the former. Tuberculosis diagnosis and treatment shall be carried out in close collaboration with the NTLP as described above. In order to step up pediatric HIV care, pediatric counselors shall be recruited to address the specific needs of these patients. The clinical care team will work closely with the FBC team and identified OVC programs to address other OVC related needs. As mentioned earlier, MJAP will put greater emphasis on local capacity building for sustainable delivery of quality pediatric care and treatment services by the health facilities and community structures by 2010. In collaboration with the Faculty of Medicine of Mbarara University of Science and Technology, MJAP will train 200 students to offer home-based support to family members in the clinics. In addition, a further 200 students of both Makerere University faculty of Medicine and Mbarara university faculty of medicine shall be offered pre-service training in HIV/AIDS pediatric care as a sustainability measure. The task-shifting of provision of care and treatment will be further enhanced through the involvement and close supervision of more PHAs. Over 100 health workers and PHAs will be trained in all or parts of comprehensive pediatric HIV care. Children requiring nutritional rehabilitation will be attached to nutritional rehabilitation centers. Reproductive health services will be offered as part of PMTCT services and adolescent care. All HIV positive mothers will be trained in infant feeding. The pediatric care and treatment program of MJAP shall target the under-served populations in rural and peri-urban areas of Mbarara. Bwizibwera offers a typical rural ART clinic in a facility with limited resources and a poor population unable to afford basic health care. The program targets to provide care and treatment to 600 HIV infected children at the two clinics with at least 350 being on ART. In addition, at least 400 babies born to HIV infected mothers (HIV exposed babies) shall be followed up until a diagnostic test of sero-status is possible. All children seen in the clinics will be given milk as they wait to be seen by the clinicians.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13279

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13279	4036.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$2,525,400
8319	4036.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$2,025,400
4036	4036.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,725,400

<b>Emphasis Areas</b>
<b>Human Capacity Development</b>
Estimated amount of funding that is planned for Human Capacity Development      \$50,000
<b>Public Health Evaluation</b>
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>
<b>Food and Nutrition: Commodities</b>
<b>Economic Strengthening</b>
<b>Education</b>
<b>Water</b>

**Table 3.3.11: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 1298.09	<b>Mechanism:</b> HIV/AIDS Project
<b>Prime Partner:</b> Mildmay International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 4414.20802.09	<b>Planned Funds:</b> \$1,733,256
<b>Activity System ID:</b> 20802	



**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 48 clients received TB+ HIV care/treatment. There were 9 sites under MU that provided TB/HIV treatment. 254 were trained in TB/HIV treatment. Two specialist clinics were started. Eye clinic was opened in November 2007 to screen and treat patients with HIV related eye conditions. 21% of the clients seen in the eye clinic are children. The community programme was introduced in February 2008. Stable children together with their carers are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. 847 health care workers trained. These include health professionals; doctors and nurses, allied health professionals; counsellors, physiotherapists, occupational therapists, nutritionists and informal caregivers; carers of children. Training not only focuses on the physiological processes of HIV/AIDS but also on the psychosocial and spiritual needs of children living with HIV. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration. The main topics in paediatric training include communication with children, disclosure of HIV status to children, supporting children who attend school as well as the usual ART and OI training issues. The challenges in paediatric treatment and care include measurement of adherence in children on syrups, linking well children to school programmes, provision of food to the families of malnourished children and those from food-insecure families, supporting carers who are elderly and linkages to skills development and IGAs for children growing into adult hood.

During FY 2009 MU will continue providing services and providing training activities at 12 sites and 4 sites at RO. In FY 2009, 4,357 children will receive basic health care and support; of these 3000 will be at TMC, 1067 at the satellite clinics and 290 at RO. The funds for this programme area will finance the purchase of drugs for management and prevention of OIs, along with symptom control and pain management. This will be done by provision of a basic care package including Cotrimoxazole, a safewater system, ITNs and treatment of specific OIs. In addition ART will be provided to children who qualify through the MU multidisciplinary team. There will be an in patient facility with 53 bed capacity where an average of 80 children with severe symptoms and OIs will be admitted for stabilisation. As part of this children will also be provided with psychosocial support through the social workers, counsellors, the child care assistants and through the children's and adolescents support group OGMAC. The adherence will also organise follow up visits to homes and schools of selected children with adherence challenges. Children with severe dental disease related to HIV, mental conditions and eye problems related to HIV will receive services on site through these weekly special clinics. These services are provided to improve welfare of the children and also to improve adherence to treatment and care regimens as well as reducing morbidity. TMC will train

**Activity Narrative:** 1500 individuals through formal courses and clinical placements to better the paediatric care in other rural sites. TMC will also work in collaboration with PSI to make the basic care kit (including 2 mosquito nets, safe water vessel, water guard,) available to patients. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. For this work to be done a multidisciplinary team of health workers will be maintained.. MU will continue training at the Centre as well as upcountry in targeted districts. Together with EMG, a USAID – funded project MU will also train health practitioners in the private sector in HIV management. MU will train – individuals through formal courses and clinical placements. The targeted group are children living with HIV and already in the programme, newly diagnosed children from the HIV testing routines at the Centre and surrounding community as well as those from the families of our established patients and the military in Mbuya.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13290

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13290	4414.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$4,490,301
8333	4414.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$4,490,301
4414	4414.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$3,271,807

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.11: Activities by Funding Mechansim**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 4057.20881.09

**Planned Funds:** \$788,720

**Activity System ID:** 20881

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

By July 31 2008, there were 8,000 children enrolled in care as OVCs regardless of serostatus; 6,126 of those children were screened for HIV either at the facility or at home under the Home Based HIV counseling and testing initiative and 4,104 tested HIV positive; 1,200 children have cumulatively been enrolled on ART (1,023 are active). Pediatric care & treatment is a part of TASO's core activities and an essential component in the positive living package that is provided to improve the quality of life of pediatric clients. Pediatric care & treatment is also part of the national HIV/AIDS response to which TASO has made an indelible contribution towards Pediatric HIV care for exposed and infected children at national, community and household levels. In FY 2008, the TASO priorities for Pediatric care & treatment included: counseling services to children and their family members; providing vital information to clients (cotrimoxazole prophylaxis, safe water, nutrition, STI, family planning for adolescents, PMTCT); management of opportunistic infections; screening and treating sexually transmitted infections (STI) among adolescents; providing cotrimoxazole prophylaxis to all children in care; providing safe water vessels and promoting safe water use; promoting malaria prevention and providing long lasting insecticide treated bed nets for children especially those under five years of age; providing nutritional supplements for infants and child clients; promoting HIV prevention among adolescent clients; and formation of adolescent peer support groups. Achievements include; functional Pediatric ART program at the 11 centers and their associated outreach clinics; low mortality (5.3%) of children on ART; pediatric HIV training needs assessment was conducted at the 11 TASO Centers; networking with partners involved in HIV AIDS care and treatment. Challenges include; unacceptably high median age of ART initiation of 9 years; and case finding of HIV infected children is problematic. TASO will address these challenges by scaling up PMTCT and early infant diagnosis and treatment.

In FY 2009, the 11 TASO Centers will provide Pediatric care & treatment services at various locations including the 34 outreach clinics and the 100 community programs. TASO will continue operating a collaborative Pediatric care initiative with the Baylor College of Medicine Children's Foundation Uganda at TASO Kanyanya. Each of the TASO centers will continue directly serving pediatric clients from the host district and up to 6 neighboring districts. All the 6,000 child clients will be facilitated to access a comprehensive package of high quality Pediatric care & treatment services as advocated for by the African Network for the Care of Children affected by AIDS (ANNECA). An additional 1,000 children will be initiated on ART during FY 2009. 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

**Activity Narrative:** infected child, caregiver & family; and referral of the infected child for specialized care if necessary; and community-based support programs.  
 The Pediatric Care & Treatment program area is related to the program areas of PMTCT, Adult Care & Treatment, TB/HIV, Psychosocial support, Counseling & Testing, ARV Drugs and Laboratory Infrastructure. The activities under pediatric 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 core areas to form a comprehensive service package accessed by TASO child clients and their care givers. TASO will use a continuous quality improvement approach Plan-Do-Study-Act (PDSA) cycles to enhance data management, as well as conduct quality assurance support visits and clinical mentoring. Staff from TASO Headquarters and Regional offices will conduct regular quarterly and adhoc mentoring, support and supervisory visits to the 11 TASO centers, outreaches and community drug distribution points to support basic primary care services for HIV exposed and infected children, OI management, ARTTB/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. Clinical case reviews, assessment of guideline use and ART regimen decisions, team meetings will also be conducted during FY 2009.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13230

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13230	4057.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$4,086,632
8361	4057.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$3,786,632
4057	4057.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$2,460,072

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* Child Survival Activities

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.11: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Treatment: Pediatric Treatment

**Budget Code:** PDTX

**Program Budget Code:** 11

**Activity ID:** 4021.21223.09

**Planned Funds:** \$90,521

**Activity System ID:** 21223

**Activity 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 grant that carries forward lessons learnt in phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts of Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based Voluntary Counseling (VCT) program, provision of basic palliative HIV care, antiretroviral therapy (ART), Prevention of Mother to Child Transmission (PMTCT), tuberculosis (TB) care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV test results are returned to these clients through program resident community counselors. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons to household members. Through the medical male circumcision service, clients seeking male circumcision service are also offered VCT. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 outreach clinics in Rakai and Lyantonde districts. These clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. Services offered include: health education, on-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, ART, HIV prevention for positives interventions, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated). The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR support, HIV-infected individuals identified through

**Activity Narrative:** MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

RHSP provides a range of HIV care and treatment services for children ages 0-14 including; early infant diagnosis using DNA-PCR, psychosocial support, VCT, nutritional counseling and education, diagnosis and treatment of opportunistic infections, laboratory monitoring, preventive services, health education, provision of antiretroviral therapy and family counseling and testing. To date, a total of 66 HIV positive children under the age of 2 years have been screened for ART eligibility. Of these, 17 are currently receiving antiretroviral treatment. Following the new WHO guidelines for infant initiation of ART, all HIV positive infants under the age of 2 years are being initiated on ART irrespective of CD4 cell percentage. Over 196 HIV positive children aged 2-14 years have been screened for ART eligibility and 55 of these are currently on treatment. Families of HIV positive children have been provided with VCT, so as to mobilize family support for these children and ensure treatment adherence. All the HIV-positive children active in care have received the HIV basic care package, comprising of a safe water vessel and sodium hypochlorite solution for water disinfection to reduce incidence of diarrheal diseases and insecticide-impregnated bed nets, for prevention of malaria. Cotrimoxazole prophylaxis is provided to all HIV infected children and to babies born to HIV positive mothers, until HIV infection is excluded (ruled out). Laboratory screening and monitoring: All children that are not yet eligible for ART will have CD4% re-assessment performed every 3 months while those on ART have semi-annual CD4 and viral load reassessment. Other laboratory testing done include: hematology (complete blood counts), chemistry, (liver and renal function tests), and serology.

These services are provided to HIV positive children residing in Rakai and Lyantonde districts.

FY 2009 and 2010 ACTIVITIES: Emphasis areas to be addressed include:

- Expansion of the early infant diagnosis program for HIV diagnosis among infants
- Diagnosis and treatment of opportunistic infections
- Provision of daily cotrimoxazole for prophylaxis
- Mobilization of family support for the children in care
- Laboratory monitoring
- Provision of antiretroviral therapy for eligible children (including infants below 12months of age who are confirmed HIV positive irrespective of CD4 count)
- Nutritional counseling and education
- HIV preventive education and services

Other non-PEPFAR support - Most of the routine viral load testing is supported by NIH-ICER.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13238

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13238	4021.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$469,023
8326	4021.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$469,023
4021	4021.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$386,705

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$12,500

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water      \$20,000



**Program Area Narrative:**

Detection and treatment of cases of tuberculosis (TB) continues to be a high priority. In Uganda, the annual incidence rate of smear positive TB cases is 154/100,000, with a prevalence of all cases of 561/100,000 and a TB mortality rate of 84 deaths /100,000 (2008 WHO Global TB Control report). The TB case detection rate of 50.2% remains below the WHO/IUATLD (International Union against TB and Lung Diseases) target of 70%. TB treatment success rate is estimated to be 73%, which is also below the WHO/IUATLD target of 85%. TB treatment outcomes remain poorly documented, with only 13% of treated pulmonary TB patients having a record of sputum smear conversion. Overall, too many newly diagnosed TB patients die during drug treatment, while others default or are lost to follow up. On the other hand, efforts to establish linkages between TB and HIV/AIDS care and treatment programs are improving. In Uganda, as in most of sub-Saharan Africa, TB remains the leading but most preventable cause of morbidity and mortality among People Living with HIV/AIDS (PLHIV).

**Challenges**

The Ugandan TB/HIV policy guidelines and the TB/HIV communication strategy were launched in 2006. Significant progress has been made in improving the collaboration between HIV and TB activities at the national level. An integrated management approach employs a decentralized service delivery and referral system. However, limited coordination and support of TB/HIV activities at the district level hampers effective collaboration. Resulting problems include: poor dissemination of TB/HIV policy guidelines to districts and facilities; under-reporting of TB/HIV indicators; frequent stock-outs; and limited application of basic TB infection control practices. Significant challenges exist in the reporting of indicators by partners; the same clients are often reported by both TB service providers and by referring HIV care and treatment partners. Other significant constraints include the lack of guidelines to address Multidrug-Resistant TB (MDR-TB), Extensively Drug Resistant TB, (XDR-TB), and childhood TB. PEPFAR/USG will work with the National TB and Leprosy Program (NTLP) towards addressing these limitations.

**FY08 achievements**

In FY08, PEPFAR/ USG supported the integration of TB/HIV activities at the facility level in 524 sites. The key TB/HIV integration activities included TB screening and TB treatment of HIV infected clients; HIV counseling, and testing (HCT); and provision of HIV prevention, care and treatment to TB patients. In FY08, USG-supported sites provided TB treatment to 12,770 HIV positive TB patients, less than the target of 20,740. The number of registered TB patients who underwent HIV counseling and testing, and received their results was 17,783. This is considerably less than the FY08 target of 53,432 TB patients to be counseled and tested for HIV. However, the target was overly ambitious, and is higher than the total number of reported TB cases nationally. Since the entry point of significant proportion of TB cases in USG supported sites is through HIV care and treatment, where counseling and testing already took place, these people do not require HCT again. A more realistic target for FY09 will be based on the actual number of total TB cases being reported by MOH.

**FY09 Focus Areas**

The USG/PEPFAR-Uganda team recognizes that integration of TB and HIV activities provides a vital contribution to achieving PEPFAR HIV treatment and prevention targets, and to improving Uganda's TB indicators. In addition, TB surveillance, monitoring and evaluation need strengthening. With this in mind, USG will continue to target the following key areas:

1. Support the National TB/HIV Coordination Committee (NCC) and district-level TB/HIV activities to integrate services across all 81 districts. This will occur through support of the Tuberculosis Control Assistance Program (TB-CAP) and other PEPFAR partners within the TB/HIV portfolio, through the TB/HIV NCC and the Uganda Stop-TB Partnership. Integration requires the rapid scale-up of routine HCT services for suspected and confirmed TB patients, and linking those who are co-infected to HIV/AIDS care and treatment services. These activities will be supported by the 20 TB/ HIV implementing partners. Partners providing HIV care and treatment will enhance TB/HIV integration through routine TB screening of HIV-positive clients, and providing treatment to those with active TB.
2. Support implementation of the "Three I's of HIV/TB" by:
  - (a) Strengthening routine Intensified TB Case Finding (ICF) among HIV-infected clients in HIV prevention, care and treatment settings.
  - (b) Implementing simple, low-tech TB Infection Control (IC) measures in health facilities to prevent TB transmission among PLHIV and health care workers. This includes workplace controls such as triaging of patients, health education of patients and health workers, and separation of TB infected patients.
  - (c) Developing policies and guidelines for Isoniazid Preventive Therapy (IPT). Existing IPT pilot programs implemented by the AIDS Information Center (AIC), MJAP and HBAC will be evaluated to generate a local evidence base to inform TB/HIV policy guidelines and the MOH.
3. Increase the availability and quality of TB and HIV diagnostic services by strengthening laboratory systems at facility, regional and national referral levels with an emphasis on laboratory infrastructure, human resources, commodities, supportive supervision, quality assurance, timely diagnosis of sputum smear negative cases and infection control.

4. Support surveillance of drug resistant TB, and linkages of persons with resistant TB to appropriate treatment services. The TB Drug Resistance Surveillance is a Strategic Information activity; a detailed description is among the SI activity narratives.

5. Strengthen monitoring and evaluation of HCT among TB patients, and improve linkages and referral to HIV care and treatment. Reporting has previously been a weak area. The national ART card is being revised to include TB indicators. TB registers currently include information on HIV, but training, supervision and improved reporting of these data are required.

#### Other donor support and leveraging

At the national level, PEPFAR funding complements other sources of TB funding that comes from WHO, the Global Fund for AIDS, TB and Malaria (GFATM), the German Leprosy and TB Relief Association, and the Foundation for Innovative Diagnostics (FIND). At the district level, PEPFAR funding is leveraging non-PEPFAR USAID funding for expansion of Community-Based (CB)-DOTS in 12 districts under TB-CAP, and nine districts through NUMAT. These non-PEPFAR funds provide district level support of CB-DOTS supervisors to oversee linkages between community- and facility-based care, and between TB and HIV activities.

#### Support of national, district and facility-level TB/HIV integration

USG support for integration of TB/HIV activities has been 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. At the district level, USG continues to help establish and support district level TB/HIV coordination, and to ensure that integration activities are incorporated into district health plans. In over 80 health care facilities, USG will continue to provide supportive supervision, quality assurance and assistance in developing Infection Control Committees to ensure that infection control procedures are in place to reduce TB transmission. In order to strengthen monitoring, evaluation, drugs and supplies for TB/HIV, USG will emphasize the support of health facilities to use national recording and reporting procedures, and logistics management information systems.

#### PHAs and referrals

Coordination mechanisms have been set up at the district level to facilitate experienced TB/HIV co-infected patients to serve as peers in their communities. Through programs that build capacity of PHA groups and networks, USG will continue to support linkages and referrals between facility- and community-based TB care. PHAs are trained to act as network support agents, to link health facilities with communities, provide adherence counseling and support, and facilitate referrals between TB and HIV care and treatment services. This is an ongoing activity.

#### Scale up of the "Three I's of HIV/TB"

In FY09, USG will facilitate the scale up of the three I's: Intensified case finding (ICF) among PHA, TB infection control (IC) in HIV settings, and Isoniazid preventive therapy (IPT). A workshop for all USG TB/HIV Implementing partners to provide guidance for ICF, IC and TB/HIV recording and reporting will be conducted. USG Implementing Partners will work with the health facilities and districts to develop and implement TB infection control in HIV care and treatment settings. USG will continue to provide technical support to NTLP and ACP to develop guidelines for TB infection control and to explore innovative ways of reducing barriers to the provision of IPT for HIV-infected patients with latent TB. At present, the MOH does not recommend implementation of IPT at facilities if there are manpower shortages, incomplete case detection rates, and lack of quality assurance for laboratory diagnosis of TB. However, AIC and MJAP have the capacity to provide IPT. AIC has already started, and MJAP is developing a programmatic approach to doing so.

#### HIV Counseling and Testing and TB Screening and Treatment

In FY09, the USG will continue to support expansion of integrated TB/HIV programs at regional referral hospitals and district health facilities. The goals are to provide HIV counseling and testing to 80% (estimated 34,061) TB patients, and to enhance routine TB screening among all HIV positive clients on care and treatment in USG supported sites. In FY09, USG targets are to provide TB treatment for 100% (estimated 16,189) HIV-positive TB patients at USG supported sites. USG/PEPFAR partners will continue to train and support health care workers to accurately perform routine TB diagnostics and conduct HIV rapid testing among both suspected and laboratory-confirmed TB patients. At rural health centers, nursing assistants are being trained as microscopists, and nurses receive training in rapid HIV-testing. National programs will be assisted to develop guidelines for screening, diagnosis and treatment of TB in HIV-infected children. Pediatric HIV programs will be supported to provide TB screening, and linkages and referrals to treatment. With USG support, the modified TB registers will be used to capture data on HCT, and the provision of cotrimoxazole and ARVs to co-infected patients.

#### Linkages with HIV Prevention, Care and Treatment

In FY09, USG will increase focus on ensuring that TB/HIV co-infected patients are regularly screened for ART eligibility. Coordination between CB-DOTS and ART programs will ensure that TB/HIV co-infected patients who are eligible receive ART, as well as support for adherence to both TB and HIV treatment. Provision of palliative care to co-infected patients will also be enhanced. A minimum package of Prevention with Positives (PWP) will be implemented in TB treatment settings. Health care providers in TB settings will be trained to provide components of the minimum package, including information on PWP, partner based counseling and testing, supported disclosure, safe sex counseling, and information on PMTCT and STI management. Expanded provision of the Basic Care Package, which includes bed nets, cotrimoxazole, condoms and a water vessel, will take place.

#### Laboratory and diagnostic support

USG will strengthen and support the Central Public Health Laboratory (CPHL) and the National TB Reference Laboratory (NTRL) to roll out a training package on TB sputum smear microscopy for laboratory technicians. Progress has been made in customizing the generic WHO/CDC/IUATLD sputum microscopy training package for use in Uganda, and roll out of this training to all TB laboratories is ongoing. Support to NTRL to conduct National External Quality Assurance of TB microscopy and diagnosis in all nine regions of the country will continue. USG will continue supporting NTRL to develop its capacity for drug sensitivity testing and for conducting surveillance of drug-resistant TB. Surveillance will be enhanced through a specimen referral system for transport of sputum from previously treated TB patients, from peripheral diagnostic labs to the NTRL for TB culture and drug sensitivity testing. Funding for this activity has just become available. The sputum referral system has been developed and the logistics of shipping sputum specimens clarified. A shipping coordinator will soon be recruited. An increase in the number of TB culture facilities to include an additional two regional labs did not occur last year, but is planned for this year through USG support to NTRL. The NTRL now has the capacity to do rapid MDR-TB screening tests using mycobacterium growth indicator tubes (MGIT), a rapid detection method for the isolation of mycobacteria from clinical specimens. Second-line drug susceptibility testing will be introduced. The USG is assisting NTRL to conduct a national TB drug resistance survey; the protocols has been finalized and submitted for IRB clearance. Results from this will provide data to inform development of national policy guidelines for management and prevention of MDR-TB.

**Table 3.3.12: Activities by Funding Mechanism**

<p><b>Mechanism ID:</b> 5738.09</p> <p><b>Prime Partner:</b> Makerere University School of Public Health</p> <p><b>Funding Source:</b> GHCS (State)</p> <p><b>Budget Code:</b> HVTB</p> <p><b>Activity ID:</b> 4018.21219.09</p> <p><b>Activity System ID:</b> 21219</p>	<p><b>Mechanism:</b> Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District</p> <p><b>USG Agency:</b> HHS/Centers for Disease Control &amp; Prevention</p> <p><b>Program Area:</b> Care: TB/HIV</p> <p><b>Program Budget Code:</b> 12</p> <p><b>Planned Funds:</b> \$14,848</p>
--	--

**Activity 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 Phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and Medical Male Circumcision (MMC) for HIV prevention.

The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. Through the medical male circumcision service, clients seeking male circumcision service are also offered counseling and testing. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis.

Services offered include: health education, On-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, provision of antiretroviral therapy, prevention for positives, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated). The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by 2 ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstinence from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown sero-status.

Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care

**Activity Narrative:** Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics.

In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

- To date, all patients seen in the 17 clinics have routine clinical evaluation for Tuberculosis and those suspected to have TB are further investigated through laboratory and radiological examination.

- In the first two quarters of FY 2008, a total of 258 clients with clinical symptoms suggestive of TB were received sputum screening. 34 of these were sputum positive and were initiated on anti-TB treatment. An additional 8 patients with negative sputum results were initiated on TB treatment basing on radiologic findings.

- Efforts to improve diagnosis of Multi-drug resistant TB have been put in place. All sputum samples of suspected MDR TB patients are sent to Joint Clinical Research (JCRC) laboratory.

- Plans are underway to start culturing sputum negative samples to completely rule out active TB among sputum-negative patients with suspected TB.

- Currently piloting the provision of Isoniazid prophylaxis to HIV positive patients.

TB screening - continue to provide routine clinical assessment of all patients for TB. This service shall be provided for patients attending the program HIV clinics as well as the general STI clinic; and provide laboratory (Gram stain, Ziehl Nelsen testing) and radiological (x-ray) investigations.

TB drugs - Rakai program was accredited by the Rakai district as a TB treatment center. All Uganda Ministry of Health TB drugs are provided free of cost through the district health office.

Monitoring- RHSP works with the district TB team to follow-up patients on TB therapy. The district has an established TB treatment follow-up system, with TB DOTS community volunteers. Strengthen the available TB treatment and follow-up services by referral of the TB patients to the community volunteers for supervised DOTS. Additionally, out TB focal clinician will continue to liaise with the district TB team and the community volunteers.

- The program will work with the district TB program to improve monitoring of patients initiated on TB treatment. A program home visitor, a key person on the TB/HIV program, will occasionally carry out unannounced home visits to these patients, to ensure adherence to treatment

- Laboratory monitoring will be provided for all patients on TB treatment. We shall specifically monitor the liver function tests every 6 months and whenever clinically indicated.

INH prophylaxis - PPD testing will be provided for patients under our care and those eligible for INH prophylaxis will be provided with this service.

Support to the district TB program - RHSP will support diagnosis of TB at 17 health units, with diagnosis reagents and support to the Rakai district x-ray facility through quarterly provision of supplies like x-ray films, and developer chemicals.

These activities will be conducted in the Rakai and Lyantonde districts. Persons targeted in this program are HIV positive persons attending our 17 clinics as well as their family members.

Emphasis areas addressed are TB Screening and diagnosis, treatment, monitoring and prevention.

All the above activities directly support the PEPFAR TB/HIV program area.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13235

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13235	4018.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$15,000
8323	4018.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$14,450
4018	4018.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$14,450

#### Emphasis Areas

Health-related Wraparound Programs

- \* Child Survival Activities
- \* TB

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$8,500

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Table 3.3.12: Activities by Funding Mechanism

---

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 4058.20877.09

**Planned Funds:** \$683,777

**Activity System ID:** 20877

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

During FY 2008, TB control and management continued to be an integral component of overall TASO programming. TB management comprised of: health education for clients and community members; routine TB screening for all clients; provision of anti-TB drugs to those diagnosed with TB; training of health service providers in delivery of TB services; adherence support for clients on TB treatment; supporting the CB-DOTS strategy of MoH; follow up of all TB clients notified for treatment until treatment completion; record keeping for TB treatment; engaging in TB partnerships and linkages; referral of TB patients where appropriate; and advocacy aimed at informing national TB policy. All active clients seen at TASO clinics were screened for TB using recommended methods including sputum examination and chest X-ray. All clients diagnosed with TB were provided treatment at TASO centers and/or referred to other partners for ongoing management as deemed appropriate. Over the period October 2007 to September 2008, the number of HIV positive clients treated for TB was 2,571 (1,056 male and 1,515 female).

In FY 2009, TASO will provide TB/HIV services at the 11 centers in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso. TASO will continue to prioritize the service components and emphasis areas outlined for FY 2008. TASO will aim at serving 3,000 HIV positive people with TB treatment (1,000 male and 2,000 female) and training 330 service providers in delivery of HIV/TB services. All the clients served by the 11 Centres will routinely be screened for TB during provision of Basic Care and ART (100% of the clients will have been screened at least once by the end of the year). The TB/HIV package will comprise of: client and community education on TB; TB management training for health service providers; routine TB screening for all clients; provision of anti-TB drugs; supply chain management for TB drugs and commodities; supporting adherence to TB treatment; supporting partnerships/linkages for TB treatment; records management for TB services; ensuring proper management of clinical waste; and referral of TB patients for specialized care. TASO Centres will provide TB/HIV services using various delivery models such as: facility-based delivery; outreach clinics; and community-based delivery. Broad outcomes aimed at will include beneficiary empowerment and family/community empowerment to appreciate and engage in TB control and management efforts. TB infection control will be given renewed focus through strategies including: continuous TB education for clients and care givers; reducing congestion in all client waiting areas; use of hoods in the laboratories; proper ventilation in clinic facilities and mandatory sorting and appropriate disposal of all clinical waste. TB/HIV 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



**Activity Narrative:** under all the above program areas to form a comprehensive service package accessed by TASO clients. The activities under this Program Area are also linked to other USG funding through USAID focusing on the Program Areas of Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13227

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13227	4058.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$600,000
8362	4058.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$525,000
4058	4058.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$465,249

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 1255.09

**Mechanism:** Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals

**Prime Partner:** Research Triangle International

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 8539.20871.09

**Planned Funds:** \$98,987

**Activity System ID:** 20871

**Activity 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 providing Routine HIV Counseling and Testing (RCT) and basic care (BC) services to patients in district hospitals and health center (HC) IV facilities. In this partnership, RTI contributes to the national response by addressing the significant service gaps in the provision of HIV counseling and testing (HCT) and basic palliative care services.

During FY 2008, the project continued to make significant progress with the integration of TB and HIV management. All project-supported facilities now have linkages between CT service delivery points, chronic care clinics and the TB clinics. This activity has been expanded to more than 12 new health facilities, and is expected to provide another 1,500 individuals with coordinated TB/HIV services by the end of September 2008.

FY 2009, RTI will further consolidate the provision of TB/HIV services in the 38 supported health facilities. The consolidation will cover an estimated 1,000 individuals between October 1, 2009 and September 30, 2010. An assessment of laboratory capacities at all targeted facilities has been completed, and key areas requiring priority attention have been identified. Building on the TB/HIV initiatives started in FY 2008, RTI will strengthen the capacity of the health units, by instructing them on the policies and guidelines for integrating TB/HIV interventions. This training will lead to better management of TB/HIV co-infected patients, maximize TB case detection, increase treatment completion rates and strengthen ART literacy. TB Infection control measures in HIV care settings will be enhanced via literacy campaigns for patients and staff, triage of symptomatic patients and enhanced TB case-finding.

The program will continue to provide cross-referrals and integrate diagnosis, treatment and support services for TB and HIV clients in target facilities. HIV+ positive individuals will be actively screened and treated for TB at initial diagnosis and during follow up appointments at the chronic care clinics. HIV counseling and testing will be offered to all patients in the TB clinics. Health facility staff will be trained in data management and analysis; which will provide better monitoring of patients' adherence to treatment regimens and to track their progress. RTI will also collaborate with MoH to ensure a constant supply of medications (TB drugs, septrin and ARVs) for individuals who are TB/HIV co-infected are available.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13315

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13315	8539.08	HHS/Centers for Disease Control & Prevention	Research Triangle International	6439	1255.08	Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals	\$100,000
8539	8539.07	HHS/Centers for Disease Control & Prevention	Research Triangle International	4872	1255.07	Routine Counseling and Testing in Two District Hospitals	\$60,000

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.12: Activities by Funding Mechanism

<b>Mechanism ID:</b> 5793.09	<b>Mechanism:</b> National Laboratory System Infrastructure Improvement Initiative
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 16902.20865.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 20865	
<b>Activity Narrative:</b> This activity will contribute to Makerere University Faculty of Medicine's activities in Palliative Care: TB/HIV. As a result of PEPFAR support, the Ministry of Health's [MoH] National TB Reference Laboratory [NTRL] has been nominated to become a supra national reference laboratory in the region. However, the culture laboratory requires rehabilitation; under the Ministry of Health (MoH) laboratory service and equipment standards, "the successful partner" will utilize this funding to rehabilitate this laboratory.	
"The successful partner" will assess and implement required infrastructure improvements ensuring that NTRL's capacity is strengthened to provide quality TB laboratory services at both national and regional levels.	
An additional \$2,585,000 is allocated in Laboratory Services for the strengthening of the Central Public Health Laboratory and District Hospitals and Health Center IVs.	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 16902	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16902	16902.08	Department of State / African Affairs	Regional Procurement Support Office/Frankfurt	7290	5793.08	Technical Assistance for National and District Laboratories Construction and Renovations	\$270,000

**Emphasis Areas**

Construction/Renovation

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1298.09	<b>Mechanism:</b> HIV/AIDS Project
<b>Prime Partner:</b> Mildmay International	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 8619.20797.09	<b>Planned Funds:</b> \$247,467
<b>Activity System ID:</b> 20797	

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral centre for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 258 patients were treated for TB at the 12 sites providing care under MU and RO. 287 health workers were trained in TB/HIV care during the reporting period. Training is designed to provide technical knowledge and skills essential for the implementation of TB/HIV collaborative activities in Uganda. The curriculum of this course has been adopted from the MOH training for district health workers and as such is in line with the national guidelines on TB/HIV management. Cadres trained have been health workers; mainly doctors, nurses and clinical officers. We enrol an average of 18 clients of TB per month, with 30% sputum smear positive and the TB treatment success rates of 63%. Currently 258 patients are receiving treatment for TB through the 12 sites under MU and RO and we have intensified case finding and prompt treatment of TB to reduce transmission and MDR.

During FY 2009 MU will continue providing TB/HIV services and related training activities at 12 sites of MU and 4 sites of RO. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. At MU 150 health workers will be trained in TB/HIV with aim of delivering quality TB services including examination, screening HIV patients for active TB, clinical monitoring, related laboratory services, and clinical care. CBVs will also be trained to monitor patients on TB treatment through DOTS (Directly Observed Short Course Therapy). For FY 2009 RO shall intensify TB case finding including contact tracing for all the TB cases (120), build the community capacity for DOTS (83), improving the laboratory services in the four RO sites with Kasaala as the new site, refresher training on TB management for the staff (40) and ensure timely supply of equipment, reagents and drugs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13286

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13286	8619.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$250,000
8619	8619.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$167,587

### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

Military Populations

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5246.09	<b>Mechanism:</b> Tuberculosis/HIV Intergration Activities
<b>Prime Partner:</b> AIDS Information Centre	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 8366.20748.09	<b>Planned Funds:</b> \$593,922
<b>Activity System ID:</b> 20748	

**Activity Narrative:** AIDS Information Centre-Uganda (AIC) is a local national Non-governmental Organization (NGO) that was established in 1990 to provide HIV Counseling and Testing (HCT). Over the years AIC has incorporated a number of other program areas that include; mobilization and sensitization of HIV and TB information looking at the ABC model, prevention of HIV transmission through AB messages, education on condom use and distribution, disclosure; provision of basic health palliative care through management of opportunistic infections, distribution of the basic care kit and Septrin for prophylaxis, Prevention of Mother to Child Transmission (PMTCT) by counseling and testing pregnant mothers and referral for ARVs in PMTCT as well as the screening and management of Tuberculosis (TB), counseling and testing TB patients for HIV as part of the TB/HIV integrated services. AIC since its inception, has grown from one branch to operate 8 branches today namely Arua, Jinja, Kabale, Kampala, Lira, Mbale, Mbarara and Soroti. AIC to provide the above services it supports district health units to offer TB/HIV integrated services by carrying out provider initiated CT. The implementation of TB/HIV activities is critical because AIC has observed that about 9% HIV positive clients often are co-infected with TB while 36% of TB patients are HIV positive. At the 8 stand-alone sites (branches), AIC uses VCT as the entry point to all services and those found to be HIV positive are screened and treated for TB and if active TB is ruled out, these clients are screened for latent TB. HIV negative clients that have symptoms of TB are also screened. All clients with positive TB results are either treated at the branches or given referrals to TB clinics of their preference, which are easier for them to access. Since AIC, offers Cotrimoxazole Prophylaxis Therapy (CPT) to all HIV positive clients, the co-infected clients are given a daily dose of CPT as well as treatment of other medical opportunistic infections. Co-infected clients are also given internal referrals for CD4 services and are continuously counseled for positive living through our post test clubs. Those clients with a low CD4 and need Anti-Retroviral therapy (ART) they are referred to accredited centers. At the district supported health units (indirect sites), AIC uses TB clinics as the entry point into HIV services by providing provided initiated CT. HCT is offered to TB patients in the TB clinics, particularly through targeting TB clinic days when most TB clients turn up for drug refills. AIC also targets patients that are admitted on the TB wards. AIC has also been requesting TB patients on CB-DOTS to go back to their health facilities for Provider Initiated Counseling and Testing (PICT). TB patients found to be co-infected with HIV are given appropriate referrals for CD4 services and ART at accredited ART centers. AIC also supports capacity building of the indirect sites to manage TB/HIV co- infection as well as the mobilization and sensitization of communities to utilize the services both at the main branches and in the public health facilities.

AIC's goal under this project is to reduce the burden of both diseases among the co-infected. The main objectives of the project over the years have been to: strengthen and expand screening, diagnosis and treatment for Active and Latent TB; promote HIV diagnostic counseling and testing among persons with TB disease and to strengthen prevention, care and support to active TB/HIV co-infected clients. AIC has been implementing TB/HIV integrated services since January 2001 and operations started with Kampala Branch. In 2003, these services were introduced in Mbale and Jinja, while in 2004 Mbarara Branch started offering these services. In 2007 TB/HIV integration was introduced to Soroti Branch. All the eight AIC branches were able to diagnose and treat TB and to support the district supported health units implement TB/HIV services. By the end of 2007, 4 (Mbarara, Kampala, Jinja and Mbale) centres were offering TB-HIV integrated services. The remaining three (Kabale, Soroti and Arua) had the challenge of not having a functional Laboratory to screen for active TB. This is the reason for not meeting the 2007 targets. Since then Soroti has acquired that capacity and is able to screen and treat for active TB and latent TB. Similar work is taking place in Kabale and Arua Branches. Since 2001, AIC has screened 45,644 HIV positive clients for TB at the AIC branches, of whom 1,717 had active TB. Of those with active TB, 1,062 were diagnosed through sputum tests while 655 were diagnosed through X-rays. AIC offered Active TB treatment to 649 patients and referred the rest to TB clinics of their choice. A total of 3,173 were diagnosed with latent TB and started on the 9 month Isoniazid Prophylaxis (INH). In FY 2008, alone, a total of 6,072 HIV positive clients were screened for TB out of whom, 136 clients had active TB. Of these, 74 clients were treated at the branches and the rest referred to clinics of their choice. Those that had latent TB were 1,543 and they were all started on a nine-month dose of INH. AIC has also worked with districts to scale up provider-initiated HCT for TB patients at selected district hospitals, Health center IVs and Health center IIIs. This activity started in January 2008 following a detailed technical needs assessment which was carried out in 2007. By the end of FY 2008, 1,200 clients had been reached, of whom 36% were HIV positive. Those found to be co-infected were given the relevant referrals for CD 4 services and ART. To ensure proper and timely implementation of the planned activities, AIC built capacity at the health facility level, provided technical assistance through regular support supervision by our medical teams at the branch, data collection tools and HIV test kits were distributed to these health facilities. The indirect sites are supported by medical officers and clinical officers at the branches. Furthermore, AIC has a dedicated team at headquarters to support the branches and the indirect sites in the districts. In FY 2008, AIC trained 25 AIC medical staff from the 8 branches in TB/HIV co-infection management. These trained staff have gone a long way to scale up TB screening and treatment of HIV positive clients with TB. 25 out of a targeted 57 AIC medical staff were trained in TB-HIV integration. At the branches six TB educators have been trained per Branch. To ensure drug adherence, AIC followed up TB patients and a total of 109 clients who had defaulted were visited in their homes. All TB clients fill in a locator form and this enables the volunteers to carry out patient visits to those that miss or default. During the home visits the volunteers check on the progress of treatment and the amount of drugs left, the condition of the patient, establish why the patient did not return for refills and assist accordingly and they also offer TB education to the family members and communities. By the end of FY 2008, all the 8 branches had CD4 machines installed, thereby enhancing AIC's laboratory capacity. Co-infected clients were able to have access to HIV disease monitoring. A total of 11,205 clients received CD4 services in FY 2008, of these 40% had a CD 4 level below 200, hence were eligible for ART and were appropriately referred. The indirect sites also have the opportunity to send HIV positive clients to have their CD4 done at the AIC branches to ensure proper management and monitoring of HIV. With assistance from other funding bodies like Uganda HIV support Program (UHSP), AIC is able to diagnose and treat malaria among its clients including the TB-HIV co-infected. With provision of Reproductive Health products like Family Planning Products from National Medical Stores, AIC will be able to resume these services as part of the wrap around services. In terms of strategic information and data management, AIC improved its data management through frequent review of its data collection tools especially the ones for HCT and TB. This is a continuous exercise that facilitates the provision of quality



**Activity Narrative:** data. The online registration program is being used in Kampala branch and a total of 142,890 clients have been registered since its inception in March 2006. This will soon be scaled up to all branches to facilitate timely data collection, analysis and utilization. Service delivery also improved in the medical department as a result of the procurement of computers for the medical staff, furniture and cupboards for the pharmacies as well as the remodeling of the Kabale laboratory. This was further strengthened by the procurement of a reliable and stable internet service provider. By the end of FY 2008, all AIC branches were on a reliable network and AIC is moving towards a Wide Area Network (WAN).

In FY 2009, AIC will continue to strengthen TB/HIV integrated services in its 8 branches of Arua, Jinja, Kabale, Kampala, Lira, Mbale, Mbarara and Soroti. Activities will include physical and clinical examination, clinical monitoring, laboratory services, treatment and prevention of TB. AIC will use the NTLP registers both for diagnosis and treatment in the clinics. At the branches, all HIV positive clients will be screened for TB. In addition, HIV negative clients with TB symptoms will be screened to reduce the overall national TB burden. It is estimated that AIC will screen a total of 12,000 clients during FY 2009. To carry out this activity, AIC will procure materials for sputum testing and PPD. Since TB diagnosis continues to be a challenge among HIV positive clients, x-ray services will continue to have a place in diagnosis and a total of 4,800 x-rays will be carried out during FY 2009.

Clients who will be diagnosed with Active TB will be treated at the AIC branches in line with the provisions and guidelines of the National TB and Leprosy Program (NTLP). A total of 300 clients will be treated for Active TB in FY 2009. For those diagnosed with latent TB, INH prophylaxis will be provided to 720 clients in FY 2009. For clients who are initiated on the nine-month treatment there is still an increasing number of cases who fail to adhere to the complete treatment and hence require follow up to eliminate drug resistance. In order to improve adherence, AIC will carry out home visits to these clients. Bio data will be collected on the locator card which will enable the TB volunteers to easily locate and follow up these clients. An estimated 1,000 visits will be made in FY 2009. AIC will continue offering diagnostic HCT for TB patients in TB clinics in 40 AIC indirect sites at a rate of 2 sites per district; in the districts of Kabale, Kanungu, Kisoro, Ntungamo, Mbarara, Isingiro, Wakiso, Mukono, Jinja, Iganga, Mbale, Butalega, Soroti, Amuria, Lira, Gulu, Apac, Arua, Nebbi, and Moyo. TB patients already diagnosed with TB will be offered provider-initiated counseling and testing (PITC). AIC will reach 10,000 such clients in FY 2009. HIV test kits will be procured and distributed to these supported sites and data collection tools provided. AIC will also carry out frequent monitoring and support supervision visits to these sites. TB patients that will be found to be co-infected with HIV will be referred for CD4 services and ARTs at accredited ART centers. AIC will therefore need to maintain an updated referral register. AIC understands the limitations in human resource capacity both at the branches and in the public health facilities. To build capacity in TB/HIV service delivery, AIC will train a total of 160 staff of whom 40 will be AIC branch medical doctors/clinicians and medical counselors; and 120 will be from the indirect sites. Staff from the supported sites will include laboratory technicians, counselors and TB/HIV program managers. To create TB awareness among communities, AIC will carry out TB outreaches and will work closely with health workers of the indirect sites. Improved awareness about TB in the communities is envisaged to lead to reduced spread of the disease and increased uptake of the TB/HIV services. These outreaches will also act as an avenue for informing the communities about the availability of TB/HIV services both at AIC and at the health units nearest to them. AIC will continue to provide monitoring and supportive supervision in form of technical assistance, on-job/mentoring to the indirect sites on a quarterly basis from the branch medical, laboratory, counseling and data teams. The data team will provide technical assistance in collecting meaningful and timely data. The medical team will be giving feedback on progress, while the laboratory and counseling team will dwell on the technicalities of HCT. These teams will also be delivering test kits, laboratory consumables and data collection tools. AIC strongly believes in reliable, timely and accurate data from the TB/HIV activities both at the indirect sites and the branches. It is with this background that AIC will install the TB/HIV software at the NTLP for data collection. To facilitate timely reporting and communication, AIC will continue to support internet connectivity for all branches. Other operation charges that will support implementation will include office supplies, vehicle maintenance, workshop facilitation and continuing medical education.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13256

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13256	8366.08	HHS/Centers for Disease Control & Prevention	AIDS Information Centre	6426	5246.08	Tuberculosis/HI V Intergration Activities	\$600,000

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

Military Populations

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$307,350

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 8670.09

**Mechanism:** Provision of Full Access Home-based Confidential HIV Counseling and Testing and Basic Care Services in Kalangala District and the Surrounding Fishing Communities

**Prime Partner:** Kalangala District Health Office

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 9443.20754.09

**Planned Funds:** \$79,190

**Activity System ID:** 20754

**Activity Narrative:** In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing and basic care in Kalangala district and the surrounding fishing communities. The objectives of the four 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 and 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 was specifically targeted with this program to respond to the prevailing needs of the fishing communities related to vulnerability to HIV. Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited and 8 habited due to fish migratory patterns and harsh weather conditions. Kalangala's unique geographical location has resulted in limited health and human services to this marginalized population of 36,661 (2002 Census) and projected population of 100,000 people (2008). The district is served by only eleven health units: two Health Centre (HC) IVs, six HC IIIs and three HC IIs. There is no hospital located within the district. Referrals for patients with complicated health problems are made to mainland Entebbe, Kitovu, and Masaka Regional Referral Hospitals which is 80 kilometers from the main island. Results from the 2005 Uganda National Health and Behavioral Survey (USHBS) demonstrate that the central region, in which Kalangala is located, has the highest HIV prevalence in the country, reported at 8.5%. The secondary analysis of the USHBS central region data indicate that Kalangala District, has a prevalence of 27% which is approximately five times the national average, thus this population of fishermen and their families have been identified as a very-high risk group.

By July 31 2008, the program office had been established and equipment procured; project staff including 45 full time staff and 100 mobilisers had been recruited and trained; 3,401 individuals including 155 couples had received HIV counseling and testing and 711 HIV-positive individuals had been identified and provided basic palliative care and referred for chronic care management. Field HIV Counseling and Testing (HCT) teams comprise a counselor and laboratory assistant who conduct counseling and testing services in clients' homes. Community mobilization and support is conducted by a team of 100 Community Owned Resource Persons (CORPS)/ Mobilisers that have been identified by the communities served and trained by TASO Uganda.

TB/HIV program area is a new component that has not been effectively addressed with FY 2008 funding. The program plans to contribute to the response to the challenges to effective TB/HIV care for patients. These challenges include a limited capacity to identify TB cases using either sputum smears or chest x-rays in most health facilities; limited access to TB treatment centers by patients; shortage of qualified/well trained health workers and; poor treatment adherence.

With FY 2009 funding the project will ensure that all 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. In collaboration with the PEPFAR laboratory strengthening initiative, this project will contribute to the functionality of health facilities' laboratory capacity for TB and HIV including an assessment of laboratory capacities at targeted facilities to identify areas that will need priority actions. The assessment will examine factors such as the availability of laboratory staff and their level of training/experience, the number and types of laboratory services currently available (with an emphasis on HIV/AIDS and TB diseases), current infrastructure (quality of testing tools, and other non-expendable equipment), availability of supplies (reagents and protective gear) and supply-chain, availability of operating procedures and protocols for laboratory management and performance, and the level of resources allocated to laboratory performance by district planning committees. From the assessment, a plan to address the gaps identified will be developed according to MOH guidelines and implemented in collaboration with the National TB and Leprosy Program. Finally in working with the district education and communication (IEC) teams, 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 in collaboration with MOH and JCRC will ensure a constant supply of TB drugs, septrin and ARVs to TB/HIV co-infected patients. Support supervision and on-job training will strengthen TB/HIV integrated services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13224

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13224	9443.08	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8670	8670.08		\$80,000
9443	9443.07	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8792	8792.07		\$50,000

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1107.09	<b>Mechanism:</b> Mulago-Mbarara Teaching Hospitals - MJAP
<b>Prime Partner:</b> Makerere University Faculty of Medicine	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 4034.20763.09	<b>Planned Funds:</b> \$1,385,818
<b>Activity System ID:</b> 20763	

**Activity Narrative:** Makerere University Faculty of Medicine (FOM) was awarded a cooperative agreement titled "Provision of Routine HIV Testing, Counseling, Basic Care and Antiretroviral Therapy at Teaching Hospitals in the Republic of Uganda" in 2004. The program named "Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV programs in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas. MJAP collaborates with the National Tuberculosis and Leprosy program (NTP), and leverages resources from the Global fund (GFATM). MJAP provides a range of HIV/AIDS services including: 1) Hospital-based routine HIV testing and counseling (RTC), 2) provision of palliative HIV/AIDS basic care, 3) provision of integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and provision of HIV post-exposure prophylaxis, 5) Family Based Care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities, and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. MJAP currently supports HIV services in 23 facilities (Mulago and Mbarara national teaching hospitals, seven regional referral hospitals, and 14 satellite health centers). In August 2006, the program was awarded another grant titled "Expanding Tuberculosis/HIV Integration Activities in the Republic of Uganda, 2006" under cooperative agreement U2G/PS000591-01 with the Faculty of Medicine. The funding was awarded to support the Uganda Ministry of health to expand integrated RTC and TB screening and care to regional referral hospitals. This was in line with the Ministry's plans of improving access to HIV testing in clinical settings and integrating TB/HIV diagnosis and care. The TB/HIV integrated services model includes i) Concurrent diagnosis of TB and HIV infection among in- and out-patients in general wards and clinics ii) Routine HIV testing for TB patients iii) enhanced TB screening for HIV positive patients in care including those on ART and iv) Integrated care and treatment for patients with TB/HIV co-infection. TB screening is conducted at several levels beginning with clinical evaluation through history taking and examination, to other investigations such as sputum smear microscopy which is the main diagnostic tool, Chest X-rays, biopsies and cultures.

Using the TB/HIV grant (cooperative agreement No.U2G/PS000591, MJAP directly supports TB /HIV services in three regional referral hospitals: Jinja, Hoima and Mbale using the model described above. MJAP has provided key equipment (Microscopes, CD4 Facs count machines, chemistry, and hematology machines) for TB diagnosis, HIV care and monitoring to these hospitals. Recording and reporting systems have been strengthened through the provision of computers and accessories, training in electronic data processing, refining and updating of ministry's data tools and, establishment of electronic data bases and linkages to the national Health Management Information Systems (HMIS). Testing supplies for HIV and TB screening have been provided and staff trained and supported on job to forecast, track and monitor supplies. Between April 1st 2007 and March 31st 2008, 19,630 persons were tested for HIV and provided with results. Out of these, 2290 were found HIV positive (12% prevalence). Among those tested, 313 were TB patients on treatment and out of these, 175 (56%) were HIV positive. TB screening is a process that involves history taking, clinical examination and investigations routinely performed by all health workers. During the period, 2807 patients were screened for TB using sputum smear microscopy in all the 3 sites. Of these, 302 were HIV patients in care of which 174 (58%) were found with smear positive TB. Overall, 349 patients were identified with TB/HIV co-infection and initiated on TB treatment. The program has set up infection control committees in the 3 hospitals, developed infection control protocols and materials to facilitate patient education and prevention of TB transmission in the facilities. The program developed training materials in partnership with MoH and conducted training for staff in the three hospitals in various aspects of TB/HIV care. 225 were trained in RTC, 240 trained in TB/HIV co-infection management, and 30 in logistics management. The program has embarked on expansion of the services to an additional 2 regional referral hospitals (Masaka and Soroti) as well as strengthening referral systems for TB and HIV care for patients with either of the two infections in partnership with the National TB program and other partners. Through the activities of the sub partners-the National TB reference laboratory (NTRL) and the Central Public health laboratories (CPHL) the program continues to strengthen the performance of regional hospital laboratories in the use of Acid-fast direct-smear microscopy through training and on job support as well as establishment of a National External Quality Assurance System (NEQAS) to increase accuracy and reproducibility in TB smear-microscopy.

In FY2009 MJAP plans to strengthen diagnosis for TB among HIV+ smear negative patients through the use of liquid cultures. This technique will be scaled up, based on experiences from a pilot service in the Mulago TB/HIV clinic and selected program sites around Kampala. Following the pilot, services will then be rolled out to all the regional hospitals. Subsequently, we envisage providing a cold chain system and also disseminating culture facilities to enable diagnosis of other difficult cases. We will continue with rapid MDR-TB screening and introduce second line drug susceptibility testing to support the DOTS-plus program in collaboration with the NTRL. Surveillance of MDR will continue through a specimen referral system and expansion of TB culture facilities to 2 other laboratories. NTRL will also improve processing of samples, biosafety at work place and storage of isolates through purchase of refrigerated centrifuges, Biosafety cabinets and freezers as well as creation of a freezer space. We will also continue to strengthen the weak aspects of CB-DOTS namely sputum smear microscopy, recording and reporting in all the regional hospitals. We will do this in collaboration with the national TB program, CPHL and other partners. As part of this process, NTRL we will strengthen the EQA System by increased problem-oriented supervision, and, provision of ongoing training to laboratory personnel to address the poorly performed areas of EQA. To sustain the EQA system, we will strengthen the district and regional laboratories by training 100 laboratory staff from the district and regional laboratories and facilitate them to carry out support supervision and problem-oriented supervision.

We will pay special focus to the quality of TB/HIV care by incorporating quality improvement plans and targets in the overall program plans. We will monitor and document TB/HIV treatment outcomes in all the program sites. The program will continue to support the improvement of existing structures and systems within the hospitals. We will hire additional staff in the regional hospitals to support integrated TB-HIV services, provide refresher training for new and existing staff, support quality assurance and support supervision, and enhance the existing referral systems between the regional referral hospitals and the lower level health facilities, and linkage to care for newly diagnosed TB-HIV patients. NTRL will hire an administrative assistant who will help in running the non technical aspects of the project such as assisting in

**Activity Narrative:** procurements and logistics, preparing accountabilities, tracking of expenditures and monitoring of stocks. This will release time from the technical staff to concentrate on their work. We will continue offering RTC and TB screening to in -and out-patients in all the 5 hospitals and care for the co-infected patients. The care will include; HIV testing and counseling of TB clients and referral or management of those found HIV positive, provision of ARVs and cotrimoxazole prophylaxis, TB screening of patients with HIV/AIDS, provision of TB treatment using DOTS management strategy for HIV infected patients with TB and implementation of infection control activities to prevent TB transmission in all our HIV care settings. 45, 000 individuals are targeted for RTC during the period, and 80% of HIV positive patients receiving HIV services in the hospitals will receive routine screening for TB disease at least once a month, by either clinical evaluation through history taking and examination, or performing investigations such as sputum smear microscopy which is the main diagnostic tool, Chest X-rays, biopsies and cultures. Data for this indicator will be retrieved from patient ART chronic care cards. 75% of patients diagnosed with TB will receive HIV counseling and testing services over the period of their treatment for TB. Data for this indicator will be retrieved from the TB treatment registers. The program will strengthen the capacity of the facilities to provide the relevant laboratory and diagnostic capacity for the TB/HIV services. We will roll out IPT prophylaxis to two Regional hospitals following the year's planned pilot in the Mulago TB/HIV clinic. The benefits of all these activities will be improved patient care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13274

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13274	4034.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$500,000
8317	4034.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$500,000
4034	4034.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$361,409

#### Emphasis Areas

Health-related Wraparound Programs

\* TB

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$450,000

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

Table 3.3.12: Activities by Funding Mechansim

---

**Mechanism ID:** 1107.09

**Mechanism:** Mulago-Mbarara Teaching  
Hospitals - MJAP

**Prime Partner:** Makerere University Faculty of  
Medicine

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 9757.20764.09

**Planned Funds:** \$494,935

**Activity System ID:** 20764

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), and Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP has continued to support TB/HIV integration activities in Mulago and Mbarara teaching hospitals, in the regional referral hospitals of Soroti, Fort Portal and Masaka, as well as in 14 specialized HIV/AIDS clinics. These activities are being initiated in Kabale regional referral hospital and will be fully established by the end of FY 2008. TB and HIV service integration happens at several levels: 1) integration of TB screening and Routine HIV testing (RTC) on the in-patient wards and out-patient clinics where patients are offered both HIV testing and screening for TB, 2) provision of RTC in the TB wards and clinics, 3) enhanced TB screening in the HIV clinics, and 4) provision of both TB and HIV care and treatment for patients who are co-infected with TB and HIV. MJAP pioneered the integration of TB and HIV management in Uganda by opening up a TB/HIV clinic at Mulago hospital in 2005. In this TB-HIV clinic, TB/HIV patients receive TB treatment, HIV palliative and basic care, and initiation of ART if eligible. After completion of TB treatment, these patients are referred for follow-up HIV care in the other established clinics. The program also completed the setting-up of an integrated TB-HIV clinic in Mbarara hospital as an extension of the Mbarara ISS clinic. TB treatment has been integrated into all the care and treatment sites, with a dedicated day for treatment of co-infected patients in each site. Key equipment (Microscopes, CD4 measuring machines, chemistry, hematology machines) for TB diagnosis, HIV care and monitoring are available at the hospitals either directly managed by MJAP or in collaboration with other PEPFAR funded partners. Recording and reporting systems have been strengthened through the provision of computers and accessories, training in electronic data processing, refining and updating of ministry's data tools and, establishment of electronic data bases and linkages to the national Health Management Information Systems (HMIS). Testing supplies for HIV and TB screening have been provided and staff trained and supported on job to forecast, track and monitor supplies. Implementation of the TB screening and treatment services is done in collaboration with MOH-NTLP. The MOH-NTLP provides TB medications free to patients; and the HIV clinics dispense TB medications supplied by MOH-NTLP. The program developed training materials in partnership with MoH and conducted training for staff in the implementing sites in various aspects of TB/HIV care. TB screening is covered in the existing RTC training curriculum.

Since February 2005, over 35,000 individuals have been screened for TB and more than 3,000 sputum positive patients identified and linked to care. More than 2,500 patients have received TB and HIV treatment in the HIV care centers. Between April 1st 2007 and March 31st 2008, a total of 26,412 patients were screened for TB in all the implementing sites. A total of 2,263 co-infected patients received treatment and care in the TB/ HIV clinics. A total of 225 health service providers were trained in TB screening as part of the basic RTC training and 240 staff was trained in TB/HIV co-infection management.

In FY 2009, four new satellite care and treatment sites will be opened to decongest the current care and treatment sites; with the Mbarara TB/HIV clinic becoming an independent site from the Mbarara ISS clinic. The integrated RTC-TB screening program will also be expanded to four additional wards in Mulago and Mbarara hospitals and four health centre IVs within the catchment areas of the regional referral hospitals. This funding will support TB screening in 28 sites ( four Mulago and Mbarara hospital wards, four regional referral hospitals, four health centre IVs and all the 18 MJAP supported HIV clinics); 18 sites will provide integrated care and treatment while ten will provide integrated diagnosis with referral to existing care and treatment facilities. The aim is to screen 100, 000 patients for TB and provide TB-HIV care to 3,000 TB-HIV co-infected patients in the coming year. MJAP will strengthen diagnosis for TB among HIV+ smear negative patients through the use of liquid cultures in collaboration with the National TB reference laboratory. This technique will start in selected hospitals and be rolled out to all the regional sites by the end of Oct 2010. MJAP will implement infection control activities to prevent TB transmission in all our HIV care settings.

To ensure sustainability, MJAP will continue to support the improvement of existing structures and systems



**Activity Narrative:** within the facilities. The program will hire additional staff to support the TB-HIV integration efforts, provide training for new and existing staff in the clinics (200 health care providers will be trained in the coming year), support logistics management and supplies, quality assurance and support supervision, and enhance the existing referral systems between the diagnosis and the care and treatment sites. The program will also support the improvement of data management/ M&E and reporting to all stakeholders within the districts, zonal supervision offices and MOH-NLTP. Although implementation will happen in the regional and national referral hospitals, health providers in the lower level health centers (including CB-DOTS providers) will also be trained, to enhance TB-HIV care, infection control and CB-DOTS. The laboratory personnel at the regional referral hospitals will be trained and supported to provide support supervision for the lower level laboratories (an area within their mandate but currently not fully implemented). We will do this in collaboration with the national TB program and other partners. Special focus will be paid to the quality of TB/HIV care by incorporating quality improvement plans and targets in the overall program plans. Through the activities of sub partners, the program will focus on culture and drug susceptibility testing of samples from previously treated patients. We will monitor and document TB/HIV treatment outcomes in all the program sites. The program will target both adults and children in all the clinics and hospitals.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13275

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13275	9757.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,400,000

### Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$214,286

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.12: Activities by Funding Mechansim**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Budget Code:** HVTB

**Activity ID:** 4382.20060.09

**Activity System ID:** 20060

**Program Area:** Care: TB/HIV

**Program Budget Code:** 12

**Planned Funds:** \$296,961

**Activity Narrative:** 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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific paediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 250 children and adults on ART; and Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider of paediatric ART services in Uganda. By June 2008, 4,918 children (0 – 14 years) and 1,254 adults (15+ years) were directly receiving ART from Baylor – Uganda sites, and indirectly 281 children were on ART through the supported 32 upcountry public health facilities. An additional 4,240 adults are being served indirectly from the upcountry public health facilities with drugs for OI management, systems strengthening, etc. In total, 6,330 children and 3,122 adults in were receiving HIV/AIDS related care & support (this includes those on ART) from her direct services delivery sites; while it had 13,647 adults and 1223 children in care from the indirectly supported upcountry sites. From direct services delivery sites, HIV positive child is used as the index of entry and basis for testing care givers & other family members. Depending on HIV test result, the adults are appropriately enrolled into HIV/AIDS prevention, care &/or treatment. Baylor – Uganda uses two services delivery modes:

(a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC); 4 Regional Centres of Excellences (COEs) in Soroti (Lwala Hospital & Kaberamaido HCIV) and Kasese (Kilmebe Mines & Bwera Hospitals) areas; and six satellite clinics [Naguru, Kirudu, Kawempe and Kitebi Kampala City Council – KCC clinics; Kanyanya TASO Centre and Post Natal Clinic at Mulago Hospital] run as family care consortium with KCC and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI), Mulago-Mbarara Joint AIDS Program (MJAP) and The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. This 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) Baylor – Uganda provides indirect services through integration of paediatric and family-centered HIV/AIDS services into existing ART accredited public health facilities in upcountry parts of Uganda. Within 3 months period of the first project year, Baylor – Uganda has supported 33 public health facilities (32 upcountry & 1 Kampala satellite clinic – Kitebi HCIV) to integrate paediatric HIV/AIDS services, and plans to roll out in additional 100 facilities over the remaining 4 years. From the 32 upcountry health facilities already covered, 104 children (0 – 14 years) and 1,200 (adults & children) were enrolled on ART and HIV/AIDS care respectively within the 3 months.

Baylor – Uganda has trained more than 1,000 health professionals in paediatric HIV/AIDS management since 2003, using multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics & Child Health. Since January 2008, the training program uses a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and tied to (3) implementation of work plan that includes enrollment of at least 5 children into HIV/AIDS care or treatment. By June 30, 2008, 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively. Continuing Medical Education programs are offered weekly at COE & monthly at Satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and their District Health Offices is on-going based on the national Health Management Information System (HMIS). In October 2008, the COE will roll out Electronic Real Time Medical records and with support of CDC, we plan to modify and roll it out to the targeted health facilities over the project period. We hope these will lead to development of paediatric HIV/AIDS database in Uganda.

The Baylor-Uganda/PIDC has an established TB care program providing diagnostic and treatment services. In FY 2008, Baylor- Uganda supported 11 service outlets to provide a family- centered approach to diagnosis and treatment of 239 children co-infected with TB and HIV. 3157 children and adults received TB/HIV related care from the direct sites. This mainly incorporated systematic TB screening within HIV care and treatment facilities. TB screening and care services include tuberculin skin testing (Mantoux) using PPD - Purified Protein Derivative performed on all newly diagnosed HIV infected children and existing PIDC patients who are symptomatic for TB. Symptomatic children are also actively screened for TB using sputum smears and radiological examination. Family members of TB patients are also encouraged to be screened for TB. Available data suggests a ~16% PPD reactive rate among newly diagnosed HIV infected PIDC and Kampala satellite clinic patients. Unmasking of post-antiretroviral TB infection within 6 month of initiating ART occurred in 6.2% (104/1669) of all children without prior TB. During the first 100 days of ART, clinic data revealed that the risk of unmasking TB-IRIS at PIDC increased 2.7 fold compared to pre-ART (95% CI=2.1 to 2.5; P<.001). Children with CD4 counts <200 cells/ul at initiation of ART will have a second PPD placed 6 months later as evidence has shown that such children had a 41% longer time to TB unmasking, implying a longer time was needed for restoration of antigen-specific immunity. As most of the TB

**Activity Narrative:** medications received through the National TB and Leprosy Program (NLP) are adult formulations which are not convenient for use in paediatric patients, most of the TB medications used by the Baylor - Uganda program are purchased through PEPFAR funding with supplements from donations from other partners like Feed the Children-Uganda. The program follows guidelines provided by MOH/NLP for management of TB in children. Children with reactive Mantoux but without evidence of active disease are provided with INH prophylactic treatment for duration of 8 months. However, as Mantoux testing is currently not feasible in rural settings due to its packaging and storage requirements, this service is only available in health facilities located in Kampala. Training of health workers in the management of TB and HIV was a key activity in FY08 reaching 359 health care providers working in both urban and rural areas. On-going training of medical and clinical officers in TB X-ray interpretation and clinical mentorship on TB diagnosis and care was also provided.

In FY2009, palliative TB/HIV care activities will continue at the Mulago PIDC and its satellite clinics in Kampala through the PEPFAR program, while Baylor-Uganda/PIDC supported satellite clinics in rural settings will work directly with the district health system to provide TB screening and treatment services according to the National guidelines. The program will continue implementing a family-centered to both HIV and TB diagnosis and care.

- Perform PPD on an estimated 2,520 children, based on average monthly HCT rates at COE (195 with 46% positive) and the Kampala Satellite clinics (708 with 17% positive). PPD will also be performed on approximately 4 family members (care givers) per PPD reactive child; therefore, ~1800 family/household members will be screened for TB using PPD.
- Perform chest X-ray on approximately 16% of those screened with PPD (403) who will be reactive or have symptoms suggestive of TB & will, thus, require chest x-rays performed.
- Procure equipment, supplies and reagents for diagnosis of Tuberculosis in collaboration with the National TB and Leprosy program.
- Perform laboratory diagnostic services (sputum smear tests) for TB.
- Provide TB treatment to an estimated 10% of the roughly 5,000 HIV infected children in active follow-up by end of June 2008, plus the ~1890 HIV+ patients recruited by March 2009, who will require TB treatment. Children will receive treatment at one of the Baylor - Uganda supported clinics, while adults -not in the family clinic- diagnosed with TB as a result of the family TB counseling and testing initiative will be referred to a National TB Program.
- Perform HIV counseling and testing for children & adolescents diagnosed with TB and who are identified and/or referred from other services entry points and vice versa.
- Provide transport reimbursement to needy clients to return for PPD reading at the clinic (It is estimated that 22% [~555] patients will need such assistance).
- Due to the frequent unavailability of pediatric TB treatment formulations, a buffer stock of TB medications will be procured to supplement medications received through the National TB and Leprosy Program.
- Conduct training for about 570 health professionals in various aspects of pediatric HIV/AIDS management, which include diagnosis, treatment and care of children with TB/HIV co-infection since TB has significant effect on morbidity, mortality and ARV treatment options and outcomes.
- Provide co-trimoxazole prophylaxis and INH to clients who are eligible for them.
- Provide antiretroviral therapy to eligible TB-HIV co-infected patients in accordance with the National treatment guidelines.
- Provide face masks to suspicious patients, those with active TB waiting for treatment and care, and to services providers.
- Provide pediatric TB formulations to support TB management in 32 rural up-country facilities, linked to TB clinics and TB DOTs program.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13244

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13244	4382.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$300,000
8285	4382.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$275,000
4382	4382.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$46,920

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$105,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 1290.09

**Prime Partner:** Catholic Relief Services

**Mechanism:** AIDSRelief

**USG Agency:** HHS/Health Resources Services Administration

---

**Funding Source:** GHCS (State)

**Budget Code:** HVTB

**Activity ID:** 4396.20741.09

**Activity System ID:** 20741

**Program Area:** Care: TB/HIV

**Program Budget Code:** 12

**Planned Funds:** \$98,987

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

#### Progress to-date; activities and achievements

As of July 31, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older; and to 5144 pediatric patients 18 years and younger, and antiretroviral treatment to 1762 HIV-infected patients 15 years and younger. In FY 2008 AIDSRelief supported 18 LPTFs and 24 satellite sites to provide a family-centered approach to diagnosis and treatment of 3,600 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 2008. AIDSRelief trained 290 community health nurses and 720 volunteers 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 2008. 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 Constella Futures, 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 2008. Constella Futures 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 2008, 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 2009 activities

In FY2009, 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 treatment to 3,600 HIV + patients, and all family members of TB patients will be screened for TB. A total of 4,800 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 290 LPTF staff will be trained in the provision of clinical treatment for TB to HIV+ patients, and 720 community volunteers will be trained 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.

**Activity Narrative:** 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, Constella Futures, 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 IQ Care, 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. 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.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13264

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13264	4396.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$100,000
8293	4396.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$30,000
4396	4396.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$13,625



## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$26,500

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,000

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.12: Activities by Funding Mechanism

**Mechanism ID:** 7406.09

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**Prime Partner:** Infectious Disease Institute

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 16312.22687.09

**Planned Funds:** \$128,683

**Activity System ID:** 22687

**Activity Narrative:** The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Dean of the Faculty of Medicine. IDI has trained 2,394 course participants from 26 African countries in the areas of HIV/AIDS, malaria, pharmacy, lab and data management. Twenty-six research projects are in progress, focusing on identifying best practices and models for prevention, care and treatment of HIV/AIDS and related infectious diseases in sub-Saharan Africa. Almost 9,000 people are receiving care at the IDI clinic, and 5,741 people are on anti-retroviral therapy (ART). In addition, a total of 3,004 people are being cared for at four Kampala City Council clinics supported by IDI, and 1,339 people are receiving ART across the four sites.

In August 2008, IDI was awarded a CDC Cooperative Agreement to build capacity for scaling up of HIV/AIDS services in Kibaale and Kiboga, two rural underserved and high prevalence districts in Uganda. IDI intends to implement this service in conjunction with the respective District Health Offices, The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) projects. These latter two organizations will support the HIV/AIDS Care and treatment and training functions respectively. Specifically the project will: (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. At the end of the project period, IDI will have scaled-up routine HIV Counseling and Testing in at least six health facilities and tested 200,000 people. In addition, the project will provide at least 3,000 HIV-infected people with a care package and to start or maintain at least 1,500 HIV-positive people on ART. Other measurable outcomes include training for at least 200 health workers in comprehensive HIV/AIDS Care and starting 900 HIV+ people on TB treatment.

In FY 2009, IDI and its partners will support TB/HIV integration activities across 6 health facilities in Kibaale and Kiboga districts. The aim of this funding will be to screen 3,000 patients for TB and provide TB/HIV integrated care to 920 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. An assessment will be conducted to identify areas that will need priority actions. The assessment will examine factors such as the availability of laboratory staff and their level of training/experience, the number and types of laboratory services currently available (with an emphasis on HIV/AIDS and TB diseases), current infrastructure (quality of testing tools, and other non-expendable equipment), availability of supplies (reagents and protective gear) and supply-chain, availability of operating procedures and protocols for laboratory management and performance, and the level of resources allocated to laboratory performance by district planning committees. From the assessment, a plan to address the gaps identified will be developed according to MOH guidelines and implemented in collaboration with the National TB and Leprosy Program. Finally in working with the district education and communication (IEC) teams, 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 respective District Health Offices will ensure a constant supply of TB drugs, septrin and ARVs to TB/HIV co-infected patients. Support supervision and on-job training will strengthen TB/HIV integrated services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16312

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16312	16312.08	HHS/Centers for Disease Control & Prevention	Infectious Disease Institute	12197	12197.08	Expansion of Routine HCT and provision of Basic Care in Clinics, Hospitals and HC IVs	\$130,000

---

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.12: Activities by Funding Mechanism****Mechanism ID:** 7156.09**Prime Partner:** John Snow, Inc.**Funding Source:** GHCS (State)**Budget Code:** HVTB**Activity ID:** 4700.21727.09**Activity System ID:** 21727**Mechanism:** NUMAT**USG Agency:** U.S. Agency for International  
Development**Program Area:** Care: TB/HIV**Program Budget Code:** 12**Planned Funds:** \$593,922

## Activity Narrative: Activity Narrative

This is part of NUMAT activities which include Prevention/Abstinence and Being Faithful, Prevention Other, PMTCT, Adult and Pediatric care and treatment, Counseling and testing, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning. The FY2009 activities are a continuation from FY2008.

In FY 2008 NUMAT continued supporting the nine districts in strengthening CB-DOTs activities and TB/HIV collaborative activities. 565 Health workers as well as 59 Network support agents were trained in TB/HIV collaborative activities. 30 Health workers from Gulu and 40 from Lira were trained on CB DOTS activities. All the districts were supported to conduct quarterly support supervision for health workers and community volunteers involved in CB-DOTs and TB/HIV collaborative activities. NUMAT supported the dissemination of TB/HIV policy guidelines and TB/HIV communication strategy to the districts' TB/HIV stake holders. This has helped the implementation of TB/HIV collaborative activities in the districts.

TB/HIV collaboration zonal activities were supported including quarterly support supervision by the Zonal TB supervisor together with NUMAT technical team. All the 9 districts were supervised and during this supervision, 86 Health units were visited and 216 health workers were supported (trained on Job) mainly on treatment of patients and recording and reporting especially of TB/HIV data. 23 patients on CB-DOTS were visited by the Zonal supervisor and the NUMAT technical team. Radio programmes have been supported to sensitise communities on TB/HIV related issues. As a result of NUMAT TB and TB/HIV supported activities, a total 6388 TB patients in 2008 were started on TB treatment of these, 3176 were new sputum positive cases, giving a case detection rate of 70.3% and 3759 were put on CB-DOTS strategy. On TB/HIV, out of the total 6388 started on TB treatment, 3589 (56.2%) were tested for HIV and given results, 2015 patients were found to be co-infected and of these 50.1% were put on co-trimoxazole prophylaxis.

Most of the targets were achieved apart from the Proportion of TB patients tested for HIV and given results where the target was 70% and we achieved 56.2%. This needs more effort especially on recording and reporting of all TB patients tested for HIV.

In FY2009, NUMAT will build on achievements of FY2008 and will continue supporting the following activities;

The 9 districts in Acholi and Lango will continue to be supported to carry out TB/HIV trainings, planning meetings, support supervision and delivery of drugs and logistics to the patients. NUMAT will make TB/HIV training of the health workers in the lower level health units a priority since the trainings of the two referral hospitals are over. NUMAT will first train the District health workers who in turn will train the lower level units in their respective districts. This will increase the number of TB patients tested for HIV from the present 56.2% to over 70% next year. This will in turn increase TB patients on HIV care.

NUMAT will Continue supporting community education efforts that provide simple messages about TB symptoms and the importance of early detection and complete cure.

Drugs and other logistics are essential in TB control activities, therefore, NUMAT will Continue providing logistical support to assure drugs and other supplies are secure and reach health units in time.

NUMAT will continue providing support to the zonal TB supervisor and District TB supervisors in form of allowances and fuel so that they are able to provide supervision and on job training of Sub County Health Workers (SCHWs).

The districts in collaboration with NTLF will be supported to develop appropriate IEC/BCC messages and tools to improve awareness of TB/HIV services and the need for HIV and TB testing. This is in the process and NUMAT is working with Health Communication Partnership to ensure that messages applicable to the two regions of Acholi and Lango are produced.

NUMAT will extend TB and TB/HIV services to those at risk eg those in prisons, police and the army by supporting the districts to carry out tests, trainings and support supervision in these uniformed forces. All the districts will be supported to improve on infection control measures so as to reduce TB/HIV co-infection. This will be done by supporting the districts to develop Infection Control plans in their health facilities and infection control topics will be included in TB/HIV trainings for the lower level units' health workers. NUMAT will improve the TB unit in Aduku Health centre IV by putting up a shed with benches and create more space for clients so as to reduce congestion thus improving infection control there.

NUMAT will continue to support the strengthening of HIV/TB collaborative activities. This will be through activities that will see more TB patients screened for HIV, and more HIV patients screened for TB. The NUMAT technical staff in TB, PHA, ART and PMTCT/HCT will continue working together integrating screening of TB in HIV patients/clients and integrating co-trimoxazole prophylaxis and ART into care for TB/HIV co infected. NUMAT will train health workers in TB /HIV collaborative activities and also encourage and support joint planning for TB/HIV at the district and facility levels.

Districts will be supported to carry out integrated out reaches and NUMAT will provide logistics to the district technical people (DTLS and DLFP) to visit the non diagnostic health units so as to screen and test patients for TB and HIV. The patients found positive will be referred for the appropriate care. In order to get credible and early information, NUMAT will facilitate all the districts' TB Supervisors (DTLS) by giving them transport support to collect TB data on a quarterly basis to reduce delays in reporting.

The project will continue working with NTLF, NGO hospitals, Private practitioners, Tuberculosis Control Assistance Program (TBCAP), CDC, WHO, AVSI, CBOs, and GLRA on TB and TB/HIV activities.

**Activity Narrative:**

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15481

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15481	4700.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$600,000
8469	4700.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$600,000
4700	4700.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$559,824

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 4363.21712.09

**Planned Funds:** ██████████

**Activity System ID:** 21712

---

**Activity Narrative:** Activity Narrative

TB continues to be the leading cause of morbidity and mortality among People Living with HIV/AIDS (PLHA) in Uganda. Of the TB patients 51% are co-infected with HIV. Uganda has an estimated annual TB incidence of 158/100,000 population and mortality rate of 6%. In 2006, there were 41,792 TB case notifications and 30 % of all TB patients that received HCT. The treatment success rate is currently 73% far below the 85% target. Case detection rates are still below the 70 percent target. TB treatment success rate has been improving, but the overall result is still low because only 31% of TB patients have documented smear conversions, far too many die during treatment, default and/or transfer without follow up.

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 two 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, among others. These initiatives have greatly improved case detection and as at March 2008, 3,769 individuals had been screened for TB and 513 (190 males and 323 females) initiated on treatment. A total of 909 (337 males and 572 females) received counseling and testing in TB settings and got their results.

USAID/Uganda's partnership with IRCU ends in June 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 PLHA 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 with 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. The follow-on program will build upon and consolidate this initiative by introducing routine counseling and testing for all individuals attending TB clinics.

By the end of FY 2009, the follow on program will have screened at least 50,000 HIV positive clients for TB. Of these, an estimated 20,000 clients will require three sputum examinations and where needed X-ray tests to confirm the infection. Using a TB positivity rate of 10%, an estimated 2,000 co-infected individuals will be treated for active TB. All these individuals will also be assessed for ART eligibility and will immediately be initiated on cotrimoxazole prophylaxis to ward off other potential opportunistic infections.

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 work with National TB and Leprosy program to streamline provision of sputum collection containers, slides for microscopy and any TB related IEC materials. The NTLF will also be expected to provide on-going support supervision and maintain oversight on the quality of TB care and the progress of efforts towards TB/HIV integration.

**New/Continuing Activity:** Continuing Activity**Continuing Activity:** 14207

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14207	4363.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,200,000
8422	4363.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,200,000
4363	4363.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$1,500,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery [REDACTED]

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4056.09	<b>Mechanism:</b> TB/HIV Integration Activity
<b>Prime Partner:</b> TB-CAP	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 6428.21779.09	<b>Planned Funds:</b> \$1,933,007
<b>Activity System ID:</b> 21779	

**Activity Narrative:** The program for integration of TB and HIV services in Uganda implemented by KNCV Foundation under the TB-CAP mechanism supports the national TB/HIV collaboration committee (NCC) to roll out the national TB/HIV integration policy. At district level, the program is building the capacity of districts to implement TB/HIV collaborative activities. At facility and community levels the program aims to expand and strengthen the quality of Community-Based-Directly Observed Treatment Short Course (CB-DOTS) and implement infection control strategies. International Union Against TB and Lung Diseases (IUATLD) is the TB-CAP lead partner in Uganda

In FY 2008, TB-CAP provided support to Ministry of Health (MOH), 12 districts and 81 service outlets to develop training materials for managers on TB/HIV and supported a national training of trainers for managers. 21 tutors from 18 nursing and midwifery schools were trained on TB/HIV collaborative activities to enable them incorporate TB/HIV in pre-service training. The program provided technical support to MOH to draft TB infection control guidelines. Over 2,000 TB registered patients received HCT and 1,000 TB/HIV co-infected patients were identified and treated for TB. In the 12 supported districts, TB treatment success rates improved from an average of 58.6% to 70%, and the percentage of TB registered patients improved from 40% to 54%. 65% of TB/HIV co-infected patients were started on cotrimoxazole prophylaxis while 23% of initiated ART.

In FY 2009, 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. Eight additional districts will be covered in FY 2009 bringing the total number of districts supported with TB/HIV integration activities to 20, covering over 90 service outlets.

At national level the program will continue to 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 national targets for number and proportion of TB patients receiving HIV/AIDS Counseling and Testing (HCT) and for those with TB/HIV co-infection, number and proportion receiving cotrimoxazole prophylaxis and anti-retroviral therapy.

In the eight additional districts the program will provide technical support to the Directorate of District Health Services (DDHS) to form TB/HIV integration committees, develop district plans, budgets and implement these plans. The districts will receive support to improve recording and reporting processes and provide regular/quarterly support supervision. 120 health workers at both the DDHS office and 90 service outlets will receive training in TB/HIV integration. In the 90 service outlets the program will provide financial and technical support to health facilities to form infection control committees and implement infection control procedures. It is estimated that through support to these service outlets 5,000 registered TB patients will receive HIV/AIDS Counseling and Testing services and receive their test results and 1,500 HIV-infected clients attending palliative care services will be screened and treated for TB. All the TB/HIV co-infected patients will receive cotrimoxazole prophylaxis. All TB/HIV co-infected patients will be screened for eligibility for anti-retroviral therapy.

A total of 100 nursing aides and assistants will be trained as microscopists to increase facility-based capacity for TB-diagnostics. Over 100 health workers will be trained to carry out HIV/AIDS counseling and rapid HIV-testing. External quality assurance for both TB diagnosis and rapid-HIV testing will be implemented at these facilities.

In order to support the expansion of CB-DOTS, the program will provide technical support to the districts TB/HIV focal persons and recruit Project Community and Outreach Officers to do community mobilization and expand CB-DOTS activities, and continue to integrate CB-DOTS with HIV care and treatment programs. 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 continue to provide technical support to USG HIV/AIDS care and treatment partners to plan, implement and monitor TB/HIV integration activities in six areas namely: infection control, cross-referrals between TB and HIV/AIDS care and treatment programs including PMTCT, initiation of provider-initiated HCT for TB registered patients, TA on supporting development of TB/HIV district work plans, TB-diagnostics and external quality assurance for TB and HIV diagnosis.

On improving TB-diagnostic capacity, the program will update the current training package for microscopy, procedures for EQA and proficiency testing for the microscopy. The program will procure over 100 AFB-Kits from Global Drug Facility and distribute to health facilities with limited TB-diagnostic capacity. The program will continue to work with NTLP and ACP to explore opportunities for scaling up Isoniazid Prophylactic Therapy (IPT) for HIV-patients with latent TB. The program will leverage USAID funding for tuberculosis control in Uganda.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14180



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14180	6428.08	U.S. Agency for International Development	TB-CAP	6726	4056.08	TB/HIV Integration Activity	\$1,893,564
9183	6428.07	U.S. Agency for International Development	International Union Against TB and Lung Disease	5064	4056.07	TB/HIV Integration Activity	\$1,300,000
6428	6428.06	U.S. Agency for International Development	Tuberculosis Control Assistance Program, KNCV Foundation	12195	12195.06	TB/HIV Integration Activity	\$500,000

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$200,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 8862.21811.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21811	

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to ARV drug procurement, Adult Care and Treatment, Pediatric Care and Treatment, CT, PMTCT, and Laboratory Infrastructure.

Ensuring the availability of laboratory supplies for TB and HIV diagnosis, and drugs for TB prevention and treatment, is fundamental to the success of the TB/HIV program. To improve the availability of anti-TB drugs, including Isoniazid preventive therapy, the MOH National Tuberculosis and Leprosy Programme (NTLP) has over the past five years received technical assistance from the DELIVER project in forecasting, procurement planning and monitoring of stock levels through a logistics management information system. The system now covers 1,385 sites that provide TB treatment. Similar technical support has also been provided to the Central Public Health Laboratory (CPHL) to strengthen HIV and TB diagnostic services through the design and implementation of a national logistics management system for laboratory supplies. Technical staff have been placed in NTLP and CPHL to assist in capacity building and thousands of supervisors, health workers and laboratory technicians have been trained in logistics management of both these systems at regional, district and facility level. Technical staff from implementing partners (UPHOLD, NUMAT) have also been trained to monitor logistics system performance in their districts and sites. These systems have improved the availability of anti-TB drugs and lab test supplies nationwide but stock outs of the former, in particular, persist because of insufficient funding available for drug procurement; new funding from GFATM to buy anti-TB drugs should improve the situation in the near future. An assessment of NTLP drug logistics management system will be carried out in 2008 to revise procedures where needed.

In FY 2009, the new procurement mechanism will provide technical assistance to national and district-level PEPFAR partners on commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. TBD will continue to work in collaboration with WHO, UNAIDS, GFATM and other stakeholders to provide technical support to the MOH to strengthen the laboratory logistics management system. Ensuring the availability of laboratory supplies for diagnosis, treatment and care is fundamental to the effectiveness of the HIV/AIDS and TB activities. The MOH and CPHL will receive assistance to build their capacity in forecasting and quantification of national laboratory needs, procurement planning and coordination, monitoring of stock levels, and training of new laboratory staff in inventory management. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submitting timely reports to keep the supplies flowing. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution from district stores to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14231

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14231	8862.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$800,000
8862	8862.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$260,000

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 16007.21549.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21549

**Activity Narrative:** The USG has been supporting provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care. It has also identified and treated 700 TB/HIV co-infected patients and trained 150 health workers on TB/HIV collaborative activities. The program is also expected to have provided anti-retroviral therapy to 500 TB/HIV co-infected clients by the end of the FY 2008.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships, which demonstrate competency and leadership in respective technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so, USAID envisions moving from sole sourcing to open competition among indigenous partners. Competition will prompt local partners on the need to be competitive, and on the requirement to develop their own capacity in designing and developing high quality and competitive proposals and programs. During the extension phase JCRC will transition the majority of the sites beyond the nine regional referral hospitals to the new USAID district based mechanisms, other PEPFAR partners who overlap in the same facilities, and to the Ministry of Health (MOH). To ensure continuity of services, USAID will award the new agreement by March 2009.

In FY 2009 the major focus of the activity is to ensure continuity of life saving services, smooth transition and building capacity of nine regional referral hospitals. 1,000 new TB/HIV co-infected patients will be identified, treated for TB and given cotrimoxazole prophylaxis. The program will implement infection control procedures at all the nine regional referral hospitals.

The program will train and support 120 expert clients from 60 groups of People Living with HIV/AIDS to facilitate referrals and linkages between facility-based and community based TB and HIV management. The groups will facilitate referrals to wrap around services available in the communities. 100 health workers will be trained to provide TB/HIV services. The program will scale-up TB/HIV integration activities including setting facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services. The activity will closely work with the MOH national TB reference laboratory and the National Tuberculosis Control Program for diagnosis and referral of Multi-Drug Resistant Tuberculosis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16007

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16007	16007.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$225,000

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9221.09	<b>Mechanism:</b> STAR-EC
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: TB/HIV
<b>Budget Code:</b> HVTB	<b>Program Budget Code:</b> 12
<b>Activity ID:</b> 21145.21578.09	<b>Planned Funds:</b> \$280,463
<b>Activity System ID:</b> 21578	

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – East Central will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus on increasing rural access to HIV/AIDS Counseling and Testing (HCT) and anti-retroviral therapy (ART) through support to 6 districts in the East Central region of the country. This region has a low ART coverage and lies along the highway connecting Uganda to neighboring countries. According to the 2005 Uganda national HIV/AIDS Sero-Behavioural Survey 2004-2005, 79% of HIV-Ugandans do not know their HIV sero-status due to various reasons including limited access and utilization of HIV counseling and testing (HCT) services. The District HIV/AIDS/TB program will increase access and utilization of HCT services at both district hospital/lower level facilities and the community through the following initiatives:

- Increasing HCT service access and utilization for people in the rural setting and hard-to-reach high risk populations e.g. fishing communities, out-of-school youth, internally displaced populations, etc.
- Promotion of home-to-home and family-based HCT. Routine counseling and testing (RCT) will be supported in all district and lower level facilities with emphasis on referring all HIV+ clients into care and treatment facilities for follow on support services such as TB. In these health facilities, HCT will be routinely provided in the high HIV-prevalence clinics namely tuberculosis and Sexually transmitted clinics and medical in-patient wards.
- Promotion of outreach activities in high activity areas such as landing sites for fishing communities, communal markets, camps for internally displaced people, tertiary institutions and trading centers
- Training of health service providers such as counselors, laboratory staff, and data assistants. The training to cover personnel from approximately 50 outlets will support the role out of routine counseling and testing, strengthening counseling skills, logistics and records management, laboratory services, referral and general integrated patient care. A total of 300 personnel will be trained
- Increase support for and utilization of post test services through post test clubs (PTCs). PTCs will be used to promote awareness about disclosure, discordance and stigma.
- Promotion of couple counseling and testing coupled with referral linkages to post test services for both HIV - and HIV- individuals

To achieve the required results, the program will support provider-initiated HCT services in 50 health facilities. It is estimated that over 50,000 clients will receive HCT services in FY2009 and those testing HIV-positive linked to palliative care and treatment services. The program will build capacity of Networks and groups of People Living with HIV/AIDS (PHAs) to provide pre-test and post-test counseling to clients and facilitate family-based HCT. PHAs will be trained to function as expert clients facilitating linkages and referrals between community-based and facility-based care and linking all those testing HIV-positive to palliative care and wrap around services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

---

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.12: Activities by Funding Mechanism****Mechanism ID:** 690.09**Prime Partner:** US Department of Defense**Funding Source:** GHCS (State)**Budget Code:** HVTB**Activity ID:** 8987.21598.09**Activity System ID:** 21598**Mechanism:** N/A**USG Agency:** Department of Defense**Program Area:** Care: TB/HIV**Program Budget Code:** 12**Planned Funds:** \$98,987

**Activity Narrative:** Introduction:

Activity Narrative – The UPDF is Uganda’s national Army. As a mobile population of primarily young men, they are considered a high-risk population. Uganda initiated programs for high-risk groups in the early phases of the epidemic and continues to promote excellent principles of nondiscrimination in its National Strategic Framework. Starting in 1987, the Minister of Defense developed an HIV/AIDS program after finding that a number of servicemen tested HIV positive. As commander in chief of the armed forces, the President mandated the UPDF’s AIDS Control Program to oversee and manage prevention, care and treatment programs through out the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members. Additionally, civilians without military affiliation can access UPDF medical care, and represent up to 50% of all visits for some of the clinics. The UPDF HIV/AIDS Control program is comprehensive and covers the critical elements of prevention, such as counseling and testing, peer education, condom distribution, and PMTCT; HIV care, such as palliative care services and ARV services; and human and infrastructure capacity building. Co-infection with TB is a substantial challenge for the medical management of HIV infected patients in the UPDF. The UPDF hopes to further strengthen the control and management of TB in the military with the initiation of PEPFAR funds in FY 2008.

Progress to Date – The army leadership is being mobilized in the management of TB to improve on adherence to therapy with promotion of DOTS in health care facilities. Overall strategies underway with this new activity include: enhanced detection of TB cases in HIV positive clients and strengthening referrals for TB treatment; HIV counseling and testing of TB suspects and TB cases; and ensuring that those found to be HIV positive are linked to HIV care and ARV treatment. All of this is being done in coordination with the national health system in the roll out of the Ugandan MOH TB/HIV policy. Additional elements include addressing the adequate and constant supply of anti TB drugs and reagents, which is accomplished through the SCMS.

Planned Activities for FY 2009 - During FY 2009, the project will continue to make significant progress in the integration of TB and HIV management through the linkage between Counseling and Testing service delivery points, chronic care clinic and the TB clinic in all supported facilities. TB/HIV activities will be expanded to 6 more new health facilities and it is expected to reach 2,000 individuals over the year 2009. At the same time we will further consolidate the provision of TB/HIV services in the supported health facilities. The program will continue to support efforts that provide cross-referral and integrate diagnosis, treatment and support services for TB and HIV in the target facilities. HIV-positive individuals will be actively screened and treated for TB at initial diagnosis and during follow up at the chronic care clinics. We will further strengthen the laboratory and radiological investigation to improve case detection. HIV counseling and testing will be offered to all patients in the TB clinics.

We will strengthen the capacity of health facilities staff to better understand policies and guidelines for integrating TB/HIV collaborative activities. This will lead to better understanding and improved case management of TB/HIV co-infected patients, to maximize TB case detection, increase treatment compliance and adherence to TB and ART. TB Infection control measures in HIV care clinics will be enhanced through literacy campaigns for patients and staff, and enhanced TB case-finding. We will also support supervision and on-job training will be done to strengthen TB/HIV integrated services

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16069

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16069	8987.08	Department of Defense	US Department of Defense	7336	690.08		\$100,000
8987	8987.07	Department of Defense	US Department of Defense	4821	690.07		\$50,000

---

**Emphasis Areas**

Military Populations

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.12: Activities by Funding Mechanism****Mechanism ID:** 3166.09**Prime Partner:** International HIV/AIDS Alliance**Funding Source:** GHCS (State)**Budget Code:** HVTB**Activity ID:** 4690.24481.09**Activity System ID:** 24481**Mechanism:** Expanding the Role of  
Networks of People Living with  
HIV/AIDS in Uganda**USG Agency:** U.S. Agency for International  
Development**Program Area:** Care: TB/HIV**Program Budget Code:** 12**Planned Funds:** \$395,948



**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members, and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008, 832 NSAs have been trained on TB/HIV integration. Following the training, the NSAs have incorporated TB awareness into HIV/AIDS awareness activities particularly disclosing the link between TB and HIV. PHAs at-risk have been identified and encouraged to access screening services for TB and identified TB clients have also been referred for counseling and testing.

**ACTIVITY UN CHANGED FROM 2008**

In FY 2009, the PLHIV project will continue to integrate TB/HIV activities into health service delivery in all the 40 districts of operation. The 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. Communities will be sensitised on respiratory tract infections in general and TB in particular. Individual PHA groups will conduct community based TB campaigns intended to increase awareness on TB/HIV integration, encourage early diagnosis and treatment, reduce stigma and defaulter rates as well as promote preventive and care aspects of tuberculosis. All identified TB/HIV patients will be enrolled in the HIV/AIDS care and support program for the PHA groups.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14201

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14201	4690.08	U.S. Agency for International Development	International HIV/AIDS Alliance	6738	3166.08	Expanding the Role of Networks of People Living with HIV/AIDS in Uganda	\$400,000
8463	4690.07	U.S. Agency for International Development	International HIV/AIDS Alliance	4851	3166.07	Expanding the role of People Living with HIV/AIDS Networks	\$400,000
4690	4690.06	U.S. Agency for International Development	International HIV/AIDS Alliance	3166	3166.06	PHA Network	\$120,000

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$26,104

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 3834.09

**Prime Partner:** International Medical Corps

**Funding Source:** GHCS (State)

**Budget Code:** HVTB

**Activity ID:** 25187.09

**Activity System ID:** 25187

**Mechanism:** Refugee HIV/AIDS services in Kyaka II Settlement

**USG Agency:** Department of State / Population, Refugees, and Migration

**Program Area:** Care: TB/HIV

**Program Budget Code:** 12

**Planned Funds:** \$69,291

**Activity Narrative:** Activity Narrative – maximum 15,000 characters

The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12,115 however there are a group of refugees known as “population on Hold” who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel.

During the past year, one service outlet was operational in providing facility based palliative care and TB diagnosis and treatment. 41 community health workers and community educators were also trained to provide palliative care. The subjects included home based provision of palliative care and CB-DOTS (TB management system). 3 health professional attended the palliative care training course organized by Hospice and they also organized an in-house training for their peers and colleagues. 35 community educators and community health workers were trained in TB and HIV identification and referral, in addition, 1,050 caregivers were trained in care and support for HIV/AIDS patients. Finally, 357 HIV+ individuals were provided with related palliative care including Cotrimazol Prophylaxis and provided with kits with support from PSI.

In FY 2009, IMC/GTZ will continue to provide TB/HIV interventions to Mukondo HCII increasing the service outlets from one to two. IMC will also provide HIV Counseling and Testing (CT) for TB patients who attend clinic. It is expected that more people will attend the CT when this is offered at the TB clinic. To ensure a continuing high standard of care, IMC will provide a refresher training to 10 health professionals to provide clinical prophylaxis (this will involve providing medications to TB patients during clinical visits over a period of time to ensure that patients are actually taking the medications), TB diagnosis, treatment protocol and elements of Community based Directly Observed Treatment Short-course (TB-DOTS) and Health Education on TB Prevention. 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 over-crowding in closed areas, adoption of good cough habits, and good ventilation. 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. However, IMC will procure TB related supplies like pipettes, and microscope sputum slides for the Mukondo HCII. All new TB patients are sensitized on TB/HIV integration, counseled and tested for HIV if they have not already been tested via the RTC. All new TB/HIV patients will be enrolled in the HIV/AIDS care and support program including nutritional support. Additional staff including a laboratory technician and a nurse will be required to initiate TB/HIV services in Mukondo HCII. This activity will support 40 (based on number of TB clients registered at the health centre in the last six months with an addition of 10%) individuals with TB/HIV care between September 1, 2008 to September 1, 2009.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

---

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** HVTB

**Activity ID:** 21476.24013.09

**Activity System ID:** 24013

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: TB/HIV

**Program Budget Code:** 12

**Planned Funds:** \$280,463

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult and pediatric), ARV drugs and laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

In addition to supporting expanded delivery of HIV/AIDS services, this activity will also support the capacity of the decentralized health delivery system 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.

Specific TB/HIV activities to be supported under this mechanism will include:

- Support to district-level TB/HIV Coordination to integrate TB and HIV services
- Assisting in the rapid scale-up of routine HCT services for suspected and confirmed TB patients
- Support linkages for co-infected patients to HIV/AIDS care and treatment services
- Strengthen routine TB screening among HIV-infected clients; among those who are co-infected,
- Provide cotrimoxazole chemoprophylaxis for TB/HIV patients
- Support implementation of simple, low-tech TB infection control measures in health facilities to prevent TB transmission among PHA and health care workers
- Increase the availability and quality of TB and HIV diagnostic services by strengthening laboratory systems in facility, infrastructure, training of lab technicians, and availing standard operations procedures and guidelines

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish or maintain facility based quality improvement teams; introduction of continuous ART quality improvement tools in coordination with HCI or HIVQUAL.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21476

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21476	21476.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.12: Activities by Funding Mechansim**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVTB

**Activity ID:** 15765.24024.09

**Activity System ID:** 24024

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: TB/HIV

**Program Budget Code:** 12

**Planned Funds:** ██████████

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult and pediatric), laboratory infrastructure, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

Specific TB/HIV activities to be supported under this mechanism will include:

- Support district-level TB/HIV Coordination to integrate TB and HIV services
- Assist the rapid scale-up of routine HCT services for suspected and confirmed TB patients
- Support linkage co-infected patients to HIV/AIDS care and treatment services
- Strengthen routine TB screening among HIV-infected clients; among those who are co-infected,
- Provide cotrimoxazole chemoprophylaxis for TB/HIV patients
- Support implementation simple, low-tech TB infection control measures in health facilities to prevent TB transmission among PHA and health care workers.
- Increase the availability and quality of TB and HIV diagnostic services by strengthening laboratory systems in facility, infrastructure, training of lab technicians, and availing standard operations procedures and guidelines.

This activity will also support integrated support supervision conducted quarterly within each health sub district; establish or maintain facility based quality improvement teams; introduction of continuous ART quality improvement tools in coordination with HCI or HIVQUAL.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15765

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15765	15765.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

### Emphasis Areas

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Table 3.3.12: Activities by Funding Mechanism

**Mechanism ID:** 5740.09

**Mechanism:** Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 26698.09

**Planned Funds:** \$79,190

**Activity System ID:** 26698



**Activity Narrative:** This is a newly funded activity and it is a component of Counseling and Testing and Adult Care and Treatment activities. Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a liaison office in Kampala. ICOBI's vision is a healthy and prosperous rural population and its mission is to improve the quality of lives of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely: Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple-S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project (NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing (HBCT) in Bushenyi district (October 2004-June 2007) with funding from CDC/PEPFAR. The home based counseling and testing program was able to offer HBCT services to about 270,000 adults and children, identified about 12,000 HIV+ clients and provide them with basic care package with collaboration of Bushenyi district health system. The current ongoing programs include Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID in Bushenyi district and OVC Care & support with funding from NPI/USAID for Mbarara and Bushenyi district.

Recently in June 2008, ICOBI received a notice of ward from CDC to implement a program entitled "Provision of Full Access Home based Confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda" (ICOBI HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013). The program will cover the districts of Mubende/ Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda but will be implemented using a phased approach beginning with Mubende and Mityana districts. The goal of the program is to provide 100% access to HIV confidential Counseling and Testing services to all adults and children at risk of HIV infection residing in the six districts in five years. In addition, the program is to provide basic HIV/AIDS care and support, strengthen TB/HIV integration services to all identified HIV infected individuals and their families. The program will also support primary prevention of HIV and prevention with positives activities. The program will be implemented by outreach counseling and testing teams who will be based at the Sub-counties and the resident community mobilizers who will be based at the Parishes. In addition, the village health teams and local councils will also be engaged during community mobilization and sensitization. ICOBI is currently in preparatory stages of identifying, recruiting and training staff; procurement of equipment, materials, services while waiting for the final approval of the work plan and budget. It is anticipated that the actual implementation of the HBCT in homes and communities will begin at the end of September 2008.

The prevalence of HIV infection in the central region/districts of Mubende, Mityana, Luwero and Nakaseke districts is about 10%. In FY 2009, ICOBI hopes to identify 5,000 HIV infected people. More than 50% of HIV infected clients (about 2,500 of the identified HIV infected) are presumed also co-infected with TB, and this increases their risk of developing TB and increased mortality attributable to TB. At least 30% (750) are expected to receive TB screening services at the health center IV, Hospitals and health center III levels. However this activity would be constrained by the staffing levels of health workers at health units which stand at 50% in all public health units and lack of equipment like microscopes and reagents for TB diagnosis. This program will contribute to the reduction of TB burden in the districts by supporting integrated TB/HIV interventions. Routine counseling and testing will be offered to all registered TB patients and those with HIV linked to care and treatment. ICOBI will collaborate with AMREF and other partners in the districts to provide TB diagnostic capacity, recruitment and training of health personnel as needed. CB-DOTS will be introduced in all sub-counties and supervision by sub-county health workers will be supported.

In order to provide TB screening to HIV infected clients an extensive community mobilization and awareness creation among the population using radio, training materials(IEC), sensitization meetings of stakeholders will be implemented. In addition, Village health teams and health workers will be trained on HIV and TB co-infection according to national guidelines. The main activities will include screening for active TB and provision of preventive therapy for TB, early identification of HIV infected clients with symptoms of TB and prompt referral, TB symptom screening to identify HIV-positive clients and, management and treatment of TB as well as implementation of joint HIV/TB activities and promotion of HIV testing among TB patients (registered TB patients).

The funds under this activity will be used for procurement of Lab related commodities that will include microscopes and reagents for distribution to health center IIIs that do not have TB diagnostic capacity, training of health workers and community based health workers, supporting the districts' health system in handling and tracking the HIV+ clients co-infected with TB referred and receiving treatment for TB from health units. In order to ensure that the HIV+ receive TB screening and diagnosis and prompt treatment, priority is given to collaboration and strengthening of the districts health systems and supporting the district TB/Leprosy supervisors, health assistants and existing community TB treatment supporters training of laboratory assistants (existing staff in public and private health units in TB screening and diagnosis of active TB).

Through collaboration with health units and field health assistants in the districts, the program basic care officers and laboratory (technologists) supervisors will assist in screening the referred cases for HIV+s and this will benefit the clients for usually they take long to reach after referral. The resident parish mobilizers/community volunteers and health workers (Health assistants, who compile and keep TB registers at health center IIIs will be encouraged to inform TB registered clients to access HBCT at home and all HIV+ clients to go for TB screening. In order to ensure success, health workers at health center IIIs, all HIV clients with symptoms like chronic cough suggestive of TB will be referred to hospitals, health center IV and health center IIIs using TB/HIV referral forms for TB screening by the HIV counseling and testing team. All TB registered clients will be offered HIV diagnostic counseling and testing services at home in all the four program districts.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 11125.09

**Mechanism:** IRCU

**Prime Partner:** Inter-Religious Council of Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 4364.26782.09

**Planned Funds:** \$0

**Activity System ID:** 26782

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCUC) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Roman Catholics Church, The Province of Church Of Uganda, Uganda Muslim Supreme Council, Uganda Orthodox and Seventh Day Adventists Uganda Union to jointly address together development challenges. In June 2006, IRCUC signed a contract with United States Agency for International Development (USAID) to Scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by the United States Government (USG) under the President's Emergency Plan for AIDS Relief (PEPFAR).

In FY 2007, IRCUC worked with 17 implementing sites in the TB/HIV program and screened 2,800 clients for TB, diagnosed and treated 275 HIV positive clients for TB and these are also assessing palliative care and ART at these sites. Using funds for FY06 and 07, IRCUC trained 40 laboratory staff in TB diagnosis through Joint Clinical Research Center (JCRC) and equipped all 17 laboratories with microscopes, centrifuges and other necessary lab equipment for TB diagnosis. IRCUC also refurbished 10 laboratories to facilitate TB diagnosis procedures.

In FY 2008, IRCUC plans to integrate TB screening in all HIV counseling and testing (HCT) sites targeting all individuals who test HIV positive. Working with the existing 17 sites and possible ten new sites, IRCUC will work with these 27 sites targeting to clinically screen 20,000 HIV positive clients for TB of which an estimated 8,000 clients will further be screened by subjecting each client to three sputum examinations and where needed X-ray tests to confirm the infection. Using a TB positivity rate of 10%, we expect to treat 800 clients in FY 2008 for active TB and follow them up in the community.

The clinical team in FY08 will also screen and identify those found with symptoms suggestive of TB in the HIV clinics and will actively screen them for TB. IRCUC will continually support implementing organizations and health units with the necessary manpower and equipment to improve systems for TB screening, diagnosis and treatment. IRCUC will continue to work with National TB and Leprosy program through each implementing unit to streamline provision of sputum collection containers slides for microscopy and any TB related IEC materials.

The increase in the number of TB cases in HIV infected individuals is attributed to primary infection in the immune incompetent who cannot control infection after exposure, reactivation of TB and flaring up of latent TB as part of immune reconstitution in patients starting ART. The dual infection of TB and HIV presents challenges of confirming TB infection, making a choice of ART regimens and the timing when to start ART in patients on TB treatment. As a result, the World Health Organization (WHO) is advocating for an integration of TB and HIV control and management activities. The integration is expected to improve detection of TB in HIV infected individuals and HIV infection in TB patients allowing for early intervention hence better treatment outcomes. The integration will further maximize use of available resources and strengthen control measures for the two interrelated infections. Unfortunately in most IRCUC implementing health facilities this integration has not yet been attained. In FY 2008, IRCUC will make this a priority area to ensure that TB diagnosis, management and treatment is integrated in HIV/AIDS service delivery.

IRCUC targets to screen 20,000 PLHA for TB in 27 sites and provide TB treatment and prevention services to 800 PLHA. 54 health workers will be trained in TB management, 27 lab technicians will be trained in diagnosis of TB, 60 counselors in TB screening and referral.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14208

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14208	4364.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$500,000
8423	4364.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$500,000
4364	4364.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$450,000

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 11126.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)

**Prime Partner:** Joint Clinical Research Center, Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: TB/HIV

**Budget Code:** HVTB

**Program Budget Code:** 12

**Activity ID:** 16007.26790.09

**Planned Funds:** \$0

**Activity System ID:** 26790

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY 2008, this activity will focus on training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis (TB) and HIV.

In the selected 25 focus districts and over 60 sites, the program will train 300 health workers to diagnosis and manage TB/HIV co-infection. 5,000 TB/HIV co-infected patients will be identified, treated for TB and given cotrimoxazole prophylaxis. The program will implement infection control procedures at all the 60 service outlets.

The program will train and support 120 expert clients from 60 groups of People Living with HIV/AIDS to facilitate referrals and linkages between facility-based and community based TB and HIV management. The groups will facilitate referrals to wrap around services available in the communities. 900 health workers will be trained to provide TB/HIV services. It is estimated that in FY2008, the program will provide anti-retroviral therapy to 1,000 TB/HIV co-infected clients.

The program will scale-up TB/HIV integration activities including setting facility infection control procedures in facilities supported, provider-initiated counseling and testing for TB-registered clients and ensuring referral and retrieval referrals between TB and HIV clinics and services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16007

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16007	16007.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$225,000

**Total Planned Funding for Program Budget Code: \$26,053,620**

**Program Area Narrative:**

Uganda is one of the countries in sub-Saharan Africa that has been devastated by the HIV/AIDS epidemic, malaria and tuberculosis. The impact of the three major diseases has led to a huge population of orphans and other vulnerable children. According to Uganda Demographic and Health Survey (UDHS) 2006, the Uganda National Household Survey (UNHS) 2005/6, and Uganda Population and Housing Census (UPHC) 2002, more than 3 million children in Uganda live below the poverty line. Approximately 7.5 million children are either orphaned or vulnerable children, making up 46% of the total number of children. An estimated 7% (2.3 million) of the country's total population are orphans, 46% of these are orphaned by AIDS. Approximately 130,000 children aged 0-14 are HIV-positive with about 7% receiving care and treatment services. Other children have been orphaned due to conflict. Of four million children living in conflict, approximately 850,000 continue to live in Internally Displaced Persons camps (2007 UNICEF).

Most U.S. Government support in this area goes to the Ministry of Gender, Labor, and Social Development (MGLSD) to build its capacity to provide strategic direction, coordination and monitoring of Uganda's response to OVC, from the national to the household level. USG, through its CORE Initiative project, undertook a detailed assessment of MGLSD and of the Community Based Services Departments (CBSD) at district level, developed and is currently implementing an extensive capacity building interventions in seven areas of coordination between sectors and levels; planning; leadership; staffing; communications and advocacy; granting; and monitoring and evaluation. The MGLSD works directly with districts to implement its OVC program. With 82 districts nationwide, and very limited resources, the USG, through its CORE Initiative, established eight OVC technical and management support services (TSOs) to effectively roll out national OVC policies, guidelines and standards to districts and lower levels. The MGLSD developed a quality and service standards tool, national, district and household indicators, and is in process of developing a national OVC management information system, including primary and secondary data and linked via tested indicators to a national OVC framework that guides the overall response. In partnership with other donors, it has established a sustainable civil society funding and granting mechanism through which the donors (USAID, DANIDA, Irish Aid, and DFID) fund Civil Society Organizations for implementation and provision of OVC services.

Despite the progress, the response to date does not match 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. For example, according to the 2006 UDHS, an estimated nine out of ten OVC households were not receiving any type of external support, leaving the traditional social net of extended families picking up the majority of the OVC burden in the country. The 2004-5 HIV/AIDS Sero-Behavioral Survey found similar results with only 23 percent receiving any kind of external support. Persistent high levels of child abuse, school drop-outs, poor nutrition and health, psychosocial deficiencies and poor livelihoods continue to disproportionately affect specific categories of vulnerable risky groups of children and their households defined in the national OVC policy. The national OVC policy and plan developed in 2004 to address the above situation needs review. In FY08, with USG support, twenty-four implementing partners reached 205,735 OVC nationwide with various services including but not limited to education (primary, secondary and vocational skills), health (immunization, sanitation and basic care for HIV-positive children), psychosocial support, food and nutrition, protection against abuse and neglect, economic and livelihood support to caregivers, emotional and mental rehabilitation of children involved in war in northern Uganda.

In FY09, USG support will be focused on: conducting an OVC situational analysis with the view of establishing the current magnitude of the OVC problem and use the evidence obtained to revise the national OVC strategic plan to effectively inform programming for the next five years 2009-2014; facilitating linkages between facility and community based OVC service providers; replicating block grant models for education support to scale up access to education services and scholarships. USG support will also be linked to networks of people living with HIV/AIDS to increase access to care for HIV-positive children and leverage private sector resources through Corporate Social Responsibility (CSR) to support OVC programs. USG further intends to strengthen the socio-economic security of the OVC households through market access models (Micro-enterprise), strengthen grants system to CSOs for OVC service delivery and build capacity of CSOs, CBOs and FBOs to expand quality OVC service delivery and integrate HIV prevention for OVC. A national OVC management information system to monitor and measure quality improvement will be established. USG further plans to strengthen the Peace Corps volunteer network to support and serve OVC through strengthening community based organization systems.

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 11125.09

**Mechanism:** IRCU

**Prime Partner:** Inter-Religious Council of Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4686.26783.09

**Planned Funds:** \$0

**Activity System ID:** 26783

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Roman Catholics Church, The Province of Church Of Uganda, Uganda Muslim Supreme Council, Uganda Orthodox and Seventh Day Adventists Uganda Union to jointly address together development challenges. In June 2006, IRCU signed a contract with United States Agency for International Development (USAID) to Scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by the United States Government (USG) under the President's Emergency Plan for AIDS Relief (PEPFAR).

During the FY06), IRCU worked with a wide range of faith based organizations to implement OVC related activities nation wide. Using funds for FY06, IRCU has served 9,000 OVC and trained 4,500 caregivers. OVC services among others included; enrolment for formal education and vocational education, apprenticeship skills training, scholastic materials, psychosocial support, meeting health care needs of OVC. At the same time, OVC caregivers were trained in income generating activities (IGAs) to enhance their business skills and ability to manage IGAs. OVC have also had their cognitive and life skills built and have been provided with HIV/AIDS education. Currently, IRCU is using funds for FY07 to enhance child protection, in collaboration with our implementing partners, and the Police. In addition, Community awareness programs are conducted to ensure increased OVC support are being promoted through drama and information, education and communication activities at community level. In the process of carrying out these activities, IRCU and FBOs have had a year of strong collaborations with a wide base of partners, and our interventions have resulted in the increased enrolment and retention of OVC in school, and the provision of totality of care for OVC. During FY08, IRCU will continue supporting similar initiatives. Currently, IRCU is using funds for FY06 and 07 to conduct training OVC caregiver's in small scale business enterprises in order to enhance their income generating activities. This is aimed at strengthening their economic security of OVC households. Therefore, during FY08 IRCU will continue to support this activity and as such, OVC care givers will be linked to micro finance institutions, to access funds in order to expand their small business and be able to support OVC services.

During FY 2008, IRCU intends to strengthen the existing strategies and ultimately improve access to and utilization of comprehensive services for OVC and their households. New approaches will include identification and referral of OVC that are HIV positive for palliative care services and ART and, increase community capacity to respond to the needs of children affected by AIDS and their caregivers by strengthening family and community structures. IRCU will again work in collaboration with the Ministry of Gender Labor and Social Development (MGLSD) through CORE Initiative program that support the roll-out of the OVC policy and implementation plan, district-wide mapping, a gap analysis of the multi-sectoral response, development of integrated and comprehensive work plans for district local government and civil society organizations (CSOs). IRCU through its myriad of partners will work towards supporting this mechanism to ensure that comprehensive, networked services are accessible to OVC and their families.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14209

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14209	4686.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8427	4686.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4686	4686.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

**Table 3.3.13: Activities by Funding Mechansim**

**Mechanism ID:** 3370.09

**Mechanism:** AIDS Capacity Enhancement Program (ACE)

**Prime Partner:** Chemonics International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 12500.26765.09

**Planned Funds:** \$0

**Activity System ID:** 26765

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program to provide organizational development technical assistance and engage highly specialized local consultants to build the capacity of targeted Ugandan institutions for improved HIV prevention, care and treatment program outcomes. This program also aimed at strengthening administrative and managerial systems to fortify in a sustainable manner the targeted institution's ability to respond effectively to emerging opportunities resulting from the vast increases in HIV/AIDS funding. The program, named AIDS Capacity Enhancement (ACE) currently works with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC), and is initiating work with the Uganda Women's Effort to Support Orphans (UWESO). Three organizations, JCRC, HAU, and IRCU play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda. IRCU, also manages over 40 sub-grants that support orphans and vulnerable children. UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The ACE project will consolidate the achievements made to date and will support the target organizations through the entire first phase of PEPFAR. ACE has made substantial progress in building the capacity of the targeted organizations.

One of the key components of the IRCU HIV/AIDS Program is support to orphans and vulnerable children (OVC). This support is provided primarily through a small grants process to faith-based community organizations who are supporting OVCs in primary education, vocational training and apprenticeship programs, psycho-social support, health care, and other areas. In addition, they are supporting OVC caregivers in obtaining skills in income-generating activities. ACE is supporting IRCU in strengthening the sub-granting processes to these organizations, improving their financial systems, upgrading and integrating their monitoring and evaluation systems, and providing skills in management and leadership to IRCU staff. ACE has supported IRCU to raise their competence and confidence in sub-granting to their implementing partners. Specifically, IRCU was assisted to gain competence in competing, negotiating and awarding grants. This support was crucial to finalizing the 44 OVC small grants.

Building on that support, ACE also provided capacity building support to the OVC grantees by developing training materials in USAID compliance and financial management. ACE trained staff from the 44 OVC grantees in leadership and management and worked with the monitoring and evaluation officers from the grantees in developing the data collection tool. ACE is providing ongoing support in monitoring, evaluation, and reporting so that the grantees can effectively manage their programs and evaluate their progress against stated PEPFAR targets. In FY 2007, ACE will be rolling out further training for these grantees on program management and will be working in close collaboration with the IRCU finance staff to provide technical assistance in financial compliance and reporting. In FY 2007 and FY 2008, ACE will continue to work with IRCU to improve the financial, monitoring, and reporting skills of the OVC grantees. In addition, in FY 2008 ACE will work with IRCU's OVC Program Advisor to develop mechanisms for quality assurance in OVC programs and ensure that all programs are being conducted in accordance with established national standards and policies for OVC work. ACE will help IRCU connect to other OVC service providers to ensure exchange of ideas and identification of best practices. Also, in FY 2008, ACE will continue to work with IRCU in ensuring that all its program areas through the various service providers at the local level are integrated and that there is an active collaboration and referral network between the palliative care/ART providers, OVC services-providers and HIV/AIDS prevention programs. All of these skills ensure these community-based OVC organizations can successfully implement their programs, and potentially expand them in the future.

UWESO has been an important player in the national response to supporting OVC for more than 20 years. It has an extensive national network that provides services to more than 70,000 OVC in four areas: food security and nutrition, HIV prevention and care, Basic Education and Improved household incomes. UWESO is also a recipient of PEPFAR funds through a sub-grant from another PEPFAR partner. In FY 2007, ACE will be initiating a working relationship with UWESO to further build their capacity to deliver high quality services on a larger scale. This process will begin with ACE working closely with UWESO to determine their greatest areas of need among the core organizational competencies that ACE supports. While this process is not complete, some likely interventions include upgrading UWESO's financial systems, establishing an organization-wide monitoring and evaluation framework and associated data collection tools and database, strengthening the leadership of the organization through coaching and mentoring or leadership training, improving their planning and management skills, and working with them to develop a new communications strategy that can position them to take a leadership role in the national OVC response. These interventions will be initiated in FY 2007 but will continue in FY 2008 and ACE will leverage its experience in systems strengthening to ensure that in FY 2008, the interventions undertaken with UWESO are consolidated and institutionalized within the organization. ACE will support UWESO to take on the leadership role in the non-governmental community of OVC providers so that it can be an effective partner to the Ministry of Labor and Gender, the governmental body coordinating the public sector response.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15628

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15628	12500.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$200,000
12500	12500.07	U.S. Agency for International Development	Chemonics International	4850	3370.07	AIDS Capacity Enhancement Program, ACE	\$150,000

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 11121.09 **Mechanism:** The Core Initiative  
**Prime Partner:** CARE International **USG Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State) **Program Area:** Care: OVC  
**Budget Code:** HKID **Program Budget Code:** 13  
**Activity ID:** 3197.26763.09 **Planned Funds:** \$0  
**Activity System ID:** 26763  
**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In FY 2009, CARE/CORE will continue to strengthen the capacity of Ministry of Gender and social Development (MGLSD) to increasingly build the capacity of districts through the established Technical Service Organizations in management, planning and coordination; monitoring and evaluation; and advocacy and communication of OVC response. CARE/CORE support will focus on improving the quality of OVC services and HIV prevention in order to strengthen district and civil society capacity to provide integrated and comprehensive services. Also, CARE/CORE will serve as the interim Technical Management Agent of the Civil Society Fund (CSF), helping in consolidating the established granting mechanism, provide operational and administrative support to the steering committee, and ensure the technical quality of the civil society OVC and HIV prevention portfolio. Key deliverables of CARE/CORE in FY09 include a) Strengthening district capacity to plan, manage, coordinate, monitor and evaluate their OVC programs, b) Supporting all districts in Uganda to roll out the OVC M&E framework and OVC MIS, and c) all civil society organizations in districts supported to implement OVC Quality Standards.

**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 14185

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14185	3197.08	U.S. Agency for International Development	CARE International	6729	1030.08	The Core Initiative	\$8,237,000
8408	3197.07	U.S. Agency for International Development	CARE International	4827	1030.07	The Core Initiative	\$4,480,000
3197	3197.06	U.S. Agency for International Development	CARE International	2760	1030.06	The Core Initiative	\$5,531,014

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 7257.09 **Mechanism:** Health Care Improvement Project - HCI/NuLife

---

**Prime Partner:** University Research Corporation, LLC

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 23930.09

**Activity System ID:** 23930

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** \$150,000



## Activity Narrative: Activity Narrative (OVC)

The Food and Nutrition Intervention for Uganda - NuLife is being implemented by University Research Co., LLC (URC) to support to Ministry of Health (MOH), CBOs/NGOs, Networks of People Living with HIV/AIDS and USG implementing partners to integrate and expand food and nutrition into HIV/AIDS prevention, care and treatment programs, with a focus on increasing the utilization, adherence to and efficacy of anti-retroviral treatment (ART) and improving the nutritional and health status of PLHIV. The program's three primary objectives include: 1) provision of technical and financial support to the MOH, CBOs/NGOs, PLHIV Networks, USG partners to integrate food and nutrition interventions in HIV and AIDS prevention, care and treatment programs; 2) development of a high quality, low-cost, nationally acceptable RUTF made from locally available ingredients and 3) the establishment of a supply chain system for the delivery of RUTF to participating health facilities. The program will provide targeted food and nutrition support that includes food supplements for vulnerable groups including OVCs, HIV-positive pregnant and lactating mothers and those with mild-to-moderate malnutrition, therapeutic foods for moderately and severely malnourished PHAs, micronutrient supplementation and replacement feeding for infants. Focused food and nutrition interventions include: 1) Food by Prescription (FBP) including nutrition assessment, counseling, prescription of food as needed and follow-up of adults and children on ARVs; 2) Infant and Young Child Feeding (IYCF) and follow-up of women participating in PMTCT programs and their HIV-exposed infants; and 3) Integrated Management of Acute Malnutrition (IMAM/CMAM), a strategy aimed at strengthening the link between the community and facility to improve nutrition assessment, counseling, referral and follow-up. Targeted food related support is focused on therapeutic foods prescribed for moderately and severely malnourished PHAs.

NuLife has made substantial progress during FY 2008 in setting the groundwork and establishing collaboration mechanisms for fully integrating food and nutrition interventions for PLHIV. At the national level, NuLife was instrumental in establishing a Sub-Committee on Nutrition (SCN) within the MOH to guide the national nutrition agenda; developed a joint work plan with the Nutrition Unit of the MOH ACP, articulating specific areas of technical and financial support; provided technical assistance in drafting the National Nutrition and HIV and TB Strategy (2008-2010); collected and reviewed a variety of guidelines, training curricula, educational materials and other documents (both national and international) related to food and nutrition for PLHIV as part of an initial benchmarking activity; supported the updating and expansion of the National Infant and Young Child Feeding (IYCF) Guidelines and the development of related counseling tools and other job aids; and facilitated a critical review of the draft National Guidelines on the Integrated Management of Acute Malnutrition (IMAM). Through the Health Care Improvement Project (HCI), NuLife secured a position for a nutritionist on the Core Team at the national level and expanded the role of the current HCI-supported Quality Improvement (QI) collaborative teams to include a nutrition focal person at each level. Through regular HCI learning sessions, a total of 223 health workers from 120 ART facilities were sensitized in the basics of integrating food and nutrition in health facilities. Working with the IHAA and the Northern Uganda Malaria and HIV/AIDS TB (NUMAT) program, a total of 605 network support agents (NSAs) and 100 health facility-in-charges from 36 districts received an initial orientation and package of educational materials on the special food and nutrition needs of PLHIV. A Geographic Information System (GIS) was established for use in prioritizing areas of operation, program planning and visual reporting; 32 phase one priority sites across 29 districts were selected and a community mobilization strategy was developed. The specifications for the production of a local RUTF were developed and the identification and selection process for a Ugandan manufacturer was completed through the issuance of an expression of interest and subsequent request for proposals.

During FY2009, NuLife will target OVC, particularly children under the age of two, born to HIV-positive mothers that are identified through and linked to PMTCT, community outreach, or other OVC programs, nutritionally vulnerable children identified in households of PHAs, HIV-positive children identified through feeding centers in conflict affected districts, and HIV-positive pregnant and lactating women. Infants born to HIV-positive mothers are at a substantially higher risk of low birth weight, early malnutrition, and mortality in the first two years of life, than children born to mothers without HIV, and the risks are greatest for infants of mothers with more advanced disease. Providing nutritional care is essential to minimize HIV transmission in the post-natal period, whilst at the same time maximizing overall child survival. The Nutrition for PHAs program will provide critical food and nutrition interventions for HIV-exposed infants that include nutritional assessment, infant feeding, counseling and support, periodic vitamin A supplementation, provision of suitable replacement foods as appropriate and regular growth monitoring. In FY 2009, NuLife will continue to promote a close collaboration with USG partners and will work through a number of official MOH structures and mechanisms including the MOH Sub-Committee on Nutrition MOH Sub-Committee and the MOH/Quality of Care Initiative.

**USG Partner Coordination:** The program will focus collaborative efforts with USG partners implementing Adult Care and Treatment programs in the selection of health care providers to be trained. Some of the major Adult Care and Treatment partners will include JCRC, TASO, International HIV AIDS Alliance, NUMAT, CRS/AIDSRelief, where programming overlaps with the 32 NuLife Phase One Sites and 45 Phase Two Sites. Adult patients participating in programs supported by USG partners will also be able to access food and nutritional care and support counseling services.

**MOH/Quality of Care Initiative (QoCI):** NuLife is collaborating closely with the MOH/Quality of Care Initiative in the introduction of food and nutrition interventions in health facilities providing ART throughout the country. The mechanisms through which NuLife will collaborate with the national QoCI including support for the participation of selected nutritionists or nutrition focal persons in the national-level Core Team (made up of technical staff from MOH, URC/HCI staff and key USG HIV care and treatment partners), the Regional Coordinator Teams (5-6 member); and the District Quality Improvement (QI) Teams. During FY2009, NuLife will introduce food and nutrition interventions in selected HCI sites through training in priority areas during learning sessions, and will provide follow-up through monthly supervision or coaching visits to Phase One and Phase Two Sites. Under the HCI model for sustainability purposes, the district QI teams are assuming the roles of the Regional Coordinator Teams in the supervision and support to participating health facilities in relation to implementation of ART guidelines, data collection and management, and improving the quality of care and services. NuLife has worked with the HCI program to strategically start with districts where there is a presence of URC-supported facilities and orienting the districts in food and nutrition interventions for

**Activity Narrative:** PLHAs. A total of 246 staff from DHT teams will be trained to provide support supervision to health facilities supported by NuLife.

Community level: Community mobilization will be used as a strategy towards creating demand for comprehensive food and nutrition services for PLHIV, mobilizing internal resources to the response, reaching the most vulnerable within the catchment area, and addressing the underlying causes of malnutrition. Approximately 400 network support agents and peer counselors from communities within the catchment area of the 32 Phase One and 45 phase Two facilities will be trained and supported by district and health facility-based teams to integrate food and nutrition interventions for PLHIV. Using the Community Action Cycles (CACs) approach, NuLife will work with USG partners to initiate relationships with existing community based groups (volunteer networks, family support groups, and community leaders) to promote good nutrition practices. Other support activities will be identification and follow up of malnourished cases within the catchment area. For each of the ART QI teams at the 32 Phase One and possibly 45 phase Two, at least 2 people from the community groups will be seconded to the QI team whose roles will be to coordinate the community component and linking the community with the health facility. At the sub-county level, a community core group (CCGs) of 4-5 persons will be formed to provide overall coordination of activities at the sub-county level including development and implementation of community action plans for food and nutrition. Trained volunteers will primarily identify and follow up malnourished PLHIV children using the mid upper arm circumference (MUAC) and simple criteria of danger signs to determine those in need of referral. Working with ACDI/VOCA and other partners, like World Vision, WFP, LWF, linkages will be made to programs that provide supplementary feeding, food assistance and livelihood assistance programs for households of PLHIV.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Safe Motherhood

Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$90,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 3834.09

**Mechanism:** Refugee HIV/AIDS services in Kyaka II Settlement

**Prime Partner:** International Medical Corps

**USG Agency:** Department of State / Population, Refugees, and Migration

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4810.25180.09

**Planned Funds:** \$52,191

**Activity System ID:** 25180

**Activity Narrative:** The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12,115 however there are a group of refugees known as "population on Hold" who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel.

During the past year 10 individuals were identified and trained in child counseling to provide psychosocial support to OVCs in their respective zones. A total of 508 OVC caregivers were trained in crop management and agricultural production. A total of 75 families were supported with seedlings and farming equipments. 657 OVCs were supported with school uniforms.

In FY 2009 IMC will strengthen OVC programs using a family centered approach where OVC 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, refresher training will be conducted for 10 volunteers trained in child counseling during the past year and IMC provide ongoing supportive supervision to these individuals. The Counselor Trainer 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. This activity will also continue to improve the food security and ability of OVC and their caretakers to secure livelihoods through the provision of seedlings, cultivation tools and training. A number of the neediest OVC families will be selected by IMC together with the Community Services Office using an established assessment and selection criterion developed by the Community Services Office and OVC Zonal Committees. IMC will also provide scholastic materials to OVCs 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. Through community dialogue with social forums, drama groups and door-to-door visits, this campaign will also emphasize the negative affects of domestic violence, neglect and exploitation of vulnerable children and will serve to reinforce IMC's ongoing campaign against under-age sex and early marriages as part of the sexual and gender-based violence program and the abstinence/be faithful activity in this program. This activity will also link up with other HIV/AIDS related services. For example the Community Educators through the door to door visits will raise awareness on HIV, HCT, PMTCT and other services available and will make any needed referrals.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16083

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16083	4810.08	Department of State / Population, Refugees, and Migration	International Medical Corps	7337	3834.08	Refugee HIV/AIDS services in Kyaka II Settlement	\$52,191
8303	4810.07	Department of State / Population, Refugees, and Migration	International Medical Corps	4801	3834.07	Refugee HIV/AIDS services in Kyaka II Settlement	\$52,191
4810	4810.06	Department of State / Population, Refugees, and Migration	International Medical Corps	3834	3834.06	Refugee HIV/AIDS services in Kyaka II Settlement	\$22,471

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources

#### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

#### Refugees/Internally Displaced Persons

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 3166.09

**Mechanism:** Expanding the Role of Networks of People Living with HIV/AIDS in Uganda

**Prime Partner:** International HIV/AIDS Alliance

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4693.24482.09

**Planned Funds:** \$250,000

**Activity System ID:** 24482

**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008 the project provided financial and technical support to 29 PLHIV groups. The groups are consortiums of 68 smaller groups based in every health sub-district across the 40 districts of operation. Over the year, the groups have been able to implement OVC interventions in addition to HIV/AIDS education, home based care and counseling of PHAs. The estimated number of OVC across the 40 districts is 760,000 but during the year, the 29 PLHIV groups have identified 2500 OVC and provided direct inputs like scholastic materials and beddings and food based on needs assessment undertaken by the groups. Through the small grants program, the PHA groups were supported to initiate income generating projects aimed at generating income to improve and sustain livelihoods of OVC and their families.

ACTIVITY UN CHANGED FROM 2008

In FY 2009 the PLHIV project will consolidate its services in 40 districts supporting at least 100 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 CORE initiative for youth, orphans and vulnerable children) 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

At district level, the project will create linkages between Community Based Services Department and PHA groups to benefit from technical assistance provided to local Governments through the Ministry of Gender Labour and Social Development with support from CORE initiative. Linkages with the districts will also provide opportunities for the groups to tap resources as well as provide information that will enrich planning and also prevent or reduce duplication of OVC services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14202

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14202	4693.08	U.S. Agency for International Development	International HIV/AIDS Alliance	6738	3166.08	Expanding the Role of Networks of People Living with HIV/AIDS in Uganda	\$250,000
8464	4693.07	U.S. Agency for International Development	International HIV/AIDS Alliance	4851	3166.07	Expanding the role of People Living with HIV/AIDS Networks	\$250,000
4693	4693.06	U.S. Agency for International Development	International HIV/AIDS Alliance	3166	3166.06	PHA Network	\$60,000

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

#### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* Safe Motherhood

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$1,500

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$10,000

### Food and Nutrition: Commodities

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$50,000

### Education

### Water

Table 3.3.13: Activities by Funding Mechanism

**Mechanism ID:** 690.09

**Mechanism:** N/A

**Prime Partner:** US Department of Defense

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 8853.21599.09

**Planned Funds:** \$150,000

**Activity System ID:** 21599

**Activity Narrative:** 1. Activity Narrative:

As commander in chief of the armed forces, the President of Uganda mandated the UPDF's AIDS Control Program to oversee and manage prevention, care, and treatment programs throughout the forces and their families. Although the exact prevalence rates of the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated with the military, with up to 50% of patient visits being non-military. AIDS and war continue to be the topmost causes of death among UPDF personnel and their families. As a result, the Uganda Peoples Defense Forces has a large burden of orphans that are either infected by HIV or vulnerable to being infected. Most of these orphans are enrolled within the army schools. Little attention has to-date been given to this vulnerable group, and 2008 was the first year year of PEPFAR funding for the UPDF orphans and vulnerable children (OVC). A central strategy is initiating support activities for the OVC as a school based program through health education about abstinence, as well as increasing the coverage of counseling and care services in the schools, and fighting stigma against those infected, especially those on ART. In achieving this, the teachers are specifically trained and empowered to enable them incorporate the activities in their routine teaching curriculum. PHA's households are targeted to ensure that the OVC are linked to OVC services as well as care and treatment.

2. Progress to-date: For FY08, a needs assessment is being done to better define the UPDF OVC population, including those not enrolled in the army school, and document current services and HIV C & T and clinical services coverage. Given the varied needs of UPDF OVC (both from HIV and conflict-related causes) part of the needs assessment effort will be defining the scope of program support to provide for OVC and their families. Clear and easy to use guidelines for integrated delivery of OVC programming in the military will be developed and disseminated. This being a new area during FY08, the program will commence on training activities for OVC school based programs that will be expanded in FY 09.

3. Activities for FY 2009. Innovative programs that target both in and out of school UPDF OVC will be scaled up during FY 2009 to empower the vulnerable children in coping up with the challenges of being affected and infected by HIV/AIDS. Activities will include training young people in life skills, reproductive health skills, stigma reduction, and income generation for teenage OVC. Opportunities for linkage of OVC intervention with other prevention, care, treatment and impact mitigation efforts that are underway in the military communities will be sought to ensure sustainable delivery of quality programs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16070

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16070	8853.08	Department of Defense	US Department of Defense	7336	690.08		\$150,000
8853	8853.07	Department of Defense	US Department of Defense	4821	690.07		\$50,000

**Table 3.3.13: Activities by Funding Mechansim**

**Mechanism ID:** 1311.09

**Mechanism:** State Department

**Prime Partner:** US Department of State

**USG Agency:** Department of State / African Affairs

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4753.21606.09

**Planned Funds:** \$226,000

**Activity System ID:** 21606

**Activity 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. 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 grass root 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.

With FY 2007 resources, the Community Grants Program funded the construction of two Vocational Training Centers in Tororo and Lira. Both are providing education and vocational training to highly vulnerable children whom are affected by HIV and the conflict in the North. The Vocational Training Centers are of sound construction and staffed by professional, qualified teachers. Tailoring, catering, beekeeping, computer studies, brick-making and masonry are being taught. Both Vocational Training Centers are also making efforts to link graduates with jobs. There is an international market for honey, and Lira's Vocational Training Center has connected with the 'Little Honey Man' in Kampala who is currently exporting to the EU. Both these Vocational Training Centers will continue to equip OVC with the necessary skills to provide for their own socio-economic security for years to come. Currently there are 10 students enrolled in Lira's Vocational Training Center, 2 of whom are OVC under 18. In FY 2008, 20 additional OVC will commence vocational training. In Tororo's Vocational Training Center, there are currently 50 OVC enrolled. Every year they will enroll an additional 50 OVC. Additionally, the Community Grants Program has also funded the construction of a four-classroom primary school for the OVC of Buwunga and Sowe fishing village on Lake Victoria. The nearest public primary school was 10km from Buwunga and inaccessible from Sowe. Classes commenced in September and currently 226 OVC are attending classes, many for the first time. Although the school can't currently cater for all the children in the area, they hope to do two sessions a day in the future. The Project Coordinator is the former Head Teacher of Ambrosoli International School, and her dedication and commitment to education is renowned. The children are thus assured to receive an excellent education. Through linkages with Hope Clinic Lukuli, we have secured free medical for the 400+ OVC of Buwunga and Sowe Fishing Village, a sesse canoe that will transport the OVC of Sowe Island to the school in Buwunga Fishing Village, donated books to create school library, and we will find out this month as to whether or not the 400 OVC households of Buwunga and Sowe will be receiving malaria treated mosquito nets from the PMI.

In FY 2008, we are funding 10 projects. They are a Community Demonstration Farm and Piggery and Goat Rearing Project that will serve as an income-generating activity for OVC households; a Solar Powered Pump and Filter that will provide clean, safe drinking water to the OVC of Buwunga and Sowe fishing communities; Education in the form of school fees, scholastic materials, school lunches for OVC; Shelters for 3 Breakfast/After School Program for OVC; Vehicle that will be used as a mobile outreach clinic/ambulance for OVC; Community and School HIV/AIDS Sensitization Program that reaches more than 200 students every week with HIV information and prevention education messages; Babies Home and Nursery School for OVC that will provide educational and developmental activities; Arts and Crafts vocational skills for war-affected children in the North, operating as an after-school art-program/art club.

In FY 2009 the Community Grants Program will continue to provide direct support to 1500 OVC throughout Uganda by providing funding for OVC in the nine core program areas. Through primary support or leveraged support, the Community Grants program will strive to provide comprehensive care to these 1500 OVC. The Community Grants Program will also 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16406



### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16406	4753.08	Department of State / African Affairs	US Department of State	7426	1311.08	State Department	\$185,000
8393	4753.07	Department of State / African Affairs	US Department of State	4822	1311.07	State Department	\$166,000
4753	4753.06	Department of State / African Affairs	US Department of State	3455	1311.06	State Department	\$215,734

### Emphasis Areas

Health-related Wraparound Programs

\* Child Survival Activities

\* Malaria (PMI)

Refugees/Internally Displaced Persons

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$10,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$10,000

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$50,000

### Education

Estimated amount of funding that is planned for Education \$80,000

### Water

Table 3.3.13: Activities by Funding Mechanism

**Mechanism ID:** 1123.09

**Mechanism:** Sustainable Income and Housing for OVC in Africa (OI OVC Track 1)

**Prime Partner:** Opportunity International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** Central GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4438.21738.09

**Planned Funds:** \$292,471

**Activity System ID:** 21738

**Activity Narrative:** The Income and Housing OVC project is implemented by Opportunity International as prime partner, UGAFODE Ltd and HFHU as sub partners, it started in 2004 to address the needs of the Orphan and Vulnerable Children (OVC). The project address four strategic objectives: provision of micro finance to caregivers, provision of safe housing to OVC, capacity building for the caregivers through HIV/AIDS training and economic strengthening for old OVC through apprenticeship training. Uganda Agency for Development (UGAFODE) is a Christian Non Government Organization founded in 1995 by a group of eight indigenous Ugandans as a company limited by guarantee. UGAFODE has seven branches operating in more than 16 districts of Uganda, the OVC project in implemented in five branches of the seven branches, namely Lyantonde, Bushenyi, Ntungamo, Mbarara and Rukungiri, active number of clients as of 6,420 as of June 30th 2008. Habitat for Humanity Uganda (HFHU) was founded in 1982 in Gulu, but was forced to close because of the war in the North. It later re-opened in Kasese district, and is now actively building houses in the districts for Luweero, Mukono, Nakasongola, Iganga, Jinja, Mayuge, Mbale, Pallisa and Ibanda, Busia, Manafa, Soroti and Kumi. Both UGAFODE and HFHU intend to maintain and consolidate the existing sites for FY2009.

#### Activities and Achievements 2004- 2008 March 2008

Since 2004, UGAFODE has provided 15,732 OVC caregivers with loans to serve 21,892 OVC (girls 12,972, 8,920 boys). The activity has contributed to the well being of the children through improved household incomes. Caregivers are now in a fairly good position to provide enough food for the children, pay school fees and scholastic materials and to provide medical care to the OVC. During the period, HFHU contrasted 142 houses serving 1,243 OVC with shelter creating a good housing environment. The activity has improved the housing conditions for the OVC and their families, they are now live in permanent houses with a clean environment, reducing chances of falling sick and morality rates among the under fives. UGAFODE and HFHU have trained 21,999 caregivers in HIV/AIDS prevention, succession planning, and business management skills. The trainings have empowered caregivers with skills to manage their businesses effectively hence increase profits, and to manage the impact of HIV/AIDS in their homes and communities. UGAFODE recruited and trained 188 OVC in livelihood skills such as tailoring, hairdressing, carpentry and building, creating jobs for the unemployed OVC. UGAFODE has trained 105 OVC caregivers as HIV/AIDS peer educators to compliment the HIV/AIDS education done by loan officers during group meetings.

#### Achievements

The activities have led to: improved household incomes and capacity for caregivers to provide for the OVC, sexual behavioral changes through HIV/AIDS educations for both caregivers and members of the community, reduced HIV/AIDS related stigma and discrimination among clients/ caregivers, about 50 jobs have been created for older OVC.

#### FY 2009 activities (Activities not changed from FY 2008).

UGAFODE and HFHU will carry out the following activities in the districts of: Bushenyi, Mbarara, Ntungamo, Rukungiri, Lyantonde and Mbarara, Mbale, Nakasongola, Luweero, Pallisa, Jinja, Bududa, Kumi, Soroti, Busia, Mayuge, Manafa and Iganga. The activities are aimed at improving the lives of OVC from 0- 17years. The activities will include:

1. Provision of loans and insurance to 3,644 new caregivers to serve 7,288 OVC through group lending methodology to empower caregivers economically to provide for the OVC. Loan officers together with the branch managers will do the mobilization through community leaders, church leaders and the existing clients. UGAFODE and HFHU will continue to strengthen the capacity of 5,220 caregivers and communities to care, protect and promote the health of the OVC through providing HIV/AIDS training in HIV prevention, testing and counseling, home based care, succession planning, food and nutrition, child protection and psychosocial support. Caregivers will also receive business management skills to improve on their work in this area. Loan officers, field support staff and specialists will provide these services. In order to make the HIV/AIDS training sustainable UGAFODE will train 150 as HIV/AIDS peer educators, refresher training will be provided to the 105 existing peer educators, the peer educators will be empowered with bicycles to ease their movements in the communities. The HIV/AIDS training will not only be limited to caregivers but will extend to cover the entire community.
2. In order to build the capacity of older OVC to provide for themselves and their families; UGAFODE and HFHU will recruit and train 270 OVC school drop outs in Youth Apprenticeship skills. They will also be trained in business management skills, life skills like dance and drama and memory book writing. 360 OVC will be trained as peer educators by Habitat. Group members and community leaders will identify the most vulnerable older OVC to be recruited; the recruited youth will be attached to local vocational training centers for a period of six (6) months to one (1) year. After training the graduates will be given start-up tools by UGAFODE and HFHU. Retreats and workshops will be organized for the older OVC where they will share experiences, be mentored and equipped with business improvement skills and life skills.
3. UGAFODE and HFHU will continue to strengthen the established partnerships with HIV/AIDS service providers like TASO and create new ones to ensure that the OVC and their families receive comprehensive care services. Both UGAFODE and HFHU do not provide services like HIV/AIDS treatment, HIV/AIDS Testing and counseling, PMTCT etc. To ensure that OVC and their caregivers access those services, informal or formal agreements will be entered with the providers to provide services on behalf of UGAFODE /HFHU; referral forms will be given to the beneficiaries.
4. HFHU will continue to provide safe and healthy housing to OVC by constructing 170 houses and renovating 27 houses for the OVC living in poor housing conditions. Communities will be mobilized to provide local materials while HFHU will buy the other construction materials.
5. UGAFODE and HFHU will continue to conduct HIV/AIDS awareness and education campaigns and family planning and food and nutrition campaigns to staff. These activities will be provided by HIV/AIDS service providers through the established relationships with TASO and AIDS Information Center (AIC). UGAFODE and HFHU will address gender issues by encouraging more women (60%) to participate in the program.

**Activity Narrative:**  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 14229

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14229	4438.08	U.S. Agency for International Development	Opportunity International	6745	1123.08	Sustainable Income and Housing for OVC in Africa (OI OVC Track 1)	\$251,345
8447	4438.07	U.S. Agency for International Development	Opportunity International	4844	1123.07	OVC Track 1/Round 1	\$436,145
4438	4438.06	U.S. Agency for International Development	Opportunity International	3349	1123.06	OVC Track 1/Round 1	\$371,117

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Safe Motherhood

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$101,900

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$111,300

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 4895.09

**Mechanism:** Breaking Barriers: Ensuring the Future of OVC through Education, Psychosocial Support and Community-Based Care (PI OVC Track 1)

---

**Prime Partner:** PLAN International

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** Central GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 8655.21739.09

**Planned Funds:** \$1,540,000

**Activity System ID:** 21739

**Activity Narrative:** The Breaking Barriers (BB)-Uganda Program is a partnership between Plan - Uganda, Save the Children in Uganda (Save the Children) and the Inter-religious Council of Uganda (IRCU). This is a four year project that started in FY 2006 and will end in FY 2009. This activity/program is a continuation from FY 2008 without significant modification on strategy and programming. The program activities are implemented in Luweero District, where all three partners are well-established and Tororo District (where Plan and IRCU already collaborate). In addition, Save the Children works in Nakasongola, Nakaseke and Wakiso Districts, while Plan Uganda and IRCU work in Tororo and Kamuli districts. The BB Uganda project also utilizes existing educational infrastructures and a broad network of faith communities to create a shared, supportive focus on OVC by coordinating the efforts of teachers, caregivers, faith communities and OVC themselves. In this regard, the BB project focuses on building capacity of the formal primary education system, expanding access to non-formal education (SC/US and Plan Uganda), and in building the capacity of religious leaders to provide home-based care (HBC), psychosocial support (PSS) and stigma reduction activities (IRCU). FY 2009 targets will include 1911 caregivers and 34599 OVC. The major objective of the program is:

The Breaking Barriers project advocates for the rights of children made vulnerable by HIV/AIDS and strengthens the capacity of local organizations responding to their needs. Through the BB program, equitable, effective and high-quality OVC programs in education, PSS and HBC for children and families affected by HIV/AIDS, will be expanded using school networks and religious institutions as a coordinated platform for rapid scale up, expansion and sustainability.

Project progress, Activities and Achievements: The Project has reached 82,098 OVC with PSS, education, and HBC. The project has trained 4537 caregivers including teachers and school management officials, religious leaders as well community based caregivers/volunteers to provide psychosocial support and fight stigma. One school latrine for girls has been constructed in Tororo reaching 63 female OVC and approximately 320 girls in the school. 22526 OVC have benefited from psychosocial support, education support project activities. Such activities include health club and group activities, HIV/AIDS awareness sessions, counseling, home visits and outreaches, school enrollment and provision of scholastic and reading materials in formal and non formal schools. Over 1200 OVC participated in the national advocacy campaigns to commemorate the Day of African Children. 22931 OVC have benefited from BDR activities in Kamuli, Tororo and Luweero districts. All these OVC have been registered and received short birth certificates. 1649 caregivers including Reproductive Health Educators, teachers, ECD facilitators, School management committee members and religious leader have been trained in provision of psychosocial support, stigma reduction use of national thematic curriculum and learning frameworks by UNICEF. 961 OVC were supported to transition to other neighboring schools with 778 (402M, 384F) from CHANCE to grade 4 and 175 (90M, 85F) to grade one from the ECD section. 512 (250M, 262F) caregivers from targeted OVC households have benefited from Family health days organized quarterly for select sites that do not have basic health services available including VCT, immunization. Caregivers support groups have mobilized community members for VCT. 591(98M, 493F) members were tested and 33 members tested positive were referred to the groups for support. 150 religious leaders have been supported with bicycles in support of their outreach activities. This has improved home based care services in the communities.

In FY 2009, Plan and its partners are targeting 34,599 OVC with psychosocial support, education and home based care support. The program will train 1,911 caregivers to support OVC and their families. The following project activities will be implemented in Kamuli, Tororo, Kampala, Luweero, Nakaseke, Nakasongola and Wakiso districts.

1. Education, Life Skills and HIV Prevention - In an effort to improve school sanitation and learning environment, Plan Uganda will construct six stance school latrines for girls. The latrines with a changing/cleaning chamber for girls who have reached menstruation age and will help to improve school attendance for girls in that age group. Each of these schools will also receive a water tank for water harvesting to improve school children's access to clean water. School health club activities identified by school children will be supported to give school children an opportunity to participate in improving their own health. In this FY 2009, Save the Children will support the renovation of CHANCE schools and ECD centre structures. Each school will also be supported to establish water harvesting systems. Working with the communities and local government, Save the Children will provide technical support and cement for this activity. Plan Uganda and save the Children will provide basic scholastic materials and reading texts to children in formal schools and non formal schools. This will lead to improved school enrollment, class attendance and retention rates for OVC. In an effort to strengthen partnership, improve quality of OVC program and implement the triangulation model, Plan Uganda, with support from Save the Children will establish ECD centers in Luweero district. Community caregivers and religious leaders trained by the project will spearhead community mobilization activities to support ECD activities.

2. Psychosocial Support - The provision of psychosocial support in schools and communities is supported through the training of teachers including Reproductive Health Educators, community based caregivers and committees, Community Care coalitions, peer support groups, community and religious leaders. In this FY, Breaking Barriers will carry out refresher trainings for these caregivers in psychosocial support, HIV/AIDS prevention and care, home based care, child counseling and protection. The training will be delivered using the national approved training guidelines and manuals on HBC and OVC. The caregivers will then provide psychosocial support, carry out home based care and outreach activities in their communities. The home based caregivers will receive kits and supplies to support their work. The teachers will carry out cascade trainings for teachers in their schools to increase the number of caregivers within the school environment. Breaking Barriers will provide funding for the training and facilitate caregivers to carry out project activities including health club activities, outreaches and home based caregivers. The School Management committees will also be trained in problem solving and psychosocial support. A combination of religious leaders, local leaders, and community based caregivers as well as schools teachers will create a web of support for OVC and their families within the community, linking OVC families to different services and service providers within and around their communities.

3. Building Capacity of Individuals - Community resource persons will be trained in improved methods and

**Activity Narrative:** provision of education, psychosocial support and community based care. Other than the religious leaders, teacher support groups and home based caregivers, the program will train district officers and district OVC committees in psychosocial support, communication and counseling. The district project support teams made up of district technical officers from the education, community development, health and planning departments will be facilitated to support and supervise community care coalitions, schools teachers and community based givers activities. Besides, the officials will be supported to participate in national and district level OVC task forces to represent the interests of OVC and their education. The program will also mobilize home based caregivers to access livelihood support through Village Savings and Loans Associations.

4. Reducing HIV Related Stigma and discrimination - Religious leaders will be trained in stigma reduction and advocacy skills to campaign in collaboration with PLWA, community leaders and children with positive messages to raise HIV/AIDS awareness. To achieve this, the program will conduct refresher trainings for religious leaders, community social workers and community care coalitions to create awareness and support community advocacy for OVC and their families. Basing on the findings of the education policy review, the program will develop advocacy messages to inform the advocacy campaigns. The program partners will jointly support national advocacy campaigns that encourage children's participation in activities aimed at improving their lives. Breaking Barriers will also support districts to disseminate the NOP and NSPPI in areas where the program is implemented.

6. Advocacy for Services and Resources - School children, teachers and community members will participate in school and community advocacy activities including awareness matches, exhibition and MDD festivals to raise awareness on the plight of OVC in their respective communities. The participants will use this platform to lobby for OVC support from community members and their local leaders. School children will also have exchange visits to share experiences and learn from one another.

7. Program Management, Monitoring and Supervision - Program meetings for partners, local and religious leaders, teachers and community based caregivers have been planned for planning, progress review and decision making. Besides, the program support team will organize quarterly joint field visits to promote shared learning. Such field visits will give the partners an opportunity to carry out internal Data Quality Assessment. The religious leaders will be trained in basic M&E to ensure the generation of quality data. The partners will also organize quarterly data validation exercise to verify data sources and consistence.

8. Wrap Around - Through activity integration, OVC and their families will benefit from other health programs that support child survival like malaria control, medical treatment, immunization and deworming. The OVC and their families will also have access to Community Based Reproductive Health Services program that provide family planning, antenatal and postnatal care to mothers in Luweero, Kamuli, Kampala and Tororo Districts. Partners will continue in their quest to include women and men in the implementation of the program. IRCU for example will ensure that more women lay religious leaders are trained to ensure that female OVC caregivers have the option of seeking support from female home based caregivers.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14237

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14237	8655.08	U.S. Agency for International Development	PLAN International	6747	4895.08	Breaking Barriers: Ensuring the Future of OVC through Education, Psychosocial Support and Community-Based Care (PI OVC Track 1)	\$1,226,720
8655	8655.07	U.S. Agency for International Development	PLAN International	4895	4895.07	Breaking Barriers/ Track 1	\$769,301

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

Estimated amount of funding that is planned for Education \$16,000

## Water

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1112.09	<b>Mechanism:</b> Community care programs for OVC (SA OVC Track 1)
<b>Prime Partner:</b> Salvation Army	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 4440.21740.09	<b>Planned Funds:</b> \$585,437
<b>Activity System ID:</b> 21740	

**Activity Narrative:** The Salvation Army (TSA) is an international faith-based organization operating in 113 countries. TSA's mission is to preach the gospel of Christ and to meet human needs without discrimination. The Mission of The Salvation Army World Service Office (SAWSO) is to support and strengthen TSA's efforts to work hand-in-hand with communities to improve the health, economic, and spiritual conditions of the poor throughout the world. TSA is an international faith-based organization operating in 113 countries.

The Salvation Army Community Care Program for OVC - SAWSO in partnership with TSA/Uganda and Pact are implementing a five year program for Orphans and Vulnerable Children (OVC) called "TSA Community Care Program For OVC" funded by PEPFAR. The purpose of the project is to strengthen and expand TSA's existing OVC response in Uganda, developing a sustainable community-based response to OVC that will endure long after donor funding ends. The project components include community capacity enhancement through community conversations (CCE-CC), the provision of psychosocial support to OVC through Kids' and Youth Clubs and home visits; the provision of care and material support for OVC; and economic strengthening of OVC households through literacy-led, savings-based village banking through the WORTH program. TSA's approach emphasizes self-help and capacity building at the community, household and individual levels.

FY 2008 Activities - By the end of June 2008, TSA had carried out 2,129 community conversations and strengthened 99 community action teams, charged with the responsibility of mobilizing care and support for the neediest orphans and vulnerable children and coordinating OVC activities. Since the program began in 2005, 22,226 OVC have been provided with services, including psychosocial support through Kids and Youth (KAY) Clubs, educational support, food and nutrition support, and care and support. The program has trained 47 Psychosocial Support Trainers, 113 Psychosocial Support Motivators, 63 KAY club leaders in Music Dance and Drama, and another 56 in First Aid. The staff members also received refresher training in CCE-CC.

FY 2009 program activities:

1. Community Capacity Enhancement through Community Conversations (CCE-CC) - Through this process, communities will continue to develop their own strategies to modify and reduce recognized risk behaviors to HIV/AIDS while they identify ways to provide care and support to orphans, other vulnerable children and their families. Communities will continue to identify the most vulnerable children using their own criteria and mobilize care and support for the neediest orphan children and families with assistance from the project through support of community initiatives. The project will also continue to raise awareness of children's rights and advocate on their behalf. CCE-CC is based on the vision and recognition that communities have the capacity to prevent HIV/AIDS, care, change, and sustain hope in the midst of the HIV/AIDS epidemic. The methodology is based on facilitation, inclusion, partnerships and respect for the community's insights, perspectives and their interest and desire for change. CCE-CC involves all community members including PLWHA, thereby breaking down barriers such as stigma. For CCE-CC activities, the service outlet is The Salvation Army church. In FY 2009, the program will continue to strengthen the existing communities through community conversations. It is estimated that the project will reach 25,000 OVC (20,000 are continuing) 13,000 male and 12,000 female. Five thousand OVC will receive Primary Direct and 20,000 will receive Supplementary Direct support.

2. Psychosocial Support - Children will continue to receive community-based psychosocial support through Kids and Youth (KAY) Clubs. The KAY Club provides a safe environment for children and youth to relax through play activities, receive PSS from caring adults, learn about children's rights, HIV/AIDS and life skills, and also learn how to identify and mobilize their own resources to enhance their ability to cope. Through the KAY Clubs, trained volunteers and counselors can identify children who need extra care, support, and advocacy. Trained volunteers facilitate the clubs and provide home visits to children. All children are welcome to participate, and this inclusive environment of fun helps to reduce the stigma of orphan-hood. All the 25,000 children are expected to either go through the KAY clubs and/or receive a home visit.

3. Training - Training TSA pastors is an important strategy for program sustainability. Therefore 131 TSA officers will be trained in the provision of PSS to children and Child Protection. Sixty-eight female TSA pastors (Officers) will be trained in the WORTH model in order to assist women's groups in economic empowerment. These trainings will enable the officers to support the project activities more effectively, and also sustain the same activities after the project closes. Fourteen new empowerment workers will be trained to give support to the second cohort of 5,000 women for the WORTH program. Eighty PSS and Community Counselors will receive refresher training. The Salvation Army (TSA) is an international faith-based organization operating in 113 countries. TSA's mission is to preach the gospel of Christ and to meet human needs without discrimination. The Mission of The Salvation Army World Service Office (SAWSO) is to support and strengthen The Salvation Army's efforts to work hand-in-hand with communities to improve the health, economic, and spiritual conditions of the poor throughout the world.

4. Economic security - WORTH is a unique income-generation training program that strengthens the ability of female-headed households to care for the growing number of orphans and other vulnerable children. Through the WORTH program women increase their family income through savings and loans to start and grow micro enterprises. Through this self-help program women also engage in self-instructional literacy, learn how to set up and manage transparent village banks, and learn good business practices. Very often the WORTH groups develop into community service outlets to provide care and support to the most needy in the communities, including orphans and other vulnerable children. WORTH staff and empowerment workers provide support to the women's groups through mobile workshops and ongoing technical support. These are conducted every other month to help management committees understand their roles and to ensure that the groups are functioning well. The first cohort of 3,336 women will continue with village banking with limited support from empowerment workers and WORTH staff. The new cohort of 4,500 female care-givers have been identified to receive income generation training through the WORTH program in FY 2009. It is also estimated that WORTH women will provide indirect support to 6,000 children.

5. Monitoring and Evaluation - Performance monitoring will continue in FY 2009, using the monitoring and evaluation plan which was developed in FY 06. The Plan will be updated from time to time. Data quality



**Activity Narrative:** assessment and Community Action Team Assessments will be carried out to prepare them for phase-out.

6. Linkages/collaboration/coordination with other programs/partners - At the National level TSA collaborates with the Ministry of Gender Labour and Social Welfare and other partners to develop guidelines to be used by organizations implementing OVC programs. At the district level TSA collaborates with the District Development Officer, the District Probation Officer and District Health Team to handle child welfare issues. TSA also works with CBOs and NGOs in the program areas to share experiences and lessons learned and for referral purposes.

Geographical coverage - The program covers 99 communities in 17 Districts in Uganda.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14240

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14240	4440.08	U.S. Agency for International Development	Salvation Army	6750	1112.08	Community care programs for OVC (SA OVC Track 1)	\$880,000
8449	4440.07	U.S. Agency for International Development	Salvation Army	4846	1112.07	OVC Track 1/Round 2	\$302,076
4440	4440.06	U.S. Agency for International Development	Salvation Army	3351	1112.06	OVC Track 1/Round 2	\$329,102

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$403,328

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$10,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechansim**

**Mechanism ID:** 1222.09

**Prime Partner:** US Peace Corps

**Mechanism:** Peace Corps

**USG Agency:** Peace Corps

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 3992.21612.09

**Planned Funds:** \$1,092,600

**Activity System ID:** 21612

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

The Peace Corps Uganda Emergency Plan program supports the USG Strategy of the Emergency Plan (the EP) for Uganda. By supporting the EP Strategy Peace Corps Uganda contributes to the Uganda National Strategic Plan (NSP) for HIV/AIDS, and, in turn, to the goals and objectives of our partner organizations which are hosting Volunteers. The program is designed so that Volunteers are closely engaged with a community through one or more hosting organizations, providing technical assistance for capacity building, and developing close personal relationships necessary for effective innovation in underserved areas. The EP allows Peace Corps Uganda to strengthen community and Volunteer HIV/AIDS expertise and service delivery, and to support highly focused community organizations in a variety of HIV/AIDS functions.

**Progress to date**

From FY 2006 to date, 55 PEPFAR funded two-year Volunteers have been added to Peace Corps Uganda's portfolio. Through these Volunteer's ongoing training and small project support activities, Peace Corps has been able to strengthen its community and Volunteer HIV/AIDS expertise and support HIV/AIDS-focused community organizations to enhance their organizational capacity and implement a variety of HIV/AIDS prevention and care interventions. From FY 2007 to date, Peace Corps Uganda has reached a total number of 6195 individuals of whom 2468 are males and 3727 females and trained 8320 service providers. In all assignments, Volunteers are prepared through pre-service training to encourage their partner organizations to either; 1) incorporate a full range of prevention, care including OVC care, and treatment services, or 2) to actively seek out and use local referral opportunities to ensure all individuals and families receive necessary services.

In FY 2009, Peace Corps Uganda is planning to scale up the OVC program by recruiting and deploying more community health and economic development Volunteers to work with both PEPFAR and non PEPFAR supported OVC partners/Civil Society Organizations focusing on care and support for Orphans and other Vulnerable Children. With FY 2009 funding, 40 PEPFAR funded two-year Volunteers will be added on to our country program of which 12 will be placed with partners focusing on OVC care and support. An additional 4 short term (6-12 months) Volunteers (Peace Corps Response Volunteers) with specific skills and expertise in areas such as organizational development, strategic planning and management, post conflict reconstruction and education systems support will be recruited and 6 of these Volunteers will be placed organizations targeting vulnerable groups. Peace Corps programming will aim at increasing OVC access to and utilization of comprehensive quality services through facilitating linkages between facility and community based service providers. In FY 2009 and 2010, Peace Corps Uganda intends to reach 8000 and 8500 OVCs respectively under primary direct and supplemental support and train 2500 caregivers. Peace Corps Volunteers working with host organization staff will continue to provide technical skills, organizational and systems strengthening support to host organizations, knowledge and information in areas of improved (less labor intensive) household food production through permaculture, economic support to OVCs, caregivers and families, psychosocial support. The program will ensure that the targeted beneficiaries access comprehensive services through networks and referrals to other service providers of essential services as defined in the NOP.

Peace Corps Orphans and other Vulnerable Children programming will focus on improving the lives of Orphans and other Vulnerable Children and families affected by HIV/AIDS. Volunteers working in this program area are assigned to a CBO, FBO or NGO that implement Orphans and other Vulnerable Children support activities. Volunteers provide capacity building services, technical support to implement community initiated activities with VAST funding, and linkages to wraparound services. Existing OVC services will be strengthened and expanded to assist Orphans and other Vulnerable Children to obtain secure livelihoods. Orphans and other Vulnerable Children and their families will also be supported to access basic care requirements through supplemental direct provision of consistent basic care services by organizations directly supported by Volunteers or through having these organizations link clients to other service providers for complete basic care. Volunteers will support the provision of comprehensive care for Orphans and other Vulnerable Children to include psychosocial support, access to education, economic support through income generation etc. Sports and entertainment outreach programs will also be supported to enhance HIV/AIDS prevention and life skills development. Youth will gain leadership skills by serving as peer educators, teamwork skills through engaging in sports, and responsibility as they engage in economic projects. Economic livelihood activities may include livestock improvements, piggeries, and food security initiatives

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15234

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15234	3992.08	Peace Corps	US Peace Corps	7091	1222.08	Peace Corps	\$592,600
8396	3992.07	Peace Corps	US Peace Corps	4823	1222.07	Peace Corps	\$542,000
3992	3992.06	Peace Corps	US Peace Corps	3162	1222.06	Peace Corps	\$182,900

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

#### Refugees/Internally Displaced Persons

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$30,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$20,000

### Education

### Water

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1116.09	<b>Mechanism:</b> Community-Based Orphan Care, Protection and Empowerment (COPE) (Africare OVC Track 1)
<b>Prime Partner:</b> Africare	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 4437.21765.09	<b>Planned Funds:</b> \$464,874
<b>Activity System ID:</b> 21765	

**Activity Narrative:** Uganda is one of the four countries implementing the PEPFAR funded Community based Orphan care, Protection and Empowerment (COPE) project. The other COPE countries include Rwanda, Mozambique and Tanzania. In Uganda, Africare is implementing the COPE project in Ntungamo District and South Western Uganda. Ntungamo District is composed of three counties (Kajara, Rushenyi and Ruhaama), and is further divided into 15 sub-counties, 96 parishes and 1001 villages. To date, the project has scaled up its activities to all 15 sub-counties: Itojo, Nyakyera, Bwongyera, Ihunga, Rukoni, Ngoma, Nyabihoko, Kibatsi, Rweikiniro, Ntungamo Sub-county, Rubaare, Rugaraama, Ruhaama and Kayonza and Ntungamo town Council. With additional FY 2007 funding from USAID/Uganda, COPE will expand its services to Isingiro District and support OVC in two sub-counties. Since inception to date, COPE Uganda has served 20,123 OVC.

In FY 2008, the project had registered commendable results and as of March 2008, a total of 10,534 (5775F, 4759M) OVC and 4077 (2760F, 1317 M) caregivers and service providers received services through 93 outlets. Activities supported by USG funds included providing life skills training, peer education and psychosocial support (PSS) for OVC and caregivers. As of March 2008, scholastic materials were provided for 3,163 OVC (1779F, 1384M,) and 700 OVC (333F, 367M) were enrolled in secondary school. Capacity building programs were held for service providers, 80 primary school teachers were trained in life skills, 1024 orphan care committee (OCC) members in home based care and 40 staff from seven CBO/FBOs were trained in M&E and home based care. 1,439 caregivers were trained in savings, governance, financial management and business development in preparation for undertaking the fruit drying income generating activity (IGA). Among the activities implemented, school block grants and income generating activities are successful program models that will be scaled up during FY 2009. The project intends to maintain the same number of service outlets and will provide at least three core services to about 20,000 OVC in the same outlets. With COPE Plus-up funds, the project will reach 5000 new OVC working through sub grantees. The additional service outlets in FY 2009 will be of sub grantees. Most of the activities to be implemented in FY 2009 are continuing from FY 2008. The project will target 20,000 OVC and 5,000 caregivers. The project will emphasize comprehensiveness of services by providing at least three core services. With additional FY 2007 funds from USAID/Uganda, the project will serve 5000 new OVC.

In FY 2009, the project intends to accomplish the following activities per strategic objective:

1) Enhanced district/community capacity to coordinate care and support services for OVC and caregivers. Refresher trainings on home based care will be given to 40 staff members from CBO/FBOs and 45 service corps volunteers. The organizations and SCV will in turn provide refresher training to 1,024 OCC members who will then train caregivers. Advocacy and lobbying for OVC support will be done through four radio talk shows. Semi-annual partners' coordination and review meetings will be held to share best practices and lessons. With a plus up grant from USAID/Uganda, COPE will scale up the methodology to Isingiro District and will sub-grant four CBOs- two in Ntungamo and two in Isingiro. These CBOs will reach 5000 new OVC with comprehensive services within a period of two years. Orientation will be conducted for Isingiro District OVC coordination committee on the COPE methodology. Training will be conducted for 20 staff from the four CBOs in Isingiro and Ntungamo Districts on OVC identification, monitoring and supervision, financial management, and on the general COPE methodology. Identification and training of community structures that will include Service Corp volunteers and Community Care Committees in OVC identification, monitoring, and supervision of OVC services will also be done. An organizational capacity assessment will be conducted for CBOs that will receive grants. COPE will work with the identified CBOs in Isingiro to carry out rapid assessment of OVC Households. Four grants will be disbursed to four CBOs, COPE will conduct a mid term survey assessment of COPE project's impact on OVC. The project will hold quarterly review meetings with sub- grantees. Hold semi-annual review, planning and coordination meetings with OVC implementing partners. Attend regularly scheduled DCF meetings for OVC coordination. Monthly monitoring and supervision visits to CSO sites will be conducted by COPE staff. COPE project will work closely with the TSO in south western Uganda to strengthen coordination mechanisms of CSOs that support OVC in Ntungamo and Isingiro districts.

2) Increased access to life skills training, peer education and psychosocial care and support to OVC and their families. The project will continue to train 5,000 in-school and out-of-school OVC in life skills and PSS. 80 teachers will receive refresher training in PSS and life skills. Caregivers, too, will be trained in PSS. 458 peer educators will be trained in a new module of peers understanding sexuality. Train 9,000 peers in HIV prevention and HIV risk factors using IMBR model. Training of OVC caregivers in PSS (200 caregivers/15 sub-counties). Hold HIV prevention awareness raising sessions in school. Hold HIV/AIDS awareness raising sessions in communities through video shows. Hold 30 exchange visits of community and school COPE clubs reaching 2000 OVC. Link OVC in schools with existing youth services of child development centers for PSS and recreational activities. Link OVC in schools with existing youth services of child development centers for PSS and recreational activities. These are new activities: 34 COPE clubs will be formed in new schools supported by sub-grantees, 5000 new OVC in Life skills, PE and PSS using IMBR model.

3) Increased access to educational support services for OVC. COPE will continue to provide scholastic materials and uniforms to 10,000 OVC from 64 primary schools. 11 secondary schools with 700 students will receive school fees under the resources exchange program. Distribute uniforms to 1000 OVC in the same schools. Monitoring OVC school attendance in those schools being supported by block grants and primary schools will continue to be done.

4) Increased access to healthcare and nutritional support (including nutrition education and food for OVC and caregivers). COPE will continue to provide improved vegetables for nutrition improvement to 500 vulnerable households to help them establish backyard gardens, support school-based food programs through the provision of seeds to support the activities of 10 COPE clubs in the schools, train 1,000 caregivers in nutrition, establishing nursery beds, less intensive farming technologies, support growing of fruit trees to supplement nutrition and to ensure the sustainability of the project. 500 caregivers will be trained in domestic hygiene and sanitation to control the occurrence of sanitation related diseases, provide hygienic materials to 10,000 OVC in schools and COPE club members, provide 3,000 long lasting insecticide treated nets (LLITN) to control malaria among OVC. COPE will continue to link 1,000 caregivers and 1,000 OVC to VCT services. Facilitate and coordinate the birth registration exercise for OVC in Isingiro

**Activity Narrative:** and Ntungamo Districts.

5) Increased access to income generating opportunities for OVC and Caregivers. The project will continue to support viable IGA for 1,300 new caregivers by working with four sub-grantees, IGA activities for 60 child headed households, place 50 OVC in artisan training programs, procure start up kits for 60 artisan graduates, Caregivers and OCC will form 10 savings and loan associations to improve the saving culture and facilitate sustainability of their projects. Training of 4 sub-grantees in the COPE IGA methodology will be conducted.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14181

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14181	4437.08	U.S. Agency for International Development	Africare	6727	1116.08	Community-Based Orphan Care, Protection and Empowerment (COPE) (Africare OVC Track 1)	\$584,044
8402	4437.07	U.S. Agency for International Development	Africare	4824	1116.07	OVC Track 1/Round 2	\$730,033
4437	4437.06	U.S. Agency for International Development	Africare	3348	1116.06	OVC Track 1/Round 2	\$243,228

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$298,577

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$25,000

## Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$31,764

## Education

## Water

Estimated amount of funding that is planned for Water \$73,181

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1118.09	<b>Mechanism:</b> Increased access and care for OVC in great lakes region (AVSI OVC Track 1)
<b>Prime Partner:</b> Associazione Volontari per il Servizio Internazionale	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 4008.21766.09	<b>Planned Funds:</b> \$1,440,000
<b>Activity System ID:</b> 21766	

**Activity Narrative:** This activity is a continuation from FY 2008 and has not been updated.

AVSI's strategic approach is as follows: a) to focus on the child as a unique and unrepeatable human being, endowed with dignity and potential; b) to follow a bottom-up approach in identification of beneficiaries and choice of delivery of the support; c) to ensure that every child supported is cared for by an adult; either in the family or by someone in the community or of a CBO; and d) to rely on and to enhance the operational capacity of the CBOs through close and continuous working relations between AVSI personnel and her partners through an operational and stable network. The objectives of AVSI's OVC Program are as follows: To strengthen the coping capabilities of OVC and their families (natural or foster) and communities affected by HIV/AIDS; To support education and skills training for OVC; To improve health status and care for OVC; To address the psychosocial needs of OVC; To support community-based relief for OVC; To enhance the capacity of AVSI's current and prospective local partners; To integrate and harmonize the OVC focused intervention with other HIV/AIDS and poverty reduction initiatives on the ground. AVSI provides support to OVC in the following core program areas: education, health care, psychosocial support, food/nutrition, shelter/care and economic strengthening.

AVSI considers education an important tool to overcoming vulnerability. We shall therefore put emphasis on supporting children in school and its related activities like provision of health care, psychosocial support, food/nutrition, shelter/care, economic strengthening, remedial classes, recreational activities as well as other requirements needed to attend school. For our project, we guarantee health care access to all children supported, which means the 6301 children to be supported in FY 2009 will receive health care whenever they may need it. AVSI will support 5,477 children with school fees for Nursery, Primary and Secondary education and 593 in vocational institutes. For these children to go to school, they will need scholastic materials like; uniform, books, pens, shoes, etc which will be provided to 3,735 most needy children during the year. AVSI partners have realized that some of our children have difficulty in learning; they have therefore organized remedial classes for 282 so as to help them cope with their study. Among children that AVSI supports, some have got nutritional needs, because they are on ARV Therapy while others live in households, who are food insecure. This problem has been escalated by the rising global food prices. AVSI has therefore planned to support the identified 2,443 children with nutrition/food assistance to save them from the possibility of starvation. Our experience in working with OVC has provided a lesson of the need for Guided Recreational/Cultural Activities like picnics, get-together parties and tournaments. Therefore; this financial year AVSI plans to have 11,774 children benefiting from this activity. Moreover; follow up visits to the homes of the OVC to get to know their families and share experiences with the children and their caregivers have been arranged. AVSI and our partners' social workers will visit total of 13,901 homes this financial year. There will also be 15,266 school visits to interact with the teachers and administrators of the schools, where our OVC attend. AVSI partners have planned to have 14,819 visits from children and their guardians to their respective offices. Some OVC enrolled on our program have no possibility of meeting basic material assistance like: beddings, clothing, sanitary towels and household utensils as well as housing.

AVSI will serve a total of 1,570 children with material support and 164 with housing. Among supplemental direct to be supported by AVSI FY 2009 will be, needy OVC from the community, who will benefit from activities mentioned above (i.e. school fees, requirements for school, remedial classes, food/nutrition, material assistance, housing, recreational/ outing, economic strengthening as well as benefiting from the support to Education) that will be given to the learning institutions they attend. Besides direct support, AVSI intends to capacity build caregivers and partner organizations. This financial year, we will hold 14 workshops and trainings on a variety of topics related to education, value of life-tailored towards encouraging VCT of OVC, Income Generating Activities-for sustainability and Nutrition for a total of 351 beneficiaries. In addition, we will continue strengthening the organizational and financial management capacities of the 40 partner organizations, through regular follow up visits and tailor made trainings whenever necessary. AVSI recognizes that OVC do not live in a vacuum and for this reason, indirect activities for families and communities within where OVC live, have been planned. Business Training which will benefit a total of 2,292 OVC, Income Generating Activities for 3,109 children, Community Sensitizations on: HIV/AIDS, Responsible parenting, family building process, etc for 10,698 contacts, Community Projects like: adult literacy, rehabilitation of houses for the poor, and construction of pit latrines for 1,912 beneficiaries as well as the rehabilitation of schools and provision of learning materials and equipment to study-institutions of our children, where also 7,682 non AVSI-USAID children attend. In addition to AVSI-OVC data base, which can give all information about number of OVC served and activities given to each one of them with a unique identifier, AVSI can also report data on the OVC-Supplemental served and the various activities given to them. The data collection tool used is similar to the one for the coded OVC only that the names of the beneficiaries are not pre-determined from AVSI-OVC database. There is absolutely, no possibility of double counting the serviced beneficiaries. In line with the view that OVC may have multiple vulnerabilities; we shall promote and encourage our partners to give a comprehensive package of services to the OVC. We shall confirm adherence to this through our standardized instrument for collecting data at the Service Outlet (i.e. the CBOs, NGOs, FBOs, and schools), where our children receive the service. Through linkages and referrals, our partners will give a comprehensive package in instances where the AVSI-USAID resources may not be sufficient. The services moreover; will be according to the assessed vulnerability of each child and support will follow an individualized plan. The plan will be made considering the age and family background of the child. Collaboration and coordination with national and district OVC fora will be ensured by participation of AVSI staff and local partners' staff to all coordination meetings held at national and district level. Moreover; we shall travel to all our 40 partners in Uganda and help them deepen their understanding so as implement activities in accordance with the National Orphans and Other Vulnerable Children-policy.

In FY 2009, we shall continue with the work on implementing an exit strategy from the OVC Project as well as ensuring sustainability of the support to children under the increased access to care and support to orphans and other vulnerable children. AVSI does not offer Voluntary Counseling and Testing Services as well as palliative care but will link and refer her beneficiaries to Organizations and institutions that offer the service. We are currently working on a countrywide mapping of these Organizations/Institutions/Hospitals, which we shall give to our partners. In FY 2009, we shall implement activities in districts of: Butaleja, Dokolo, Gulu, Hoima, Jinja, Kampala, Kamuli, Kibaale, Kitgum, Lira, Luwero, Masaka, Masindi, Mpigi,

**Activity Narrative:** Mukono, Nebbi, Tororo, Wakiso, Busenyi, Busia, Iganga, Kiruhura and Fort Portal.  
**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14182

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14182	4008.08	U.S. Agency for International Development	Associazione Volontari per il Servizio Internazionale	6728	1118.08	Increased access and care for OVC in great lakes region (AVSI OVC Track 1)	\$780,719
8407	4008.07	U.S. Agency for International Development	Associazione Volontari per il Servizio Internazionale	4826	1118.07	OVC Track 1/Round 2	\$1,169,125
4008	4008.06	U.S. Agency for International Development	Associazione Volontari per il Servizio Internazionale	3168	1118.06	OVC Track 1/Round 2	\$1,117,099

**Emphasis Areas**

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 7261.09

**Mechanism:** Food Security and Nutrition Support for OVC Households (APEP follow-on)

**Prime Partner:** Associates in Rural Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 15818.21750.09

**Planned Funds:** \$300,000

**Activity System ID:** 21750



**Activity Narrative:** Background objective

The overall objective of the LEAD activity is to expand economic opportunities in the Ugandan agricultural sector by increasing the productivity and marketing of key food and cash crops. To achieve this objective, LEAD addresses the underlying causes of low agricultural productivity, by identifying and providing support to selected value chains, where productivity gains will cause significant impacts on the economy and affect a significant segment of the rural population. Specifically LEAD's aim is to catalyze the commercialization of targeted commodity systems through increasing on-farm productivity and improving enterprise efficiencies along the entire value chain. Therefore, LEAD focuses on activities that contribute towards achieving these results, which include strengthening of corporate linkages with smallholders, developing and strengthening of producer organizations (PO), and increasing adoption of productivity enhancing technologies. Emphasis is also put on leveraging USAID resources with other public and private sector partners, through a Strategic Activities Fund, to improve outreach and ensure sustainability of the program results and impact. The Underlying theory is that, with improved access to agricultural inputs, services, and output markets, technology demonstration coupled with farmer organization and training will lead to increased adoption of improved technology, which will in turn lead to increased productivity, production, and output marketing ultimately resulting in increased incomes to farmers. Specifically, 60% of LEAD resources are devoted to Northern Uganda.

**Food production and Nutrition support for OVC households**

Given the technical competencies, household farming and production mobilization and organizational niche LEAD has at village level, USAID strongly feels that this is a great opportunity to wrap around the HIVAIDS care support for OVC activity with the aim of reducing vulnerabilities of OVC household to sustain food security but also enhance their skills to produce enough food for household consumption. Many of the rural are facing food insecurity due to large household size coupled with poor infrastructure, uneven food distribution, poor food storage, inadequate nutritional knowledge, socio-cultural barriers, civil strife, disease especially HIVAIDS, and poverty. Consequently, there is high prevalence of malnutrition especially among children under five years of age and lactating mothers.

Therefore, this activity will focus on ensuring that OVC households produce adequate nutritious food and sustain food security working through and with support of farmer groups, improving productivity and storage of food in households caring for orphans and other vulnerable children, strengthening nutrition education targeting such households and lastly, establishing community-based early warning food security systems and mechanisms.

Specifically, this activity will ensure that the following activities are conducted:

- Identify and Register OVC households who need support for adequate amounts of properly prepared, wholesome and nutritious food in accordance with local dietary habits
- Train farmers and community volunteers to provide information and advice on recommended nutritious foods, nutrition practices, and nutrition-related diseases.
- Provision of basic assistance (food and agricultural support) such as agricultural household tools and seedlings
- Training of farmers in counseling for caregivers of chronically ill household members about alternative food security practices
- Support OVC households construct granaries and store food and seed after harvesting.
- Training of caregivers in appropriate nutrition and backyard gardening for OVC households
- Training of caregivers about food storage and access to food markets
- Training caregivers about the prevention care and impact of HIV/AIDS for agricultural and veterinary extension staff
- Conducting community-based awareness campaigns regarding food and water needs for OVC households and general community
- Income support through income generating activities that factor in entrepreneurial skills building programs to benefit OVC and their caregivers
- It is further expected that caregivers with participating in the program will be able to link OVC to access other critical services such as education, health and child protection. At minimum, OVC will be receiving fairly comprehensive services and that caregivers will be equipped with skills to sustain support to OVC receiving critical services for their growth and development.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15818

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15818	15818.08	U.S. Agency for International Development	Associates for Rural Development	12203	12203.08	Food Security and Nutrition Support for OVC Households (APEP Follow on)	\$300,000

---

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.13: Activities by Funding Mechanism****Mechanism ID:** 5028.09**Prime Partner:** Emerging Markets**Funding Source:** GHCS (State)**Budget Code:** HKID**Activity ID:** 9081.21755.09**Activity System ID:** 21755**Mechanism:** HIPS (Health Initiatives in the Private Sector)**USG Agency:** U.S. Agency for International Development**Program Area:** Care: OVC**Program Budget Code:** 13**Planned Funds:** \$150,000

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives

In partnership with the private sector, HIPS implements activities in OVC care and support. HIPS conducted an international and national study aimed at identifying OVC best practices in the private sector, which led to the project's development of corporate engagement models to steer OVC programming in the private sector; leveraging a company's resources, competencies, market access and networks (supply chain). These corporate engagement models have been rolled out in partnership with two companies: Nile breweries and Kakira Sugar Works Ltd, leveraging up to \$20,000. To date, an OVC caregivers' training curriculum has been developed, while nearly 300 OVC have been selected and over 150 caregivers have received training in OVC care and support. HIPS has also established a small matching grants mechanism, intended to encourage companies' involvement in OVC care and support to their neighboring communities. HIPS implements all OVC interventions using a family centered approach, focusing on the OVC household with special emphasis on the specific socio-economic activities that the OVC caregivers are already engaged in namely sorghum farming and sugar cane growing. Central to ensuring comprehensive care and support services is the increased involvement of the Community Development Office, with special emphasis on ensuring collaboration, partnership building with existing community based organizations, wrapping around of services, and referral to ensure totality of care and sustainability of services. Trained caregivers have selected members to represent them on the district specific OVC committees in the districts of Pallisa, Kumi, Budaka and Bukedea. OVC monitoring and follow up tools have been developed to ensure follow up at school and at home. Referral tools too have been developed and heads of farmers' associations sensitized on these tools.

The OVC activities for FY 2009 include but are not limited to the following:

1. HIPS will continue to identify, partner and promote best practices in corporate OVC support, furthering the implementation of corporate engagement models identified in year 1, seeking a 1:1 matching grant with companies to extend OVC care and support through strengthening capacity of families and the community to access OVC services supported by the private sector as part of their corporate social responsibility.
2. HIPS will train over 150 OVC caregivers in the catchment area of selected companies in psychosocial support, economic strengthening, child protection, food and nutrition.
3. Over 1500 OVC will be receive at a minimum three services in the following area, education, psychosocial support, health care, child protection, basic life planning skills, focusing on age appropriate interventions to meet the social and psychosocial needs of OVC.
4. HIPS will continue to support programs to identify OVC that are HIV positive and refer them for palliative care and treatment services.
5. HIPS in partnership with the probation and social welfare department, police family protection unit, will conduct training for local leaders and religious leaders on child protection at the community level.
6. Working in partnership with the probation office, CDOs, and other NGOs, HIPS will focus on ensuring quality service delivery through institution of quality assurance mechanisms in OVC care and support activities, continue to build partnerships with the district, NGOs, and CBOs, ensure referral for services and wrapping around of services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14172

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14172	9081.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$150,000
9081	9081.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$100,000

## Emphasis Areas

### Gender

- \* Increasing women's access to income and productive resources

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$35,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$20,000

## Food and Nutrition: Commodities

## Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$30,000

## Education

## Water

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9326.09	<b>Mechanism:</b> Monitoring and Evaluation Agent/Civil Society Fund
<b>Prime Partner:</b> Chemonics International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 21478.21586.09	<b>Planned Funds:</b> \$1,400,000
<b>Activity System ID:</b> 21586	

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities; with another 90 expected in be awarded at the end of FY 2008 in both the areas of prevention and OVC service delivery. The monitoring and evaluation component of the CSF will function similar to the MEEPP project for the USG PEPFAR program in Uganda and will help the CSF grantees to set reasonable targets and report on their progress. The participating development partners, UNAIDS and the Uganda AIDS Commission are currently mapping out the best way to manage and support this M&E function under the new national M&E plan but it is anticipated that these results will feed into the larger information system at the Uganda AIDS Commission. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Tracking the impact of HIV programs remains a challenge within civil society and resources will continue to be used to provide capacity building support to CSOs competitively selected to receive grants. Upon award in FY08, the Monitoring and Evaluation Agent will immediately be responsible for measuring the impact of the CSF through monitoring the 200+ grantees performances, and improving the capacity of these grantees to collect better data and use such data for future decision-making. These activities will not change in FY09. The requested resources will be used to support a portion of the management fees (along with funding from other key program areas such as Sexual Prevention and OVC) for the Monitoring and Evaluation Agent, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Technical and Financial Management Agents, in addition to providing technical support to the Steering Committee. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the M&E component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21478

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21478	21478.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$600,000

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 21885.09

**Planned Funds:** ██████████

**Activity System ID:** 21885

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 6181.09

**Prime Partner:** Deloitte Touche Tohmatsu

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 12499.21747.09

**Activity System ID:** 21747

**Mechanism:** Financial Management Agent/  
Civil Society Fund (FMA/CSF)

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** \$5,675,787

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities.

USG/PEPFAR support to the Ministry of Gender, Labor and Social Development (MGLSD) will continue to be channeled through this mechanism. Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded by the CSF to NGOs implementing prevention service delivery activities; with another 30 expected to be awarded at the end of FY 2008 that will specifically target organizations providing services to OVCs. Special grants will also be given to a selected group of NGOs tasked with establishing better linkages between pediatric HIV services and community level OVC care and support; an area identified as critical to improving the overall care of children affected and infected with HIV/AIDS. The target of this granting mechanism is support the goal of the Uganda MGLSD in ensuring that OVCs have access to integrated, comprehensive services and that HIV prevention is an integral component throughout all OVC intervention areas. These grants will provide funds to local NGOs to implement priority activities targeting direct service provision for OVCs in one or more of the Core Program Areas. Priority will be given to programs that directly and holistically benefit households and communities, rather than focusing solely on individual OVCs or programs that take place in residential care settings. The goal is always to keep OVCs in their homes and communities where they will receive the best care. Furthermore, the program will ensure that within households, all OVC services are made available to any child within the household and not just to selected OVCs. Socioeconomic support interventions will be strongly encouraged to focus on strengthening the long term socioeconomic security of OVC households; thus avoiding short term solutions such as cash transfers or individual loans to OVC. Grantees will be encouraged to consider vocational training, apprenticeships and residential job training. Psychosocial support will also remain a key intervention area.

Further solicitations are to be issued in FY 2009 to ensure a wide geographical reach, especially targeting mutually identified underserved areas such as districts in the North, West Nile and Karamojong regions. It is anticipated that a total of 68,500 OVC will receive services and 10,740 caregivers will be trained in FY 2009. Technical Service Organizations established under the CORE Initiative will continue to support the smaller, local grantees accessing CSF funding. Further support will be provided through Chief Administrative Officers in the district local governments who will be engaged in ensuring that effective mapping and support to the grantees is provided.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14189

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14189	12499.08	U.S. Agency for International Development	Deloitte Touche Tohmatsu	6733	6181.08	Financial Management Agent/ Civil Society Fund (FMA/CSF)	\$4,738,787
12499	12499.07	U.S. Agency for International Development	Deloitte Touche Tohmatsu	6181	6181.07	CSF/Deloitte and Touche	\$4,771,521



<b>Emphasis Areas</b>
<b>Human Capacity Development</b>
Estimated amount of funding that is planned for Human Capacity Development      \$300,000
<b>Public Health Evaluation</b>
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>
<b>Food and Nutrition: Commodities</b>
<b>Economic Strengthening</b>
<b>Education</b>
<b>Water</b>

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7274.09	<b>Mechanism:</b> SPRING (Stability, Peace and Reconciliation In Northern Uganda)
<b>Prime Partner:</b> Emerging Markets	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 15852.21803.09	<b>Planned Funds:</b> \$150,000
<b>Activity System ID:</b> 21803	

**Activity Narrative:** The U.S. Government (USG) and Uganda government are working together to ensure peace and security, good governance, access to social services, economic growth, and humanitarian assistance in northern Uganda. The United States Agency for International Development (USAID) Mission in Uganda intends to support an integrated program to promote peace and stability in northern Uganda. The program is entitled Stability, Peace and Reconciliation In Northern Uganda (SPRING). In light of recent developments in northern Uganda, including the ongoing peace talks between the Government of Uganda (GoU) and the Lord's Resistance Army (LRA), improved security and the return home of large numbers of internally displaced populations, the new program will contribute to the transition from relief to recovery and development. SPRING will support a core set of activities in three component areas: (1) Peace-building and reconciliation, (2) Economic security and social inclusion, and (3) Access to justice. Not only are justice institutions weak but public awareness of rights and responsibilities under the law is very limited in the North. Moreover, both statutory and customary policies and laws on key issues such as land remain unclear. Therefore, as the return process picks up pace and new disputes begin to accrue on top of past ones, it will become increasingly critical that the population is educated about their rights and responsibilities and that vulnerable OVC households are facilitated to have access to their ancestral assets such as land which is a key factor to their livelihoods. Child protection with a focus on legal aid and paralegal support activities will be the focus of this new activity. Linkages will be made with the SPRING AB & Policy activities.

The project is on track having started in January 2008. Implementation of activities will begin shortly and therefore little progress has been made.

It is expected that with FY 2009 funds, SPRING can support activities that promote non-violent decision-making and constructive social and economic participation. SPRING will work with young people most at-risk for marginalization, HIV/AIDS or recruitment into destructive activities and through proactive outreach, will engage people constructively. This project will link with and complement the SPRING OVC and Policy activities. SPRING will include HIV/AIDS components (prevention, education, OVC, and advocacy support for HIV/AIDS-affected families and individuals) as part of its overall strategy to promote equity and economic growth for HIV vulnerable women and youth.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15852

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15852	15852.08	U.S. Agency for International Development	Emerging Markets	7274	7274.08	SPRING (Stability, Peace and Reconciliation In Northern Uganda)	\$150,000

**Emphasis Areas**

Gender  
 \* Reducing violence and coercion  
 Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1030.09	<b>Mechanism:</b> Support to OVC Services/CORE Follow-on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 3197.21783.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21783	

**Activity Narrative:** This activity is a follow on to the CORE Initiative project implemented by CARE Inc. to support the Ministry of Gender, Labor and social Development (MGLSD). CORE Initiative has had three main components: 1) Strengthening the capacity of the MGLSD to lead, manage, coordinate, monitor and evaluate the national response to Orphans and Other Vulnerable Children; 2) Improving the quality of OVC services provided through civil society implementing partners; and 3) providing technical support to the Civil Society Fund (CSF) steering committee.

**Achievements of CORE Initiative:**

CORE Initiative has worked with the MGLSD to build its capacity to provide strategic direction, coordination and monitoring to Uganda's response to OVC, from the national to the household level. It undertook a detailed assessment of MGLSD and of the Community Based Services Departments (where services are coordinated at district level), developed and are now implementing an extensive plan to build capacity in seven areas: coordination between sectors and levels, planning, leadership, staffing, communications and advocacy, granting and monitoring and evaluation. CORE Initiative's original mandate was extended to play a substantial role in creating and supporting the Civil Society Fund for HIV/AIDS (OVC care and youth HIV prevention), tuberculosis and malaria, and bringing to it the knowledge and experience in making and managing grants to local organizations. The CORE Initiative further supported MGLSD's national response to create a national Quality Standards framework, in which MGLSD's plans, strategy and principles at the national level are connected logically to interventions on behalf of vulnerable children at the household. The country now has (a) Quality Standards, and (b) national, district and household Indicators. These practical tools help all actors in the multisectoral OVC response to understand the environment in which they work, and the type and quality of work required of them. MGLSD, with support from the CORE Initiative has undertaken Program Assessments for interventions in two Core Program Areas of Socio-economic Security and Psychosocial Support. A report from these assessments will be shared to all stakeholders. Among MGLSD and CORE Initiative's achievements to strengthen districts' ability to plan for and serve the OVC in their midst, two merit particular mention; All 80 districts carried out a first-ever mapping of OVC service providers, learning who (whether informal group or formal organisation) was doing what (type of service) with whom (number and category of children) and where (a single household, numerous villages, and entire district). The exercise also quantified and localized the enormous service gaps that prevail in the country. By combining the OVC service mapping results with data from the secondary analysis, all the 80 districts have created specific plans and strategies to reach OVC via government-civil society partnerships. Lastly the CORE Initiative provided capacity building and technical support to MGLSD, to districts and to 48 CSOs so that they can scale up and improve the quality of programs for OVC and youth HIV prevention.

**CORE follow on FY 2009 activity details:**

In collaboration with the MGLSD, the CORE follow activity will focus on strengthening the capacity of district local governments, lower local governments (in a decentralized system) and Civil Society Organizations to ensure Improved Delivery of Quality Social Protection Services for Orphans and Other Vulnerable Children. To achieve this, this activity will continue working through the MGLSD to support Technical Services Organizations (TSOs) to a) roll out national level OVC policies, guidelines, quality assurance standards, tools and data collection systems to Local governments and district level CSOs and b) provide technical support to districts and municipalities for building capacity to plan, manage, supervise, monitor and evaluate and strengthen OVC service provision c) develop and strengthen the roll out of national OVC management information system basing on the national monitoring and Evaluation frame that will be developed by MGLSD d) provide sub grants to TSOs that will support the roll out of the OVC response through eight respective zones covering all the districts of Uganda and e) after the successful implementation of the national OVC situational analysis, participate in national review, and development of the second national strategic program plan of interventions for OVC for next five years (2009/10 to 2014/15).

Specifically, this follow-on activity is designed to focus on consolidating and strengthening the local governments in areas of management, strategic planning, quality improvement, and coordination of OVC response, rolling out OVC MIS, M&E, advocacy and communication through supporting the TSO structure. TSOs are envisioned as long term technical partners and are a key element of the MGLSD technical infrastructure and capacity to lead and manage the national response. It is envisioned that current TSO partners will have their grants renewed through September 2009 and this activity will continue to support sub grants to the TSO structure under the MGLSD in following years. Through this activity, TSOs will ensure that the OVC response is supported in the districts by focusing on the following activities;

1. Support sustainable multisectoral coordination mechanisms for an OVC program that is fully functional at district /municipality and sub county levels by a) operationalizing OVC coordination mechanisms at national and district and municipality levels, b) disseminating OVC coordination Committees' operational guidelines and other technical resource materials c) facilitating the coordination of quarterly review and planning meetings, sharing and lessons learned workshops at district and lower levels, d) Integrating OVC issues into multisectoral district sector programs, plans, systems, strategies, standards and tools e) Integrating OVC issues into the agenda for PTC and other relevant forum f) establishing and/or strengthening OVC related multisectoral district technical working groups and committees for guidance and supervision of quality service delivery.

2. Strengthen/ build the capacity of districts/municipalities with emphasis on the Community Based Service Departments (CBSD) and OVC coordination committees; a) Support districts to develop program targets and systematically cost OVC strategic plans, b) Familiarize districts/municipalities with OVC guidelines for management skills development of the OVC implementers, c) Organize bi-annual OVC implementers sharing and learning meetings for district/zonal OVC stakeholders d) Adapt key OVC technical materials for CPAs for implementation of capacity building plans for districts/CSOs including community mapping guides, counseling and guidance manuals, PSS training manuals, economic strengthening implementer's guides and program assessment toolkits, e) Organize annual program reviews and document best practices

3. Strengthen the technical and management capacity of CSOs involved in implementing OVC interventions; a) Assess technical and management capacity needs for district-level CSOs and develop capacity development plans for improved program management and quality service delivery, b) Build

**Activity Narrative:** technical and management capacity of OVC CSOs using multiple strategies, c) Field test and disseminate program assessment toolkits for assessing, analyzing and sharing best practices/effective interventions.

4. Develop and operationalize the OVC MIS system at district and lower local government levels; a) Support training of district and subcounty staff, and district level service providers, on the national OVC M&E framework including indicators, b) Support districts to develop OVC program log frame and targets linked to national framework, c) Participate with the MGLSD in developing OVC indicators and the MIS at district level, d) Support districts to develop district specific OVC M&E plans and support routine district data collection and reporting, e) Support training of district and subcounty staff on the collection and collation of data for the OVC MIS Local Government Capacity Module, d) Support training of local government staff on the updating and maintenance of the OVC MIS Local Government Capacity Module, e) Support district and subcounty staff, and district-level Service Providers in the analysis, interpretation and dissemination of OVC data from the OVC MIS.

5. Roll out National quality standards (QS), quality of care improvement and quality of care measurement guidelines to all implementing partners at national, district and community levels, a) Disseminate the OVC QS framework (with national QS and service level standards harmonized), using standard QS dissemination guidelines, b) Support implementing agencies to define quality assurance at district and program level, c) Support Integration of Quality assurance standards Guidelines to all key programs and plans at district levels, d) Set guidelines for improving quality outcomes at service delivery level, e) Set guidelines for measuring quality using child status index tools, f) Identify and strengthen quality improvement sites for OVC service delivery approaches among implementers, g) Facilitate self and peer intervention assessments/cross partner visits among implementers of OVC interventions, using the guidelines for assessing best practices and quality improvement, h) Facilitate communities of practice, sharing and learning experiences for quality service delivery improvement, i) Document OVC best practices and human interest stories and widely disseminate them.

6. Strengthen the capacity of districts and district based CSOs to advocate for OVC plans and programs: a) Develop consistent messages and facts and disseminate them to be used to advocate for OVC issues and concerns, B) Facilitate advocacy meetings at district /municipalities NGO-forums and other child-rights advocacy organizations for evidenced based information sharing to increase public awareness on OVC.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14185

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14185	3197.08	U.S. Agency for International Development	CARE International	6729	1030.08	The Core Initiative	\$8,237,000
8408	3197.07	U.S. Agency for International Development	CARE International	4827	1030.07	The Core Initiative	\$4,480,000
3197	3197.06	U.S. Agency for International Development	CARE International	2760	1030.06	The Core Initiative	\$5,531,014

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening [REDACTED]

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechansim**

**Mechanism ID:** 9320.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 21469.21771.09

**Activity System ID:** 21771

**Mechanism:** Community-based Care and Support/TASO Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** [REDACTED]

**Activity Narrative:** This is follow-on to the USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to Government of Uganda and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting a large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated the capacity to manage USAID programs as prime partners.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support and OVC activities through indigenous partnerships which demonstrated competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from sole sourcing or sub grant approach to direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs.

In FY 2009, this activity will support key OVC interventions with a focus on PHA groups and families reached with the care and support activities. The interventions will include: economic strengthening of OVC households, education support, child protection and linking HIV exposed and infected children to pediatrics care and treatment services. At this time OVC funding is a small part of the portfolio within this mechanism but there is the potential to increase this funding in subsequent years based on availability of funding. A total of 5,000 OVC should be reached during the first year of this activity. Education services will be provided using a block grants approach to enable children to complete education levels. In addition OVC caregivers will be trained in skills to enhance incomes at household level and improved knowledge in the areas of food and nutrition and psychosocial support. The target group will include parents and guardians of OVC.

OVC will be linked to Counseling and medical support that is available for eligible orphans and vulnerable children enrolled under ART activity: The services provided include child counseling, treatment of opportunistic infections and home care. This OVC activity however excludes provision of ARVs which is covered under the CDC ART service budget.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21469

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21469	21469.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$1,954,780

**Emphasis Areas**

Gender

\* Reducing violence and coercion

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening

██████

**Education**

Estimated amount of funding that is planned for Education

██████

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 4686.21714.09

**Planned Funds:** ██████

**Activity System ID:** 21714

**Activity Narrative:** The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Roman Catholics Church, The Province of Church Of Uganda, Uganda Muslim Supreme Council, Uganda Orthodox and Seventh Day Adventists Uganda Union to jointly address together development challenges.

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 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. The major focus has been on initiatives that aim to keep OVC in school as the most appropriate mechanism for guaranteeing their protection and survival. Both basic education and vocational training have been emphasized. Other interventions have been in areas of health, psychosocial support, as well as HIV prevention education. 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.

As at March 2008, IRCU had provided care and support to 11,752 OVC. Of these, 3,342 (1,540 males and 1,802 females) received primary direct care while 8,410 (3,947 males and 4,463 females) received supplemental direct services. 3,077 caregivers (791 males and 2,286 females) were trained in micro-enterprise development and linked to various 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 economic vulnerability of households. Over 1,000 community-based religious leaders have been trained and complement IRCU's efforts in following up OVC at community level.

USAID/Uganda's partnership with IRCU ends in June 2009. USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU. One of the primary priorities for the follow-on program will be to strengthen the economic capacity of OVC households as a long term strategy of enhancing their ability to effectively meet OVC needs.

The follow-on program will also strive to ensure that OVC enrolled for basic education continue since this is the foundation for their future growth and survival. 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. 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.

Psychosocial support and legal protection for orphans and caregivers remain strongly felt but least addressed needs. 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 program will adopt the family approach which will emphasize care targeted at all eligible OVC in the household.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14209



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14209	4686.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8427	4686.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4686	4686.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening



**Education**

Estimated amount of funding that is planned for Education



**Water**

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1258.09	<b>Mechanism:</b> Roads to a Healthy Future/ROADS II-SafeTStop Project
<b>Prime Partner:</b> Family Health International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 23183.09	<b>Planned Funds:</b> \$200,000
<b>Activity System ID:</b> 23183	

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these sites, truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. HIV services in the sites, including direct support for OVC, have historically been underdeveloped.

Since launching SafeTStop in Katuna, ROADS provided psychosocial support services to 740 OVC (May 2008). This has been accomplished in partnership with seven community-based organizations, which were organized into an OVC cluster for joint program planning, training/capacity building and implementation. Activities to be implemented through the existing cluster agreement include psychosocial support, provision of scholastic materials and uniforms, referral for services, succession planning, training in business/entrepreneurship and strengthening IGA programming targeted for OVC families, training in advocacy and strengthening the community response, sporting activities, and participation in special events.

In FY 2009, ROADS will provide direct OVC support in Katuna, dropping the Busia and Malaba sites due to lack of funding. During October 1, 2008 and September 30, 2009 the project will reach 1,500 OVC (735 males and 765 females). This includes 485 males and 505 females with primary direct support; 250 males and 260 females with supplemental direct support. In FY 2009 ROADS will train 150 caregivers (new and expanded), including extended family members, teachers, youth, women and faith groups, community social workers and people living with HIV and AIDS. ROADS will provide 450 children with supplemental feeding. Given flat funding, the same targets apply for FY 2010. Recognizing the emotional and physical toll that orphan care can have on caregivers, ROADS will introduce programming specifically to address the needs of OVC caregivers, i.e., extended families especially grandparents who have absorbed these children into their households, by providing psychosocial support, 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. This will be linked with youth involvement in OVC and may include regular, organized activities for orphans to provide respite for family and volunteer caregivers. Youth and FBO clusters will organize social/day care facilities where caregivers can periodically drop their children while they access care and support services. Older orphans, a large and underserved population, will be a key focus, recognizing their unique challenges and needs. The project will expand HIV risk-reduction and care strategies specifically for older OVC, including heads of households, linking them and siblings with C&T; family planning/reproductive, malaria, child survival, safe motherhood, and TB services; psychosocial support; legal counsel; and emergency care in cases of rape and sexual assault. Children who test HIV-positive will be referred for pediatric AIDS services. Orphans who raise siblings are under severe pressure to earn income, often driving them into transactional sex for survival of the family. This is a particularly serious issue in border sites, where the demand for transactional and trans-generational sex and the potential for trafficking are high. The project will work with existing child-welfare organizations, FBOs, local officials and, importantly, the private sector/business community to meet the daily needs of OVC. One strategy will be to implement home food production strategies to enhance the food security of orphan-headed households. However ROADS' efforts will go beyond daily sustenance of OVC, attempting to secure the longer-term well-being of orphan-headed households. This will entail job training linked with micro-finance, job creation and other economic opportunities for OVC breadwinners through the LifeWorks Partnership. To pave the way for greater access to services and OVC involvement in community life, the project will address the intense stigma and discrimination often faced by children who have lost one or both parents to AIDS. Activities will include sensitization of teachers and health providers to help ensure OVC have full access to services. Ensuring HIV-positive parents have access to care and treatment will be a key strategy in forestalling or even preventing orphaning. Effective treatment, coupled with food/nutrition and other support, should enable many HIV-positive parents to raise their children to adulthood.

**SUSTAINABILITY:** Almost all partners on the project are local entities that exist without external funding, indigenous volunteer groups caring for OVC. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project, including those that can provide community-based OVC care and support, were established without outside assistance and will continue functioning over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

**EXPANSION SITES:** Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DR Congo; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Increasing women's legal rights
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$50,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$50,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 9847.09

**Mechanism:** Integrated Community-Based Initiatives/NPI

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 23777.09

**Planned Funds:** \$0

**Activity System ID:** 23777

**Activity Narrative:** Integrated Community Based Initiatives (ICOBI) is currently implementing NPI Round 2 OVC project that began April 4, 2008. ICOBI is a Ugandan Non Governmental Organization with 15 years of experience implementing HIV/AIDS related activities OVC inclusive and supporting indigenous community based and faith-based organizations in S.W.Uganda Uganda. ICOBI is working in Bushenyi district but also with a mutually supporting network of two sub-partners in Mbarara district to respond to the President's Emergency Plan for AIDS Relief (PEPFAR) i.e.: Good Care and Family Support (GCFS) and Ankole Diocese (AD).

During the first year (6 months), ICOBI has been heavily involved in project key start up activities. By the third quarter of FY2008 (1st quarter of the project), ICOBI and its sub-partners had recruited and trained 43 project staffs to kick start the process of identifying and reaching 3,600 OVC (1,728 males and 1,872 females) with at least two or more services. In addition, within 5 months since the project started, ICOBI successfully developed a Workplan & budget, sensitized district and sub-county leaders, held a review meeting and procured some equipment. ICOBI is now establishing Community Care Committees (CCC), identifying OVC and sensitizing communities on identifying OVC needs after which 2,000 caregivers will be trained to provide improved care and support for OVC.

The expected outcome of the NPI Round 2 project in S.W.Uganda for FY 2008 is to improve the quality of life for 3,600 OVC residing in 37 sub-counties of Bushenyi and Mbarara. The outcomes that will be worked towards to support the achievement of this impact are: 1) OVC have access to essential services such as education, health, care & support, food and nutrition, income generation, and psychosocial support. 2) OVC protected from stigma, discrimination, exploitation, violence, and sexual abuse; 3) capacity of sub-partners and community institutions developed to support quality OVC programming; and 4) lessons learnt, models, and best practices shared and replicated. In FY 2009, ICOBI and its partners will provide care and support to 28,000. 10,000 will receive care and support and economic security; 14,000 primary and secondary education; 1,000 apprenticeship or vocational training and 3,000 food security and nutrition. All the 28,000 OVC will be eligible for psychosocial care and support, legal and child protection. The 14,000 OVC for education, 3,000 for food and nutrition and 1,000 for apprenticeship will be eligible for health care. At least 18,000 will benefit from three or more services. In addition, the caregivers identified will be trained to provide improved care and support to these OVC.

To achieve the anticipated impact and outcomes, the project will scale up and strengthen its innovative and indigenously developed community-based approach to provide OVC with holistic and sustainable care and support.

1. The human resource is very essential and pertinent to the implementation and delivery of services to the target OVC population and their households hence contributing to the overall objective. Without them, no other activity can take off. They will cover all the 18 sub-counties in Mbarara and 20 out of 29 in Bushenyi and in so doing reach the targeted OVC in communities and families. They will be assisted by community volunteers (CCC) in every parish who likewise will be facilitated to be able to come up with the appropriate, most deserving beneficiaries and households.
2. The Social Workers and CCC members will mobilize the communities and sensitize the targeted beneficiaries on socio economic security opportunities/options available. The Caregivers and beneficiaries will identify their preferred economic activity (IGA) to undertake. Support will be channeled through groups of households (five) and not individuals because individuals tend to misuse the support and group formation helps in training, marketing, animal/plant disease control as well as ensuring sustainability. The facilitators will be Extension Workers who will train the caregiver groups at community social centres in their localities. A simple tailored training guide/manuals adopted from the approved National Training Manuals has been developed which will be uniformly used by facilitators. The IGA selected depending on group will be given out to them and constant follow ups made to the groups to ensure success.
3. OVC beneficiaries in primary and secondary will be provided scholastic materials, school tuition, sanitary pads, and school uniforms, shoes depending on the needs of individuals identified by the community for help. Each Social Worker in his/her respective sub-county will compile a list of schools in which OVC identified for assistance study from, fees per child. A mechanism will be established with the school authorities for payment of school dues for a period of full year from project account. This will minimize the inconveniences the OVC go through every term as they look for fees. Out of school OVC youth will be supported to join Apprenticeship centers and Vocational schools providing marketable skills within or nearby their communities. Upon completion of studying, they will be provided with basic startup tools of their trade to enable them set up their business (IGA) and become self employed.
4. Caregivers/guardians of OVC will be sensitized about food security and nutritional practices to address not only the problem of food shortages OVC households face but also appropriate nutrition for persons who are vulnerable to poverty. They will be sensitized about less labor intensive farming methods. Later, they will receive enhanced highly nutritious seeds, crops like Irish potatoes or fruits that require smaller pieces of land. The project will link up with the GoU supported NAADS and AAMP programs in the project area and even those funded by USG.
5. The OVC households in dire need of emergency supplies like clothes and beddings especially child-headed will be prioritized. This is short term assistance that will not be supplied again because the same families will get socio-economic security support for long term family support.
6. In order to holistically improve the quality of life of OVC, the project will cater for their health problems by contracting health service providers to offer them medical care whenever one falls sick through micro care health insurance program. The project will contribute a premium of 10 US dollars for each of these OVC per year which will entitle them to comprehensive medical care irrespective of the total cost of the medical charges by the contracted health providers. The CCC will link / refer OVC to health service providers centre. The grants given out in kind to start income generating activities or acquire skills will enable them to continue paying for their premiums in future when the project is no longer paying for them. They will further receive preventive health care messages, immunization to prevent killer diseases, increased access to safe water and sanitation, improved nutrition and balanced diet, access to bed nets and information on adolescent reproductive health through field and radio sensitizations. The health service providers in the area have youth friendly services and HIV/AIDS related services.
7. ICOBI will work with its partners to identify key persons from CCC to receive orientation in psychosocial counseling and supplement the efforts of Social workers' services in their respective communities.

**Activity Narrative:** Caregivers, guardians and school teachers will receive basics on psychosocial care and support needs of OVC who are in schools, at risk of falling out, or have fallen out. Social Workers will work with teachers at schools and institutions where OVCs are receiving education to initiate and establish Kids clubs for children between the ages of 6-12 years where trained peer facilitators will take the children through structured manuals developed by MGLSD. In this way, these children will receive quality, structured PSS. Likewise, youth clubs for (13-17 years) will be formed and all children including OVC will participate in the program's life skills sessions. The sessions will be facilitated by trained peer educators with materials developed by Population Services International (PSI) and MGLSD. Through the life skills sessions, these older OVC will benefit from both health care support (reproductive health) and PSS.

8. The project will facilitate sensitization meetings for all Secretaries of children affairs and other stakeholder groups like Local council leaders, Local police, teachers in schools, religious leaders and train them on Child rights and Protection issues. The Secretaries are targeted because they are the custodians of the Children's Act and Statute in Uganda. They will receive training in child protection, rights and laws, awareness-raising to reduce stigma and discrimination towards OVC. They will later be passed out as community paralegals having been equipped with knowledge on child rights and legal protection. The national Acts on Children including the Uganda Constitution will be the guiding tool/source of information trainings. The existing community referral system responsible for children affairs will be revived from village, to parish, sub county where established Family and Children Court (FCC) exists. The Local Police, the Probation and Welfare Officers at Sub county level who acts as officers of court in child abuse related matters will act as our referral system. The offices of the LC V Chairpersons, Resident District Commissioners (RDC) and State Attorney have desks and tasks responsible for children affairs. These will act as / provide a referral system for abused children and even when the project winds up, these will stay continue protecting children particularly OVC in this case. In case of child abuse the Social Worker in the respective area in collaboration with CCC will link up with this referral system upon receipt of such cases.

Through the above community-based approach, OVC and their household will access most if not all of the following core services: economic security, PSS, healthcare, food and nutrition, child and legal protection, education, care and support. This will ensure that they receive comprehensive quality support. By channeling support and capacity building through the groups, ICOBI and its sub-partners will guarantee that the services provided to the OVC are family focused and sustainable, as it is highly likely that these groups will continue to operate after the end of the project. The Community Care Committees will be linked to local government structures and other sources of support. Further, by ensuring that the Kids Club and Life Skills activities target younger and older OVC respectively, ICOBI and partners will ensure that the interventions are age appropriate. Gender sensitivity is also promoted by ensuring that there are both male and female peer educators to support direct work with the OVC. The life skills activities will in addition build the capacity of OVC between the ages of 13 to 17 to avoid contracting HIV, other sexually transmitted infections (STIs), and prevent them from succumbing to unwanted pregnancy.

The above interventions are in line with and in support of the National Orphans and Other Vulnerable Children Policy (NOP) and the National Strategic Programme Plan of Interventions (NSSPI) for Orphans and Other Vulnerable Children 2005/6 – 2009/10. The NOP's guiding principles i.e. the rights based approach, ensuring that the family and community is the first line of response, focusing on the most vulnerable children, and community participation and empowerment to mention but a few clearly lay at the foundation of ICOBI OVC project. Uganda's goal of ensuring the realization of the rights of OVC is in line with the project's goal of "enhancing the ability of 38,000 OVC and OVC household in Bushenyi and Mbarara districts to fully enjoy their rights and aspiration to their full potential". The project will also ensure the realization of the objectives of Uganda's OVC policy by supporting the development of a more protective environment for children in the participating communities, ensuring that OVC access essential services and that resources for OVC programming are used strategically and efficiently, and that the capacity gaps of guardians, local leaders, and community institutions are addressed to ensure that they can support the realization of the rights of OVC for the long-term. ICOBI will ensure that the program is effectively coordinated with the work of local governments and sub-partners attend district-level coordination meetings and submit programmatic reports on a quarterly basis.

#### 4. CONTRIBUTIONS TO OVERALL PROGRAM AREA:

ICOBI's project focuses on ensuring that OVC access the core program areas of support as spelt out in the NOP. It will ensure that each OVC receives a holistic package of support based on his/ her own particular needs. The OVC Program Area's guiding principles are closely followed. For instance focusing interventions on the family and the community and not only on the affected child; developing the capacity of OVC households and communities to provide better and sustained support to OVC through the promotion of groups and OVC CCC; ensuring the meaningful participation of children in the program through their representation on the CCC; their integration into monitoring and evaluation (M&E) processes; and reducing gender disparities by ensuring both girl and boy OVC are closely monitored and protected from exploitation, abuse, and discrimination and by empowering both boy and girl OVC with vital life skills.

#### 5. LINKS TO OTHER ACTIVITIES:

Through the groups of five under economic security, specific interventions will continue to be undertaken in FY 2009 to encourage members and even OVC under their care access home based counseling and testing (VCT) services provided by ICOBI with support from JSI, such that if they are HIV positive, they can be linked to HIV treatment providers such as Kabwohe Clinical Research Centre (KCRC). In conclusion, efforts will be made to link the beneficiary households to other service providers in both districts, so as to access complementary forms of support.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's access to income and productive resources
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 9462.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 21856.09

**Activity System ID:** 21856

**Mechanism:** Technical Management  
Agent/Civil Society Fund

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** ██████████

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities, with another 90 expected to be awarded at the end of FY 2008. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community.

Resources for the Technical Management Agent (TMA) will primarily be used to provide technical support and capacity building to CSOs competitively selected to receive grants. The TMA will identify, obtain and adapt technical resources with the aim of producing a comprehensive and standard package of resources to be used by all grantees working in prevention and OVC service delivery. Through a variety of strategies, small workshops, one-on-one training, site visits and cross-visits among grantees, the TMA will provide necessary and critical support to ensure that grantees are implementing their programs with the most up-to-date technical information and best-practices available. The TMA will also support the CSF Secretariate at the Uganda AIDS Commission, supporting the operational functions of the Steering Committee and the institutionalization of transparent and competitive granting mechanisms used by the CSF to solicit, review and award civil society grants. These resources will be used to support a portion of the management fees (along with funding from other key program areas such as AB/OP) for the TMA, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Financial Management and Monitoring and Evaluation Agents. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the TMA component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 1290.09

**Prime Partner:** Catholic Relief Services

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 4397.20742.09

**Activity System ID:** 20742

**Mechanism:** AIDSRelief

**USG Agency:** HHS/Health Resources  
Services Administration

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** \$500,000



**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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.

AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs as well as three CBOs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

As of the end of February 2009, AIDSRelief in Uganda will have supported 18 LPTFs and 24 satellite sites to provide 7839 orphans and vulnerable children (OVC) with support including psychosocial, life skills, leveraged education, leveraged nutrition support and leveraged child protection.

In order to enhance linkages and access to health care for OVC, AIDSRelief carried out regional trainings using facilitators from the Ministry of Gender and Social Development. Trainings were conducted in line with the Ministry's OVC policy and reached 360 health professionals (Social Workers, Counselors, and medical personnel) and community volunteers. The objectives of the trainings included equipping OVC service providers with information and skills in all key areas of focus for OVC, as outlined in the NOP & NSSPI. The primary goal was to enable OVC community service providers to strengthen linkages between various OVC interventions and to enhance collaboration and partnership between various stakeholders involved in implementing OVC work. Following these trainings, the health workers and volunteers acquired relevant skills that helped them in identifying and sensitizing communities about OVC issues.

Additionally, positive parenting training targeting parents and guardians of OVCs was carried out at 18 LPTFs. 72 such trainings took place, reaching out to 1,500 parents/guardians. The trainings focused on: parenting skills; children's rights and responsibilities; child abuse and neglect; substance and drug abuse among adolescents; communicating to children; and general hygiene and nutrition for OVCs.

AIDSRelief has created two entry points in the identification of OVC, the AIDSRelief HIV clinics at all the LPTFs and the community. At the clinic, the program has identified and supported the HIV+ children as well as OVCs under the care of the adult clients. Support for OVCs at the facility level includes: identifying the vulnerable households, nutritional counseling and food supplements as needed, psychosocial support and training of care givers in OVC management. Also at the facility level, AIDSRelief supported LPTFs to create a family-centered care environment, and enhanced community support systems, including support for OVC peer groups, foster homes and paralegal support. All LPTFs established two support groups each, one for children and one for adolescents, making a total 36 support groups; 70% of the facilities have designated child friendly corners and child days that typically occurred quarterly.

On child days, children were grouped by age and age appropriate activities were carried out. These activities included sessions on discipline, behavior life skills, and leadership skills. Identification of skills and talents also took place, and the OVC were linked to livelihood support programs such as vocational skills and apprenticeship. Additionally, adolescents were trained in prevention activities, using the Value of Life Curriculum, with a focus on abstinence. Every year, the program organizes 80 such child days throughout the supported LPTFs.

Through the community approach, trained health workers and volunteers carried out community mobilization and sensitization at community and family level using existing structures like churches and religious leadership, community meetings, and youth peer groups. As a result, they were able to identify 2,900 OVCs and linked them to comprehensive OVC packages provided by the program. AIDSRelief additionally connected LPTFs with other organizations that provide vital nutritional services often required by OVC. Through establishing linkages with the Ministry of Health and the Clinton Foundation, LPTFs in Northern Uganda were trained in the Community Therapeutic Care model. This training equipped them to provide out-patient care for severely malnourished children without other medical complications, including the provision of ready to use therapeutic food (PlumpyNut) to 245 OVC. Additional linkages in other geographical areas have been established with government facilities, such as Mwanamujimu in Mulago Hospital, which also provides nutritional support. The AIDSRelief Nutritionist also identified nutritional centers close to the AIDSRelief LPTFs and has engaged these centers to allow the AIDSRelief facilities to refer the OVC that need nutritional supplements. Other linkages for OVC services including school fees, and additional nutritional support have been established at nearby health facilities e.g. Jajja's home in Bushenyi. A total of 2,000 OVCs were supported with school fees; over 3,500 accessed food supplements, especially OVCs in the Northern LPTFs.

Coordinated by Constella Futures, strategic information (SI) activities incorporate program level reporting, enhancing the effectiveness and efficiency of both paper-based and computerized client monitoring and management (CMM) 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 CMM system using in-country networks and available technology at 18 LPTFs in FY 2008. Constella Futures 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. Using standard data collection tools, the program tracked and reported on OVC supported under each core program area. This enabled LPTFs to accurately report on OVC receiving primary direct, primary supplemental, or any leveraged support.

**Activity Narrative:** In FY 2009 AIDSRelief will maintain its services at the 18 LPTFs and 24 satellite sites with the goal to provide supplemental direct support to 7,300 OVCs. The core areas under here will include: psychosocial support to infected and affected OVCs; and health care services including nutrition security on child days.

In FY 2009 AIDSRelief will provide a comprehensive OVC package that caters for the provision of age appropriate interventions to children in order to meet the social, physical and psychosocial needs of the OVC. The OVC services offered through AIDSRelief will include: care and support, health services, and psychosocial support (including the mitigation of conflict impact on OVC). Care and support will focus on empowering families and communities to provide quality care and support for OVC, and ensuring that OVC are able to get their basic needs. AIDSRelief will provide a package of psychosocial support that will include: counseling for families of the OVCs in positive parenting skills; caring skills to parents and guardians; and career guidance to OVCs to enable them live in the challenging environment. The psychosocial activities will also address: reproductive concerns of adolescent OVCs and trauma and how to treat it. Through linkages with paralegal programs identified by the LPTFs, succession planning activities will be carried out. These will target parents/guardians of OVCs, to give them skills to write wills, talk to their children about their family history, and help families prepare for life after death. The program aims at reaching 1,080 care providers with these activities.

AIDSRelief will continue to build the capacities of health workers, social workers, counselors and community volunteers to be able to identify OVC both at the health facilities and in the community and to link them to comprehensive OVC packages. Specific regional trainings in OVC management will be provided for LPTF health workers and volunteers with facilitators from the Ministry of Gender, Labour and Social Development. Training for health workers will enhance skills for providing an OVC friendly approach, i.e. 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 care facilities for necessary health services. A total of 290 health workers and 720 community volunteers will be trained. AIDSRelief, will also provide mosquito nets to 3,500 OVCs families identified in communities.

The LPTFswill be supported to establish adolescent clubs, with adolescent days and targeted services. Additional child focused support mechanisms such as support groups, which strengthen knowledge, provide mutual support and address the many psychosocial problems faced by these children, will continue to be strengthened. The 36 psychosocial support groups for children and adolescents, established in FY 2008, will remain active. These will bring together over 7,000 OVCs both HIV negative and positive, to share experiences, access career guidance, ongoing counseling support, and acquire life skills, like being assertive. AIDSRelief will work with both in-school and out of school OVC support groups, supporting them with communication messages, leadership trainings, and peer to peer counseling skills.

To ensure that the OVC identified under the AIDSRelief program get a holistic OVC package, LPTFs will be supported to create linkages with other programs that provide additional OVC program components. AIDSRelief will leverage support for the following services: 1) Food and nutrition - AIDSRelief will continue linking with organizations that provide ready to use therapeutic food for severely malnourished children. It is hoped this activity will reach 2,900 OVCs. 2) With respect to education, AIDSRelief will link with existing CRS and other agencies that support OVC programs to meet OVC educational needs, such as school fees, vocational training and apprenticeship opportunities, reaching 3,000 OVC. 3) Activities that support child protection and economic security will be leveraged from agencies that provide the same, like district probation offices, and GOAL Uganda in Northern Uganda. Under the CRS Savings and Internal Lending Communities (SILC) program, 300 families will be reached. This will provide opportunities for caregivers of OVC to increase their economic resources, enabling them to provide for the basic needs of children in their care. The SILC program activities will also serve as a venue for identifying additional OVC needs not addressed by the caregivers.

Additionally, AIDSRelief will dedicate staff time and effort towards strengthening the implementation, monitoring and reporting on OVC activities. A full time Project Officer (PO) will be supported by the program for this activity. The PO will be the contact person for OVC activities, follow up on linkages with other service providers, and organize and facilitate OVC trainings. The PO will work with LPTFs to look for additional opportunities in their catchment areas for OVC support programs and relevant linkages. AIDSRelief will also continue working within the Ministry of Gender and Social Development OVC policy in carrying out all its activities, and access OVC materials.

With respect to strategic information activities, Constella Futures will continue to utilize paper-based and computerized client monitoring and management systems. All 18 LPTFs will continue to receive site visits and technical assistance, in order to ensure continued quality data collection, data entry, data validation and analysis, and dissemination of findings across a range of stakeholders. In FY 2009, 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 skills in tracking, monitoring, and reporting on OVC activities. The training will also focus on understanding the various definitions of OVC activities, core program areas, and avoiding double reporting.

Sustainability lies at the heart of the AIDS RELIEF program, and is based on durable OVC support programs and health systems strengthening. AR will focus on the transition of the management of OVC 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 activities 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, the organization will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13265	4397.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$500,000
8294	4397.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$400,000
4397	4397.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$85,313

**Emphasis Areas**

- Gender
  - \* Addressing male norms and behaviors
  - \* Increasing gender equity in HIV/AIDS programs
- Health-related Wraparound Programs
  - \* Child Survival Activities
  - \* Malaria (PMI)
  - \* TB
- Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$137,500

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$5,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

---

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 4392.20061.09

**Activity System ID:** 20061

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** \$300,000

**Activity Narrative:** Baylor College of Medicine Children's Foundation-Uganda (Baylor-Uganda BU) is a child health, not-for-profit NGO committed to delivering high quality, high impact and highly ethical paediatric & 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 at Houston, Texas, USA. BU started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed. This Centre will provide additional space for HIV/AIDS services provision to children and families, and training in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. In addition this facility will serve as a referral center for HIV inflicted OVCs with complicated health issues. BU has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Soroti and Kasese, and is due to initiate one site in Kitgum so as to reach more OVCs in this war torn area. Other collaborating partners like Feed the Children - Uganda support our nutrition program as a way of mitigating malnutrition that may arise due to HIV/AIDS. Save the Children in Uganda, Christian Children's Fund and Plan International serve as our links to the community for cross referral of OVCs that are suspected to have HIV/AIDS while BU refers clients to them for other OVC support. BU is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. BU uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics in Naguru, Kiruddu, Kawempe, Kanyanya and Kitebi Kampala City Council clinics run as family care clinic consortium with partners. These partners include: KCC, Makerere University John Hopkins University Research collaboration; Infectious Diseases Institute and Mulago-Mbarara Joint AIDS Program and The AIDS Support Organization. A comprehensive package of paediatric and family HIV care and treatment services and some OVC services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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, ARVs when indicated, play therapy, and linking OVC and their families to other services like education, Income Generating Activities and food security within the communities. A small number of in and out school adolescents are supported in senior secondary education and in vocational skills training. Over the last year, numeric and literacy lessons have been introduced in order to give a chance to those OVC's who may never have had a chance to benefit while they wait to see clinicians. (b) BU provides indirect services through integration of pediatric HIV/AIDS and OVC services in ART accredited government facilities in rural parts of Uganda. BU has successfully integrated paediatric HIV/AIDS and OVC services in 33 government facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time; the identified OVCs are provided/linked to appropriate services according to need. In districts where we collaborate with PLAN International and Christian Children's Fund HIV infected children are linked to OVC services that include nutrition support and education; where BU operates together with Save the Children in Uganda, play areas and play materials are supported through this partnership. BU has trained more than 1,000 health professionals in pediatric HIV/AIDS and OVC management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. At the PIDC, approximately 350 caretakers have benefited from training in income generation to support and sustain the OVCs that live within their households. Since January 2008 with the current grant, the health professional training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5000 OVCs into care. This approach was devised so as improve the care and support of OVCs in the designated health facilities. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS and OVC services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics in order to sustain the knowledge and skills in managing paediatric HIV as a key issue with OVCs. Monthly mortality audits to further understand the causes of death in these OVCs are also held for all the clinics in Kampala and will be initiated in all our supported sites in the next year. In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. This has been very useful in mapping OVCs so that they can be linked to Civil Society Organizations for OVC care. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going to support similar OVC mapping.

The main BU COE at Mulago Hospital and its satellite clinics in Kampala retain the services of play therapists. The main COE has 1 full-time play therapist, while the satellite clinics support volunteer play therapist on clinic days. Through this service, children benefit from education and recreational activities while waiting for their appointment. This could be the only exposure some children have to an educational environment as some have been denied opportunity to attend school due to their health status or their caregivers' poor socio-economic situation. In collaboration with Feed the Children-Uganda, Baylor-Uganda provides direct nutritional support to OVCs at the clinic and also supports a few families in the Kampala satellites with starter seeds as part of improving food security. In all the newly added health facilities, PEPFAR funds provide for in-clinic snack to children, i.e. porridge and a banana in the morning and juice and a cake in the afternoon while they wait for their appointments. As Uganda's national referral hospital, Mulago provides care and treatment to patients from a variety of socio-economic strata. A recent review of clinic data revealed that ~54% of the children seen at the COE/PIDC have lost one or more biological parent; 66% have baseline weight and height less than the 2.5th centile indicating inadequate nutrition; while others are deemed vulnerable simply due to their HIV positive status, care giver's low household income, and lack of access to education. Hence, all children attending BU's supported clinics are considered vulnerable. By March 2008, BU had provided OVC services such as psychosocial support, basic health and food to 16,298 beneficiaries. A few families (350) that participate in the caregivers support group received social economic security and food security and knowledge on IGA. Over 300 children and adolescents borrowed story books which are currently got through donations and gifts from friends of the

**Activity Narrative:** organization. Two camps, one for children aged 9-11 years another for the adolescents were held successfully and post camp analysis showed children's perception to life was changed. In FY 2009, based on new patient projections, more than 9,000 HIV+ children and their siblings from vulnerable households, will benefit from OVC services. The following activities are planned for implementation over the period.

- Vulnerable adolescents (about 600) would benefit from life skills training, including making of handcrafts to be sold.
- Providing clinic based feeding and supplemental take home food rations for those OVC families in rural health facilities that have severe food security as determined by a standardized tool. As many families leave their homes for their clinic appointments before breakfast, BU will continue to provide clinic-based nutritional supplementation through PEPFAR grant to 42 health facilities which we currently support. This supplementation includes a morning and afternoon snack for children where feasible. We will also work with Canadian Feed The Children and Feed the Children–Uganda, to provide individual and family take-home nutritional supplements for children attending COE and Kampala Satellite clinics. However, the nutritional support for Feed The Children NGOs is only available to children <12 years who attend the main COE. Hence more food will be required to support those not catered for.
- Three play therapists will continue to support children play & early stimulation at the COE (50children/clinic, with 4 clinic days/month) and in the Kampala Satellite clinics (120/month). In all these facilities the play therapists have organized teaching for the children including teaching about life skills. A technical person preferably a PHA hired on part time basis, will continue to teach adolescents (100/year) at the clinics how to make hand craft while they wait to see clinicians. The Social Worker hired in 2008 and a new one who will be hired will continue to support community outreach & individual child/family psychosocial needs counseling, including coordination of OVC & community program. One social worker will be dedicated to support OVC linkages from health facilities in districts where we collaborate with partners.
- The adolescent and caretaker drama groups will continue to be empowered so that the individuals can later be professionals in this area and use the skill for their livelihoods.
- Through recently conducted operation research, over 60% of clients at the Mulago PIDC earn less than Uganda Shillings 50,000 per month. Hence as an additional support to the neediest of families, OVC funds will continue to be used to provide transport reimbursement to those identified with the greatest need (960/year) to facilitate their transportation in order to ensure their regular clinic attendance, treatment adherence including in clinic OVC services.
- Support for child participation/adolescent activities such as monthly, quarterly and annual meetings and camps for OVC who are HIV infected. Training adolescents OVCs in leadership during camp and the monthly meetings will continue.
- Procurement and supply of toys for children to play with while waiting for treatment and care at the COE and some supported sites.
- Regular assessment and provision of psycho-social and emotional support services, including counseling to OVCs and strengthening capacity of communities to provide counseling and identification of OVC.
- Conducting nutritional education to OVC families both at the COE and the rural clinics while caretakers wait to be seen by clinicians.
- Providing basic treatment and care services for OVCs at our facilities as a way of mitigating the impact of HIV/AIDS and other forms of child neglect.
- Through our collaboration with FTCU, clients served at COE and Kampala Satellites will be linked to the FTCU micro finance project (100/year). The responsible officer has already met the care takers in the support group to teach them on the modalities involved.
- Clients served through BU's supported rural health facilities will be linked to OVC supported programs of our new partners: Save the Children in Uganda (150/year), Plan International (200/year), Christian Children's Fund (200/year), AIDS Information Centre (150/year) and Northern Uganda Malaria, AIDS and TB program (180/year) according to OVC need.
- In order to take services closer to OVCs, Baylor–Uganda will conduct targeted pediatric outreaches for (HCT, Early Infant Diagnosis) and use these opportunities to offer OVC services to both those identified positive and negative; such as provision of insecticide treated bed nets, clean water vessels and, training caregivers in IGAs and food security. These activities will seek the collaboration of Ministry of Gender, Labour and Social Development (MoGLSD) to assist in the trainings. In collaboration with our community partners- SCiU, Plan, CCF and MOGLS - we will support monitoring of the OVC activities that Baylor-Uganda will have participated in.
- In partnership with other actors, Baylor – Uganda will also be involved in tracking & monitoring children's well being as part of national advocacy campaign
- Increase the number of out of school adolescents benefiting from vocational skills training from 10 to 50. We will work with FCU to support these adolescents.
- Train about 200 community volunteers and counselors in provision of quality care and support to OVC's and other concepts of OVCs.
- BU will also continue to support partnership coordination meetings at national and district levels in order to identify potentials for networking on OVC issues as well as bring synergy in HIV/AIDS response. Support will go towards issues that directly tackle OVC issues in the national paediatric HIV/AIDS conference and participation in meetings
- Support will be provided for orientation of Civil Society Organizations (CSOs) on linkage between OVC services and improving delivery of health care services for OVC
- A second teacher for older OVCs at the COE (6-12years) will be hired to allow for smaller and age appropriate classes at the COE. This will also allow for none interruption of this important educational services while one is away on leave.
- Procurement and supply of more toys for children to play with while waiting to be seen at the COE and the district health facilities.
- Procurement of books and other educational materials to read and borrow while waiting (for clinics that have at least 50 HIV positive children and their siblings in care).
- 3 camps supported where OVCs from our upcountry health facilities will attend.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13245

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13245	4392.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$300,000
8286	4392.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children's Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$200,000
4392	4392.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$985,033

**Emphasis Areas**

- Gender
  - \* Increasing gender equity in HIV/AIDS programs
  - \* Increasing women's access to income and productive resources
- Health-related Wraparound Programs
  - \* Child Survival Activities
- Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$90,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

Estimated amount of funding that is planned for Education \$16,000

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1122.09	<b>Mechanism:</b> Community-based care of OVC (CA OVC Track 1)
<b>Prime Partner:</b> Christian Aid	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 25608.09	<b>Planned Funds:</b> \$306,794
<b>Activity System ID:</b> 25608	



**Activity Narrative:** ACTIVITY DESCRIPTION (Activities Unchanged from FY 2008):

Christian Aid (CA) is currently implementing a Track 1 OVC project that began in FY 2005. CA is a UK based international development agency with over 40 years of experience supporting more than 550 indigenous non-governmental and faith-based organizations in 60 countries. CA is working with a mutually supporting network of three sub-partners in north and north-eastern Uganda (Kitgum, Amuria, Gulu and Amuru districts) to respond to the President's Emergency Plan for AIDS Relief (PEPFAR): AIDS Care, Education, and Training (ACET), Concerned Parents Association (CPA), and Youth With a Mission (YWAM).

By the third quarter of FY 2008, CA and the sub-partners supported a total of 11,155 OVC (5,747 boys and 5,335 girls), 10,526 with three or more services. In addition, 3,112 caregivers were trained to provide improved care and support for these same OVC. Core areas of support included: economic strengthening, child protection and food/nutrition, psychosocial, healthcare and educational support.

The expected impact of the CA Track 1 project for Uganda for FY 2008 is to improve the quality of life for 1,200 OVC residing in 11 sub-counties in northern Uganda. The outcomes that will be worked towards to support the achievement of this impact are: 1) OVC have sustainable access to essential services such as education, food and nutrition and psychosocial and income generation support; 2) OVC protected from stigma, discrimination, exploitation, violence, and sexual abuse; 3) capacity of sub-partners and community institutions developed to support quality OVC programming; and 4) lessons learnt, models, and best practices shared and replicated. It is expected that the project will reach at least 9,000 OVC in Uganda in FY 2007. In FY 2009, Christian Aid and its partners will provide care and support to these same 12,000 OVC – of which at least 10,000 will benefit from three or more services. In addition, 3,200 caregivers will be trained to provide improved care and support to these OVC. (The same 15 sites that were supported in FY 2008 will continue to be supported in FY 2009.)

To achieve the expected impact and outcomes, the project will continue to roll-out and strengthen its innovative and organically developed community-based model to provide OVC with holistic and sustainable care and support. In particular:

1. Representatives of priority OVC households in the Ugandan sites will continue to be supported in Savings and Loan Associations (SLAs). Here, the members save for several months until their savings become significantly large, thereby, allowing the members to draw small loans, which they use for income generation activities, school fees and uniforms, etc. To complement this economic strengthening work and bolster their food and nutritional security, the groups are also supported with self-help projects in agriculture and complementary sectors, e.g., seed and livestock multiplication.
2. OVC between the ages of six to 11 years of age whose guardians are attached to the SLA groups participate in Kids Clubs activities on a weekly basis. Trained peer facilitators take the children through a structured manual informed by material developed by the Regional Psychosocial Support Initiative (REPSSI). In this way, these children receive quality, structured PSS.
3. Older OVC – those between the ages of 12 to 17 years of age – are mobilized into youth clubs and participate in the program's life skills sessions on a weekly basis. The sessions are also facilitated by trained peer educators by material informed by Population Services International (PSI) and other national and international reputable material. Through the life skills sessions, these older OVC benefit from both healthcare support (i.e., reproductive health) and PSS.
4. Within the SLA groups, child protection Mentors are appointed. The Mentors are responsible for visiting the homes of each of their fellow SLA members at least twice per month. Here, they spend time with the OVC, thereby, providing adult mentorship support, as well as ensure they are not being physically or mentally abused, stigmatized, and/or discriminated against. When minor child protection cases are revealed, they counsel the guardians in question to explore alternative ways of treating the children. More serious cases are reported to the OVC Support Committees, child protection committees, and/or local government officers/police for resolution. Through this mechanism, the project is working to ensure that all the children are systematically monitored and, therefore, benefit from child protection support, as well as one-one-one counseling support.
5. Despite the economic strengthening work that is being undertaken, there are still many OVC that are unable to attend school, particularly at the secondary level. Given this, rigorous targeting is undertaken with the OVC Support Committees and SLA groups to identify older OVC in most need of secondary school support, and this is provided. In addition, older OVC that cannot be integrated into the formal education system, i.e., those that do not even possess a basic educational foundation on which to build, will be provided with vocational training through local training colleges.

Through the above community-based model, the participating OVC will access most, if not all, of the following core services: economic strengthening, PSS, healthcare support, food and nutrition, protection, and educational support. This will, thereby, ensure that they receive comprehensive, quality support. Furthermore, by channeling support and capacity building through the SLA groups, CA will ensure that the services provided to the OVC are family focused and sustainable, as it is highly likely that these groups will continue to operate in the post-implementation period. The larger OVC Support Committees who they are apart will also continue to be linked to local government structures and other sources of support. In addition, by ensuring that the Kids Club and Life Skills activities target younger and older OVC, respectively, CA will ensure that the interventions are age appropriate. Gender sensitivity is additionally promoted by ensuring that there are both male and female peer educators to support direct work with the OVC. The life skills activities will furthermore build the capacity of OVC between the ages of 12 to 17 to avoid contracting HIV and other sexually transmitted infections (STIs), as well as preventing them from succumbing to unwanted pregnancy.

The above interventions are directly informed by and in support of the National Orphans and Other

**Activity Narrative:** Vulnerable Children Policy and the National Programme Plan of Interventions for Orphans and Other Vulnerable Children 2005/6 – 2009/10. In particular, the former document's guiding principles – including those related to the rights based approach, ensuring that the family and community is the first line of response, focus on the most vulnerable children, and community participation and empowerment – lay at the very foundation of CA's project. Moreover, Uganda's goal of ensuring the realization of the rights of OVC is directly in line with the project's goal. The project will also ensure the realization of the objectives of Uganda's OVC policy by supporting the development of a more protective environment for children in the participating communities, ensuring that OVC access essential services and that resources for OVC programming are used strategically and efficiently, and that the capacity gaps of guardians, local leaders, and community institutions are addressed to ensure that they can support the realization of the rights of OVC for the long-term. CA will also ensure that the program is effectively coordinated with and mutually reinforces the work of local government by ensuring that the sub-partners attend district-level coordination meetings, as well as the timely submission of programmatic reports on a quarterly basis.

**CONTRIBUTIONS TO OVERALL PROGRAM AREA:**

As explained above, CA's project focuses on ensuring that OVC access the core program areas of support, as spelled out in the Guidance. The vision is to ensure that each OVC receives a holistic package of support based on his or her own particular needs. Moreover, this Program Area's Guiding Principles are being closely followed. This includes: focusing interventions on the family unit and the community and not only on the affected child; developing the capacity of OVC households and communities to provide better and sustained support to OVC through the promotion of SLA groups and OVC Support Committees; ensuring the meaningful participation of children in the program through their representation on the OVC Support Committees and integration into monitoring and evaluation (M&E) processes; and reducing gender disparities by ensuring both girl and boy OVC are closely monitored and protected from exploitation, abuse, and discrimination and by empowering both boy and girl OVC with vital life skills.

**LINKS TO OTHER ACTIVITIES:**

Through the SLA groups, specific interventions will continue to be undertaken in FY 2008 to encourage both the SLA members and even the OVC under their care access local voluntary counseling and testing (VCT) services, so they, if necessary, can be effectively linked to HIV treatment providers such as the Joint Clinical Research Center (JCRC). In fact, specific training materials will be developed and delivered to the groups to this effect. Finally, efforts will continue to be made to link the participating households to other developmental organizations in the districts, so they can access complementary forms of support in the food security, economic strengthening, and water and environmental sanitation sectors.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$50,000

**Education**

Estimated amount of funding that is planned for Education \$16,000

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1245.09	<b>Mechanism:</b> Makerere University Walter Reed Project (MUWRP)
<b>Prime Partner:</b> Walter Reed	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13

**Activity System ID:** 20035

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

During FY2008, and in collaboration with Child Advocacy International (CAI), MUWRP has expanded activities through this home-based counseling/ follow-up program which provides community based outreach, support, counseling, and education for District OVC's, their families, and the community. 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 offers OVC's a comprehensive list of home-based services which include HIV education, counseling, psycho-social activities, emotional backing and (when appropriate) school fees, scholastic materials, clothes, nutritional evaluation and counseling and supplemental food based on need. Also during FY2008, a consultation was held with 120 caretakers of OVC and as a result nearly 400 mattresses and blankets were supplied to the caretakers. CAI has continued their on-going home-based education 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. During the past year, CAI has maximized OVC identification and expanded provision of services District-wide. This included expansion of home-based OVC services to the fishing villages and the remote northern and southern most regions of Kayunga District. CAI also has refined their quality of services at each of the existing OVC 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 prevention services to Kayunga Districts' youth population, and especially their orphans and vulnerable children. 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 meet 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. 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. 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, and (12) the Rubaga Youth Development Association.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:  
All of the above activities will continue in FY 2009. MUWRP funding levels to CAI currently supports the cost of some staffing, training of volunteers in HIV service provision (home-based care), and community-based activities including monthly home visits/follow-up visits to OVC, care-giver counseling, tools for home monitoring of OVC and household evaluation, psycho-social activities, and community sensitizations. However MUWRP has had to increase its funding to CAI. Because of their excellent track record MUWRP proposes to continue this level of funding of CAI for activities in Kayunga.. With MUWRP as its primary partner, CAI will be able to 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 above) to strengthen the capacity of the family unit (caregiver) to care for OVC.

**New/Continuing Activity:** Continuing Activity**Continuing Activity:** 15711

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15711	6408.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$200,000
8531	6408.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$200,000
6408	6408.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$170,000

**Emphasis Areas**

Gender

\* Reducing violence and coercion

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$23,500

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$16,000

**Economic Strengthening**

Estimated amount of funding that is planned for Economic Strengthening \$24,000

**Education**

Estimated amount of funding that is planned for Education \$22,000

**Water**

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Prime Partner:** Makerere University Faculty of Medicine

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Care: OVC

**Program Budget Code:** 13

---

**Activity ID:** 4372.20765.09

**Planned Funds:** \$200,000

**Activity System ID:** 20765

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the National Tuberculosis and Leprosy Program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including; 1) hospital-based routine HIV testing and counseling (RTC); 2) palliative HIV/AIDS basic care; 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients; 4) antiretroviral treatment, and HIV post-exposure prophylaxis; 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT); and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

Activities for Orphans and Vulnerable Children (OVC) are integrated in all MJAP activities but more so in the Family Based Care (FBC)/Community HIV Counseling and Testing (HCT) program. Other OVCs are accessed through the hospital based MJAP HIV testing and counseling program. The integrated OVC services are run by social workers, field nurse counselors and community based people living with HIV/AIDS. The team serves OVCs and caregivers in households of index HIV patients attending MJAP care clinics. Through the FBC/community HCT program, OVCs and caregivers in households of index HIV are offered Home-based HIV counseling and Testing (HBHCT) and health education about HIV/AIDS. The OVCs identified in the homes are given Insecticide Treated mosquito Nets (ITNs) for prevention of malaria, safe water vessels, anti-helminthes, and multivitamins. Adolescents aged 12-17 are counseled about HIV prevention. In case of bereavement, this target group is encouraged and given reassurance so that they accept their situation, learn how to cope and remain positive about life. Psychosocial support is also offered to OVCs to whom parents/guardians have disclosed sero-status.

The FBC team works closely with the Mulago ISS clinical care team and other satellite HIV clinics in Naguru and Kawempe (Kampala) and Bwizibwera and Mbarara Municipality Council (Mbarara) to offer clinic based OVC services. Services offered include providing a snack at the clinic site as the children wait for care, psycho-social reassurance and information giving. OVCs that require other services that MJAP does not provide such as legal support, shelter, education, security are given referral forms to other OVC service provider organizations for further support. how do you do the linking?. In 2007/8, the FBC program reached a total of 2,113 index client households. Within these households, XXX OVCs were identified, 804 were tested and 4.5% (35) were HIV positive. In Mbarara, 1928 OVCs were identified and tested, 5% (98) were HIV positive. The positive ones were incorporated into care while all the OVCs (infected and uninfected) received 10,000 ITNs, 100 safe water vessels distributed by the FBC team in their homes. 350 OVCs were offered snacks during clinic visits and 1,000 OVC care takers received health education talks to improve knowledge and skills in OVC care.

In FY 2009, MJAP will further enrich the package of services provided to OVC. The package will include health, psychosocial support, education, nutrition and socio-economic security. The target group will be all children of index adult patients receiving care in Mulago ISS clinic, Mbarara Pediatric clinic (Toto Clinic), Mbarara Municipality (MMC) and Bwizibwera clinics as these are all considered to be vulnerable, and some may be orphans, in case they have lost one or both of the parents. Adult patients will be encouraged to bring their children with them to the clinics. As per the RCT program HCT for these children will be offered in the clinics according to MOH guidelines and those found to be HIV positive in Mulago ISS clinic will be referred to Baylor Uganda for further care. MJAP will however continue providing family based OVC services for those found to be HIV negative in these clinics. Through the family based home visiting program to the homes of consenting index patients, additional children will be identified, cared for as above. Through the clinics and the home visits, MJAP hopes to identify and support a total of 4,000 OVCs with food support. The FBC team will through the index case that agrees to disclose to the community, reach more households and thus identify more OVCs. All these OVCs will be given health care and psychosocial support as needed. The basic health package will consist of de-worming, insecticide treated nets, safe water vessels, up-date immunizations and health education. We shall distribute 6,000 mosquito nets (2000 to OVCs identified through Index HIV patients households and 4000 to other OVC households identified through community FBC) and 1000 water vessels to the respective OVCs families. Since the OVCs needs are many, MJAP will assess the specific needs and identify the most needy OVCs and target these ones. Educational support will be given to about 1,000 OVCs in form of scholastic materials which will include pens, pencils, uniforms and books targeting all OVCs in a household. In the households visited, identified OVCs will be offered nutritional supplements such as soya flour, maize flour, rice, and sugar as needed.

**Activity Narrative:** Families will also be given some advice on how to improve their nutrition and household income. In Bwizibwera, Mbarara Pediatric clinic and MMC, the HIV positive children who come for care and the HIV negative ones who come with their HIV positive parents/guardians because they are too young to be left at home will all receive snacks as they wait to receive care. A snack will also be provided for OVCs who come with parents/guardians at the Mulago adult ISS clinic while in waiting. Through this approach, all the targeted 4,000 OVCs will be accessed with food support. Socio-economic security for OVC will be addressed during this year. This activity will target out of school OVC aged 16-17 years. These will be identified as above and will be supported to receive skills apprenticeship training. MJAP will hold discussions with these OVCs and their caregivers to identify suitable short course apprenticeship trainings that range from 2 to 12 months. Such trainings will include hair dressing, cookery, mechanics, carpentry, brick laying, metal works and tailoring. A total of 100 OVCs will benefit from this activity.

OVCs will be given psychosocial support in various ways. Quarterly adolescent/peer support group meetings intended to strengthen coping mechanisms against HIV and mitigating the impact of HIV among them will be initiated by the FBC teams at the two clinics. All OVC caregivers from the 2000 households which will be visited will be equipped with information on OVC care, including effective ways of disclosing HIV status to them, linking them to schools and other CBOs in the area who offer OVC services. In order to enhance the capacity of communities to handle OVCs including assisting the HIV negative to remain so and disclosure of HIV status to OVCs, MJAP will train 100 community based PHAs caregivers in income generating activities, during which sessions, HIV prevention messages will be passed on. For other services not provided by MJAP like secondary education, child protection and legal support, efforts will be made to identify other OVC support and care Institutions for referrals.

Through this capacity building among OVC care givers and adolescents we hope to improve coping mechanisms towards HIV/AIDS as well as mitigating its effects on families and communities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13276

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13276	4372.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$200,000
8321	4372.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$175,000
4372	4372.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$49,241

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$90,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Estimated amount of funding that is planned for Water      \$20,000

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Funding Source:** GHCS (State)

**Budget Code:** HKID

**Activity ID:** 4417.20798.09

**Activity System ID:** 20798

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Care: OVC

**Program Budget Code:** 13

**Planned Funds:** \$750,000



**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral centre for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, there were 9 sites under MU providing services for OVCs and 1,083 OVC received primary direct support while 2,139 received supplemental direct support. A total of 985 OVC received food and nutritional supplements. Further more 1,331 were reached with life skills training. These activities were done through school visits, community outreaches, and training at TMC. Other services provided to OVC include nutritional counselling, and psychosocial support. The program continued to follow the national guidelines on OVC support, which is implemented through the Ministry of Gender Labour, and Social Development (MOGLSD). The OVC programme at TMC networked with other organisations providing complementary services and through working with schools, churches, and communities. In the rural areas HIV-infected OVC in care were linked to existing community OVC programs. Home visits were carried out for OVCs that needed special attention. The community programme was introduced in February 2008 for children. The seven community outreaches are currently in operation and the main activities under this program area include involvement of family members in caring for affected children, home visits for the children faced with social problems like stigma and discrimination, trainings carried out for families and schools nurses, carers and patients, provision of career guidance and psychotherapy services plus peer support clubs for OVCs. By the end of FY 2008 it is expected that 200 persons will have been trained in care for children, and that 5,000 children (below 18 years) will have been reached and it expects to offer psychosocial support to 35 child-headed and 65 grandparent-headed homes. The trainings run at MU target improving the lives of orphans and other vulnerable children affected or infected by HIV/AIDS. The OVC services at RO aim at supporting the children infected and affected in areas of Income Generating Activities, school fees including scholastic material, nutrition and psychosocial support. As per June 2008, a total of 221 OVC received support from RO in at least three core areas of OVC support and 976 children benefited as supplemental direct support. On average three children are supported per OVC family through RO. 100 service providers were trained, these were mainly health professionals; doctors and nurses, allied health professionals; counsellors and social workers and informal caregivers; carers of children. Training focuses on the psychosocial support of carers of OVCs. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration. During FY 2009 MU will continue providing services and providing training activities at 12 sites of MU and 4 sites of RO. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. MU will continue training at the Centre as well as upcountry in targeted districts. MU will train 150 individuals through formal courses and clinical placements. Training of community Based Volunteers (CBVs) will be carried out both at MU as well as targeted rural districts as this is a cadre that is directly involved in the care of OVCs living in vulnerable families. Other funders like Oslo fund supports the children's choir and other recreational

**Activity Narrative:** activities in addition to what is received from PEPFAR and overall the emphasis areas include child survival activities, strengthening households to cater for the OVCs and training in life skills.

MU expects to reach 10,964 OVC (TMC 7,000 while MPCC covers 3,964) and in FY2010, a total of 12,464 OVC is expected to benefit from OVC services (8,500 OVC by TMC and 3,964 by MPCC). It is expected that 140 people in FY2009 and 170 in FY2010 will be trained in OVC issues and communication with children in order to strengthen the capacity of the family unit and community structures, which protect and promote healthy child development. A total of 1,790 OVC will be reached with food and nutrition supplementation in FY 2009 while the number is expected to come down to 1,540 in FY2010 due to the planned move to the community and the expected training sessions planned for the community. The caregivers targeted include: parents, guardians, other caregivers, extended family, neighbors, community leaders, police officers, social workers, health care workers, teachers, and community workers will receive training on how to address the needs of OVC. The funds under this program will finance training especially in life skills development, HIV/AIDS prevention among the positives and negatives, communicating with children skills, and, the funds will give psychosocial support, tuition for selected children, child advocacy, and human resource. The schools, churches, clinics, child protection committees in the community around TMC clinics will be targeted. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. RO intends to provide OVC support to 360 as primary direct target and 1,080 supplementary direct target using a family based approach for FY 2009/10.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13287

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13287	4417.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$750,000
8336	4417.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$500,000
4417	4417.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$909,020

#### Emphasis Areas

Health-related Wraparound Programs

\* Child Survival Activities

Military Populations

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

Estimated amount of funding that is planned for Education \$16,000

#### Water

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.13: Activities by Funding Mechanism**

**Mechanism ID:** 7273.09

**Mechanism:** Project SEARCH

**Prime Partner:** Population Council

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Care: OVC

**Budget Code:** HKID

**Program Budget Code:** 13

**Activity ID:** 15843.21541.09

**Planned Funds:** \$1,100,000

**Activity System ID:** 21541

**Activity Narrative:** The Project Search/ Population Council, in partnership with Uganda Bureau of statistics (UBOS), are conducting the Ministry of Gender Labor and Social development (MGLSD) 2008/9 OVC situation analysis (formative assessment) with two main objectives, 1) conduct an updated orphans and vulnerable children (OVC) situational analysis, and 2) identify the strategies, approaches and funding necessary to deliver comprehensive services to OVC in Uganda. The last OVC situational analysis in Uganda was conducted in 2001 and was limited in both scope and geographical coverage. The last OVC situation analysis done in 2001 primarily focused on orphans (did not include vulnerable children) and only covered eight districts. This analysis was used extensively in the development of the Ministry of Gender, Labor and Social Development's (MGLSD) National OVC policy and Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI). Since that time, the national OVC response has grown considerably and there is a need to re-examine and better understand the situation of OVC in Uganda, including child and family access to comprehensive OVC services throughout the country, and the actual cost of delivering these services. As a major OVC development partner in Uganda, the United States Government (USG) is supporting the Government of Uganda (GOU) through MGLSD to conduct a situation analysis (formative assessment) to update the NSPPI and provide a more accurate baseline of the situation for OVC in the country. Data will be instrumental in facilitating country-wide planning and in improving future OVC program design and implementation. This assessment will also serve as a USG PEPFAR program area review to inform ongoing and future USG investments for OVC. This activity is expected to end in June 2009.

After the successful completion of the OVC situation analysis, Population Council will make and disseminate to all stakeholders a report highlighting the current and future projected OVC population, a clear and context specific definitions of OVC, the causes of problems facing families and communities and their coping strategies with OVC. This formative assessment will inform the country of the comprehensiveness of services currently received by OVC, models of care, cost of providing comprehensive OVC services and will identify successes, best practices, and areas for further development. Lastly the report will recommend to the government, HIV/AIDS development partners, the national OVC steering committee, NGOs, and other cooperating partners appropriate strategies for addressing the needs of communities coping with orphaned children.

FY09 follow on activities

The OVC situation analysis report will be the basis for 1) informing the review of the current OVC policy and strategic program plan of interventions; 2) developing stronger programs to meet the needs of orphans and vulnerable children, families, and communities; 3) developing relevant and appropriate interventions that protect the rights of children and ensure their quality comprehensive care; 4) revising and developing a new monitoring and evaluation framework for continued assessment of the situation of orphans and other vulnerable children; and constructing a user friendly OVC information system; 5) advocating for and mobilizing additional financial resources and other forms of support for action and generating social and community mobilization responses. Strengthening the capacity of the Ministry of Gender, Labor and Social Development (MGLSD) to provide strategic direction, coordination, and monitoring of the overall response to Orphans and Vulnerable Children (OVC), which includes strengthening links to Districts and civil society responses. Specific activities will include;

1. Policy and strategic plans; a) Conduct consultative meetings to review the national OVC policy and the National strategic program plan of interventions (NSPPI), b) Initiate legislative review to explore whether the country has reviewed and updated the legal framework relating to orphans and other children made vulnerable by HIV/AIDS c) Develop a new 2009/10 – 2014/15 NSPPI, and disseminate the new policy and plan d) Translate the revised policy document into 5 Uganda main languages

2. Management, Planning and Coordination mechanism; a) Revitalize the NOSC in inter-ministerial planning, coordination, oversight and monitoring of the multisectoral response to OVC at national. b) Establish or strengthen process for policy and program planning at national level. c) Strengthen the capacity of senior NIU staff to strategically plan, cost and budget, review OVC program frameworks and workplans; d) Strengthen the capacity of NIU and Planning Unit within MGLSD to plan, monitor and analyze OVC data and disseminate performance reports and results. e) Strengthen capacity of NIU effectively coordinate OVC response at national levels. f) Support NIU to effectively supervise TSOs g) Strengthen working relationships and effective partnerships with civil society fund, private partners and public services in the national OVC response

3. MONITORING & EVALUATION; a) Determine whether M & E is being conducted nationally into the situation of orphans and other children made vulnerable by HIV/AIDS, and into programs addressing their needs.

4. RESOURCES; monitor the availability and utilization of government and donor resources to meet the needs of orphans and other children made vulnerable by HIV/AIDS and other causes.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15843	15843.08	U.S. Agency for International Development	To Be Determined	7273	7273.08	Project SEARCH: OVC Formative Assessment	

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$400,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Program Budget Code: 14 - HVCT Prevention: Counseling and Testing

**Total Planned Funding for Program Budget Code: \$18,588,347**

**Program Area Narrative:**

HIV/AIDS Counseling and Testing (CT) is an entry point for HIV positive clients to HIV prevention, care, treatment and support services and also provides uninfected people with an opportunity to receive reinforcement and advice on how to remain negative. A key goal of the national CT policy is to provide universal CT, so that all Ugandans above 15 know their status and receive appropriate support to prevent transmission of HIV for those testing positive and avoid infection for those testing negative. In FY09, the Emergency Plan in Uganda will continue to support a mix of CT approaches to respond to the national priorities.

In FY08, 2 million Ugandans, accounting for nine percent of the adult population, received CT services. Of these, 80% (1.6 million) received them from USG supported services. Less men access CT services due to low perception of risk and low health seeking behavior. The USG program currently supports at least one CT service organization in all but four districts, but accounts for a geographical coverage of less than 10 percent. According to the 2005 Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS), 70 percent of HIV-positive Ugandans do not know their sero-status due to stigma, poverty, insecurity, limited access and lack of information.

USG supports multiple CT models to increase access: 1) Voluntary Counseling and Testing (VCT); 2) Routine Counseling and Testing (RCT); and 3) Home-Based Counseling and Testing. VCT accounts for more than 50% of people currently reached. In FY09, increased community outreach and work-based programs will bring VCT services closer to communities with a specific emphasis on targeting high-risk groups like fishing communities, truck drivers and, internally displaced people. In FY09, RCT will be expanded to cover more regional and district hospitals and lower level health facilities so that more patients attending a health facility can be tested for HIV. CT can be provided through 100 percent community door-to-door access or through a family-based approach. In family-based CT, index HIV positive clients serve as entry points to members of entire households, including spouses and children. Family based CT is beneficial in supporting disclosure of HIV status, obtaining support for discordant couples and promoting adherence. In FY09, care and treatment organizations will continue to support family-based CT, quality post-test counseling and referral to post-test clubs (PTCs) to enhance care and on-going support for those testing positive. Door-

to-Door CT will also be supported in high HIV prevalence communities in central and northern Uganda. During FY07, USG conducted a cost effectiveness study of each of these approaches; and preliminary findings indicate that 100% door-to-door CT is cheapest per individual tested and at identifying first time testers; RCT is most effective at identifying HIV-positive individuals, couples while stand-alone VCT is most effective at identifying eligible couples and, family based VCT through the index client is most effective at identifying HIV infected children. In addition, the USG is completing an assessment to evaluate the behavior change impact from implementing a district wide door-to-door program.

The Ugandan CT policy sets standards for training, provision of CT services, testing algorithms, quality assurance, and monitoring and evaluation. Post-test counseling with emphasis on HIV status disclosure and partner testing, referral linkages to care, treatment, and follow up, are emphasized for all those testing HIV positive. For clients testing HIV negative, risk avoidance/reduction counseling and linkages to PTCs are made. In addition, community based support programs will be supported to adopt the prevention package for those who test negative. The prevention package includes, linking risk assessment with risk reduction counseling including condom use; messaging around repeat HIV tests; emphasis on mutual sexual faithfulness; couple communication and decision-making; STI management; Family planning and Medical Male Circumcision counseling. Working with CT17, the prevention package will need to be consolidated, approved and popularized among different stakeholders. Standards are provided for special groups including children, couples and people with disabilities. Testing protocols are in place for new CT approaches. Rapid HIV testing using serial algorithms is recommended; using Determine for screening, Statpak for confirmation and Unigold as the tie-breaker. Blood collection by finger stick is the preferred method but is not widely used in Uganda due to a lack of supplies and support supervision. In FY09, USG will support MOH in providing support supervision and refresher training to CT service providers. In addition, USG will support training for counselors in TB/HIV integration and ensure adequate supplies and effective referral and linkages between CT and TB treatment sites.

Procuring and distributing test kits is largely done by National Medical Stores (NMS). Most public health facilities receive their test kits through the NMS supply chain management system. Global fund, UNICEF and other donors pool their donations to NMS. In prior years, irregular supplies, inconsistent forecasting and limited capacity to distribute CT commodities to public health facilities led to stock-outs. In FY09, the Supply Chain Management project will continue to strengthen supply chain management of CT commodities by providing technical assistance to NMS and Joint Medical Stores. This will cover forecasting procurement, and distribution CT commodities--first to the districts, and then to health facilities. As TB/HIV integration is strengthened and RCT expanded, additional test kits will be procured to address the resulting increase in demand for CT.

Currently, TASO, AIC and MOH conduct most of the training of counselors and CT service providers. All certified CT providers have a MOH CT register, and all laboratories have a laboratory request form. While centers are required to report monthly, the shortage of staff at MOH and acute shortages of health workers at all levels of the healthcare delivery system have resulted in delays in data entry and analysis. In FY09 USG will continue to support task shifting through the training and use of alternative human resources, including volunteers and People Living with HIV/AIDS (PHAs), to bridge the gap. The MOH will develop guidelines and protocols that define the working relationship between the public health facility health workers and the PHA networks. In addition, the USG will work closely with the MOH to ensure that appropriate guidelines that help monitor CT quality within the private sector are in place.

USG utilizes an integrated approach to promote CT services. Community mobilization is integrated into all prevention, care, and treatment programs. In Uganda, political leaders such as parliamentarians and district leaders are effective community mobilizers. USG will support programs that promote "Know Your Status" targeting married and cohabiting couples and programs that build the capacity of health workers and district and national political leadership to promote HIV/AIDS, TB, and malaria awareness and the importance of being tested for HIV.

Under the Health Sector Strategic Plan II, all Health Center IVs and Health Center IIIs should have CT services by 2006 and 2010 respectively. These targets for HC IVs have not been achieved. USG will support the MOH scale-up the number of sites providing CT as well as the individuals and couples reached with CT services. Emphasis will be placed on the enhancing male participation in CT services. Priority will be placed in expanding RCT to Regional, and District hospitals as well as Health centre IVs. In FY09, quality assurance, support supervision, and equity considerations in CT provision will be stepped up. Post-test counseling for those testing HIV negative will be strengthened and linkages will be made to existing prevention programs. Through the PHA networks program and strengthening of PTCs, referral linkages to care and treatment and community support will be strengthened. In FY09, USG will continue to support the training of PHAs and volunteers as counselors to bridge the human resources gap and reduce the counseling load on the "traditional" health workers. The MOH will develop guidelines and protocols that define the working relationship between the public health facility health workers and the PHA networks. CT for OVCs and the use of pediatric clients as an entry point to households will be strengthened. All these activities will be implemented in collaboration with national CT technical working group, CT17, and the MOH CT policy committee.

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 4403.21233.09

**Planned Funds:** \$60,000

**Activity System ID:** 21233

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

HCT remains the cornerstone for HIV prevention, control, care and support interventions. HCT is a prerequisite for all core medical interventions such as ART, PMTCT, and Prophylaxis. The HSSP II and NSP recommend an increase in identification of infections for early diagnosis, treatment and positive prevention to reduce transmission. To maximize benefits of HCT it is necessary to increase coverage and access to these services delivered based on national and international standards. The demand for HIV testing is high and access to HCT has increased from 12% in 2004/2005 to 25% in 2006 (UDHS 2006). Previous support under this activity, all HCT approaches and practices in service planning, development and implementation have been standardized albeit the challenges. These include Stand alone VCT, Provider initiated counselling and testing and home based HCT. However because of evolution of events and experiences there is needed to update these standards. In 2005, a revised HIV National Counseling and Testing policy which adopted key HCT approaches: routine provider-initiated opt-out; home-based and client-initiated VCT; post-exposure prophylaxis and, considerations for testing children under 18 years of age was developed and disseminated.

With rapid expansion of HCT over 600 sites (including all hospitals and HC IV, and 40% of HC III), HCT data was integrated into the in the national HMIS data collection systems. The national HCT coordination committee (CT17) was expanded from 17 members to over 30 stakeholders. They meet and identify successes and challenges in the CT implementation and help in standardization of HCT approaches in Uganda. MOH supported the launch of several counseling and testing and prevention curricula through the TASO/SCOT project. MOH and MJAP supported training and roll out of PITC at five regional hospitals. Some of the challenges faced in FY 2008 were lack of human resources, lack of HIV test kits, and delayed disbursement of funds.

In FY 2009 the thrust at national level will be responsive to accelerating HCT to facilitate universal access to care and treatment. The policy guidelines last reviewed in 2005 will be updated in line with HSSP indicators and other coverage indicators e.g. ART and PMTCT access and country demand for HIV testing. Several coordination/planning meetings will be major activities. The technical coordination committees shall review and update the national approved testing algorithms. To sustain data collection in the HMIS, tools will be produced and distributed to all service points. Given that only 40% of HC III currently provide HCT services and yet the HSSP 2 target is 100% HC II, this activity will support the expansion of HCT to about 50% of HC IIIs by 2010. Support under this activity directly relates to all other activities supported by the USG through PEPFAR as well as other HCT and other activities supported by other bilateral and multilateral development partners in the country. In response to the need to target couples and MARPS with HIV prevention and CT services, MOH in collaboration with Health Communication Partnerships (HCP), AIDS Information Centre (AIC) and other stakeholders will provide oversight to the 'Know your HIV status' campaign targeting couples and MARPS. MOH will also provide oversight for HCT training using the training standards that were launched in FY2008.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13297

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13297	4403.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$60,000
8342	4403.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$60,000
4403	4403.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$49,154

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of  
Public Health

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 4024.21220.09

**Activity System ID:** 21220

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Prevention: Counseling and  
Testing

**Program Budget Code:** 14

**Planned Funds:** \$150,000



**Activity 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 phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a smaller extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. The range of tests carried out include: HIV testing by 2 ELISA tests and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others.

The RHSP medical male circumcision program: Three trials of male medical circumcision (MMC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MMC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MMC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. As part of the MMC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstention from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus.

Through PEPFAR, HIV-infected individuals identified through MMC service are offered a free Basic Care Package, including cotrimoxazole, bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as a regional MC training center.

The program has provided counseling and testing to a total of about 7000 clients through the HIV care clinics, the male circumcision service and the Rakai community cohort study (RCCS). Through these programs, persons wishing to have HIV testing have been educated, counseled and been tested at the Rakai program laboratory. Of these, about 2800 are new testers. Provision of counseling and testing services through three different avenues has increased the population access to CT services.

Men and women who wish to have couple counseling or assisted disclosure are offered the service through counselors resident in the communities, as well as through mobile counselors attached to the mobile ART clinics and to circumcision mobile hubs. We have established discordant couple clubs for discordant

**Activity Narrative:** couples through which clients share experiences, support, and encourage each other and are educated on how to avoid transmitting or acquiring HIV from their partners.

RHSP counselors have been trained and certified in pediatric and child counseling. In FY2008 we have provided counseling and testing to 292 children of whom 82 were HIV positive. The children are mainly identified through the HIV clinics.

The Rakai Health Sciences Program will continue to;

- Provide CT through the HIV clinics and the Rakai annual home based surveys. The CT budget will support pre and post test HIV counseling in this program area.
- Actively trace HIV positive clients who delay to seek receipt of their test results with support of community-based counselors and a team of mobile counselors for clients who are in areas that are not covered by the community resident counselors.
- Support discordant couple clubs that were established in FY 2008 and form new clubs to cover the underserved areas. Through these clubs, couples living in discordant relationships will receive enhanced counseling and education on how to prevent HIV transmission and acquisition. Emphasis will be put on abstinence, being faithful to one partner and consistent use of condoms. We will also address other reproductive health issues including family planning in these clubs to assist the discordant couples in making informed choices
- Offer CT and follow up counseling for exposed children. Children will be recruited and followed up through the HIV clinics and other testing centers.

The CT services will be provided mainly to residents of Rakai and Lyantonde districts and to a smaller extent to residents of communities in neighboring districts like Masaka which border with Rakai.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13236

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13236	4024.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$521,850
8329	4024.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$521,850
4024	4024.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$119,400

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$132,600

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 7631.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 17049.21195.09

**Activity System ID:** 21195

**Mechanism:** PEPFAR/PMI Collaboration

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** ██████████

**Activity Narrative:** THIS ACTIVITY IS UNCHANGED FROM FY 2008.

In FY07 the Uganda President's Malaria Initiative (PMI) program under the direction of the MOH Malaria Control Program established a national electronic database to track and map the distribution of LLITNs. PMI also established four sentinel surveillance sites to collect malaria indicators in Apac which has been identified as having one of the highest malaria rates in the world, with an infectivity rate of 1564 bites/per person/per year. Additionally as reported in the Uganda AIS, Apac is located in the north-central region which has an 8.2% HIV prevalence. Given the high disease-burden of both diseases in Apac, this district is uniquely placed to provide a forum for a district-wide PMI-PEPFAR collaboration. Apac has a total population of 480,000 settled in 100,000 households and is located at the edge of the conflict region in northern Uganda making it vulnerable to all the concomitant issues.

Following the OGAC directive to program an additional \$4 million specifically for new initiatives with a focus on sexual transmission, especially discordant couples, this PEPFAR-PMI collaboration proposal will initiate a district-wide door-to-door counseling and testing program in collaboration with the current PMI activities.

In FY08 a door-to-door counseling and testing program including provision of the basic care package and referrals for care and treatment to all HIV+ individuals identified will be initiated. The PMI program will support malaria diagnosis using the same blood draws from the HIV test. In addition PMI will measure the district malaria prevalence rates and provide valuable information on the long-term impact of the two large scale PMI prevention interventions (IRS in all residences annually with support from PMI and universal coverage of LLITNs by the MOH) using the national electronic database to track the distribution of LLITNs they established in 2007 and PDAs to map all households with GIS and record household demographics and bed net use.

Through leveraging the PEPFAR and PMI initiatives in Apac with reliable data readily available to both programs the district will gain a better understanding of the population-based impact of the programs' interventions: identifying discordance, use of basic care package commodities, especially bed-net usage and, IPTp (intermittent preventive malaria treatment during pregnancy).

Finally, the performance of district-level ANC clinics will be enhanced by merging the HIV and Malaria surveillance activities including the strengthening of laboratory services in all district health center IIIs and IVs; training of health care providers; and, expansion of diagnosis and treatment of both HIV and malaria and will contribute to improved PMTCT services throughout Apac.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17049

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17049	17049.08	HHS/Centers for Disease Control & Prevention	To Be Determined	7631	7631.08	PEPFAR/PMI Collaboration	

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 7624.09 **Mechanism:** New Partners Initiative:Visions in Action

**Prime Partner:** Visions in Action **USG Agency:** HHS/Health Resources Services Administration

**Funding Source:** GHCS (State) **Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT **Program Budget Code:** 14

**Activity ID:** 17260.20853.09 **Planned Funds:** \$0

**Activity System ID:** 20853

**Activity Narrative:** Visions in Action is a non profit organization committed to achieving social and economic justice in the developing world through grassroots programs and communities of self-reliant volunteers. VIA aims to combat the spread of HIV/AIDS by expanding its volunteer model to include local Ugandan volunteers as peer HIV counselors and is currently implementing a large VCT program targeting the war-affected youth of Northern Uganda. This is a 3 year program that began in June 2007, the first VCT services commenced on 31st July 2007 and the program is due to end November 2009. The goal of this program is to decrease the HIV/AIDS incidence and prevalence rates amongst youth in Northern Uganda. Counselors provide free counseling and testing services so that the target beneficiaries can voluntarily become aware of their HIV status, receive information on keeping safe, be referred for medical care and support and participate in ongoing support groups.

The total number of people tested to date is 24,000, this is lower than our anticipated targets, mainly due to late disbursement of funds for program start-up and limited resources. One of the major logistical challenges we face is the increased efforts in the transition of the internally displaced persons back to their homes of origin, thus dispersing people over a wider geographical area. FY 2008 the program planned to recruit and train local Ugandan volunteers to become peer youth HIV/AIDS counselors. VIA set up two VCT centers and two mobile VCT clinics in Gulu and Kitgum Districts. With an anticipated client testing volume of 28 persons per day and 22 testing days a month, 625 persons are expected to be tested by each center each month. With 4 centers in operation, the program will test & counsel 2400 persons a month, making a total of 28,000 tests performed per year. A total of 21,747 clients have been counselled and tested between September 2007 to August 2008. Each client is given adequate age appropriate pre and post-test HIV counseling to voluntarily become aware of their HIV status thus enabling them to remain HIV negative or further curtail the spread of the virus if they are positive. They receive appropriate medical referrals for STIs and opportunistic infections, those that test positive are offered education on the disease and counselors provide appropriate referrals that allow youth to have access to free or affordable drugs, medical supervision, food and tuition assistance. Those that test negative will be given information on how to remain HIV negative. All clients may join support groups. Close collaboration with the four referral hospitals and other NGOs working in AIDS (TASO, AVSI, IRC) ensures adequate medical support. Despite the challenges a 3 year flat funded program faces with ever-increasing costs, we are seeing a steady increase in the number of people coming to be tested, due to a significantly raised level of awareness through our IEC campaign. VIA's FY 2009 plan is to continue to build on the success of the past 2 months, providing VCT services from 4 VCT clinics in Gulu and Kitgum. The emphasis for the coming year is to strengthen now established procedures and provide staff with refresher training to ensure we continue to deliver a quality service. More focus will be given to Kitgum to ensure an increase in clients similar to that of our Gulu clinics. The aim is to ensure we test 2500 persons per month. Capacity building support will be provided to our partner NGO to actively write grant proposals and to take over the running of the four VCT Centres responsibly.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17260

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17260	17260.08	HHS/Health Resources Services Administration	Visions in Action	7624	7624.08	New Partners Initiative:Visions in Action	\$0

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 693.09

**Prime Partner:** The AIDS Support Organization

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 8363.20883.09

**Activity System ID:** 20883

**Mechanism:** Strengthening HIV Counselor Training

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** \$600,000

**Activity Narrative:** The Strengthening HIV Counselor Training Project (SCOT) is a collaboration among organizations with a stake in HIV counselor training in Uganda. It aims at improving the quality of HIV counselor training through standardizing curricula, building the capacity of institutions to utilize standardized curricula, supporting the development of accreditation and certification criteria for HIV counselor training institutions, supporting advocacy for the counseling profession and developing a standardized monitoring and evaluation system for HIV counselor training. SCOT has continued to work very closely with the Ministry of Health (MOH), Uganda AIDS Commission (UAC), Uganda Counseling Association (UCA), other line ministries, 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.

In FY 2008, 5 counseling curricula and accompanying training materials were launched and printed for National use. These are the HIV Counseling and Testing (HCT), Home-based HCT (HBHCT), Provider Initiated HCT in the Healthcare setting (PICT), Positive Prevention (PP) Counseling, and HIV Counseling Supervision (HCS). The Child and Adolescent counseling, HIV Discordant couples counseling and the Positive Prevention Peer Counseling & Community Education curricula have been developed and shall be launched while the counseling for ART curriculum has been updated and is being utilized to train 200 service providers for MOH and other implementers. Twenty three national level trainers from MJAP and TASO were oriented in the use of PICT curriculum and these have trained 474 health workers from Masaka and Mbale Regional Referral Hospitals. Sixteen trainers for HIV counseling supervision were trained and are rolling out the training through out the country where 7 Regional Referral Hospitals have so far benefited. 90 service providers have been trained in counseling for ART and 20 national trainers and additional 110 counselors are yet to be trained. 247 scholarships were given to individuals from stakeholder organizations to attend accredited HIV counseling courses; with an additional 410 to be distributed to partner institutions. Discussions for SCOT to partner with TASO Training centre are ongoing to train 20 trainers who shall then train 100 people with disabilities.

In FY 2009, SCOT will continue to improve the quality of HIV counseling training so as to improve the quality of HCT service delivery and access in Uganda. The following targets shall be reached:

- 300 health workers trained in PICT in collaboration with MOH and other partners for 2 district hospitals.
- 200 scholarships will be given to individuals from stakeholder organizations to attend accredited HIV counseling courses provided by SCOT partners.
- 20 trainers and 200 service providers will be trained for each new curriculum developed in FY 2008
- 1,000 manuals per curriculum will be printed for ART counseling, HIV discordant couples counseling and PP Peer counseling and Education curricula will be disseminated to the certified HIV Counselor training institutions.

SCOT shall also review and update the HCT, HBHCT and PICT curricula and accompanying IEC materials for counselors and community mobilizers to address emerging counseling issues. The review shall focus on developing key counseling and behavioral messages for the delivery of safe medical male circumcision services, and other priority areas as per MOH policy guidelines. Twenty (20) trainers and 200 service providers from key implementing programs shall be oriented on the updated curricula through refresher trainings. Two other new curricula arising from service provider needs identified in the mid-term review of the project shall also be developed. These include Nutritional counseling and supporting the integration of HIV counseling into pre-service training for health workers. SCOT shall also partner with MOH and key implementing partners like University Research Council (URC)-Nulife project to develop the national Nutritional counseling curriculum. This will contribute to the nutritional wellbeing of PHA and national targets on nutrition.

In FY 2010, SCOT shall continue to review and update HCS, PP curricula and accompanying IEC materials to include emerging issues in HIV prevention, care and treatment. The targets in this period are based on the 6 months period available to implement activities and these shall be as follows;

- 100 service providers shall be trained in Refresher courses for each of the updated curricula (HBHCT, PP, PICT, HCS and HCT).
- 200 health workers shall be trained for one district level Hospital identified by MOH.
- 1,000 manuals per updated curricula (HBHCT, PP, PICT, HCS and HCT) will be printed and disseminated to the certified HIV Counselor training institutions.

FY 2010 marks the end of the SCOT project life, so most of the activities shall be related to winding up the project activities but ensuring continuity of services. The activities shall include conducting an end-of-project evaluation, documenting best practices and conducting dissemination workshops.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13318

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13318	8363.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6441	693.08	Strengthening HIV Counselor Training	\$600,000

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$321,592

**Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.14: Activities by Funding Mechanism****Mechanism ID:** 1255.09**Prime Partner:** Research Triangle International**Funding Source:** GHCS (State)**Budget Code:** HVCT**Activity ID:** 4045.20872.09**Activity System ID:** 20872**Mechanism:** Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals**USG Agency:** HHS/Centers for Disease Control & Prevention**Program Area:** Prevention: Counseling and Testing**Program Budget Code:** 14**Planned Funds:** \$850,000



**Activity 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. During FY 2008, RTI in partnership with AIDS Healthcare Foundation (AHF) continued to support the Uganda Ministry of Health (MOH) to scale up provision of Routine HIV Counseling and Testing (RCT) and basic care (BC) services to patients in district hospitals and health center IVs in the districts of Kaberemaido, Kasese, Kabarole, Masindi, Mubende, Mpigi and Pallisa. By September 2008, the program will have extended to facilities in Mityana, Sembabule, Iganga and Kyenjojo districts, leading to a total of 38 health facilities providing RCT and BC services with program support.

Since the inception of the program in March 2005, a number of accomplishments have been made in the program area of Counseling and Testing (CT): (a) as of July 2008, an estimated 191,470 persons had accessed CT services and received their results. By the end of FY 2008, under current program funding, more than 210,000 persons will have been provided with CT services; (b) In collaboration with several other partners in the country, RTI contributed to the development of materials for use in training health workers in the implementation process of RCT activities. These materials include training manuals, provider cue cards, standard operating procedures and implementation protocols; the tools have been extremely useful in the coordination of HCT training programs for health workers around the country; (c) More than 2,000 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. IEC materials were produced in English and local languages; materials were distributed and posted in prominent places throughout supported health facilities. Similarly, IEC will further inform the target audience about the program via sensitization meetings with health facilities, and with district and community leaders; (e) The project has adapted MOH health management information (HMIS) tools to generate accurate RCT/BC data.

FY 2009 is the fourth year of implementing the RTI CT project. During this fiscal year, RTI will consolidate the CT services offered in their thirty-eight supported health facilities. The program will also expand to three new facilities, increasing the total number of supported facilities to forty-one. This expansion activity is expected to reach 150,000 individuals with CT services between October 1, 2009 and September 30, 2010. In FY 2010, the program will scale back and consolidate activities since the project period ends in March 2010. FY 2008 is the second to last year of the program; all three of the new facilities have been selected to scale up, ensuring the rapid initiation of CT activities. RTI project staff will provide in-service training and technical support supervision to health workers working in current and new facilities. During this time, the program will also identify counselor supervisors. These individuals will strengthen facility-based services by supporting the health worker staff. This strategy will guarantee the delivery of consistent high quality CT services at all supported facilities; including those affected by the closing-out phase in FY 2010. Quality Assurance for the counseling and testing process will be emphasized and external quality control for HIV testing will be conducted. Facilities that maintain more than 95% concordance on a sufficient numbers of re-tested samples for three consecutive months, will gradually transition from conducting external monthly re-tests to providing RTI with a quarterly report.

RTI will also train and provide technical support supervision to health facility waste management committees, adhering to guidelines related to proper management and disposal of medical waste. Standard operating procedures and protocols for implementation of RCT and waste disposal will be distributed to the new sites. RTI will focus primarily on providing materials for managing medical waste, at points of waste generation (testing points and wards). RTI will also facilitate the start up of clinic-based support groups and post-test clubs; as both groups will assist in providing post-test counseling and psychosocial support to persons who test for HIV. Health workers will be equipped to support clients who need couple counseling, disclosure of HIV testing results to partners and support for discordant couples. In the case of infant testing and testing for pregnant women, the program will partner with other implementing agencies working in this area; more specifically, with the Pediatric Infectious Diseases Clinic (PIDC) and Protecting Families against HIV/AIDS (PREFA) to provide CT services to children. RTI's support in these areas will vary, depending on level of presence of PIDC, PREFA and or similar partners in the supported facilities. In each case, RTI will clearly delineate the roles of the various partners to avoid duplication of support. The project will also be partnering with lower level health facilities to transport specimens to referral laboratories, in order to conduct (PCR) and HIV testing on the dry blood spot (DBS) samples; RTI will submit the results back to the facilities. Where there is discordance between the health facility and reference laboratory results, RTI will conduct refresher training for the health facility staff.

RTI will work closely with the district health teams (DHT) and health unit CT point persons, to enhance ownership and sustainability of the services, in order to increase program utilization. Likewise, RTI will also continue to produce IEC/CT materials in English and the various local languages; the materials will be disseminated in the various health facilities, and to community leaders and clients. RTI will collaborate with MOH, National Medical Stores (NMS) and Supply Chain Management Systems (SCMS) to strengthen logistics management to minimize stock-outs. The technical assistance will also improve upon data collection, analysis, and distribution to inform and improve program activities.

Additionally, RTI will open 18 of its 41 sites for a proposed two-year multi-country Public Health Evaluation Process entitled 'HIV Counseling and Testing to Optimize Client Enrollment (COPE)', which is pending review and approval. During this PHE, RTI will serve as the Uganda country RCT implementing partner; there are other partners in this role in Tanzania, South Africa and Cote d'Ivoire. The study will be a group randomized trial, based at clinic level. The study will have three arms: 1) Enhanced provider referral to VCT, 2) HIV testing and counseling during consultation and 3) HIV testing and counseling prior to clinical consultation. The specific objectives of this evaluation are: 1) To demonstrate whether outpatient departments are appropriate settings in which to provide HIV counseling and testing; 2) To determine if HIV-infected persons are identified in outpatient departments or are referred at an earlier stage of infection; or upon entering care and treatment versus patients referred from other sources; 3) Determine which model of HIV testing and counseling (HTC) in out-patient departments shows the greatest increase of outpatients who receive an HIV test.

**Activity Narrative:** Study outcomes include: 1) The number of HIV positive patients who are newly diagnosed, 2) The percentage of HIV-positive patients identified in or referred from out-patient departments who register for care and treatment, 3) The percentage of patients whose HIV test results are noted in their OPD medical chart prior to or during clinical consultation so that test results can be used for diagnosis of the presenting problem and the patient's knowledge of HIV status, and 4) Availability of care and appropriate prevention strategies based on HIV status.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13316

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13316	4045.08	HHS/Centers for Disease Control & Prevention	Research Triangle International	6439	1255.08	Expansion of Routine Counseling and Testing and the Provision of Basic Care in Clinics and Hospitals	\$850,000
8518	4045.07	HHS/Centers for Disease Control & Prevention	Research Triangle International	4872	1255.07	Routine Counseling and Testing in Two District Hospitals	\$750,000
4045	4045.06	HHS/Centers for Disease Control & Prevention	Research Triangle International	3184	1255.06	Routine Counseling and Testing in Two District Hospitals	\$233,000

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$155,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 8359.20878.09

**Planned Funds:** \$986,475

**Activity System ID:** 20878

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

During FY 2008, HIV Counseling & Testing (HCT) was provided as an integrated component of the TASO comprehensive HIV prevention package. TASO provided HCT services using the Home Based HIV Counseling & Testing (HBHCT) model developed in partnership with CDC Uganda. HBHCT is provided to household members of clients registered at the 11 TASO centers nationwide. TASO realized high acceptance levels (over 90%) for HCT among household members of clients. Over the period October 2007 to September 2008, the key outputs were as follows: 13,683 clients were counseled (5,748 male and 7,935 female); 12,609 new clients were tested for HIV (5,291 male and 7,318 female); 12,609 clients tested for HIV were given results (5,291 male and 7,318 female); and 856 clients tested HIV positive (316 male and 540 female). Other HCT priorities included: conducting health education; client mobilization; conducting HCT beneficiary census; home visits; conducting counseling sessions (pre- and post-test); couple counseling targeting sexual partners; child counseling targeting child members of client households; HIV testing or dry-blood spots for children below 18 months; linking HIV positive household members to care; supporting HIV negative household members to maintain HIV negative serostatus; linking discordant and HIV positive concordant couples to peer support systems; ensuring a reliable supply chain for HCT supplies; management of HCT clinical waste; ensuring quality control of HCT services; training service providers in HCT; reviewing and improving HCT models for service delivery. TASO observed that HIV prevalence in targeted households was highest among adults and children below 5 years; and over 85% of the family members reached were testing for HIV for the first time. In preparation for HBHCT services, clients were also supported to disclose their serostatus to their sexual partners. The clients were counseled on the benefits of disclosure and guided on the process of disclosure and approaches. Clients chose either self disclosure or supported disclosure and very few opt for anonymous disclosure. Self-disclosure with counselors supporting client through coaching; supported disclosure where the client receives coaching and discloses to partner in presence of the counselor as a mediator; and anonymous third party disclosure where a client requests the counselor to offer couple counseling and testing to both partners. HCT revealed discordance rate of 65% amongst TASO clients and their partners. This prompted TASO to focus on supporting discordant couples through partner counseling and testing, provision of prevention information including Family Planning and Prevention of Mother-to-Child Transmission (PMTCT) services. Discordant couple clubs were established at the centers and outreach clinics to address the couple's psychosocial concerns about discordance and to support club members towards behavior change. Regular meetings and quarterly workshops were held club members shared experiences and received vital information. Parents who had not disclosed HIV status to the child clients were supported by the counselors to disclose.

**Activity Narrative:** In FY 2009, TASO will provide HCT services to household members of clients registered at the 11 centers located in Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso districts. Approximately 40,000 household members of clients require HCT services. All the targeted household members will have the opportunity to benefit from the whole spectrum of the HCT package, which comprises: health education; home visits; counseling (pre-test, post-test); couple counseling targeting sexual partners; child counseling targeting children in the targeted households; HIV testing or dry-blood spots for children below 18 months; giving of test results; linking HIV+ household members to care; supporting HIV negative household members to maintain their status; linking HIV discordant and concordant couples to peer support systems; ensuring reliable HCT supply chain; clinical waste management; quality control of HCT services; training service providers in HCT; and reviewing HCT delivery models. TASO will provide HCT to 40,000 people (15,000 male and 25,000 female). The targeted beneficiaries will be reached through service delivery at various venues including: HBHCT, Outreach Clinics, Community Drug Distribution Points (CDDP) and facility laboratories. TASO sites will partner with the CDC and JCRC laboratories to do DNA-PCR testing. The broad service delivery strategies will include mobilization and sensitization, capacity-building, beneficiary involvement, health education (including gender and legal issues influencing HCT), partnership and collaboration. HCT is related to the program areas of Adult Care & Treatment, Paediatric Care & Treatment, TB/HIV, PMTCT, ARV Drugs and Laboratory Infrastructure. The activities under the counseling and testing 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. The activities under this Program Area are also linked to other USG funding through USAID focusing on Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13228

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13228	8359.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$986,475

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

### Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1250.09	<b>Mechanism:</b> Rapid Strengthening of Blood Transfusion Services
<b>Prime Partner:</b> Uganda Blood Transfusion Services	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> Central GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 8585.20886.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 20886	

**Activity Narrative:** Provision of safe blood is an essential component of Uganda's Health Sector Strategic Plan (2006-2011) as indicated in the minimum health care package of the plan. It is also one of the main strategies of the country's HIV/AIDS prevention and care. PEPFAR support to the Uganda Blood Transfusion Service (UBTS) and sub-partner, the Uganda Red Cross Society (URCS) has enabled them to maintain and increase the supply of safe blood to 166 hospitals in the country by 45.6% and reduce the HIV prevalence among the blood donor population from 1.7% in 2004 to 1.36% in 2006 (a reduction of 20%). It is estimated that over 21,000 new HIV infections have been prevented through provision of safe blood since the beginning of the PEPFAR support to UBTS; 75% of these infections would have occurred in children and pregnant women who receive most of the blood transfusion.

In FY08 existing blood donor clubs will be encouraged to recruit more members, and new donor clubs will be formed. The URCS plays a key role in the blood donor recruitment, counseling activities as well as overseeing and maintaining the blood donor clubs. The main objective of pre-donation counseling is selection of low-risk healthy blood donors, whereas post-donation counseling (donor notification) gives opportunity to blood donors to learn their health status and make informed decisions about their lives, be encouraged to continue donating blood, as well as preventing infected blood donors from donating once again. UBTS and URCS collaborate with several AIDS Support Organizations in the country and refer identified HIV positive blood donors for care and support. During FY08 the percentage of blood donors who receive post-donation counseling will increase from the current 70% to at least 80%. Currently, 100% of donors in Uganda are voluntary, non-remunerated individuals; this trend will be maintained in FY08. For every 100 persons that receive HIV health education aimed at recruiting blood donors, only 10 donate blood.

Although HIV counseling and testing is not the main activity for the Blood Safety program, but key to the provision of adequate amounts of safe blood, UBTS and URCS indirectly contribute to this program area. UBTS and URCS have to provide health education to 1,300,000 individuals in order to obtain 100,000 blood donors. These donors will receive HCT; most of them are young people above 17 years in education institutions, and others in rural communities and urban work places. Through the blood donor mobilization and recruiting activities, UBTS/URCS reach large numbers of individuals as far as HIV prevention campaign is concerned.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13321

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13321	8585.08	HHS/Centers for Disease Control & Prevention	Uganda Blood Transfusion Services	6442	1250.08	Rapid Strengthening of Blood Transfusion Services	\$0
8585	8585.07	HHS/Centers for Disease Control & Prevention	Uganda Blood Transfusion Services	4817	1250.07		\$0

**Table 3.3.14: Activities by Funding Mechansim**

**Mechanism ID:** 3440.09 **Mechanism:** Laboratory Quality Assurance-Cooperative Agreement

**Prime Partner:** Uganda Virus Research Institute **USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State) **Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT **Program Budget Code:** 14

**Activity ID:** 12494.20887.09 **Planned Funds:** \$400,000

**Activity System ID:** 20887

**Activity Narrative:** The Uganda Virus Research Institute (UVRI) is a department within the Ugandan Ministry of Health (MOH), and has been dedicated to conducting research on viral diseases since 1936. In the area of HIV/AIDS, UVRI conducts research on the isolation and characterization of HIV strains, the epidemiology and molecular epidemiology of HIV before and after the introduction of ART, comparing modalities of delivering ART, HIV vaccines and microbicides, and PMTCT. UVRI also assists in the implementation of national sero-behavioural surveys, and provides the MOH with HIV surveillance data from ante-natal clinic (ANC) and STI clinics. UVRI is mandated by MOH to perform Quality Assurance/Quality Control (QA/QC) of all HIV serological testing sites, both public and private. With USG funding assistance, 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 biosafety guidelines. These three cadres of staff after proper training in rapid HIV testing nationwide will provide high quality results to inform prevention, care, and treatment of HIV/AIDS.

Of the targeted 93 staff, 78 (Regional Laboratory Coordinator-RLC and District Laboratory Focal Persons (DLFPs)) were trained in QA/QC, because 15 were not available. In-service training in QA/QC was provided only to 98 staff due to unreliable transport. Five SOPs for laboratory safety, sample processing, rapid HIV laboratory testing, Elisa HIV testing, rapid syphilis testing and proficiency panel preparations for HIV were reviewed, updated and distributed. Unfortunately there was no input from other stakeholders. Prepared and distributed 700 proficiency testing panels to 216 testing sites. Unreliable transport was a limiting factor. 135 internal controls were prepared and 15 test runs performed where they have been incorporated. Re-testing was carried out on 1,435 samples from 34 sites including National Referral Hospitals, Regional Referral Hospitals, and District Hospitals, Health Center IV, Health Center III and private facilities. Results have been returned within 6 weeks. Concordance positive rates have ranged from 50% to 100%, while negative rates have ranged from 82.4% to 100%. PT results at all these sites were 100%. Obtaining quality samples for re-testing proved difficult. However, 36 discordant tests were resolved and results returned within 6 weeks. Compiled an inventory of 216 sites, held 216 sensitization meetings with the staff at the sites regarding quality assurance, 700 distributed Proficiency Testing (PT) panels, collected 216 PT results and provided corrective action when required, provided 17 out of 216 support supervision visits in collaboration with RLCs and DLFPs, distributed 1085 SOPs and other information tools, provided 216 formal reports disseminating the findings of support supervision to 216 testing sites. The UVRI cold room has been equipped to handle additional samples. Adherence to SOPs was assessed at these sites and revealed availability of 77.8%, accessibility of 86.7%; two thirds displayed the SOPs, 79.2% understood them, and 80.6% of the sites followed them. 203 out of 216(94%) 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. There is however a high demand for counseling and testing as from the unmet need for HCT (UDHS 2006). Strategies include both client and provider initiated HIV counseling and testing services and Ministry of Health [MOH] intends to scale up HIV counseling and testing to all Health Center III by year 2010. There is need to further scale up through training of service providers and ensuring quality control for HIV testing.

In FY 2006, MOH developed an HIV prevention strategy which places special emphasis on HIV testing especially for the epidemic drivers (fishermen, commercial sex workers, discordant couples, those with multiple sexual partners, transactional sexual relationships, etc). This calls for increased testing at health facilities, home and through outreach/mobile clinics. UVRI shall ensure quality HIV testing is offered to individuals through training, support supervision and continuous assessment of laboratories for QA/QC in all laboratories testing for HIV, TB, STI and Malaria. It has been estimated that 1/3 of clients that seek HIV testing are dually infected with TB. Thus all HIV testing sites are encouraged to offer TB diagnostics especially to those clients with productive coughs. Through these means we shall support the TB, and malaria strategic plans. The GFATM round three, phase one, targeted to test 2,200,000 people by the end of June 2008, and, an additional 58,000 started on ART. Extra effort is required in counseling and testing to achieve this target and more but ensuring high quality of the results. 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.

UVRI shall maintain and develop new partnerships with PEPFAR funded partners e.g. CPHL/MOH, AMREF, NUMAT, MJAP, JCRC, NMS, MUWRP, RHSP, RTI and other stakeholders in laboratory services and CT to ensure sustainability of internal and external quality assurance at regional and district levels using Regional Laboratory Coordinators (RLCs) and DLFPs as change agents. In collaboration with these stakeholders and others especially Ministry of Health Quality Assurance Unit and Community Service Organizations, UVRI shall identify suitable candidates for training in QA/QC. During support supervision visits to the testing sites in collaboration with CPHL/MOH, Malaria Control Program, National Leprosy and Tuberculosis Program and other stakeholders, UVRI shall identify needs in infrastructure, staffing, laboratory management, commodity availability, storage capacity, recording keeping, availability and implementation of SOPs, M&E tools and customer service satisfaction. UVRI will provide QC/QA of HIV serology to TB sites that offer HIV testing. Supply chain management of HIV commodities, will be addressed to avoid duplication. UVRI will draw up a consumption plan of HCT commodities and work with NMS to ensure their availability. Buffer stock will be budgeted for to avoid any disruption of services. Due to the scarcity of trained laboratory staff and the need to get millions of people counseled and HIV tested, MOH has decided to provide quality training to non-laboratory staff including PHAs to conduct HIV rapid testing. Despite this approach only 12% of the entire population knows their HIV status. UVRI in collaboration with CPHL will continue to train lay and community health workers in quality HIV testing through support supervision to ensure they provide quality results. In collaboration with RLCs and DLFPs, UVRI shall develop a strategy to achieve this and shall emphasize during training the need for these groups providing complementary services to coordinate their activities. The UVRI clinic shall continue providing apprenticeship to both counselors and laboratory trainees. Training sessions for personnel at CT sites will



**Activity Narrative:** emphasize the need for QA/QC in whatever service they render. The SOP for counseling and testing will be integrated for the benefit of the counselors, phlebotomists, and laboratory staff. UVRI shall prepare and distribute Dried Tube Serum (DTS) to all testing sites for proficiency testing and obtain the results later by means yet to be agreed upon. QA/QC testing will be conducted on samples obtained from CT and PMTCT sites. Samples yielding discordant results in the field retested at UVRI and the results returned within six weeks. These outcomes will be used to measure the effect of pre-analytical and analytical QA/QC training on the quality of results provided to clients. Medical waste generated at UVRI will be disposed of using disinfectants, incineration and sharps containers as appropriate. Hospitals will be requested to support other testing centers in their area of jurisdiction for incineration of medical waste. These issues will be emphasized during training and support supervisory visits. The funding in this programme area will increase gender equity by ensuring that both male and female staff are equally represented in the various activities, and courses promote females who are currently fewer in the counseling and testing profession in the country.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13322

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13322	12494.08	HHS/Centers for Disease Control & Prevention	Uganda Virus Research Institute	6443	3440.08	Laboratory Quality Assurance-Cooperative Agreement	\$400,000
12494	12494.07	HHS/Centers for Disease Control & Prevention	Uganda Virus Research Institute	4816	3440.07	Laboratory Quality Assurance-Cooperative Agreement	\$350,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$130,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Funding Source:** GHCS (State)

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Prevention: Counseling and Testing

---

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 4418.20799.09

**Planned Funds:** \$200,000

**Activity System ID:** 20799

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral centre for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and care givers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

The Mildmay Centre provides HIV Counselling and Testing (HCT) using several strategies which include HCT at TMC, community VCT outreach in collaboration with other partners, such as churches and private businesses, home-based VCT for relatives of patients during home visits, couple counselling and testing, and by supporting the rural sites to provide VCT to pregnant women and other patients who visit those clinics. Partners of TMC clients are provided with CT as part of the package before starting ART to adults who are sexually active. All adults attending TMC are strongly encouraged to bring their children for testing. All Counselling and training for HIV/AIDS care providers is done using the national and international guidelines. CT training targets doctors, nurses, counsellors, pharmacists, pharmacy technicians, laboratory personnel, clinical officers, religious leaders, community leaders, people living with HIV/AIDS (PHAs), schoolteachers, school nurses, and other lay caregivers. By March 2007, 22,423 people accessed CT at TMC and 3,510 at Reach Out Mbuya. As part of the targeted evaluation, TMC provides home-based CT for clients and their families. All patients who are found to be HIV positive are recruited into care, started on Cotrimoxazole prophylaxis and CD4 tests are performed, and where appropriate ART is initiated. Between October 1, 2007 and March 31, 2008, there were 12 sites under MU and RO providing CT with a total of 9,310 individuals receiving CT and 2300 at RO. This is progress for have the year. Multi-disciplinary hospital and home visits continued. The community programme was introduced in February 2008. Stable children together with their carers are referred and followed up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The main reasons for which counselling services were sought were mainly pre-ART counselling, Adherence and positive prevention. 386 were trained and the training in this area includes imparting communication and counselling skills where knowledge of HIV status enables the individual to access care and support. Trainees are trained at both TMC and the rural districts. Workplace sensitisation programmes have also been carried out, notably to the Parliament of Uganda, where 300 individuals were trained and encouraged to know their HIV status. Training courses are typically 5 days to three weeks in duration. By June 2008 RO had expanded its HCT services to Kasaala in Luweero where needs assessment has already been conducted.

During FY 2009 MU will continue providing HCT and training activities at 12 sites of MU and 4 sites of RO. This is a continuing activity and involvement of rural partners and training will help the sustainability of the activities. MU will continue to train health workers and workplaces in counselling and testing, to encourage employees to know their status. Using the TMC family approach, 31,000 patients will be provided with CT (8,500 at TMC, 5,500 at rural sites, 8,500 in community outreaches and 1,700 at MPCC) and 7000 at RO, while an additional 3000 will be reached in the FY2010. Areas around TMC clinics will take first priority. Two special groups; drivers through their organisation of Uganda Taxi operators and armed personnel i.e Police

**Activity Narrative:** and Military will be targeted these two years. The funding for this programme is for the procurement of CT logistics, the provision of CT services, human resources, training activities, and capacity building particularly for the rural sites. The other targeted population is people living with or affected by HIV/AIDS. RO shall be providing various forms of counselling services to 7,210 individuals and their family members both at Nakawa Division, Kampala and Kasala (Luwero District). Males will be reached through the family approach and through couple counselling.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13288

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13288	4418.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$200,000
8337	4418.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$200,000
4418	4418.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$157,652

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 629.09	<b>Mechanism:</b> Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services
<b>Prime Partner:</b> National Medical Stores	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 4030.20819.09	<b>Planned Funds:</b> \$4,103,523

**Activity System ID: 20819**

**Activity 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 health facilities throughout Uganda. NMS has developed a countrywide distribution supply chain for essential medicines and supplies; as well as providing HIV/AIDS-related Laboratory materials which are supported by PEPFAR funding Health facilities and HIV Counseling and Testing (HCT), can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. Following the national credit line for essential medicines, the Ministry of Health (MOH) provides a 20% contribution to JMS for faith-based and mission health facilities and NMS allocates the same 20% of PEPFAR funding for JMS to procure and store HIV/AIDS-related laboratory commodities.

Since, starting the project in 2004, all eligible laboratories (public, NGO / FBO, private health facilities and armed forces health facilities) across the country have received HIV/AIDS-related laboratory commodities and supplies from NMS and JMS. These laboratory reagents have enabled health facilities and implementing partners provide HIV testing. HIV testing kits and related accessories are now being distributed nation-wide to 980 MOH accredited testing sites and projects. As of March 31, 2008, 2.2 million tests have been procured and distributed. During the same time period, the MOH utilized funding from the Global Fund, to procure an additional 3.2 million tests; of which 2.6 million were distributed by NMS. As a result, testing sites and projects have expanded their capacity to perform HIV testing.

During FY 2009, NMS and their sub-partner JMS will continue to procure, store and distribute HIV test kits and accessories to all health facilities and testing projects countrywide. With FY 2009 funding, the project will secure another 1.8 million test kits, to contribute to the national HIV/AIDS testing program; as the MOH projects that there are 10 million people in need of testing. Additionally, the Global Fund, Makerere University's Joint Aids Programme (MJAP) and the Clinton Foundation will continue to procure test kits and accessories to meet the national projected need. All of these combined activities contribute to the overall success of HCT program areas; by ensuring the consistent availability of required test kits and related supplies.

In addition, both NMS and JMS will support training their management and support staff in order to build internal human resource capacity to improve the supply chain system. NMS has also received support from DANIDA for several areas, most recently for the construction of a 20,000 m3 volume extension to the main warehouse in Entebbe. This additional space will eliminate the need for rented warehousing. The World Health Organization (WHO) is also supporting NMS, by conducting a business process and information systems assessment review. This WHO technical assistance will also identify gaps, outline strategies, and improve NMS management capacity to fully implement the national supply chain system. Finally, JMS had recently been supported by the PEPFAR funded Supply Chain Management System (SCMS) project to conduct a business process review, and assist JMS with the acquisition of a new logistics management information system.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13304

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13304	4030.08	HHS/Centers for Disease Control & Prevention	National Medical Stores	6435	629.08	Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services	\$4,103,523
8351	4030.07	HHS/Centers for Disease Control & Prevention	National Medical Stores	4810	629.07		\$3,645,000
4030	4030.06	HHS/Centers for Disease Control & Prevention	National Medical Stores	3178	629.06		\$1,950,000

---

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$76,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Prime Partner:** Makerere University Faculty of  
Medicine

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 4033.20766.09

**Activity System ID:** 20766

**Mechanism:** Mulago-Mbarara Teaching  
Hospitals - MJAP

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Prevention: Counseling and  
Testing

**Program Budget Code:** 14

**Planned Funds:** \$1,400,000

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP started implementing Routine HIV Testing and Counseling (RTC) in November 2004, in Mulago and Mbarara University teaching hospitals. Since that time, the RTC program has expanded from six to 49 hospital wards and clinics (30 in Mulago and 19 in Mbarara). The current unit coverage represents over 95% in Mbarara and about 75% at Mulago although over 95% of the high prevalence units provide RTC. In line with Uganda's HIV/AIDS National Strategic Plan 2007/2008-2011/12, MJAP has expanded RTC to seven regional referral hospitals: Jinja, Mbale, Hoima, Soroti, Masaka, Fort Portal and Kabale as well as to the satellite clinics listed above. In RTC, HIV testing is routinely offered to all patients seeking care in the wards/clinics where the program is operational but those who decide not to test receive other hospital services without discrimination. The RTC program is implemented in line with the three C's – confidentiality, informed consent (opt out) and counseling/information, as recommended by WHO, and the MOH HIV testing policy. Care for identified HIV positive patients is initiated at the time of diagnosis; all HIV positive patients receive cotrimoxazole prophylaxis. In 2006 MJAP integrated TB screening and treatment within its existing routine HIV testing and care program. In this regard TB screening is provided for all patients with history of cough for more than 3 weeks irrespective of the HIV status. HIV positive patients are also referred for follow-up care in the HIV clinics where they receive basic HIV care, psychosocial support and ART when eligible. For patients found to be HIV negative, HIV prevention messages are emphasized to reduce risk of infection. The program also offers HIV testing to family members of patients in the hospital and has found a high HIV prevalence (24%) among these. In order to strengthen prevention with positives, MJAP provides home-based HIV counseling and testing (HBHCT) for household members of index HIV positive patients attending Mulago, Mbarara and the satellite clinics who consent to be visited which has led to identification of more HIV positive persons and early referral to care. Initial efforts have already been made to extend this service to communities, other than only the household members. HIV testing for family members of HIV positive patients identifies other HIV infected individuals in their households, facilitates partner disclosure and testing, and identifies many discordant couples. Additionally, testing of family members encourages early entry into care and support for the HIV infected individuals. To date, the program has trained over 1,200 health care providers in the implementing sites in the provision of RTC. Cumulatively, more than 170,000 in- and outpatients have received HIV testing and over 56,000 HIV infected individuals identified and linked to care and treatment.

In FY 2009, (October 2008-september 2009), MJAP will extend RTC services to an additional six units in Mulago, four lower level Health Center IV in the catchment areas of regional referral hospitals, 2 units and one satellite clinic in Mbarara. In Mbarara we will achieve 100% coverage of all wards and clinics and increase coverage in Mulago to 85%. We will achieve 100% coverage for all units with a high HIV prevalence. MJAP will continue providing RTC in the seven regional referral hospitals and in the satellite clinics. We intend to provide HIV testing to a minimum of 170,000 individuals in FY 2009. In the RTC units, all patients with undocumented HIV status will be routinely offered HIV testing but this will not preclude the right to opt-out of testing. The program will target all categories of patients and family members including adults, infants, children, health care workers. Through the revised HBHCT program, MJAP will provide HIV counseling and testing to 2,000 households (10,000 individuals) in FY 2009. By the end of FY 2010, the program will have offered its services to 15,000 individuals in 2,500 homes. Newly diagnosed HIV positive patients will receive a month's supply of cotrimoxazole before referral for follow-up palliative care and treatment. The program will endeavor to improve linkages to care and treatment services providers as well as strengthen linkages with clinical services for better performance. The HIV testing through the MJAP integrated TB-HIV services will be consolidated in all MJAP sites. It will endeavor to offer TB screening to 80% of all its patients and clients who benefit from RTC services. We will strengthen prevention with positives (PWP) and offer counseling and support including HIV testing for spouses of patients in the HIV clinics and RTC wards. Discordant couples will be referred to the 'Discordant couples' clubs which are

**Activity Narrative:** currently being piloted at two sites (one in Mulago and another in Mbarara). In those clubs, the couples will be supported to enable them understand and cope with HIV, ensure reduction of sexual transmission by using condoms, and other means and share experiences with similar couples. For the concordant negative couples and other HIV negative patients, MJAP will re-emphasize the HIV preventive messages. To ensure sustainability, MJAP will support the improvement of existing structures and systems within the facilities. The program will support the engagement of people living with HIV/AIDS to supplement personnel for HIV counseling and testing. A total of 1,000 new and existing health care providers will be trained in RTC/TB service provision. MJAP will support the existing logistics management system, procure HCT items to cover gaps, strengthen quality assurance and support supervision, and enhance the existing referral systems to improve linkage to care for newly diagnosed HIV patients. The program will also support the improvement of data management/ M&E and reporting to all stakeholders within the districts and MOH. In addition, targeted evaluations will be conducted to provide the program with lessons learnt and plans for the future.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13277

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13277	4033.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,400,000
8316	4033.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$1,400,000
4033	4033.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$984,058

#### Emphasis Areas

##### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

##### Health-related Wraparound Programs

- \* TB

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$729,501

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water



**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 8670.09

**Mechanism:** Provision of Full Access Home-based Confidential HIV Counseling and Testing and Basic Care Services in Kalangala District and the Surrounding Fishing Communities

**Prime Partner:** Kalangala District Health Office

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 9429.20755.09

**Planned Funds:** \$400,000

**Activity System ID:** 20755

**Activity Narrative:** In January 2008, Kalangala District Local Government received PEPFAR funding to implement a full access 100% home based HIV counseling and testing and basic care in Kalangala district and the surrounding fishing communities. The objectives of the four 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 and 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 was specifically targeted with this program to respond to the prevailing needs of the fishing communities related to vulnerability to HIV. Kalangala District, located in Central Uganda is comprised of 84 Islands in Lake Victoria of which 64 are permanently habited and 8 habited due to fish migratory patterns and harsh weather conditions. Kalangala's unique geographical location has resulted in limited health and human services to this marginalized population of 36,661 (2002 Census) and projected population of 100,000 people (2008). The district is served by only eleven health units: two Health Centre (HC) IVs, six HC IIIs and three HC IIs. There is no hospital located within the district. Referrals for patients with complicated health problems are made to mainland Entebbe, Kitovu, and Masaka Regional Referral Hospitals which is 80 kilometers from the main island. Results from the 2005 Uganda National Health and Behavioral Survey (USHBS) demonstrate that the central region, in which Kalangala is located, has the highest HIV prevalence in the country, reported at 8.5%. The secondary analysis of the USHBS central region data indicate that Kalangala District, has a prevalence of 27% which is approximately five times the national average, thus this population of fishermen and their families have been identified as a very-high risk group.

By July 31st 2008, the program office had been established and equipment procured; project staff including 45 full time staff and 100 mobilisers had been recruited and trained; 3,401 individuals including 155 couples had received HIV counseling and testing and 711 HIV-positive individuals had been identified and provided basic palliative care and referred for chronic care management. Field HIV Counseling and Testing (HCT) teams comprise a counselor and laboratory assistant who conduct counseling and testing services in clients' homes. Community mobilization and support is conducted by a team of 100 Community Owned Resource Persons (CORPS)/ Mobilisers that have been identified by the communities served and trained by TASO Uganda. Actual HBHCT started on June 11th 2008, and by the end of July 31st 2008, an estimated 3,401 persons had been counseled, tested for HIV and received their results in their homes on the mainland as well as along the fish landing sites in Lake Victoria. Counseling and testing in-home environment has been indicated to improve community knowledge and communication about HIV/AIDS among family members and in turn contribute to the reduction of stigma and discrimination. In addition, as demonstrated in the other districts implementing this approach, there is a greater potential when targeting the family in their home to identify undiagnosed HIV among family members especially in the identification of discordant couples. Results from the 2004-2005 Uganda HIV/AIDS sero-behavioral survey report that 85% of HIV positive people have not been tested for HIV and approximately half of HIV+ married/co-inhabiting individuals are sero-discordant creating a high potential for transmission. This program also promotes participation of and enhanced partnerships with community based organizations (CBOs) and non-governmental organizations (NGOs) operating in HIV/AIDS services delivery in the district, thus building capacity and infrastructure for sustainable services.

In FY 2009, the program will continue the door-to-door HCT initiative in Kalangala to increase the number of individuals who receive HCT in the district as part of scale-up. This activity proposes to reach 23,000 individuals with HBCT services with FY 2009 funding. The number of HCT teams trained to provide HBHCT will be increased to 35 and the program 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 to increase the capacity to provide comprehensive HIV/AIDS services as needed to individuals in the district.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13225

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13225	9429.08	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8670	8670.08		\$400,000
9429	9429.07	HHS/Centers for Disease Control & Prevention	Kalangala District Health Office	8792	8792.07		\$400,000

### Emphasis Areas

#### Gender

- \* Increasing gender equity in HIV/AIDS programs

#### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1245.09	<b>Mechanism:</b> Makerere University Walter Reed Project (MUWRP)
<b>Prime Partner:</b> Walter Reed	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 8543.20036.09	<b>Planned Funds:</b> \$297,000
<b>Activity System ID:</b> 20036	

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a variety of counseling and testing and prevention programs.

The HIV counseling and testing (CT) program described below is part of a comprehensive program and activities do link to other program areas. Specific program activities that are included in this comprehensive program include care, treatment, prevention, laboratory, and OVC services. Since ART was first made available in Kayunga District in April 2005, the number of residents who have sought out CT services has increased extremely dramatically. 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 in the District to ensure that there will be no stock outs. Funds have been 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 has worked alongside other health agencies in Kayunga, such as Doctors with Africa (CUJAMM) 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. In addition to CT services provided through fixed sites and clinics, a major focus on the MUWRP CT program has been provision of services to two high-risk groups, especially youth and fishing communities. Toward this end, MUWRP collaborated with Kayunga District Health authorities to establish a Youth Center in Kayunga Town. MUWRP administers the Center while volunteer district clinicians staff the Youth HIV/ART clinic. Any of the youth that are counseled and tested at the Youth Center who are identified as HIV+ are referred for evaluation for ART by clinical staff of the District Hospital. Close links with the nearby District Hospital are maintained through medical staff providing clinical services at the Center, ensuring quick referrals and evaluation for treatment eligibility at the Center or the District Hospital. Increased outreach through advertising and community campaigns have focused on a youth approach/audience using such venues as sports, drama, and music concerts to increase youth attendance at the Center and accessing of CT. To reach the other at-risk population in need of CT and access to HIV care and treatment services in Kayunga, such as fishing communities, MUWRP expanded mobile operations to reach these populations along the Nile and at the inlet to Lake Kioga. Furthermore, MUWRP mobile community program has also included bi-monthly community sensitizations, usually implemented by a MUWRP partner, which always include provision of CT services. Working along-side MUWRP's prevention program, MUWRP's mobile CT program expanded programs during 2008, targeting out of school youth as well as youth in schools. Another aspect of the CT program implemented in 2008 was the District-wide post-exposure prophylaxis program for victims of rape, defilement, or for any other person who has had immediate exposure to HIV. Beginning in 2007, MUWRP linked with MJAP for technical assistance and supported implementation of RTC services at four fixed clinical sites in Kayunga, including one health center III which primarily delivers services to fishing communities. The program has gone extremely well with many unexpected benefits coming to light. This program was the subject of an oral presentation at the 2008 implementers meeting in Kampala. All staff (approx 170) at each of these health centers (including the District Hospital) have been comprehensively trained in RTC administration and in particular, they have learned the finger stick method of blood draw to facilitate fast turn around times for RTC clients. In order to strengthen linkages between TB and HIV as well as PMTCT and HIV, MUWRP staff worked alongside other health agencies in Kayunga to ensure that pregnant mothers and individuals being screened for TB were concurrently tested for HIV and referred to HIV services if HIV-positive. To accomplish all of this, MUWRP trained District lay workers and youth volunteers in CT service delivery to meet staffing demands. As a quality control measure, the MUWRP Lab Coordinator prepares serum samples with known results on a quarterly basis. These samples are sent out to all the RTC sites for the Health Worker to test and return for accuracy checks, feedback, and follow-up if needed. Funds were utilized to modify infrastructure to ensure confidential counseling space and scaling up RCT services to each of the four health centers. Finally in 2008, MUWRP implemented a house-to-house HIV CT (HTHCT) program beginning in Busana sub-county in Kayunga. This program was modeled largely after the successful HTHCT program implemented in Kumi and Busheni Uganda. MUWRP began the process by coordinating with another partner in Kayunga, planning specific HTHCT activities, consultations with the Kayunga District health authorities, sub-county sensitizations, and with the leaders of the Kumi and Busheni programs. Staff were identified and trained in all the various subject matters. The HTHCT program commenced on July 2, 2008. For program quality control, dried blood spots are prepared for every positive result and for the negative partner in discordant situations. For negative results, dried blood spots are prepared for every 25th or 50th negative result.

**ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:**

During FY09, the HTHCT program that began in Busana sub-district in Kayunga will continue until all 9 sub-districts in Kayunga have been completed. In order for this program to operate successfully, MUWRP will require more PEPFAR CT support to cover staffing, transportation, HIV testing, data management and ongoing training and community sensitizations. This mobile unit will be staffed with MUWRP staff as well as District health service personnel and will be supervised daily for quality counseling and testing. In addition, in FY09 MUWRP intends to enter Mukono District in order to initially support the Kojja Health Center IV. The initial aims of this support will be to promote VCT and RTC for the entire sub-district of Mukono South; including supporting three surrounding health center III's for the same services via mobile VCT outreaches into the surrounding fishing communities. If the partnership with Kojja works well, we could consider duplicating a house-to-house VCT program throughout Mukono South. Presently, the only HIV service

**Activity Narrative:** provision operating at Kojja is a PMTCT component and a treatment club for mothers, both supported by EGPAF. Mukono South sub-district has a population of 120,000 persons and using data from the Uganda sera-survey, it is anticipated that approximately 12,000 residents are HIV positive.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15712

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15712	8543.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$300,000
8543	8543.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$216,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$146,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Mechanism:** Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers

**Prime Partner:** Baylor College of Medicine Children's Foundation/Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

---

**Budget Code:** HVCT

**Activity ID:** 4378.20062.09

**Activity System ID:** 20062

**Program Budget Code:** 14

**Planned Funds:** \$250,000

**Activity Narrative:** 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 pediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Pediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum) with UNICEF. Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kiruddu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), and The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These direct services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala. In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these activities will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC roll it to all our supported health facilities over the five years.

Counseling and Testing is the prime entry point into HIV prevention and/or HIV/AIDS care and treatment services. Baylor-Uganda conducts HIV Counseling and Testing in several forms: 1) early diagnosis of children below 18 months of age with DNA-PCR; 2) VCT for children aged 18 months to 18 years; 3) in clinic HIV counseling and testing of family/household members of our index clients; 4) clinic based HIV counseling & testing of index TB patients; 5) home-based HIV counseling and testing (HBHCT) of family/household members of index patients from our clinic; and, 6) support routine counseling and testing in all the national expansion health facilities and UNICEF supported sites. The target populations benefiting from these services include vulnerable infants, children and youth, and adults in HIV/AIDS-affected families. HIV infected individuals are linked to palliative and ART services while the HIV negative have enhanced prevention messages during post test counseling. Specialized infant feeding counseling messages are provided to HIV+ mothers who continue to breastfeed their HIV- infants to reduce future possibilities for HIV transmission to the infant. Baylor – Uganda supported the development of and will continue to disseminate guidelines on early infant diagnosis (EID) and monitoring tools, and is currently the chair of the EID sub-committee. Abbott Laboratories made donation of 50,000 HIV test kits in 2007, which we hope to continue in 2008/9. By March 2008, Baylor- Uganda had provided HCT to 15,077 individuals at the various sites using the approaches outlined above.

In FY2009 Baylor-Uganda will procure HIV test kits for mass screening, confirmatory test and tie-breaker.

- Procure reagents for running of CD4 machine and regularly service the machine.
- Provide HIV counseling and testing services: EID, VCT, HBHCT to an estimated 40,000 children and adults from Baylor – Uganda direct service outlets (COE -1; Satellites – 6; UNICEF supported sites – 4) & their outreaches; and indirect services points (33 rural sites & their outreaches). More than 10,000 of the 40,000 screened, are anticipated to be infants <18 months. These infants will require DNA-PCR testing.
- In line with HIV counseling and testing (HCT) policy of 2005, Baylor-Uganda will increase access to HCT by rolling out Paediatric HIV Routine Counseling & Testing (RCT) in all facilities (30/52) supported by Baylor-Uganda, where there is no other provider doing RCT.
- Baylor – Uganda in collaboration with Ministry of Health will continue to train about 570 health care

**Activity Narrative:** professionals in early infant diagnosis, pediatric HIV/AIDS counseling, etc. through didactic training sessions, mentorship and support supervision

- Counseling and peer support groups will continue to provide psychosocial counseling & support, including stigma reduction, of the Baylor-Uganda clinic patients.
- Community outreach activities and drama by peer support groups will be enhanced to support community knowledge of the need for pediatric HIV CT services and care, since 75% of HIV+ children who do not receive any care services die before their 5th birthday.
- Baylor – Uganda will continue to directly conduct HIV counseling and Testing outreach services to most at risk populations and underserved areas such as orphanages, children retention centres; and indirectly through partners to support to rural health facilities we support, to rural based Early Childhood Care and Development centres, Internally Displaced Camps, etc. Initially, Baylor – Uganda would conduct outreaches in the general communities and the patient yield (HIV+ positive children were low), questioning the cost effectiveness of such interventions.
- Baylor – Uganda will also modify her “Know Your Child’s HIV Status” campaign to target only the positive community receiving HIV/AIDS care and treatment services or through mobilization from PHA networks.

- In rural areas, Baylor-Uganda will support the transportation of samples for DNA-PCR testing to regional sites, since previous fee-for-service contract with Joint Clinical Research Centre (JCRC) have been waived.
- In rural health facilities where there are no Routine Counseling and Testing services, Baylor – Uganda will introduce and support this component in order to prevent any missed opportunity in patient identification and enrollment into HIV/AIDS care and treatment.
- Some minor renovations of rural health facilities may be undertaken to provide space for confidential and private counseling and safe custody of patient records.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13246

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13246	4378.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$250,000
8282	4378.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$250,000
4378	4378.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$175,261

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* TB

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$92,500

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 1290.09

**Prime Partner:** Catholic Relief Services

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 4398.20743.09

**Activity System ID:** 20743

**Mechanism:** AIDSRelief

**USG Agency:** HHS/Health Resources  
Services Administration

**Program Area:** Prevention: Counseling and  
Testing

**Program Budget Code:** 14

**Planned Funds:** \$150,000



**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, their families, communities and the health institutions. Its goal is to ensure that people living with HIV/AIDS have increased access to Antiretroviral Therapy (ART) and quality comprehensive medical care. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the prime agency, the Institute of Human Virology (IHV) of the University of Maryland School of Medicine, Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed across Uganda in some of the most underserved and rural areas. These include St. Mary's Lacor, St Joseph Kitgum, Kalongo Hospital, Aber Hospital and Amai Hospital in Northern Uganda; Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Villa Maria Hospital and Nkozi Hospital in Central Uganda; Family Hope Center Jinja and Nyenga Hospital in Eastern Uganda; Virika Hospital, Kabarole Hospital, Bushenyi Medical Center - Katungu, KCRC – Bushenyi, Kyamuhunga Comboni Hospital, Kasanga Health Centre in Western Uganda. In order to get services closer to the communities served, AIDSRelief supports devolution of services to satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs. As of July 31, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. In addition it was providing care and support to 5,144 infected children under the age of 18, and antiretroviral treatment to 1762 children under the age of 15.

In FY2008 at AIDSRelief supported centers, 40,000 individuals (35,200 excluding TB patients) received counseling and testing for HIV and received test results (including TB patients). This comprised 19,600 males (17,248 excluding TB patients) and 20,400 females (17,952 excluding TB patients). In order to avoid stock outs of test kits at the LPTFs, In FY2008 AIDSRelief procured test kits to carry out tests on 100,000 individuals 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 Samaritan in 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.

By the end of FY2008 the AIDSRelief Technical team will have made an average of one visit to each LPTF/quarter, each lasting on the average one week. As part of the purpose of the above trainings and CMEs is to further equip the LPTFs with knowledge and skills to improve their support to patients.

In FY2009, through greater coordination and integration of services provided within the community by networking with other service providers including the Ministry of Health, and should additional resources be made available, 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 FY2009, 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 FY2009, 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 20,000 tests to temporarily fulfill the gap created. Linkages will be created between the MCH, out- and in-patient departments promoting routine counseling and testing and testing 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 290 health workers and 720 community volunteers will be trained.

**Activity Narrative:** 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 Constella Futures, 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 2008. In FY 2009, 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. In FY 2009, AIDSRelief will support LPTFs roll-out of IQCare, electronic data management software deployed in FY 2008, to enhance sustainability of PMM systems. The program will promote these 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.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13266

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13266	4398.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$150,000
8295	4398.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$150,000
4398	4398.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$120,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$41,250

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$1,500

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.14: Activities by Funding Mechanism

**Mechanism ID:** 7406.09

**Prime Partner:** Infectious Disease Institute

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 16303.22688.09

**Activity System ID:** 22688

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** \$480,000

**Activity Narrative:** The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Dean of the Faculty of Medicine. IDI has trained 2,394 course participants from 26 African countries in the areas of HIV/AIDS, malaria, pharmacy, lab and data management. Twenty-six research projects are in progress, focusing on identifying best practices and models for prevention, care and treatment of HIV/AIDS and related infectious diseases in sub-Saharan Africa. Almost 9,000 people are receiving care at the IDI clinic, and 5,741 people are on anti-retroviral therapy (ART). In addition, a total of 3,004 people are being cared for at four Kampala City Council clinics supported by IDI, and 1,339 people are receiving ART across the four sites.

In August 2008, IDI was awarded a CDC Cooperative Agreement to build capacity for scaling up of HIV/AIDS services in Kibaale and Kiboga, two rural underserved and high prevalence districts in Uganda. IDI intends to implement this service in conjunction with the respective District Health Offices, The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) projects. These latter two organizations will support the HIV/AIDS Care and treatment and training functions respectively. Specifically the project will: (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. At the end of the project period, IDI will have scaled-up routine HIV Counseling and Testing in at least six health facilities and tested 200,000 people. In addition, the project will provide at least 3,000 HIV-infected people with a care package and to start or maintain at least 1,500 HIV-positive people on ART. Other measurable outcomes include training for at least 200 health workers in comprehensive HIV/AIDS Care and starting 900 HIV+ people on TB treatment.

In FY 2009, IDI and its partners will support the implementation of routine HIV counseling and testing in 6 district and lower level facilities. This activity proposes to reach 100,000 unique individuals with CT services between 1st October 2009 and 30th September 2010. In FY 2010, the same targets will be reached. In-service training and technical support supervision will be provided by project staff health workers in the health facilities. IDI will identify and strengthen facility-based counselor supervisors who will continue to provide technical support in this area to the other health workers. Quality Assurance for the counseling and testing process will be emphasized and external quality control for HIV testing will be conducted. The project will also train and provide technical support supervision to adhere to guidelines related to proper management and disposal of medical waste. Standard operating procedures and protocols for implementation of RCT and waste disposal will be distributed to the new sites. IDI's support will focus primarily on providing materials for managing medical waste at the point of waste generation (testing points and wards). IDI will also support the setting up of, or strengthening of clinic-based support groups and post-test clubs to assist in providing post-test counseling and psychosocial support to persons who test for HIV. Health workers will be equipped to support clients who need couple counseling, disclosure of HIV testing results to partners and support for discordant couples. In the case of infant testing and testing for pregnant women, the program will partner with other implementing agencies working in this area especially the Pediatric Infectious Diseases Clinic (PIDC), EGPAF and Protecting Families Against HIV/AIDS (PREFA) to provide CT services to children. IDI support in these areas will be varied depending on level of presence of PIDC, EGPAF, PREFA and/or similar partners in the supported facilities. In each case, the roles of the various partners will be delineated to avoid duplication of support. IDI will work closely with the district health teams and health unit CT focal persons to enhance ownership and sustainability of the service, and to increase its utilization. IDI will also produce IEC materials on routine CT in English and the various local languages used in the focus areas, which will be disseminated in the health facilities, to community leaders and clients. IDI will collaborate with MOH, National Medical Stores (NMS) and Supply Chain Management Systems (SCMS) to strengthen logistics management to minimize stock-outs. Technical support will also be provided to improve collection, analysis, distribution and use of data on RCT so as to inform and improve program activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16303

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16303	16303.08	HHS/Centers for Disease Control & Prevention	Infectious Disease Institute	12197	12197.08	Expansion of Routine HCT and provision of Basic Care in Clinics, Hospitals and HC IVs	\$480,000

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 4365.21717.09

**Activity System ID:** 21717

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** ██████████

**Activity Narrative:** 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 a lead role in expanding access to counseling and testing, using both static and outreach models. As at March 2008, IRCU had counseled and tested 52,878 individuals. Of this total, 33,314 were women and 19,564 were men. Using FY2007 funds, IRCU has trained several community based religious leaders to serve as HIV and AIDS resource persons at community level, whose primary roles include among others, mobilization and referral of individuals for counseling and testing. The approach is paying off already as some of the outreach sites often report challenges with failure to meet the demand. At the current level of service delivery, IRCU is poised to become one of the leading providers of counseling and testing in Uganda.

USAID/Uganda's partnership with IRCU ends in June 2009. USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU. One of the primary priorities for the follow-on program will be to consolidate the facility and community outreach networks already established by IRCU and continue to harness and optimize their potential to reach more people. The follow-on program is also expected to come up with more creative ways, particularly in the area of strengthening couple counseling and testing as well as reaching out to high risk and vulnerable groups.

IRCU procures HIV testing kits through the Joint Medical Stores (JMS) and the distribution process is managed by the Logistics Officer working at the IRCU secretariat. With support from the Program for Supply Chain Management Systems (SCMS), IRCU has developed a logistics log frame for the implementing sites to facilitate proper forecasting and ordering of HIV test kits. This resulted in greater improvements in the supply and distribution of HIV testing kits and other associated supplies. The follow-on program will be expected to review this partnership and assess its viability in meeting increased demand for counseling and testing services. If found appropriate, it will continue to be strengthened through FY2009.

IRCU initiated the newly introduced provider-initiated testing and counseling model, commonly known as Routine Testing and Counseling (RTC) as part of the routine clinical care at all its hospital based sites. However, this approach remains largely nascent and the follow on program will be required to make further improvements in terms of further training for health workers, establishment of protocols with partner sites as well as raising awareness among patients and health care providers about this strategy. Similarly, IRCU has initiated counseling and testing within TB care settings. This will also require further focus, 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.

Given the high opportunity cost of seeking medical care in Uganda, facility based delivery of counseling and testing services severely limits 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. 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 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. By the end of FY2008 IRCU targets to counsel and test 112,000 individuals. With the same level of resources, the follow-on program will counsel and test approximately 120,000 by intensifying cost-effective approaches such as outreaches.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14210

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14210	4365.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8424	4365.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4365	4365.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

### Emphasis Areas

#### Gender

- \* Increasing gender equity in HIV/AIDS programs

#### Health-related Wraparound Programs

- \* Family Planning
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development ██████████

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7156.09	<b>Mechanism:</b> NUMAT
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 4702.21728.09	<b>Planned Funds:</b> \$560,000
<b>Activity System ID:</b> 21728	

**Activity Narrative:** This is part of NUMAT activities which include Prevention /Abstinence and Being Faithful, Prevention Other, Adult and Pediatric care and treatment, PMTCT, Laboratory infrastructure, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning. The FY2009 activities are a continuation from FY2008.

In FY 2008, NUMAT supported HCT activities together with AIDS Information Centre (AIC), the NUMAT sub-partner; National Guidance and Empowerment Network of People Living with HIV/AIDS (NGEN+); Straight Talk Foundation / Gulu Youth Centre; among others. These partners helped to roll out HCT services through voluntary CT, provider initiated CT and outreach approaches by targeting the most at risk populations, namely internally displaced persons in camps, youth, prison inmates, uniformed personnel, students in higher institutions and fishing communities. A total of 91 health facilities including hospitals, health centre IVs, health centre IIIs and selected health centre IIs were supported to provide HCT. The support offered included: technical supervision; capacity building; provision of logistics tools, registers, cards and HIV test kits to facilities without these commodities.

Ten Post Test Clubs (PTCs) were established in 5 districts of Amuru, Amolatar, Apac, Dokolo and Oyam and the clubs were supported with equipment and costumes for drama and music activities. Over 3,000 HIV positive and negative individuals have benefited from PTC activities including psycho-social support meetings; educational talks; and music, dance and drama activities. A total of 404 health workers from Gulu and Lira regional referral hospitals were trained in provider initiated counseling and testing while 161 support and administrative staff from the same hospitals received orientation. Blood samples were sent to a reference laboratory at Uganda Virus Research Institute for quality control/assurance of HIV tests conducted in all sites. As a result of the mentioned support, over 100,000 people benefited from HCT services from the project supported static and outreach sites in FY 2008. The average sero-positivity rate was 12.6%.

Activities for FY 2009 will build on FY 2008 achievements and will involve working closely with the central and local governments, CSOs and the private sector, to develop HCT services tailored not only to individual, family and community needs but also to the needs of the most at risk populations. NUMAT will consolidate and strengthen existing facilities, where HCT services are provided and support the establishment of new HCT service delivery points. This will be done in order to increase geographical and population coverage. The project will also support the roll out of the national approach of provider-initiated HCT to all hospitals and selected HC IVs. NUMAT partner, AIC will continue to take lead in HCT activities and work to transfer best practices to government systems, including the VCT model of HCT service delivery. NUMAT will continue to support directly other CSOs that have demonstrated capacity to provide outreach HCT services to difficult to reach areas. Using the Ministry of Health approved curriculum within a rationalized human resources development strategy, health workers will be trained as HIV/AIDS counsellors and laboratory and other critical staff will be trained on HIV testing in selected facilities. Counselors will also be trained to deal with pediatric and couples counseling. NUMAT will also work with the existing structures and local human resources in camps; integrating HCT activities into existing activities and strengthening existing groups like CBOs. NUMAT will continue to support outreach services in HCT to peripheral communities and IDPs and to identified most-at-risk-populations including fishing communities. Other populations vulnerable to HIV infection, such as pregnant women and their partners, TB-infected individuals and persons with STIs will be given particular attention. The outreaches will be initially to HC III facilities that do not have the capability to offer these services. Logistical support will be provided by NUMAT to enable implementation of these activities. NUMAT will focus on integrating prevention, care and support services into ongoing outreaches and fill gaps in the 9 districts. In addition, referrals will be emphasized to ensure linkages between community and facility-based HCT, care and support services so that the tested individuals can access a wide range of wrap around services. HIV testing at static and outreach sites will generate a lot of wastes. NUMAT plans to procure waste management supplies including bins, bin liners and fuel as well as protective wear in order to handle these wastes and control infections. Support will also be extended towards transportation of wastes for incineration to Lira and Gulu regional referral hospitals.

In order to increase demand for testing, targeted HCT promotion and community mobilization as well as distribution of IEC materials in all communities will continue to be given 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. To ensure the smooth flow of supplies for uninterrupted service delivery, the project will invest in logistics training of the concerned health workers with support from SCMS and MOH. The project will also support the District Health Offices and CSO providers of HCT accessing 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 establish PTCs at selected health facilities providing HCT as well as camps that do not currently have such groups. Each PTC will be supported to form a drama group for sensitizing and mobilizing people to access HCT, availed psychosocial support counselors to offer ongoing counseling to members, provided with regular educational talks and indoor games and also provided with training in peer education and other activities. Working with PTCs and through strengthening referral mechanisms, those who test positive from the HCT sites will be supported and linked to a wide range of palliative care, ART and other wrap around services. Quality control/assurance will be strengthened in order to promote provision of quality services.



**Activity Narrative:**  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 15486

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15486	4702.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$570,000
8470	4702.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$500,000
4702	4702.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$400,000

**Emphasis Areas**

Military Populations  
 Refugees/Internally Displaced Persons

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 8882.21813.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21813	

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment and other HIV/AIDS services. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

This activity is linked to ARV drug procurement, Adult Care and Treatment, Pediatric Care and Treatment, PMTCT, TB/HIV, and Laboratory Infrastructure.

With the introduction of routine counseling and testing, and expansion of PMTCT services throughout the country, the demand for HIV test supplies has risen sharply. In FY 2008 alone, 7 million HIV tests were planned to be procured with funds from GFATM, PEPFAR and Clinton Foundation. At the national level, SCMS supported the MOH in providing capacity building in logistics data capture and management, forecasting, procurement planning, and coordination of emergency responses to product shortfalls in HIV test kits and other HIV/AIDS commodities. SCMS provided regular status updates on HIV test procurement in light of the almost six 6 month stock out of the screening test.

In FY 2009, SCMS will continue to provide procurement services to USAID-supported partners to buy ARVs and other commodities as appropriate for PMTCT and other HIV/AIDS services. The new procurement mechanism will provide technical assistance to national and district-level PEPFAR partners on commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. In addition, TBD will continue to work in collaboration with WHO, UNAIDS, GFATM and other stakeholders to provide technical support to the MOH to strengthen the laboratory logistics management system. Ensuring the availability of laboratory supplies for diagnosis, treatment and care is fundamental to the effectiveness of the CT and other HIV/AIDS and TB services. The MOH and CPHL will receive technical assistance to build their capacity in forecasting and quantification of national laboratory needs, procurement planning and coordination, monitoring of stock levels, and training of new laboratory staff in logistics management. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submitting timely reports to keep the supplies flowing. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution from district stores to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14233

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14233	8882.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$440,000
8882	8882.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$390,000

**Table 3.3.14: Activities by Funding Mechanism**

---

**Mechanism ID:** 7287.09

**Prime Partner:** World Vision International

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 15900.21808.09

**Activity System ID:** 21808

**Mechanism:** SPEAR

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Prevention: Counseling and  
Testing

**Program Budget Code:** 14

**Planned Funds:** \$150,000

**Activity Narrative:** This activity relates to palliative care - home-based and sexual prevention.

Building on the USG public sector programs, this activity is a follow-on to the Education Sector Workplace AIDS Policy Implementation (ESWAPI) that provided support to the education sector that ended in July 2008. The new follow-on program called Supporting Public sector workplaces to Expand Action and Responses against HIV/AIDS (SPEAR) is the USG prime mechanism for leveraging public sector support to increase access to and utilization of HIV/AIDS treatment, prevention and care services to selected sectors that include: ministries of Internal Affairs (MoIA); Local Government (MoLG); and Education and Sports (MoES). The SPEAR program is supporting 3 sectors that have worked with the National HIV/AIDS Program to develop and integrate HIV/AIDS into their work place through operationalization of the new National HIV/AIDS workplace policy. World Vision is the lead implementing agency for the USAID funded-five year program. The SPEAR initiative, which begun in June 2008 aims to achieve three key results:

1. Supporting public sectors have policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees
2. Increasing 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
3. Improving 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

On the overall, ESWAPI which ended in July 2008 facilitated around 12,500 MoES employees to access and utilize HCT services.

HCT is a critical entry point for prevention, care and treatment efforts. Therefore for HIV-infected patients to optimally benefit from the therapies available to them, they must be diagnosed early and appropriately. However, only 12% of Ugandans aged 15-49 know their HIV status. The rise in the number of discordant couples and HIV transmission via marriage is evidence of the need for increased and improved counseling and testing for couples. HCT is an essential component of prevention, both among sero-positive individuals (to prevent re-infection) and sero-negative individuals (to clarify understanding about HIV risk and transmission). In addition, demand for HCT remains unmet for a significant proportion of the general population. This activity focuses on increasing demand and utilization of HCT services public sector employees and their families not only for enhancing HIV/AIDS prevention, but also as a foundation for care, treatment and support services.

In FY 2009, SPEAR project activities under the Counseling and Testing program area will be geared towards increasing access to and utilization of HCT services by MoLG, MoES and MoIA public sector workers and their families. SPEAR will partner with approximately 50 HCT outlets to provide HCT (VCT, RCT, PITC, Outreach HCT, & Home-based HCT) to benefit public sector employees. 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. This will be accomplished through collaboration and partnership with HCT service providers; and expertly designed IEC materials and other HIV/AIDS educational opportunities by both the project team and other partners. To ensure accurate and consistent messaging, a standard HCT promotional guide will be developed covering the main aspects and key information about HCT. In the partnerships, SPEAR project's role will be mobilizing public sector employees and their families to go for HCT; promoting HCT; networking with MoH to ensure adequate supply of HIV testing kits; referring interested individuals for confidential HCT; and facilitating HCT service providers to take outreach or mobile counseling and testing services to workplaces in remote and underserved where necessary. Approximately 150,000 public sector employees and their families are targeted in FY 2009.

SPEAR will facilitate selected HCT service providers including district hospitals, health center IVs and other HCT service programs to ensure effective outreach and access to HCT by rural-based public sector workers, without neglecting urban areas where most of the target population groups (police/prisons, security guards and officers) are based. Facilitation of service providers will be in form of grants, contracts and advances depending on agreed scopes of work. Additionally, SPEAR will support training of health workers based in health units owned by the Uganda police and prisons in protocols and new approaches to HCT (e.g. RCT, PITC), Couples counseling and testing, home-based counseling, etc so as to increase opportunities and HCT coverage among target groups. These activities will be conducted in the workplaces of the three target ministries i.e. MoES, MoIA and MoLG countrywide, starting from headquarter employees through the districts to the lower levels.

Additionally, SPEAR will promote and facilitate pre-marital and couples HCT and mutual disclosure among public sector workers. To increase convenience and opportunities for public sector workers to receive HCT in a friendlier environment, SPEAR will work with public and private health facilities to promote "weekend service windows." Experience from ESWAPI shows that some government workers are unable to visit service centers during working hours.

Generate evidence for HCT promotion: SPEAR team will carry out limited operations research activities. For example, a prospective cohort study could be conducted comparing sexual behaviors of workers in public education workplaces (beneficiaries of this program) with those in the private education workplaces (non-beneficiaries) in order to assess the effectiveness of HCT.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15900

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15900	15900.08	U.S. Agency for International Development	World Vision Uganda	12196	12196.08	Public Sector Work Place Program (ESWAPI)	\$150,000

**Emphasis Areas**

Gender

\* Addressing male norms and behaviors

Health-related Wraparound Programs

\* Family Planning

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9220.09	<b>Mechanism:</b> TBD - HCT/AIC Follow on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 21458.21570.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21570	

**Activity Narrative:** This activity is an on-going program related to the CSF/Deloitte and Touche HIV Counseling and Testing program that was approved in COP 08 implemented by a national indigenous organization contributing towards the national goal of scaling up HIV counselling and testing services in Uganda. The goal of this program is to support the MOH, districts, private sector; and Community based Organizations (CBOs)/ Non-governmental organizations (NGOs) to scale up provision of integrated HCT services at the Regional HCT Centers of Excellence, public, private, and CBO/NGO/FBO HCT sites. This program will establish Regional HCT Centers of Excellence and scale up HCT services to cover all Regional referral hospitals, all District hospitals, all private hospitals, and all health centers up to H/C II sites that are not covered by the USAID funded District based program and other PEPFRAR HCT implementing partners. In addition, the program will establish HCT outreaches to the communities in collaboration with existing HCT service providers and CBOs in order to increase access to most at risk populations and remote areas. Outreach activities will include those held in schools, fishing landing sites, military/police establishments, mobile populations including internally displaced persons (IDPs), truck drivers, institutions of higher learning and People with Disabilities. The Regional HCT Centers of Excellence will be a focus point for coordination of M&E systems, Operational research, External quality assurance, training and mentoring of other HCT service providers within the health system in accordance with national and international guidelines.

Couple Counselling and testing will be enhanced through Couple Clubs and will entail providing training in key communication skills, prevention of gender-based violence among couples and promotion of disclosure. These Couple Clubs will continue to be a vessel in mobilization and promotion of HCT uptake by their fellow couples and promotion of faithfulness. It is estimated that 100,000 couples (200,000 individuals) will benefit from free couple HCT.

The program will continue to support the MOH in human capacity development of HCT service providers in both the public sector and private sector through training on HCT services and mentoring. PHAs and community volunteers will also be trained as counselors to bridge the human resources gap and reduce the workload of health workers. Further support to the MOH entails technical support to the National CT17 technical work group and support National HCT Campaigns to promote HIV prevention.

In FY 2009, the program will further promote functional laboratory and logistics management systems for HCT services. The program will strengthen supply, distribution and management of HCT commodities, by providing technical assistance, which will include forecasting, procurement and distribution of HCT commodities to all facilities supported by this program. In addition, the program will support and collaborate with National Medical Stores and other MOH service providers in the provision of buffer HIV test kits in relation to existing National gaps.

Linkages to care, treatment and support services for HIV-infected clients and their families will be strengthened at all levels of the health system. HCT services will be provided as an integrated HIV/AIDS service in addition to medical treatment of opportunistic infections (OIs) and minor ailments; STD diagnosis and management; septrin prophylaxis; psychosocial support; and on-going counseling. HIV positive clients will receive CD4+ screening to establish eligibility for ART. Other clinical services include related laboratory services, pain and symptom relief and nutritional assessment and support. 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 at improving quality of life of PHAs. The HIV+ client will be encouraged to mobilize other family members and community to access HCT 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21458

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21458	21458.08	U.S. Agency for International Development	To Be Determined	9220	9220.08	TBD/HCT	

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* TB

Military Populations

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 21145.21579.09

**Activity System ID:** 21579

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** \$300,000

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – East Central will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus on increasing rural access to HIV/AIDS Counseling and Testing (HCT) and anti-retroviral therapy (ART) through support to 6 districts in the East Central region of the country. This region has a low ART coverage and lies along the highway connecting Uganda to neighboring countries. According to the 2005 Uganda national HIV/AIDS Sero-Behavioural Survey 2004-2005, 79% of HIV-Ugandans do not know their HIV sero-status due to various reasons including limited access and utilization of HIV counseling and testing (HCT) services. The District HIV/AIDS/TB program will increase access and utilization of HCT services at both district hospital/lower level facilities and the community through the following initiatives:

- Increasing HCT service access and utilization for people in the rural setting and hard-to-reach high risk populations e.g. fishing communities, out-of-school youth, internally displaced populations, etc.
- Promotion of home-to-home and family-based HCT. Routine counseling and testing (RCT) will be supported in all district and lower level facilities with emphasis on referring all HIV+ clients into care and treatment facilities for follow on support services such as TB. In these health facilities, HCT will be routinely provided in the high HIV-prevalence clinics namely tuberculosis and Sexually transmitted clinics and medical in-patient wards.
- Promotion of outreach activities in high activity areas such as landing sites for fishing communities, communal markets, camps for internally displaced people, tertiary institutions and trading centers
- Training of health service providers such as counselors, laboratory staff, and data assistants. The training to cover personnel from approximately 50 outlets will support the role out of routine counseling and testing, strengthening counseling skills, logistics and records management, laboratory services, referral and general integrated patient care. A total of 300 personnel will be trained
- Increase support for and utilization of post test services through post test clubs (PTCs). PTCs will be used to promote awareness about disclosure, discordance and stigma.
- Promotion of couple counseling and testing coupled with referral linkages to post test services for both HIV - and HIV- individuals

To achieve the required results, the program will support provider-initiated HCT services in 50 health facilities. It is estimated that over 50,000 clients will receive HCT services in FY2009 and those testing HIV-positive linked to palliative care and treatment services. The program will build capacity of Networks and groups of People Living with HIV/AIDS (PHAs) to provide pre-test and post-test counseling to clients and facilitate family-based HCT. PHAs will be trained to function as expert clients facilitating linkages and referrals between community-based and facility-based care and linking all those testing HIV-positive to palliative care and wrap around services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 5028.09

**Prime Partner:** Emerging Markets

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 9080.21756.09

**Activity System ID:** 21756

**Mechanism:** HIPS (Health Initiatives in the Private Sector)

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** \$100,000

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides 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 improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

In partnership with the private sector, HIPS will continue to implement activities in HIV voluntary counseling and testing in partner company facilities, community outreaches and in health fairs. To date HIPS has trained over 100 counselors from partner facilities, and over 5,000 people received VCT services from both outreach and on site clinics. Special attention has been given to ensure that couples come for counseling and testing. Both male and female peer educators have been trained among company staff, out growers and community members to break the silence on CT, communicating the need to know one's status to their peers. To date over 100,000 persons have been reached with the 'know your status' campaign. Activities under this program area include purchase of test kits and distribution to partner facilities, conducting outreach VCT sessions in health fairs and in facilities and community mobilization for CT.

The counseling and testing activities for FY 2009 include but are not limited to the following:

1. Support the development of work place policies and programs aimed at reducing stigma and increasing access and utilization of CT services. These policies are developed and publicized in the workplace so as to mitigate stigma and thus increasing up take of CT services. This will be implemented among all HIPS partner companies across the country.
2. Train peer educators and HIV/AIDS champions in the work place and surrounding communities to break the silence on HIV/AIDS.
3. Support pre and post test counseling services to those that agree to test and receive results. Those who test HIV+ will be referred to access free care and treatment services.
4. Support the promotion of CT outreach services to benefit employee dependants and the surrounding community. For the communities surrounded by a most at risk population such as migrant workers, fishing communities and commercial sex workers, greater emphasis will be placed in ensuring periodic mobile CT outreaches with referrals to care and treatment.
5. Continue to promote and support counseling and testing services through HIPS community health fairs and private clinics.
6. HIPS will support training of 50 private providers in counseling and testing.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14173

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14173	9080.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$100,000
9080	9080.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$100,000

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$20,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1258.09	<b>Mechanism:</b> Roads to a Healthy Future/ROADS II-SafeTStop Project
<b>Prime Partner:</b> Family Health International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 4510.21763.09	<b>Planned Funds:</b> \$360,000
<b>Activity System ID:</b> 21763	

**Activity Narrative:** Regional mapping and HIV prevalence statistics support the need to more effectively target most-at-risk populations (MARPs), especially along high-prevalence transport corridors. The overall goal of the multi-sectoral Transport Corridor Initiative, branded SafeTStop, is to stem HIV transmission and mitigate impact in vulnerable communities along transport routes in East and Central Africa. In addition to high HIV prevalence, many of these communities, particularly in outlying areas, are severely underserved by HIV services. To date the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project has launched SafeTStop in Burundi, Democratic Republic of the Congo, Djibouti, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The ROADS strategy is to develop comprehensive, integrated programming that is designed and implemented by communities themselves, harnessing and strengthening their own resources to enhance long-term sustainability. Busia, Malaba and Katuna are sizable and characterized by high HIV prevalence relative to the national estimate. In these sites, truck drivers can spend up to a week waiting to clear customs. The combination of poverty, high concentration of transient workers, high HIV prevalence, hazardous sexual networking, lack of alcohol-free recreational facilities, lack of HIV services (CT, PMTCT, care and treatment for adults and children, TB/HIV), and limited support for OVC have created an environment in which HIV spreads rapidly. The sites are important targets for HIV programming in their own right; they are also bridges of infection to the rest of the country. Counseling and testing (CT) services in the sites remain underdeveloped and should be scaled up further to meet demand generated by ROADS community mobilization and outreach. For example, in Malaba the dearth of quality CT has led many residents to cross into Kenya for this service. Upgrading of Malaba Health Centre 3 is improving the situation though there is still a need for CT at fixed outreach sites during hours convenient for MARPs.

Since launching SafeTStop in Busia, Malaba and Katuna, ROADS has reached more than 11,800 people with facility- and community-based CT (January 2006-March 2008). The ROADS "cluster" model, which mobilizes community- and faith-based groups, has generated significant interest in and demand for CT at upgraded facilities. In Malaba, for example, the health center refurbished by ROADS now has three counseling rooms. The health center is currently providing CT services to an average of 242 people per week.

With FY 2009 funds the project will continue to establish and build demand for CT, reaching 7,000 people (4,500 females and 2,500 males) with this service (excluding TB) between October 1, 2008-September 30, 2009 and 8,050 people (5,300 females and 2,750 males) between October 1, 2009 and September 30, 2010. Recognizing the shortage of trained counselors in the sites the project will train 45 individuals in CT in FY 2009 and 55 in FY 2010. Training will include counseling skills to serve discordant couples, identify and counsel CT clients with hazardous drinking behavior, and discuss family planning. ROADS will actively promote testing to all family members where the index patient is found to be positive. An important strategy will be home testing, which has proven successful in several sites in East and Central Africa. Testing all family members will be the entry point to accessing 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 2009, ROADS will support 15 CT outlets in Busia, Malaba and Katuna with hours and locations appropriate for MARPs, particularly truck drivers, their sexual partners and out-of-school youth; in 2010 we will support 15 sites. Sites will include the wellness centers to be established within the SafeTStop resource centers, which serve as alcohol-free recreation sites and a venue for a range of HIV services. With new partner JHPIEGO, ROADS will work with local health facilities to ensure provider-initiated counseling and testing (PICT). In conjunction with ROADS partner Howard University/PACE Center, the Pharmaceutical Society and Pharmacy Board of Uganda, and the Uganda Ministry of Health, the project will pilot CT services in pharmacies/drug shops. ROADS will continue to support Malaba Health Centre 3, including purchase of test kits. ROADS will continue to work with community-based organizations to expand fixed outreach CT services. Importantly, ROADS will organize meetings between CT staff, health providers and community caregivers to ensure CT clients and family members are referred to and from services. As a wrap-around to CT, the project will address gender barriers to uptake of CT at health facilities, fixed outreach sites or the home, safe disclosure of results and training of CT counselors to identify and refer clients who may be suffering from alcohol abuse. SUSTAINABILITY: Almost all partners on the project are local entities that exist without external funding, including private and most public outlets that promote and/or offer CT services. As a result project activities are highly sustainable. Indigenous volunteer groups partnering with the project, including those that can provide community-based CT (e.g., FBOs), were established without outside assistance and will continue functioning over the long term. It is critical to manage the roster of volunteers so that individual volunteers are not overburdened and do not drop out of the program. ROADS has developed strategies to motivate volunteers (non-monetary incentives, implementing activities with people in their immediate networks) to minimize attrition and enhance sustainability.

EXPANSION SITES: Kasese, the end of a rail line and a key industrial center, attracts significant traffic going to and from DR Congo; Koboko is a major transit hub for drivers from around East and Central Africa carrying goods into South Sudan. The Uganda-South Sudan border is porous and experiences significant cross-border traffic; there is heavy interaction between Ugandans and South Sudanese in this area, given common tribal affiliation (Kakwa). These are important sites for expansion to safeguard progress against the epidemic in Uganda. Because Kasese and Koboko are growing rapidly it would be most cost-effective to intervene early with prevention programming including C&T. This would include a special focus on migrant populations, including poor women who travel across borders to work in the service industry, such as Ugandan women from Arua and Koboko who travel to Kaya, South Sudan, for employment in bars and lodges.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14194

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14194	4510.08	U.S. Agency for International Development	Family Health International	6736	1258.08	ROADS - SafeTstop Project	\$550,000
8418	4510.07	U.S. Agency for International Development	Family Health International	4833	1258.07	Northern Corridor Program/Uganda Section	\$525,000
4510	4510.06	U.S. Agency for International Development	Family Health International	3366	1258.06	Northern Corridor Program/Uganda Section	\$75,000

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

#### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$75,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 3166.09

**Prime Partner:** International HIV/AIDS Alliance

**Funding Source:** GHCS (State)

**Mechanism:** Expanding the Role of Networks of People Living with HIV/AIDS in Uganda

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 8900.24483.09

**Planned Funds:** \$184,000

**Activity System ID:** 24483

**Activity Narrative:** The International HIV/AIDS Alliance is an International NGO registered both in Uganda and United Kingdom. The Alliance's goal is to support community action on AIDS and to date the Alliance provides support to organizations in more than 40 developing countries focusing on people who are most likely to impact on the spread of HIV, and those who are most affected by the epidemic. With USAID support, the Alliance has been implementing a three year project that started in July 2006 aimed at expanding the role of individuals living with HIV and AIDS and their networks, groups and associations in prevention, care and treatment services in Uganda through increasing the number of PLHIV groups and networks mobilized and able to provide services to their members and facilitate referrals and linkages between facility-based and home-based care and treatment. The program employs the network model that focuses on strengthening referral systems and linkages in HIV/AIDS service delivery, reducing stigma and bringing services closer to the community. Critical to ensuring that a PLHIV is able to access a complete package of care throughout the HIV stages of disease progression, the program focuses on the building of skills and creation of space for men and women openly living with HIV to deliver quality counseling services, ensure linkages and provide referral services in areas of HIV prevention, care, treatment and support. The program works through open and experienced HIV positive individuals called Network Support Agents (NSAs) who are trained and placed in health facilities at Health Sub-District (HSD) level. They serve as providers of intermediate care and support as well as sources of HIV and AIDS information at community level. NSAs are facilitated, mentored and monitored to strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation including referrals between HBC providers and facility based care.

In FY 2008, the project trained and facilitated 839 NSAs placed at 416 health Facilities in 40 districts to carry out pre and post test counseling. The NSAs by virtue of being expert clients have been very supportive to clients to deal with their positive results. Through increased mobilization, education and referrals by NSAs and PHA groups, the health facilities reported increased uptake of HIV counseling and testing (HCT), PMTCT and ART. They facilitated a total of 148,544 individuals who were counseled tested and received results. The project has also contributed to the reduction of workload of health workers as a result of PHAs being involved in service delivery.

**ACTIVITY UNCHANGED FROM 2008**

In FY 2009, the project will continue to facilitate delivery for HCT services since it is an entry point into prevention, care, treatment and other services. The Network Support Agents (NSAs) will be 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. Due to the vital role NSAs have played in reducing workload of health workers in health facilities and recognizing the fact that the World Health Organization in collaboration with the Ministry of Health has identified the use of alternative sources of man power for health care through task shifting, the Project plans to advocate for the integration of NSAs into the formal district health care delivery system for purposes of improving health services delivery and ensuring quality of HIV-related services including HCT.

The PHA groups and networks will play a key role in community mobilization for HCT through conducting dramas, public dialogues and HCT campaigns. PHA networks and groups will also be trained to play a supportive role in providing counseling and testing in public health facilities. In addition they will also be facilitated to link up with several HCT providers namely AIC, PREFEA, JCRC, TASO to provide community outreaches for HCT services. There will be special focus on couples' counseling and testing, disclosure of sero-status to spouses and support for discordant couples. The PHA groups and networks will be trained to provide couples counseling, counseling of pediatric clients and provision of support for discordant couples. The groups and the NSAs will ensure that all those that test positive for HIV are linked to care and treatment services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14203

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14203	8900.08	U.S. Agency for International Development	International HIV/AIDS Alliance	6738	3166.08	Expanding the Role of Networks of People Living with HIV/AIDS in Uganda	\$200,000
8900	8900.07	U.S. Agency for International Development	International HIV/AIDS Alliance	4851	3166.07	Expanding the role of People Living with HIV/AIDS Networks	\$200,000

### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Military Populations

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$27,104

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3834.09	<b>Mechanism:</b> Refugee HIV/AIDS services in Kyaka II Settlement
<b>Prime Partner:</b> International Medical Corps	<b>USG Agency:</b> Department of State / Population, Refugees, and Migration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 4814.25181.09	<b>Planned Funds:</b> \$47,408
<b>Activity System ID:</b> 25181	

**Activity Narrative:** The proposed project will take place in Kyaka II settlement of Kyenjonjo district. According to the UNHCR August 2008 report, the refugee population in the area is currently 12,115 however there are a group of refugees known as "population on Hold" who are about 5,761. These are refugees who are not yet documented by the UNHCR and have unrestricted movement within the settlement, thus they could leave any time or stay for a longer period. The population of the host community within the 4 surrounding villages who benefit directly from the services is about 4,500. The refugee population consists mainly of Congolese origin that makes up about 80.7% of the total refugee population. The gender composition of the population is distributed such that the female population including women of childbearing age makes up about 50.2% of the total refugee population. Health services are provided by GTZ (German Development and Technical Cooperation) with support from UNHCR out of the health center in the settlement. Services provided include curative, preventive, VCT, PMTCT, palliative care and ART services. IMC supports the provision of these services together with GTZ and its partners using trained nurses, laboratory technicians and other health care personnel. In the FY 2009 FY, IMC will provide HIV counseling and testing services to 1,500 pregnant women through its single service outlet while making plans to open up another outlet. Community mobilization and awareness through use of information campaigns, dramas & door to door visits etc to increase PMTCT uptake will be done including encouragement of spouses to attend PMTCT services.

During the past year one service outlet was operational in providing VCT services. There was a steady access of VCT services to the target population through the Health centers and community outreach programs. Three post-test clubs were organized and remained active in providing people living with HIV/AIDS with support. The programs also helped in sensitizing people in the value of VCT. A total of 1640 refugees consisting of 875 males and 745 females were tested in addition to 2,482 host population, consisting of 1,183 males and 1,299 females. Of the number tested 107 males and 133 females tested positive.

In FY 2009, the project will continue to provide services at Mukondo HCII, thus providing adequate coverage to the community. VCT services will continue to be the primary point for delivering HVCT services although Routine Counseling and Testing (RCT) will continue to be used within the context of PMTCT. RTC will be offered as part of clinical evaluation along with tests or investigations recommended by health providers. 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 Aides 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, will address issues related to disclosure of status to partners and families and the need for couple counseling and testing. Couple counseling will continue to be provided and health staff will be provided with refresher trained to carry out couple counseling. In addition incentives such as T-shirts and refreshments will be provided to couples that turn up for HVCT meetings and those who complete the full program will also be giving a certificate of completion. Community Educators will emphasize the importance of testing for children at risk of infection as part of this campaign. HVCT for children will be done mainly within the PMTCT context where babies born to HIV positive mothers or those with symptoms of HIV/AIDS will be tested at 18 months. GTZ will also explore the possibility of working with JCRC in Fort Portal to provide PCR in the long run. Other children will be tested as part of clinical evaluations while those above 12 years will be sensitized in school or during community sensitizations. In addition those above 12 years can access VCT at the different outlets or outreaches. Market days and church activities will continue to provide an entry point to HVCT. Links between the ongoing SGBV program and market/church activities will be key to the promotion of increased gender equity, challenging of male norms and behaviors conducive to HIV and STIs transmission, and the reduction of violence and coercion. All individuals who test HIV positive will be counseled and informed about available care and support services for PHAs including treatment for OIs, ART, PMTCT and palliative care services and enrolled on to the care and support program. Expectant mother who attend VCT will be referred to health centers for ANC and PMTCT services as well.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16084



### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16084	4814.08	Department of State / Population, Refugees, and Migration	International Medical Corps	7337	3834.08	Refugee HIV/AIDS services in Kyaka II Settlement	\$49,744
8304	4814.07	Department of State / Population, Refugees, and Migration	International Medical Corps	4801	3834.07	Refugee HIV/AIDS services in Kyaka II Settlement	\$49,744
4814	4814.06	Department of State / Population, Refugees, and Migration	International Medical Corps	3834	3834.06	Refugee HIV/AIDS services in Kyaka II Settlement	\$57,551

### Emphasis Areas

#### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

#### Health-related Wraparound Programs

- \* Family Planning
- \* Safe Motherhood

#### Refugees/Internally Displaced Persons

### Human Capacity Development

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Table 3.3.14: Activities by Funding Mechanism

Mechanism ID: 5740.09

Mechanism: Provision of Full Access Home-Based Confidential HIV Counseling and Testing and Basic Care Services in High HIV Prevalence Central Region Districts

**Prime Partner:** Integrated Community Based Initiatives

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 26507.09

**Planned Funds:** \$333,041

**Activity System ID:** 26507

**Activity Narrative:** Integrated Community Based Initiatives (ICOBI is an indigenous Non-Governmental Organization (NGO), non-profit making, non-denominational, charitable organization founded in 1994. It was first registered with the NGO Board in 1996 and incorporated in 2004. ICOBI has been operating in South Western Uganda since its inception with its head quarters in Kabwohe-Itendero Town Council-Bushenyi District and a Liaison office in Kampala. ICOBI's vision is a healthy and prosperous rural population and its mission is to improve the quality of life of people living in rural communities. ICOBI has implemented various HIV/AIDS health related programs namely. Prevention of Mother To Child Transmission (PMTCT) with support from EGPAF; FP/Reproductive health; STD/STI; IEC through Radio & Tripple~S talk show targeting the youth in South Western sub region; Nutrition and early Childhood development project(NECDP) with world bank support and recently completed a district wide Home Based Voluntary HIV Counseling and testing in Bushenyi district (October 2004-June 2007) with funding from CDC/PEPFAR, Home Based VCT and Home Based Care with support from UPHOLD, JSI/UHSP/USAID(on going in Bushenyi district); and recently April 2008; OVC Care & support with funding from NPI/USAID. ICOBI received a notice of award on 30th June 2008 from CDC to implement a program entitled "Provision of Full Access Home based confidential HIV counseling and testing (HBCT) and Basic care in the high HIV prevalence districts of central region of the Republic of Uganda". ICOBI HBCT cooperative Agreement Grant Number: 1U2GPS001076-01, Program period: 07/01/2008-06/30/2013. The program will cover the districts of Mubende/Mityana, Luwero/Nakaseke, Nakasongola and Wakiso districts of Central Region of Uganda. The goal of the program is to provide 100% Full access Home Based HIV confidential Counseling and Testing services to all adults and at risk children residing in the six districts in five years. The program will provide preventive basic care and support to all identified HIV infected individuals and their families in five years.

ICOBI received notice of award on 30th June 2008. Currently we are in preparatory stages of identifying, recruiting and training staff, procurement of equipment, materials, services and opening of project offices for the program. ICOBI is still waiting for the final approval of the work plan and budget after responding to technical review comments from CDC and hopes to start actual implementation of the HBCT in homes and communities at the end of September 2008.

During the period 1st October 2009 to 30th September 2010. ICOBI will implement a Full Access Home Based Confidential HIV Counseling and testing in the districts of Mubende, Mityana, Luwero and Nakaseke. The service outlets in the four districts are 46 sub counties (Mubende (15), Mityana (9), Luwero (13) and Nakaseke (9)). We hope to provide HBCT to about 150,000 adults (>14 years) and children at risk of HIV infection (eg mother HIV positive) at home and provide the clients their HIV test results at home. Forty Six (46) outreach teams (each consisting of a counselor and laboratory assistant) based at each of the 46 sub counties in the four program districts will be supported to do home based counseling and testing, the outreach counseling and testing teams will be supported by community resource persons called Resident Parish Mobilisers (295 RPMs) in each of the 295 parishes in Mubende, Mityana, Luwero and Nakaseke. During the visits to the homes the counseling and testing teams will further be supported by about 2,405 village health teams and, local council officials and other volunteers. It is anticipated that at least each village/local council one will be visited thrice by the counseling and testing teams. The counseling and testing teams will be facilitated with a motorcycle each so as to ease their movement during outreach visits to homes and the parish mobilisers will be facilitated with a bicycle each to carry out community mobilization and HIV/AIDS education to household members, and supportive counseling to HIV infected clients. The counseling and testing teams, and the resident parish mobilisers will further be supported by the counselor and laboratory supervisors, basic care officers, community educators and the monitoring and evaluation officer this is to ensure quality of the services offered to clients in the homes. The laboratory assistants and the laboratory supervisors will ensure that quality control and assurance is ensured by collecting relevant dried blood spots (DBS) and re tested at the reference laboratory/CDC Entebbe. Similarly the counselor supervisors will use the quality assurance guide/ tool so as to support CT teams and ensure the quality of counseling in homes. In order to achieve the targets all the HBCT teams will be re-trained in HIV counseling and testing. The resident parish mobilisers will also receive re-orientation and training using a tailored curriculum as assistant counselors. About 200 health workers will also be oriented on HBCT, basic care provision and 2,405 village health teams/local councils will be oriented on HBCT. Home based counseling and testing will be offered to the following principal target populations: All adults resident in Mubende, Mityana, Luwero and Nakaseke districts (>14 years) and all children at risk of HIV infection (e.g. mother HIV+ or mother suspected to have died of AIDS related illness). This funding will go specifically to support the procurement of test kits, training, payment of staff salaries, providing logistics for home-based counseling and testing and for community education and mobilization.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Mechanism ID:** 690.09

**Mechanism:** N/A

**Prime Partner:** US Department of Defense

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 26469.09

**Planned Funds:** \$130,000

**Activity System ID:** 26469

**Activity Narrative:** Activity Narrative – The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members. AIDS and war continue to be the topmost causes of death among UPDF personnel and their families. At recruitment, all UPDF officers and men are HIV negative and therefore almost all the infection is acquired while in service. Counseling and testing is considered to be one of the strongest strategies of HIV infection prevention in the context of knowledge is power and because knowing you are HIV negative motivates one to remain negative. HIV counseling and testing is also the gateway/entry-point to all other HIV care and treatment services. With increasing access to ARVs by all UPDF cadre serving in any corner of Uganda, CT is becoming more and more important as a means of identifying infected military personnel and/or their infected family members and keeping them healthy to serve their country.

With PEPFAR support, CT has been ongoing in all the military medical establishments. UPDF continues to have challenges due to a lack of HIV test kits and other supplies, poor records keeping of the people who receive the service, and inadequately trained personnel, especially in routine counseling and testing and early infant diagnosis. These inadequacies are being systematically addressed via the support from the USG, focusing on all the military hospitals. The HIV test kits and sundries are being procured for the testing centers. On job training for doctors, nurses, counselors and clinical officers has been an area of emphasis. Efforts are underway to improve collaborations with Ministry of Health in the area of data management and monitoring and evaluation. HIV test registers have been secured from the MoH and other partners involved in CT.

2. Progress to-date. In spite of the highlighted challenges, in the FY08, UPDF conducted 16,747 HIV tests, the majority of which were male and 656 were for patients who presented with TB. These clients were tested both at the static Health facilities and through outreaches and house to house HIV testing activities. Awareness about the availability of the service is increasing partly because of the advocacy and sensitization through the UPDF command structure. With the intensified community based HIV testing activities, it is anticipated that more people will be reached. More healthcare providers will be reached and oriented in the Uganda Ministry of Health (MOH) guidelines for routine counseling and testing and early infant diagnosis. Introduction of community volunteers will ensure that we reach those most in need and increase linkage to care and treatment services.

3. Planned activities for FY 2009. ACTIVITY UNCHANGED FROM FY 2008  
UPDF has just acquired a film van from DoD/PEPFAR, which will further strengthen the community sensitization strategy. Messages from film shows will be re-enforced by person to person messages from peer educators and other community volunteers. Emphasis will be put on accurate reporting to enhance monitoring of implementation through training of health professionals in proper records management. Advocacy meetings will be held for UPDF commanders and the healthcare professionals. The program will also procure HIV test kits for use in the military health facilities, to supplement MoH supplies. On-job trainings and support supervision will be conducted to support health professionals implement the routine counseling and testing according to MoH guidelines.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.14: Activities by Funding Mechansim**

**Mechanism ID:** 9833.09

**Mechanism:** Health Communication Partnership

**Prime Partner:** Johns Hopkins University Center for Communication Programs

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

Budget Code: HVCT

Program Budget Code: 14

Activity ID: 23758.09

Planned Funds: \$385,000

Activity System ID: 23758

**Activity Narrative:** Health Communication Partnership (HCP) is a three-year USAID Associate Award for health communication support in Uganda managed by the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs that was awarded in July, 2007. Its purpose is to provide communication support to the Government of Uganda, PEPFAR and USAID HIV/AIDS and health programs and to strengthen capacity for strategic, evidence-based HIV/AIDS and health communication in Uganda.

According to the Uganda HIV/AIDS Sero-Behavioural Survey 2004-05 (HSBS), only 10 – 13% of men and women have ever tested for HIV, although approximately 70% would like to test. The national HCT testing and disclosure campaign, which was designed in FY2007 and will be launched in FY2008, targets cohabiting couples for counseling and testing, as approximately 42% of new HIV infections occur within this group according to the HSBS. As more than 50% of cohabiting adults who are HIV-positive have an HIV-negative partner, and most new infections are occurring within marriage (HSBS), this intervention is aimed at protecting uninfected partners in discordant relationships. The campaign is also designed to link HIV-positive couples and individuals to supportive services; and help HIV-negative couples to discuss and adopt preventive behaviour.

ACTIVITY UNCHANGED FROM FY 2008; ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: This is a continuation from FY 2008. During FY2008, HCP in partnership with the AIDS Information Center (AIC), is working with the National HIV Counseling and Testing (HCT) Coordinating Committee (CT17) to design and launch a communication campaign promoting counseling, testing and disclosure of HIV status among cohabiting partners in six regions of Uganda where AIC has services: central, north central, northwestern, eastern, southwestern and northeastern. The campaign will encourage and motivate couples to assess their risks of HIV, test, and share their status with each other, and will direct them to all health facilities in their areas offering 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 is to design the "Know and Share Your Status" communication strategy, map locations of HCT services in the six regions, develop/adapt campaign media and materials, develop community mobilization tools for couple testing days, monitor communication and community mobilization interventions, and conduct a small evaluation of the campaign as it unfolds. AIC will primarily be responsible for assisting the MOH to review and update HCT guidelines and training materials, training national trainers in the updated training materials, organizing couple counseling and testing weeks in six districts, and collecting and reporting on HIV counseling and testing clinical data. AIC will also provide technical input for a radio distance learning program focusing on new guidance concerning HIV counseling and testing for health workers; HCP will design and produce the radio series, which will also focus on other priority HIV/AIDS and reproductive health priority areas. HCP will also provide training for AIC staff in strategic communication and media relations. The media and mobilization campaign will be rolled out in all districts in the six regions, and will utilize 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 will culminate in couple counseling and testing days or weeks in six districts where AIC has services, during which HCT services will be made available free of charge to couples. AIC and the MOH will ensure that needles and other biological wastes are disposed of according to infection prevention guidelines and protocols.

During FY2009, HCP will continue to support the national HCT and disclosure "Know and Share your Status" campaign, and will expand its focus beyond cohabiting couples to include other high-risk populations. During FY 2009, counseling and testing days or weeks will be expanded to more districts, and the campaign will target most at risk populations in order to identify people who are HIV-positive and enroll them in PHA services, and to promote HIV protective behavior among HIV-negatives. Specifically, communication will be tailored to high risk populations such as refugees, fishermen, mobile transport workers, transient laborers, members of uniformed services, and their spouses.

HCP will also conduct assessments of the effectiveness of HCT communication that took place during FY2008, to inform the design of HCT communication in FY2009 and beyond. This national communication campaign will 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 between 1 October 2009 and 30 June 2010. HCP will strive to build the capacity of AIC and other Ugandan partners, including the Ministry of Health AIDS Control Program, to design and coordinate national HCT communication and education campaigns. In this way, the HCT campaign will become a sustainable activity of the Ministry of Health and its HCT partners.

AIC will report numbers of HCT clients resulting from the communication campaign.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$50,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.14: Activities by Funding Mechansim**

**Mechanism ID:** 9858.09

**Prime Partner:** American Refugee Committee

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 23773.09

**Activity System ID:** 23773

**Mechanism:** NU APPROACH/NPI

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** \$0

**Activity Narrative:** The American Refugee Committee (ARC) is a non-profit, non-sectarian humanitarian relief organization working for the survival, health, and well being of refugees, displaced persons and those at risk caught in the crossfire of civil violence, warfare and other disasters. Founded in 1979, ARC has grown to over 1,800 employees and has received recognition for its efficient and effective delivery of humanitarian assistance. Today, ARC operates in Guinea, Liberia, Pakistan, Rwanda, Sierra Leone, Sri Lanka, Sudan (Darfur and Southern Sudan), Thailand, and Uganda.

ARC has provided life-saving assistance to refugees, displaced persons, and other war-affected populations in post-conflict settings around the world and brings accumulated technical capability and experience in emergency relief, transitional relief, and post-conflict stabilization from 25 years of experience in Asia, Africa and Eastern Europe. ARC's sectors of expertise include HIV/AIDS awareness and prevention, primary and curative health care, community health education and awareness, vocational health training, water and sanitation, gender-based violence prevention and counseling, emergency shelter assistance and transition services, and microcredit/income generation. ARC strives not merely to provide emergency aid to those in need but also to enable them to achieve self-sufficiency; ARC's "refugee to return" model sees relief assistance not as an end to itself but rather as part of a process whose eventual goal is a population's durable return to their homes. ARC takes a community-based approach to developing and implementing all programs and encourages beneficiaries to take as much ownership and responsibility as possible.

ARC's PEPFAR project, NU APPROACH (Northern Uganda Access, Prevention, Referrals, and Organizational Assistance to Combat HIV/AIDS) focuses on three mutually supportive objectives focused on prevention, care and support, and organizational development/capacity building. These complementary components all link into the needs of the larger Ugandan health context. ARC is proposing to work with national community based partners in its response to HIV/AIDS, as community-level outreach and capacity-building, and support to the lower level Health Centers (Health Center level 2), remain serious gaps in Northern Uganda.

ARC's strategy will include a combination of increasing knowledge and facilitating behavior change, supporting key service provision, and capacity building of local systems and organizations to better respond to the situation. ARC's first objective will address the lack of basic HIV knowledge among the population. ARC and its partners will design and execute, based on best practices in Uganda, a Behavior Change Communication (BCC) strategy to educate high-risk groups about basic HIV facts, including the nature of the disease, modes of transmission, and prevention. These activities will target married couples, pregnant mothers, youth, members of the security forces, ex-combatants and ex-abductees, and women who engage in transactional sex. To implement the BCC strategy, ARC and its partner HIDO will establish peer education structures throughout IDP and returnee communities.

ARC's second objective will support the quality and accessibility of HIV-related services. Given the low availability of HIV Counseling and Testing (HCT) in the North, ARC will operate mobile HCT teams to bring HCT services closer to the people as they continue to leave the main camps and return to their original homes. ARC will also promote PMTCT access by training midwives and TBAs as sensitization and referral agents, creating a link between HIV+ mothers and PMTCT services. In the Home-Based Care sector, ARC will work with the wide range of existing HBC actors to better coordinate, standardize, and upgrade the services they offer. ARC will address the issue of treatment of STIs and opportunistic infections (OIs) by providing training to MOH health workers on syndromic management of STIs and on referral procedures for relevant cases. Lastly, ARC has secured an agreement from a major HIV service provider in Uganda, The AIDS Support Organization (TASO), to receive referrals of PLWHA from ARC and its partners; this will link TASO with the IDP population and thus expand treatment and service options for the displaced. Although ART treatment is not a direct component of this project ARC will prioritize referral of PLWHA to ART providers, including TASO and appropriate health facilities.

Finally, ARC's third objective will focus on improving the capacity of Ugandan actors operating in the North. ARC will work with local NGOs and CBOs to improve their technical and operational capacity. The capacity building will focus on upgrading the technical capacity of partners in areas such as BCC/IEC, peer education, HCT, HBC, and referral. It will also focus on improving those organizations' ability to manage and implement activities, and so will cover project planning, operational support, finance and administration, staff management, and fundraising. ARC has already identified its first principal partner, HIDO, and will also identify between 3- 5 other partners via a competitive process. Tailored capacity-building plans for those agencies will be elaborated by ARC in collaboration with the partners to establish a continuous capacity building process for them. Gradually, as the partners' capacities are strengthened, ARC will begin handing over responsibility of project implementation to them, via sub-grants.

Since the grant became operational in the beginning of June 2008, ARC has now reached the final stages of project start up and preparation. ARC has been dialoguing with USAID CTO to finalize all necessary revisions of the workplan and the supporting documentation and to formalize any modifications to the Cooperative Agreement.

Some of the main activities to date include:

- \* Logistical and administrative set up
- \* Liaising with key HIV stakeholders (District authorities and key partners)
- \* Staff recruitment initiated
- \* Elaboration of ToR for KAP Baseline Assessment Consultancy; discussions with CDC on development of survey tool and methodology; call for proposals for consultancy.
- \* Technical support to sub-grantee, HIDO, in development of their first year workplan, corresponding budget, budget narrative, timeline, and logframe; technical support in development of job descriptions and recruitment.
- \* Modification of JSI template sub-grant agreement for one year sub-grant with HIDO
- \* Elaboration of ARC "small grants package" for use with future partners (ongoing)
- \* HIDO has begun identification of available IEC materials for use in its BCC campaign
- \* Identification and consultative meetings held with key HBC actors

**Activity Narrative:** \* Gap analysis initiated

ARC will liaise with local authorities and Health Center (HC) staff to finalize an agreed upon HCT outreach schedule targeting 15 HC2 as outreach sites, addressing gaps identified by the health sector. All 10 HCT counselors hired by ARC will receive a skills-building refresher to ensure counselors are not only capable of conducting rapid tests, but also well versed in referral mechanisms and in other RH concerns that may arise through the outreach counseling sessions.

The HCT program will coordinate with other HC service outreaches for TB, FP, STI clinics, or on market days as appropriate, so as to ensure confidentiality and minimize issues of stigma and discrimination. The HCT outreaches will be conducted in collaboration between ARC HCT counselors (working in teams of 2) and any qualified and available HC2 staff, to ensure their involvement and ownership of the outreaches. Any necessary referrals will be made by the counselors to HC3s or other partner organizations providing the relevant services (TASO, JCRC, PNFP health centers, etc). All HCT data will be submitted to the corresponding health center Health Management Information System (HMIS) reports to ensure that ARC-supported HCT is recorded at the District level.

During the outreaches, HCT counselors will identify existing post test clubs, promote the creation of post test clubs where none exist, refer tested patients to them, and provide the groups with technical support, conducting information sessions or further counseling sessions where needed. The post test clubs will promote testing and counseling and will encourage various groups to create their own "support groups" (particularly for PLWHAs, positive mothers, discordant couples).

Individual follow-up of previously tested clients through home visits will be conducted as needed; those who have been previously tested will be encouraged to retest after the appropriate 3-month window period, particularly if they believe they have been exposed to risky situations. Those who have received referrals on previous outreaches will be monitored to ensure that they were able to access the necessary services. The HCT counselors will also help in identifying local HBC providers, which will be evaluated for support through ARC's HBC component. Where available, Village Health Teams (VHT) will be involved in mobilizing the communities and in following up patients referred for further services.

It is estimated that in this 12 month period 6,075 people will be tested (9 months x 15 outreach sites x 45 people tested/outreach).

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.14: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7204.09	<b>Mechanism:</b> Eastern Region - HIV/AIDS & TB Program
<b>Prime Partner:</b> Management Sciences for Health	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 15987.24014.09	<b>Planned Funds:</b> \$300,000
<b>Activity System ID:</b> 24014	

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – Eastern will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus on increasing rural access to HIV/AIDS Counseling and Testing (HCT) and anti-retroviral therapy (ART) through support to 8 districts in the Eastern region of the country. This region has a low ART coverage and lies along the highway connecting Uganda to neighboring countries. According to the 2005 Uganda national HIV/AIDS Sero-Behavioural Survey 2004-2005, 79% of HIV- Ugandans do not know their HIV sero-status due to various reasons including limited access and utilization of HIV counseling and testing (HCT) services. The District HIV/AIDS/TB program will increase access and utilization of HCT services at both district hospital/lower level facilities and the community through the following initiatives:

- Increasing HCT service access and utilization for people in the rural setting and hard-to-reach high risk populations e.g. fishing communities, out-of-school youth, internally displaced populations, etc.
- Promotion of home-to-home and family-based HCT. Routine counseling and testing (RCT) will be supported in all district and lower level facilities with emphasis on referring all HIV+ clients into care and treatment facilities for follow on support services such as TB. In these health facilities, HCT will be routinely provided in the high HIV-prevalence clinics namely tuberculosis and sexually transmitted clinics and medical in-patient wards.
- Promotion of outreach activities in high activity areas such as landing sites for fishing communities, communal markets, camps for internally displaced people, tertiary institutions and trading centers
- Training of health service providers such as counselors, laboratory staff, and data assistants. The training to cover personnel from approximately 50 outlets will support the role out of routine counseling and testing, strengthening counseling skills, logistics and records management, laboratory services, referral and general integrated patient care. A total of 300 personnel will be trained
- Increase support for and utilization of post test services through post test clubs (PTCs). PTCs will be used to promote awareness about disclosure, discordance and stigma.
- Promotion of couple counseling and testing coupled with referral linkages to post test services for both HIV - and HIV- individuals

To achieve the required results, the program will support provider-initiated HCT services in 50 health facilities. It is estimated that over 50,000 clients will receive HCT services in FY 2009 and those testing HIV-positive linked to palliative care and treatment services. The program will build capacity of Networks and groups of People Living with HIV/AIDS (PHAs) to provide pre-test and post-test counseling to clients and facilitate family-based HCT. PHAs will be trained to function as expert clients facilitating linkages and referrals between community-based and facility-based care and linking all those testing HIV-positive to palliative care and wrap around services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15987

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15987	15987.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 15768.24025.09

**Activity System ID:** 24025

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Prevention: Counseling and Testing

**Program Budget Code:** 14

**Planned Funds:** ██████████

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – West-South West will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus on increasing rural access to HIV/AIDS Counseling and Testing (HCT) and anti-retroviral therapy (ART) through support to 9 districts in the Western region of the country. This region has a low ART coverage and lies along the highway connecting Uganda to neighboring countries. According to the 2005 Uganda national HIV/AIDS Sero-Behavioural Survey 2004-2005, 79% of HIV- Ugandans do not know their HIV sero-status due to various reasons including limited access and utilization of HIV counseling and testing (HCT) services. The District HIV/AIDS/TB program will increase access and utilization of HCT services at both district hospital/lower level facilities and the community through the following initiatives:

- Increasing HCT service access and utilization for people in the rural setting and hard-to-reach high risk populations e.g. fishing communities, out-of-school youth, internally displaced populations, etc.
- Promotion of home-to-home and family-based HCT. Routine counseling and testing (RCT) will be supported in all district and lower level facilities with emphasis on referring all HIV+ clients into care and treatment facilities for follow on support services such as TB. In these health facilities, HCT will be routinely provided in the high HIV-prevalence clinics namely tuberculosis and Sexually transmitted clinics and medical in-patient wards.
- Promotion of outreach activities in high activity areas such as landing sites for fishing communities, communal markets, camps for internally displaced people, tertiary institutions and trading centers
- Training of health service providers such as counselors, laboratory staff, and data assistants. The training to cover personnel from approximately 50 outlets will support the role out of routine counseling and testing, strengthening counseling skills, logistics and records management, laboratory services, referral and general integrated patient care. A total of 300 personnel will be trained
- Increase support for and utilization of post test services through post test clubs (PTCs). PTCs will be used to promote awareness about disclosure, discordance and stigma.
- Promotion of couple counseling and testing coupled with referral linkages to post test services for both HIV- and HIV- individuals

To achieve the required results, the program will support provider-initiated HCT services in 50 health facilities. It is estimated that over 50,000 clients will receive HCT services in FY2009 and those testing HIV-positive linked to palliative care and treatment services. The program will build capacity of Networks and groups of People Living with HIV/AIDS (PHAs) to provide pre-test and post-test counseling to clients and facilitate family-based HCT. PHAs will be trained to function as expert clients facilitating linkages and referrals between community-based and facility-based care and linking all those testing HIV-positive to palliative care and wrap around services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15768

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15768	15768.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 11125.09

**Prime Partner:** Inter-Religious Council of  
Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HVCT

**Activity ID:** 4365.26784.09

**Activity System ID:** 26784

**Mechanism:** IRCU

**USG Agency:** U.S. Agency for International  
Development

**Program Area:** Prevention: Counseling and  
Testing

**Program Budget Code:** 14

**Planned Funds:** \$0

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to address mutually identified development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. In June 2006, IRCU initiated a program to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by the United States Government (USG) under the President's Emergency Plan for AIDS Relief (PEPFAR).

HIV counseling and testing (HCT) coverage in Uganda still remains low. The National HIV Sero-Behavior Survey 2004/05 showed that only 13% of women aged 15-49 years and 11% of men in the same age group had been tested. The Uganda Demographic and Health Survey (UDHS) 2006 further indicates that 71% of women and 77% of men in Uganda have never tested at all. The same survey indicated, interestingly, that over 80% of the population knew where to get an HIV test. This implies that constraints related to physical access to facilities is a major issue. In 2005, the Ministry of Health launched the new National Policy Guidelines for HIV Counseling and Testing with the vision of putting high-quality voluntary counselling and testing (VCT) services within the reach of every Ugandan. The policy further acknowledges that with the advent of affordable treatment options, there is urgent need to increase access to HCT in order to reach those who need treatment, care and support. Therefore, MOH has moved on to adopt new approaches to delivery of HCT, including routine testing in clinical settings, as well as home and family-based counselling and testing. These approaches are designed to remove some of the barriers to testing imposed by the VCT approach. IRCU works through its faith-based partners to support the MOH in operationalising its vision of scaling up HCT coverage, especially to rural and underserved areas.

Using FY 2006 funds, IRCU rolled out counseling and testing in 22 faith-based sites based in 17 districts in Uganda. Through these sites, over 30,000 individuals were counseled and tested of which 95% were adult clients. IRCU also supported these sites with improvements in infrastructure, strengthening human resources through training in new HCT technologies. IRCU worked extensively with the Program for Supply Chain Management Systems (SCMS) to develop a logistics log frame for the implementing sites to facilitate proper forecasting and ordering of HIV test kits. This resulted in greater improvements in the supply and distribution of HIV testing kits and other associated supplies. This partnership will continue to be strengthened through FY 2007 and FY 2008. With FY 2007 funds, IRCU will continue to expand access to quality HCT services through the existing networks of faith based organizations (FBOs). Currently IRCU is in the final stages of site assessment which will culminate into adding ten new sites to those currently supported. This will facilitate delivery of quality HCT services to approximately 160,000 individuals by the end of FY 2008.

IRCU initiated the newly introduced provider-initiated testing and counseling model, commonly known as Routine Testing and Counseling (RTC) as part of the routine clinical care at all it is hospital based sites. RTC has been initially implemented in high HIV prevalence units of these hospitals such as the medical wards and STI clinics. With the new PEPFAR guidance to monitor individuals with TB that access HCT, IRCU will move rapidly to expand RCT to cover TB wards. Focal persons at these units will continue to coordinate the testing and counseling process. IRCU will also continue to consolidate and streamline the existing referral systems between HCT, care, treatment and PMTCT units to ensure access to comprehensive HIV/AIDS services for its clients.

HCT services are provided in accordance with the Ministry of Health (MOH) guidelines. For instance the HIV testing algorithm is aligned with the national policy which emphasizes a three tier protocol using Determine® to screen for HIV infection, Statpac® to confirm infection and Unigold® as a tie breaker. IRCU procures and stores the HIV kits at Joint Medical Stores and the distribution process is manned by the logistics officer working at the IRCU secretariat. As part of the quality assurance, all sites implementing HCT are required to send 10 samples of specimens out of every 100 tests performed for re-testing at other major HCT providers in Uganda. Using FY 2006 funds, IRCU trained scores of religious leaders at community level who have played vital roles in raising community awareness and referral for HCT.

In FY 2008, IRCU in partnership with other USG-funded partners, including the Strengthening of Counseling and Testing Training (SCOTT) and Mulago-Mbarara Joint AIDS Program (MJAP), will continue to build the capacity within its supported health facilities to deliver quality HCT by focusing on training more staff and in particular lay providers like PHAs involved in the out reach VCT clinics in new HCT technologies.

In FY 2007, IRCU provided support to form Post-Test Clubs composed of individuals who are found to be HIV positive through the HCT services. These cadres of volunteers are used to further raise advocacy for HCT in the communities surrounding the health units and also act as a support system for living positively in the community. In FY 2008, IRCU will continue to consolidate these programs.

Some of the main challenges the IRCU HCT program has faced relate to limited pediatric counseling skills and poor integration of PMTCT. This has led to low coverage of both pediatric HIV testing and PMTCT at the implementing sites. In FY 2008, IRCU will focus on these issues as to increase the number of mothers and children in care. IRCU in FY 2008 targets to counsel and test 160,000 clients, train 240 counselors, 250 district leaders and 1,270 religious leaders.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14210

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14210	4365.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$600,000
8424	4365.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$600,000
4365	4365.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$600,000

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 12191.09

**Mechanism:** TBD - STATUS

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 29694.09

**Planned Funds:** ██████████

**Activity System ID:** 29694

**Activity Narrative:** FY08 Collaborative Uganda n PHE- UG.08.0202: Multi-country CT HIV Counseling and Testing to Optimize Patient Enrollment in HIV Care and Treatment

Strengthening Test Acceptance and Treatment Uptake Study (STATUS) Project is a multi-country HIV Counseling and Testing public health evaluation is proposed to determine whether HIV Counseling and testing (HCT) can be provided to a large percentage of persons in outpatient departments, and if this venue can be used to efficiently identify HIV infected patients early in the course of HIV disease. Additionally, the study will evaluate three models of HIV testing and counseling in outpatient departments to determine the most effective model across countries to increase testing uptake and linkage to care and treatment services for those who test HIV positive.

Despite the central importance of HIV testing and counseling (HTC) in achieving the above goals, it is estimated that just 10% of people in low and middle income countries have ever been tested for HIV. Due to these low rates of testing, many HIV positive people learn their status too late to take advantage of available services. Health facilities are optimal places to counsel and test people who do not know their HIV status, although studies have shown that opportunities to diagnose people in these settings are being missed. When HIV testing is offered and provided in health facilities, evidence has shown that test acceptance is high.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Program Budget Code:** 15 - HTXD ARV Drugs

**Total Planned Funding for Program Budget Code:** \$38,662,390

**Program Area Narrative:**

The procurement and distribution of antiretroviral drugs (ARVs) is a critical component of PEPFAR Uganda which supports the Ministry of Health (MOH) National Plan for the roll-out of ARV treatment. The ongoing focus areas of the ARV Drugs Program are to: a) continue working within the Ugandan Three-Year National Plan for Procurement of Essential Medicines and Health Supplies

(EMHS); b) strengthen the Government of Uganda (GOU) capacity for timely procurement, distribution, monitoring and quality assurance; and c) support the provision of appropriate and adequate HIV/AIDS related drugs and commodities to treatment partners.

USG will continue to leverage other donor resources for drugs including the Global Fund for AIDS, TB and Malaria (GFATM), pediatric and second line drugs donated through the Clinton Foundation, as well as other donations to increase the number of individuals receiving ART. The Clinton Foundation will continue to provide pediatric drugs through 2010, but will discontinue adult second-line drugs at the end of 2009. By the end of September 2008, 130,837 individuals in Uganda were currently receiving ARV treatment with direct USG support, and an additional 12,700 were indirectly supported through USG inputs in national logistics systems, training, quality assurance and policy.

New in FY08 was the establishment of a local Ugandan pharmaceutical manufacturing firm, made possible through a private-public partnership initiative between the GOU, Quality Chemicals Limited, and Cipla India. Local production of anti-malarial and ARV drugs is expected to start later this calendar year. This firm is currently undergoing FDA and WHO assessment for approval. If approved, this initiative is anticipated to significantly increase access to ART through reduced costs of ARV drugs and elimination of long lead times. Supplemental drug supplies have already been delivered by Cipla/India. For FY08/09, the GOU has committed up to \$40 million towards the purchase of ARV and anti-malarial drugs from Quality Chemicals.

#### The National Three-Year Rolling Procurement Plan

In 2007, the MOH Medicines and Health Supplies Technical Working Group developed a National "Three-year Rolling Procurement Plan for Essential Medicines and Health Supplies" for FY06/07-2008/09 (EMHS). Although this plan is in place, it is not yet fully functional. All development partners, including USG and its implementing partners, are to share their procurement plans with MOH and these are consolidated annually into one national procurement plan. The plan is intended to identify all projected procurements of health and HIV/AIDS commodities by organizations and donors so that MOH can coordinate and systematically address gaps in a timely manner. Currently, Supply Chain Management Systems (SCMS) is providing assistance to MOH and PEPFAR partners in forecasting and quantifying ARV drug needs.

#### Procurement Mechanisms

To respond to Uganda's ARV requirement, four PEPFAR procurement mechanisms are in place: the AIDS Relief Project, SCMS, Joint Clinical Research Center (JCRC), and Medical Access. (The latter two pre-date PEPFAR). These different procurement mechanisms provide the flexibility to service the individual needs of MOH and partner treatment sites. PEPFAR drugs provide a buffer when MOH sites experience stock outs of ARV drugs.

JCRC and AIDS Relief/ Catholic Relief Services Consortium directly procure ARVs from manufacturers and deliver them to designated sites throughout the country. JCRC also supplies ARVs to USG Department of Defense and Walter Reed supported ART sites, and responds to emergency ARV stock outs at MOH sites. Medical Access, Limited is a non-profit local Ugandan NGO that was formed under the Ugandan Drug Access Initiative in 1998. Medical Access procures and distributes drugs for the following USG partners: Mildmay, The AIDS Support Organization (TASO), Mulago Mbarara Joint AIDS Program (MJAP), Rakai Health Sciences Program, Baylor Uganda / PIDC, and Reach-Out, Mbuya. SCMS procures ARVs and HIV/AIDS commodities for the Inter-religious Council of Uganda (IRCU), the Northern Uganda Malaria, AIDS, and TB (NUMAT) project and will procure for three new district-based HIV/AIDS programs.

In FY09, USG will continue strengthening the national procurement system through technical assistance and training. Recently, Crown Agents was awarded the contract as the third party procurement agent for GFATM commodities. USG, through participation in the MOH medicines technical workgroup, will ensure close coordination between Crown Agents and the other procurement mechanisms.

Ongoing challenges in the national system include:

1) ARV drug stock-outs at GFATM-supported sites. The 2007 the Uganda Service Provision Assessment survey showed that 83 percent of hospitals and 74 of Health Center (HC) IV facilities had a stock out of first line adult regimen in the previous six months. Reasons for stock outs included GFATM funding delays, late delivery of drugs, and delayed forecasting. (Only two-thirds of sites submit the required bimonthly reports and orders for ARVs).

2) A series of assessments of the National Medical Stores (NMS) identified key issues that have contributed to inadequate performance. These include critical lack of finances due to lack of capital, delayed payment from customers, insufficient personnel, and the burden of managing third party commodities, inefficient management information systems, limited warehousing, and an aging transportation fleet.

3) The MOH Pharmacy Division and AIDS Control Program are responsible for forecasting, procurement planning, and management of the ARV logistics information system, monitoring stock levels, and coordinating with the NMS to ensure timely distribution. Budget constraints and limited staff and office space have delayed the full transfer of logistics management to the national program. A demonstrated commitment from the MOH to provide resources is needed so that USG technical assistance is fully realized.

#### FY09 Identified Focus Areas

In order to plan for FY09, the USG Country Team carried out a program review of the USG treatment portfolio; conducted field visits to implementing partner sites; participated in the National ART Committee that revised the National Treatment Guidelines;

held a stakeholders consultative meeting; and performed a critical analysis of the FY08 Semi-Annual Program Results. These planning exercises resulted in the identification of three major focus areas for FY09:

- 1) Continue to provide technical assistance to strengthen national forecasting and procurement capability and continue to work within the Ugandan 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, thereby preventing ARV stock outs and emergency procurements. In addition, continue support to the NMS to strengthen their warehousing, management information systems and distribution operations.
- 2) Maintain support to the National Drug Authority to enable them to implement quality assurance procedures and monitor acceptability of ARV drugs.
- 3) Build capacity of district health offices and ART health facilities in ARV logistics management through training, technical assistance and support supervision.

#### Product/Drug Selection and Treatment Policy

The National ART Treatment Guidelines were revised (June 2008). The new recommendations include:

- 1) Phase out stavudine (D4T) as a first line drug due to toxicity. The USG-supported PHE, Home Based AIDS Care (HBAC), demonstrated that D4T-associated neuropathy occurred in an estimated 36% of patients in a cohort of 1,000 over 3 years; 9% required drug switches due to D4T side effects; and D4T associated lactic acidosis was responsible for several fatalities and significant lipodystrophy.
- 2) The recommended Initial Treatment Regimens now include one of the following NRTI combinations: zidovudine and lamivudine (ZDV +3TC); Tenofovir and lamivudine (TDF + 3TC); Tenofovir and Emtricitabine, called Truvada (TDF + FTC); stavudine and lamivudine (D4T + 3TC) only as a last option; plus either efavirenz (EFV) or nevirapine (NVP).
- 3) ART eligibility criteria have been revised to include all adults and older children with a CD4 count less than 250 cells/mm<sup>3</sup>, women and TB co-infected patients with CD4 less than 350 cells/mm<sup>3</sup>, and infants less than 12 months with HIV infection.

In compliance with these guidelines, USG will make use of the recommended first line regimens. TDF combinations have a low toxicity profile, can be used safely in pregnancy and concurrently with TB medication, and are dosed once-a-day, potentially improving adherence. In addition, using TDF in a first-line regimen reserves thymidine analogues (ZDV) and protease inhibitors (PIs) for second line therapy. Despite these advantages, one of the most commonly procured first line drugs (SCMS) is the triple fixed dose combination (FDC) of ZDV+3TC+NVP, because of the cost difference between generic Duovir (\$13.38/month), versus Truvada (\$26.25/month) plus NVP (\$3.40/month) or EFV (\$11.72/month). Truvada is used as a first-line regimen for those patients who cannot be started on ZDV, as well as a second-line regimen. The MOH in October 2008 recommended changing patients at MOH supported sites who are on Truvada to generic TDF+3TC (\$13.25/month), also based on cost considerations.

Given these recommendations, USG supported patients may also be started on TDF+3TC rather than Duovir or Truvada in order to benefit from the advantages of using TDF. TDF and FTC are not available as single generic drugs. It should be noted that the US HHS recommendations Truvada for first line drug initiation in the US.

Kaletra syrup and heat-stable Alluvia are also purchased for initiation of pediatric patients, and for second-line treatment of adults, respectively. Significant progress has been made in using generic formulations. The vast majority of drugs procured are now generics; only Truvada, TDF single dose, and PIs remain as non-generic formulations.

An increase in the number of patients who can be placed on ART may be constrained in future years by flat-lined funding as the number of patients who require second-line therapy increases. Given that almost all drugs are now generic, with the exception of PIs, TDF, and Truvada, it is unlikely that significant decreases in drug costs will occur. In addition, the WHO recommendations for initiation of ART are for adults with CD4 <350 CD4 cells/mm<sup>3</sup>, rather than the current MOH guideline of CD4 <250 cells/mm<sup>3</sup>. If MOH changes its recommendations, then the number who need to be initiated on treatment will increase.

#### Quality Assurance

USG is providing technical support to the National Drug Authority (NDA) to strengthen information systems, provide equipment and training to expedite drug registration, and to renew and facilitate quality testing of ARVs on arrival into the country. Eight computers have been procured, and internet connectivity will be established at headquarters and regional centers. NDA is currently awaiting delivery of additional machines to expand their testing capacity. To date, they have tested 34 batches of ARV drugs among the 46 received. USG also provides technical and financial support to NDA to establish a system for monitoring and reporting drug adverse events (pharmacovigilance). The first pharmacovigilance center is being established in Fort Portal in the next few months. Guidelines for reporting adverse events and a pharmacovigilance bulletin have been developed for healthcare personnel to record and report to NDA. To date, 9 reports have been received through spontaneous reporting through clinical trials, and 13 received at the regions. Pharmacovigilance sensitization meetings have been conducted for 111 private pharmacies and clinic owners.

#### FY09 Targets

USG plans to directly support 155,519 people including 12,735 children with ART in FY09. This represents an increase in the number of people requiring antiretroviral therapy. The overall cost of ARV drug regimens will increase due to the changes in the

drug combinations that are now officially recommended for first line treatment. However, when TDF goes off patent, there may be a reduction in overall costs. The total estimated cost of ARV drugs supported by PEPFAR will be \$39 million. Since 2004, treatment partners have maintained a three-month buffer stock of medications, which greatly assisted the national program in overcoming stock-outs due to unanticipated and problematic disruptions in GFATM funding. USG will continue to support a three-month buffer supply, and a special provision to procure ARVs in the event of other emergency needs at MOH-supported facilities.

**Table 3.3.15: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11125.09	<b>Mechanism:</b> IRCU
<b>Prime Partner:</b> Inter-Religious Council of Uganda	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> ARV Drugs
<b>Budget Code:</b> HTXD	<b>Program Budget Code:</b> 15
<b>Activity ID:</b> 4687.26785.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26785	



**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to jointly address HIV/AIDS and other development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. In June 2006, IRCU signed a contract with United States Agency for International Development (USAID) to Scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by the United States Government (USG) under the President's Emergency Plan for AIDS Relief (PEPFAR).

By the end of December 2006, there were 24.7 million HIV infected adults and children living in Sub Saharan Africa (SSA) with 2.8 new infections that year. SSA contributed to 72% of the HIV related deaths in 2006. The HIV epidemic in Uganda has since stabilized at a national prevalence rate of 6.7%. The burden on women still remains high as they are the most infected at a prevalence rate of 8% and most affected as they carry the burden of caring for those with the disease. In Uganda, we have approximately 1.2 million people living with HIV and just over 80,000 of the people living with HIV infection are on the life saving antiretroviral therapy (ART). Though the national scale up of the ART program in Uganda is yield promising results, there are still many HIV infected people still in need of ART but can not access these services.

In FY 2006, IRCU initiated partnerships with 13 implementing sites to offer antiretroviral drugs. To date, we have over 900 new clients on the IRCU program receiving life saving antiretroviral drugs. IRCU is also supporting over 2,000 clients under Ministry of Health (MOH) in various aspects of care. IRCU has intervened by providing ARVs to the Ministry of Health (MOH) in addition to providing ARVs to the MOH clients at our sites. Thus the total number of clients we served by providing drugs was approximately 3070 using FY 2006 funds.

AT the beginning of FY 2006, IRCU initiated a partnership with Supply Chain Management Systems (SCMS) in to procure the required Food and Drug Administration (FDA) approved antiretroviral drugs for the program. SCMS sources the market and procures from well established reliable pharmaceuticals with the cheapest market prices for individual drugs. This is one of their strategies to save as much drug money for the program which allows the program to recruit more clients on ART.

The first procurement assignment arrived in country in January 2007 and consisted only of United states (US) brand ARVs. Our first line choice of therapy is Nevirapine (NVP) + Zidovudine (ZDV) + Lamivudine (3TC) as a combination pack or blister pack called Combi-pack. We procured the drug items in reference to the Uganda National treatment guidelines which includes first line alternatives. In FY 2006, IRCU through SCMS worked with MOH to provide all the needed second line regimens and pediatric formulations for the implementing partners. The MOH drugs are provided through the country partnership with Global Fund Initiative.

Due to the sudden drop of ARV drug prices worldwide, IRCU is still procuring drugs using FY 2006 funds. In view of this, we have ordered a second consignment of ARV drugs which will contain both US brand drugs as well as FDA approved generics. Triomune (NVP + 3TC + Stavudine (D4T)) manufactured by Cipla® was recently approved by FDA. We have included Triomune 30 in our forecast to cater for the MOH clients and Truvada (TDF/FTC) as an alternate drug for either first or second line therapy. We have also decided to procure our own second line drugs as the MOH supply is not reliable. In regard to pediatric formulations, IRCU will continue to collaborate with the Clinton Foundation Agency, who will provide these drugs for the IRCU related sites. I

Once the drugs arrive in country, they are cleared by the Uganda customs and there after registered by the National Drug Authority (NDA). The drugs are verified and analyzed by NDA at a total of 2% of the drug cost.

In FY 2006, IRCU approached Joint Medical Stores (JMS) to establish a collaboration with them to store and distribute the ARVs to the IRCU implementing partners at 5% of the cost of drugs. IRCU later signed a memorandum of understanding (MOU) with JMS as a sign of commitment.

SCSM trained the technical staff at IRCU in logistic management information systems using a standard software which tracks the consumption rates both at JMS and at the individual sites. The 13 implementing sites providing ARV drugs submit bimonthly reports and forecasts to the logistic officer at IRCU. The reports are feed into supply chain manager software which assess the consumption rates and develops an allocation list which is submitted to JMS for distribution. In addition, IRCU together with SCMS have set up working logistic systems at each site to ensure there is prompt reporting and forecasting of ART usage to IRCU, which will lead to prompt delivery of ARVs from JMS at these sites and will minimize the issue of stock outs of medicines.

IRCU working with SCMS offered technical support and training to the health unit staff in forecasting, supply chain management as well as drug recording and storage using FY 2006 funds. In FY 2007, IRCU is planning to bring on board 10 new sites for the ART program. Using FY 2007 and FY 2008 funds, IRCU will continue to provide targeted training and capacity building for the old and new staff at the implementing sites directly responsible for the ARVs to promptly forecasting and report in order to avoid stock out of drugs which interrupts care and is a renowned factor for ARV drug resistance.

In FY 2006/07, IRCU had two main challenges which included delays in supply of drugs to treat opportunistic infections and lack of ARV drugs for PMTCT and post exposure prophylaxis (PEP). As a strategy to optimally use our FY 2007 fund for drugs as well as try to solve this challenge, IRCU with permission from USAID will procure essential life saving drugs to treat fatal opportunistic infections. In FY 2008, IRCU through SCMS will continue to work at ensuring the timely supply of these drugs.

**Activity Narrative:** IRCU also in FY 2007 has made provisions in the ARV forecasting and quantifications to include quantities of drugs to cater for PMTC and PEP in cases where the MOH supplies are erratic. In FY 2008, IRCU will continue to consolidate the procurement of these line items and will adjust the forecasts according to the drug needs at the sites

Using FY 2008 funds, IRCU will continue to provide the necessary human resource, data systems and logistics to ensure both IRCU and MOH drugs are optimally utilized and accounted for at all sites.

By the end of FY 2008, IRCU will support 1,600 new IRCU adult clients and 500 new Pediatric clients on ART as well as maintain care for the 910 old IRCU clients from FY 2007 and 2100 MOH clients thus IRCU will be providing ARV drugs for over 5,000 clients on ART through this program. An estimated 2% of these clients will be receiving second line drugs through the program. Of the total drug budget, we estimate that IRCU will spend 98% of the money to procure ARV drugs and 2% to procure drugs for treating opportunistic infections.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14211

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14211	4687.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$1,000,000
8428	4687.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$1,000,000
4687	4687.06	U.S. Agency for International Development	Inter-Religious Council of Uganda	3327	3327.06	IRCU	\$100,000

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 11126.09

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)

**Prime Partner:** Joint Clinical Research Center, Uganda

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** ARV Drugs

**Budget Code:** HTXD

**Program Budget Code:** 15

**Activity ID:** 15623.26791.09

**Planned Funds:** \$0

**Activity System ID:** 26791

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY 2008, this activity will focus on strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide.

The program will provide training of over 1,000 health workers in 30 districts in ARV logistics and procurement focusing on forecasting, warehouse management and distribution of ARVs. The program will strengthen the Directorate of District Health Services in the 30 focus districts in ARV drugs procurement and distribution and reporting to Ministry of Health.

The program will procure ARVs to cater for over 20,000 patients on first line treatment and 5,000 on second line. The program will also procure a buffer stock to respond to emergency stock-outs of ARV in the public health sites. The program will introduce a pharmacy dispensing tool to capture and report on clients accessing ARVs, track patients and report on treatment outcomes. Opportunities of introducing a Smart Card will be looked at during this financial year.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15623

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15623	15623.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$7,800,000

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09 **Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**Prime Partner:** To Be Determined **USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State) **Program Area:** ARV Drugs

**Budget Code:** HTXD **Program Budget Code:** 15

**Activity ID:** 16008.21548.09 **Planned Funds:** ██████████

**Activity System ID:** 21548

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal.

In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

The USAID cooperative agreement with JCRC has been extended to September 2009. USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in respective technical areas. During the extension phase JCRC will transition majority of the sites beyond the nine regional referral hospitals, to the new USAID district based mechanisms, other PEPFAR partners who overlap in the same facilities, and to the Ministry of Health (MOH). To ensure continuity of services USAID will award the TBD new mechanism by March 2009, this will ensure smooth transition between the current JCRC program and the TBD mechanism.

In FY 2009 the major focus of the activity is to ensure continuity of life saving services, smooth transition and building capacity of nine regional referral hospitals. The program will provide training of over 200 health workers in ARV logistics and procurement focusing on forecasting, warehouse management and distribution of ARVs.

The program will procure ARVs to cater for over 30,000 patients on first line treatment and 1500 on second line. The program will also procure a buffer stock to respond to emergency stock-outs of ARV in the public health sites. The program will introduce a pharmacy dispensing tool to capture and report on clients accessing ARVs, track patients and report on treatment outcomes.

A key area of focus for this program will be support for the scale-up of access to ART for pregnant women by ensuring that ARVs are available in the ante-natal clinics and that staff in the antenatal clinics are trained to counsel, initiate and manage ART in pregnant women. The program will also work closely with the maternity ward and pediatrics unit to identify HIV-exposed and infected children, provide infant-diagnostic services and provide care and ARVs for those that are eligible.

In FY 2009, the program will continue to support the Department of Defense (DOD) ART programs through Walter Reed in Kayunga district and Uganda People Defense Forces (UPDF) in Gulu, providing ART to 2,000 additional clients.

In conjunction with Supply Chain Management Systems (SCMS), the program will continue to explore the introduction of the Smart Card and an ART Dispensing Tool in all supported ART sites to improve patient tracking.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16008

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16008	16008.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$340,000

**Emphasis Areas**

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery



**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 7406.09

**Mechanism:** Expansion of Routine HCT and Provision of Basic Care in Clinics, Hospitals & HC IV

**Prime Partner:** Infectious Disease Institute

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** ARV Drugs

**Budget Code:** HTXD

**Program Budget Code:** 15

**Activity ID:** 21591.22689.09

**Planned Funds:** \$400,000

**Activity System ID:** 22689

**Activity Narrative:** The Infectious Diseases Institute (IDI) is a Uganda-registered NGO, owned by Makerere University. It has an independent Board led by the Dean of the Faculty of Medicine. IDI has trained 2,394 course participants from 26 African countries in the areas of HIV/AIDS, malaria, pharmacy, lab and data management. Twenty-six research projects are in progress, focusing on identifying best practices and models for prevention, care and treatment of HIV/AIDS and related infectious diseases in sub-Saharan Africa. Almost 9,000 people are receiving care at the IDI clinic, and 5,741 people are on anti-retroviral therapy (ART). In addition, a total of 3,004 people are being cared for at four Kampala City Council clinics supported by IDI, and 1,339 people are receiving ART across the four sites.

In August 2008, IDI was awarded a CDC Cooperative Agreement to build capacity for scaling up of HIV/AIDS services in Kibaale and Kiboga, two rural underserved and high prevalence districts in Uganda. IDI intends to implement this service in conjunction with the respective District Health Offices, The AIDS Support Organization (TASO) and Strengthening Counselor Training (SCOT) projects. These latter two organizations will support the HIV/AIDS Care and treatment and training functions respectively. Specifically the project will: (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. At the end of the project period, IDI will have scaled-up routine HIV Counseling and Testing in at least six health facilities and tested 200,000 people. In addition, the project will provide at least 3,000 HIV-infected people with a care package and to start or maintain at least 1,500 HIV-positive people on ART. Other measurable outcomes include training for at least 200 health workers in comprehensive HIV/AIDS Care and starting 900 HIV+ people on TB treatment.

In FY 2009, IDI and its partners will conduct activities under ARV Drugs to support HIV treatment services by the 6 facilities in Kibaale and Kiboga districts. The ARV Drugs related activities will comprise of: procuring buffer stocks of ARVs for the GOU/MOH ART accredited sites when the need arises. In addition, MOH accredited sites will be supported to procure ARV drugs for prophylaxis for 200 eligible pregnant women and their newborn babies; maintaining a primary buffer stock of ARV drugs covering at least 3 months at each of the 6 facilities; maintaining and regularly updating the 12 month rolling forecast for ARV drugs; ensuring professional stores and stock control practices for ARV drugs; maintaining a computerized stores information management system for ARV drugs integrated with drug consumption information systems; training/re-training pharmacy and stores personnel; and liaising with ARV drug supply partners to keep abreast with critical market trends. The ARV Drugs program area is related to the program areas of PMTCT, Palliative Care (Basic), Palliative Care (TB/HIV), Counseling & Testing, ARV Services and Laboratory Infrastructure.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21591

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21591	21591.08	HHS/Centers for Disease Control & Prevention	Infectious Disease Institute	12197	12197.08	Expansion of Routine HCT and provision of Basic Care in Clinics, Hospitals and HC IVs	\$400,000

## Emphasis Areas

### Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

### Health-related Wraparound Programs

- \* Child Survival Activities
- \* Family Planning
- \* Malaria (PMI)
- \* Safe Motherhood
- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 10313.09

**Prime Partner:** John Snow International

**Funding Source:** GHCS (State)

**Budget Code:** HTXD

**Activity ID:** 23927.09

**Activity System ID:** 23927

**Mechanism:** Partnership for Supply Chain Management

**USG Agency:** U.S. Agency for International Development

**Program Area:** ARV Drugs

**Program Budget Code:** 15

**Planned Funds:** \$6,600,000

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system to improve coordination and build upon the work of the three implementing partners that currently provide technical assistance on logistics management in the country. It is expected that procurement services for ARVs and other HIV/AIDS commodities will continue to be provided by SCMS to ensure that there is no disruption in ART patient treatment. The new mechanism will provide technical assistance (only) to improve the functioning of the national supply chain for ARVs and other HIV/AIDS health commodities including improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement mechanisms to ensure the right products are purchased in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate logistics information at all levels of the supply chain. The new mechanism will work with key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices and health facilities, Joint Medical Stores (JMS), and in-country and international partners.

The Supply Chain Management System (SCMS) partnership 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 toward deploying 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 is providing technical assistance to the Ministry of Health, Joint Medical Stores, and National Medical Stores as well as some PEPFAR programs. SCMS also provides procurement services for the Inter-Religious Council of Uganda (IRCU), and the Northern Uganda Malaria AIDS and TB program (NUMAT) and emergency procurement for the Ministry of Health. SCMS provides support the Ministry of Health's ART coordination mechanism, and continues to strengthen logistics information system through formal and on-going training during supervisory visits

This activity is linked to PMTCT, Adult Care and Treatment, Pediatric Care and Treatment, Counseling and Testing, Laboratory Infrastructure, TB/HIV

In FY 2008, the SCMS project provided procurement services and technical assistance to the Inter-Religious Council of Uganda (IRCU), Northern Uganda Malaria AIDS and TB program (NUMAT), and UPHOLD (now ended) to improve the availability and management of ARV drugs in their sites. SCMS also provided funds to the MOH for emergency ARV procurements. To-date, a total of \$1,795,000 of ARVs and related commodities has been procured through SCMS for these partners. SCMS will also procure ARVs for EGPAF. NUMAT, in partnership with SCMS, established logistic management systems and procedures for ARV supply in its ART sites and a working arrangement was developed with Joint Medical Stores, a central warehouse for FBOs and other private sector organizations, to deliver to the partner sites based upon requisition. NUMAT technical officers trained and mentored ART teams in logistics management to ensure smooth system performance and logistics tools and materials adopted from MOH formats were distributed to the ART sites to ensure proper reporting of drug consumption. During the period, two cycles were delivered of first and second line adult ARV formulations for 17 existing ART sites and later for 6 additional newly accredited ART sites in the nine districts. Gaps in pediatric support were identified, which led to negotiations with Baylor Children College (Uganda) to provide the ART clinics with ARV formulations for young children. The choices of ARV drugs selected by the program were determined by the current GoU ARV policy that took into consideration efficacy, adverse effect profile, and pill burden. The ARV drugs selected also took into consideration needs of the clients gaining entry through the other program areas of PMTCT and TB.

SCMS also procured ARVs and drugs for opportunistic infections for the IRCU program. Technical staff have been trained in forecasting drug needs for the program and on the ARV logistics management system. A computerized logistics management information system was installed using standard software to track consumption and stock levels at the individual sites. Thirteen implementing sites are currently submitting bimonthly ARV drug reports and orders to the IRCU Logistics Officer. The partnership with SCMS and JMS has been successful to date and has guaranteed steady availability of ARVs at all IRCU supported sites. In addition, as a result of this partnership, IRCU has been able to procure quality ARVs at the most competitive rates available on the market, guaranteeing that its clients are accessing quality products and, with the savings, enabling the program to recruit more ART clients.

At the national level, SCMS provided technical assistance to the MOH to forecast and quantify the country's ARV needs, coordinate procurement with donors, and train new district and new ART site staff on logistics management and reporting. SCMS also assisted in support supervision activities at district level to improve facility level performance. Specific achievements include 683 health workers country-wide trained on the redesigned MOH ART logistics management system, 28 MOH regional pharmacists and senior dispensers trained on management of ART logistics activities, and 92 health workers from 38 newly accredited ART sites trained on the logistics management system. The SCMS supervisory team visited a total of 174 ART sites to monitor performance and provide on-the-job support to health workers charged with logistics management. Efforts to harmonize ARV procurement among PEPFAR partners and communicate supply issues continued through various technical working groups and technical support was provided to the GFTAM third party procurement agent (WHO/UNICEF). In FY08, technical assistance was provided to JMS to completely overhaul its warehousing and inventory management system including installation and training in the new warehouse management information system (MACS) and the financial system (SAGE) software. Support was also provided to NMS to assess its warehousing and inventory management system, the recommendations of which were endorsed by the NMS Board of Directors.

In FY2009, SCMS will continue to provide procurement services to buy ARVs (and other HIV/AIDS commodities as required) for USAID-supported partners including IRCU, NUMAT, the new partners implementing the three district-based HIV/AIDS/TB programs, and EGPAF. SCMS will also continue to buy ARV buffer stocks for the MOH. NUMAT will continue to improve access by working with MOH to accredit both public and private health facilities not currently served by other USG supported agencies.

**Activity Narrative:** USAID/Uganda's partnership with IRCU ends in June 2009. USAID/Uganda plans to initiate a follow on program to build upon and further expand the current achievements of IRCU.

Capacity building in ARV logistics management will continue in FY 2009 at the sites and national level but through the new partner (TBD). This new partner will provide the logistics management technical assistance that SCMS used to provide, including commodity forecasting and quantification, procurement planning, donor coordination, and strengthening the logistics management information systems for ARVs and other HIV/AIDS related commodities. The ART procurement harmonization exercise begun in FY 2008 will continue in FY 2009 to achieve a consolidated supply plan for all PEPFAR partners offering ART services. TBD will continue to participate in technical working groups to address emerging issues that impact on logistics management systems, e.g. changes in treatment protocols. Logistics advisors will work closely with MOH technical programs, the Pharmacy Division and NMS to build capacity and facilitate the transition of logistics management functions to local counterparts. To improve central level management and distribution of ARVs and other commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submit timely reports to keep the system moving. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution to health centers in selected districts.

The Uganda National Treatment Guidelines have been revised and the recommended first line choice of therapy is Nevirapine (NVP) + Zidovudine (AZT) + Lamuvidine (3TC) as a combination pack or blister pack called Combi-pack. In the event of failure on this combination, the alternative combination recommended, albeit more costly, is Truvada + Nevirapine + Efavirenz. Unless changed, the follow-on program will follow the same prescription protocols. Other than Truvada, generic versions of all other drugs recommended by MOH for use as first line have been approved by FDA. This has helped to standardize care and compliance with the national treatment guidelines, especially in health facilities receiving support from PEPFAR and Global Fund. In situations of stock-outs in the MOH ART program, PEPFAR drugs are used as a buffer to ensure that patients receive uninterrupted treatment. Development of ART drug resistance threshold monitoring mechanisms at representative sentinel sites will ensure that we supply drugs that remain efficacious. In FY 2010 the activities will continue unchanged.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.15: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> ARV Drugs
<b>Budget Code:</b> HTXD	<b>Program Budget Code:</b> 15
<b>Activity ID:</b> 4377.20744.09	<b>Planned Funds:</b> \$4,667,621
<b>Activity System ID:</b> 20744	



**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV- UMSOM), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, , Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nyenga Hospital and Nkozi Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages four of the LPTFs.

#### Progress to-date; activities and achievements

In FY 2008, AIDSRelief expanded its services to four new LPTFs. As of July 31, 2008, AIDSRelief in Uganda was supporting 18 LPTFs and 24 satellite sites to provide care and support to 61,859 patients and antiretroviral treatment to 20,590 (18,395 supported by AIDSRelief) HIV-infected people of which 1,726 were children.

AIDSRelief improved supply chain management capacity at all 18 LPTFs . AIDSRelief procured Antiretroviral drugs (ARVs) through a global procurement mechanism which provides very competitive pricing, with delivery, warehousing and distribution through Joint Medical Stores (JMS). Strengthening local capacity at critical points has ensured excellent supply chain management and uninterrupted ARVs provision. To date, AIDSRelief has not experienced any stock-out. The program continues to work closely with the USG in-country team and the Ministry of Health to harmonize and integrate the procurement of ARVs. The choice of regimen has been guided by recent evidence to ensure that the most effective and durable regimen with the minimum toxicity and resistance profile is used. The choice of regimen is based on the more favorable pharmacokinetic and safety profile and is supported by extensive clinical evidence. The choice of regimen is also designed to preserve optimal therapeutic choices for second line regimens. In order to support existing institutions and avoid creating parallel systems, Joint Medical Stores (JMS) a local faith based organization continued to warehouse and distribute ARVs on behalf of the program with continued support from AIDSRelief. Reporting and forecasting of ARVs by LPTFs has been improved with the introduction of the dispensing tool. In FY 2008, AIDSRelief received additional drug support from Clinton Foundation which enabled the program to scale up treatment beyond that supported by FY 2008 funding.

AIDSRelief continued to institutionalize Standard Operating Procedures (SOPs), which were developed in accordance with national guidelines. These guide supply chain activities from product selection and forecasting, procurement, distribution and consumption monitoring. Throughout FY 2008, AIDSRelief institutionalized these SOPs to ensure efficient supply chain management, and thus provided an uninterrupted supply of ARVs to LPTFs.

The program also conducted further trainings for all LPTF staff on the general principles of supply chain management and the ART Dispensing Tool, developed by MSH RPM Plus. This dispensing tool allowed LPTF to capture accurate pharmacy data, forecast drug needs, monitor patient numbers on ARVs and OI drugs, generate accurate pharmacy reports, and initiate appropriate stock replenishment through placing monthly orders. These pharmacy reports tracked stock inventory movement through the supply chain from deliveries by JMS up to the point of use by the patient. This permitted continuous modulation of patient enrollment to reflect ARV drugs availability, and ensured a guaranteed and continuous supply of drugs for each patient initiated on therapy. The use of the dispensing tool has been found to be very helpful in ensuring patient adherence because it maintains a patient diary. This was further enhanced by on site training and one-on-one mentoring during routine Pharmaceutical TA for all LPTFs. Furthermore, AIDSRelief supported LPTFs to establish Therapeutic Drug Committees (TDCs) to assist among others in the pharmaceutical and clinical management of the program.

#### FY 2009 activities

In FY 2009 AIDSRelief will maintain its support for services at the 18 LPTFs and 24 satellite sites in order to maintain 20,590 patients on ART, of which 2,800 will be children (provided additional funding is made available). AIDSRelief will also provide care and support to 63,620 (55,781 adults, and 7,839 children). The program will continue to leverage ARVs for pediatric patients from the Clinton Foundation, but will cover other ART related support such as purchase of OI drugs, laboratory supplies and technical assistance to the LPTFs. The program will continue to procure adult 1st line, alternative 1st line, and 2nd line therapies for adults and children. The AIDSRelief Supply Chain Management Team will continue capacity building through technical backstopping and on-going training and mentoring in Supply Chain Management.

Technical support to LPTFs to institutionalize standard operating procedures (SOPs) for drug management will continue in COP09. AR will train and retrain the LPTF pharmacists and other health workers including pharmacy technicians or assistants in the development and use of SOPs which are in line with national guidelines. In-depth training of the LPTF staff in the utilization of SOPs, forecasting and quantification for ARVs and general drug management issues will be conducted.

The Pharmaceutical Management Team manages country operations with a Medicines and Therapeutic Committee (MTC/TDC) of clinicians, pharmacists, strategic information advisors and program managers. The MTC/TDC reviews drug utilization patterns across all LPTFs, assesses scale-up progress and develops required technical support plans. The Pharmaceutical Management Team will support the strengthening or establishment of medicines and Therapeutics committees (MTC) at all Local Partner Treatment Facility. The Medicines and Therapeutic committees will have the key responsibility of developing policies for managing medicines use and administration, evaluating the clinical use of drugs and managing a formulary system. The MTC will promote rational use of medicines (RUM) through the medication use reviews, provision of

**Activity Narrative:** drug information to patients, monitoring medication errors, development and implementation of pharmacovigilance plan and development and implementation of continuing education plans. The AR technical team will provide technical assistance through training and on site mentorship for these committees. Technical assistance will be provided to the LPTFs in development and implementation of Pharmacovigilance plan (data gathering activities relating to detection, assessment and understanding of adverse drug events / reactions i.e. ADEs or ADRs and treatment failure). Functional MTC at LPTF level will ensure that the ARV supply chain management is clinically informed and logistically supported. The training and backstopping on the use of electronic tools like the dispensing tool will be continued to further improve the Drug Information Management System of the LPTFs. To facilitate the recruitment and retention of competent pharmacy staff for LPTFs, linkages will continue to be strengthened with pharmacy training institutions with a purpose of recommending graduate students to AIDSRelief LPTFs.

The Institute for Human Virology will participate in the periodic review of National Treatment Guidelines in order to assist in the selection of regimens most appropriate to the Ugandan context guided by the Ministry of Health. Choice of regimen is guided by most recent evidence to ensure that the most effective and durable regimen available within the national guidelines with the least possible toxicity and resistance profile is used. The current choice of primary regimen for AIDSRelief sites consists of Truvada (TVD) combined with Nevirapine (NVP) or Efavirenz (EFV) for patients on Rifampicin containing tuberculosis protocols or intolerant to NVP. Aluvia (lopinavir/ritonavir) is used for those who are intolerant to both NVP and EFV. For those who have renal insufficiency, AZT/3TC will be substituted for TVD. Limited quantities of Stavudine (D4T30) to be combined with Lamivudine (3TC) are also procured to be used for patients with both renal insufficiency and anemia. The choice of regimen is based on the more favorable pharmacokinetic and safety profile and is supported by extensive clinical evidence. The choice of regimen is also designed to preserve optimal therapeutic choices for second line regimens, which in the AR program consists of AZT (or D4T in cases of anemia, or TDF in patients failing AZT or D4T as their primary regimen) coupled with 3TC and Aluvia. All drugs with exception of Aluvia (which is currently not available as generics) are procured in generic form. AIDSRelief provides AZT, 3TC and NVP for children less than 5 years of age, and AZT or D4T, 3TC and EFV/NVP for those above 5 years and ABC as an alternative for those affected by severe anemia.

Constella Futures coordinates the overall monitoring and evaluation of the AIDSRelief program, and will support LPTFs in harmonizing patient numbers for both adults and children, to ensure that accurate reports are produced. This will be done through: updating of the clinical management tools to ensure that they capture relevant pharmacy information; training and targeted TA to staff focusing on identifying and reporting active and terminated patients; and properly documenting clients on each regimen. This will involve emphasizing to clinical staff the relevance of documenting patients switching regimens, and the reasons for the same. Every quarter, this information will be available, and harmonized with that from the dispensing tool, so as to inform forecasting and procurements processes

AIDSRelief initiated the development of its sustainability plan in Year 5 focusing on technical, organizational, funding, policy and advocacy dimensions. To date, the program has been able to increase access to quality care and treatment, while simultaneously strengthening health facility systems through human resource support, equipment, financial training and improvements in health management information. In FY2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions. These approaches will ensure continuity of skills training. AIDSRelief will particularly focus on its relationship with indigenous organizations such as the Uganda Catholic Medical Bureau and Uganda Protestant Medical Bureau; Joint Medical Stores to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care services. These strategies will enable AIDSRelief to fully transfer its knowledge, skills and responsibilities to in country service providers.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13267

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13267	4377.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$4,667,621
8288	4377.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$3,667,621
4377	4377.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$3,667,621

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Malaria (PMI)

- \* TB

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 5739.09

**Prime Partner:** Baylor College of Medicine  
Children's Foundation/Uganda

**Funding Source:** GHCS (State)

**Budget Code:** HTXD

**Activity ID:** 4380.20063.09

**Activity System ID:** 20063

**Mechanism:** Expansion of National  
Pediatric HIV/AIDS Prevention,  
Care and Treatment Services  
and Training of Service  
Providers

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** ARV Drugs

**Program Budget Code:** 15

**Planned Funds:** \$2,706,832

**Activity Narrative:** 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 pediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Pediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence (COE) has been constructed and was opened in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital, Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific pediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in the North (Kitgum). Other collaborating partners include Feed the Children- Uganda which supports the nutrition program, Pediatric AIDS Canada provides some support for 320 children on ART, Save the Children in Uganda, Christian Children's Fund, Plan International, AIDS Information Centre, etc.

Baylor – Uganda is the single largest provider (3,750 children) of pediatric ART services in Uganda; and has enrolled over 8,000 children and care givers in active HIV/AIDS care. Baylor – Uganda uses two services delivery modes: (a) direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC) and Post Natal Clinic at Mulago Hospital; 4 rural clinics in Soroti and Kasese districts, and five satellite clinics (Naguru, Kiruddu, Kawempe, Kanyanya and Kitebi Kampala City Council (KCC) clinics,) run as family care clinic consortium with KCC, and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI) and Mulago-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. These services include HIV counseling and testing for children 6-weeks to 18 years and their 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) Baylor – Uganda provides indirect services through integration of pediatric HIV/AIDS services in ART accredited public health facilities in rural parts of Uganda. Baylor-Uganda has successfully integrated paediatric HIV/AIDS services in 33 public health facilities in this first year of the grant & will roll out to 133 sites in total, over the five year period. More than 1,200 adults and their 305 children have been enrolled into care and ART respectively from these rural health facilities in 3 months time.

Baylor – Uganda has trained more than 1,000 health professionals in pediatric HIV/AIDS management since 2003, by multiple teams of trainers from PIDC, Ministry of Health and Makerere University Department of Pediatrics and Child Health. Since January 2008 with the current grant, the training program takes on a three-pronged approach with (1) didactic training combined with (2) practical clinical training attachments and on-site mentorship, and (3) implementation of work plan developed, which include achieving enrollment of at least 5 children into care and treatment. To date, more than 200 and 320 health professionals have benefited from clinical attachments and on-site mentorship support respectively through the 32 health facilities where pediatric HIV/AIDS services have been integrated. Continuing Medical Education programs are offered weekly at the COE and monthly at the satellite clinics. In addition, a weekly case conference is held at the PIDC for education and consultation on challenging cases. Monthly mortality audits to further understand the causes of death are also held for all the clinics in Kampala.

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at the COE and Satellite clinics to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and District Health Offices is on-going. We hope these will lead to the development of many clinical best practices for pediatric HIV care in Uganda and other international Baylor network countries. In October 2008, the COE will roll out Electronic Real Time Medical records and with the support of CDC extend it to all our supported health facilities over the five years.

Funds allocated to ARV Drugs Program Area primarily focus on ARV drug management (forecasting, procurement, transportation, storage, distribution, prescription and dispensing) and HIV/AIDS treatment for HIV-infected children and care givers attending Baylor-Uganda supported clinics. Currently, more than 8,000 HIV exposed and infected children and their care givers are in active care from 44 Baylor – Uganda supported sites. About 3,750 children receive ART through Baylor-Uganda CDC supported service outlets at the Mulago Hospital Baylor Center of Excellence (COE); 6 Satellite clinics at Mulago post natal clinic, Naguru HCIV, Kawempe HCIV, Kitebi HCIV, Kirudu HCIV and Kanyanya TASO centre); and UNICEF supported Regional Centres in Eastern Uganda (Lwala Hospital, Kaberamaido HCIV) and Western (Kilembe Mines & Bwera Hospitals). The 32 rural health facilities have recorded more than 1,200 children enrolled in active care, with 305 enrolled on ART in 3 months period, yet they have no functional system for regular supply and management of their ARVs and non-ARV drugs. In the previous year (2007/8), the majority of 1st & 2nd line ARV drug regimens were donated through Clinton Foundation support, which is due to end by December, 2009. Baylor-Uganda procures ARV drugs through Medical Access Uganda Limited and ensures supply chain management and uninterrupted ARV provision through strengthening of local capacity at critical points.

In FY2009, the following activities are anticipated to continue, while some will be modified to suit circumstances;

- Forecasting, procurement, distribution, handling and storage of both 1st and 2nd line ARV drugs.
- Procurement of equipment, including pill cutters, fitting drug cabinets/shelves, refurbishing and reinforcing security in pharmacies, etc.
- Continued provision of ART services to about 5,000 (about 3,500 old cases and 1,500 new cases enrolled) children, adolescents and family members infected with HIV from existing and 32 additional health facilities that will have integrated paediatric HIV/AIDS management. Approximately 250 additional patients will

**Activity Narrative:** receive ARV treatment from other sources specifically, Pediatric AIDS Canada (PAC). Adults are treated within Baylor – Uganda’s supported facilities in the context of family centered care, using an index HIV infected child.

- Provision of ARV for management of Post Exposure Prophylaxis for victims of rape/defilement.
- As the national referral hospital, children who are failing on 1st line treatment are often referred to PIDC. It is estimated that approximately 5% of the children receiving ARVs through Baylor-Uganda will need to switch from 1st to 2nd line treatment in 2008/2009.
- Our pharmacy staff will continue to develop logistical and operational policies and procedures to accurately forecast, procure, store, and inventory the ARVs dispensed to Baylor-Uganda/PIDC supported patients at all the clinics.
- The pharmacy and data management teams will also work closely with locally identified ARV procurement and distribution organizations to develop an automated stock control/pharmacy management database to more efficiently track, forecast and manage ARV procurement and dispensing practices at the main PIDC and the satellite centers.
- In addition, program management will continue to hire services of external auditor to conduct monthly & quarterly drug audits. These activities will be developed and documented for sharing of best practices with other local health institutions to enhance national capacity to care for & prescribe ARVs to HIV-infected children and their families.
- Our pharmacy staff will provide training in logistics management (ARV) and on-going technical support (mentorship, support supervision, tools and systems development) to all Baylor – Uganda supported sites for better ARV and other logistics management and accountability. In addition, the Baylor-Uganda supported health professional trainings will continue to include pediatric ARV dosing and principles as part of its curriculum. It is estimated that such training initiatives will reach no less than 570 health professionals in this period. The Baylor-Uganda/PIDC program will continue to work with the MOH, PAC, and the Clinton Foundation in order to maximize access to ARVs from all available sources.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13247

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13247	4380.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$2,706,832
8283	4380.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$2,306,832
4380	4380.06	HHS/Centers for Disease Control & Prevention	Baylor University, College of Medicine	3331	1186.06	Pediatric Infectious Disease Clinic	\$861,623

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$119,900

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

Estimated amount of funding that is planned for Food and Nutrition: Commodities \$3,000

## Economic Strengthening

## Education

## Water

**Table 3.3.15: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1107.09	<b>Mechanism:</b> Mulago-Mbarara Teaching Hospitals - MJAP
<b>Prime Partner:</b> Makerere University Faculty of Medicine	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> ARV Drugs
<b>Budget Code:</b> HTXD	<b>Program Budget Code:</b> 15
<b>Activity ID:</b> 4035.20767.09	<b>Planned Funds:</b> \$4,242,541
<b>Activity System ID:</b> 20767	

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

Currently, MJAP procures and distributes ARV drugs for 15 service outlets as listed above through Medical Access – (provide some description of Med Access). The 15 outlets serve over 27, 000 patients in care, 9,365 of whom have their ARV drugs procured through MJAP funding. The current (July 2008) distribution of these patients who receive the MJAP directly procured ARVs are 1400 at AIDC, 1620 in Mbarara ISS clinic, 2,645 in Mulago ISS clinic, 730 in Mbarara municipality clinic, 598 in Kawempe KCC, 482 in Bwizibwera HC IV, 239 at Mulago TB/HIV clinic, 379 in Naguru, 332 at Kiruddu, 167 Kiswa, 145 at Kawaala, and 650 at the centres of Kisenyi, Komamboga and Kitebi. The target is to procure ARVs for at least 10,000 patients by March 2009. In addition, the program targets at least a further direct leverage of ARV drugs from the Clinton Foundation HIV/AIDS Initiative drug donation program. The program in FY 2008 achieved a 150% recruitment target by getting 7510 patients on to the directly procured ARVs. This was achieved as a result of the timely switch from branded to generic FDA approved ARVs medicines that are cheaper and became increasingly available locally. The program has continued to utilize the available opportunity of global price reductions to allow many more patients onto treatment in FY 2008. In addition to the switch to generic medicines, the program will continue to promote the increased use of fixed-dose combination medicines in order to improve patients' adherence to therapy. The demand for ART in the clinics continues to increase with the expansion and strengthening of RTC (provider-initiated testing) in the hospitals. The Mbarara ISS and AIDC are now at maximum carrying capacity yet the trend of identification of newly identified HIV-infected persons remains the same. Majority of HIV positive patients identified through the RTC program (55%) need ARVs (WHO Stages 3 and 4 and/or CD4+ cells count of  $\leq 250$ ). Currently, we estimate that only about 70% of clinically eligible patients are receiving ART at the clinic sites despite increased efforts to have them on treatment. MJAP has trained over 800 health care providers in the provision of antiretroviral therapy and strengthened systems for ART delivery including staffing, laboratory support, logistics and data management. As a result of the capacity building of lower level clinics within the catchment's areas of Mulago and Mbarara for HIV care by MJAP, an additional >8,500 patients are able to access ARV drugs from MOH/ GFATM and Clinton Foundation HIV/AIDS Initiative at the MJAP supported sites. The program as well as able and will continue to support over 100 children on ART at the Mbarara municipal council clinic and Bwizibwera health centre in Mbarara districts. In the past year, due to ART drug procurement interruptions for global fund, MJAP supported the procurement of 2-3 months' buffer stock for up to 5,000 of these patients on both first and second line art regimens. In addition, MJAP continued to increase access to treatment for pregnant mothers and patients with hepatitis co-infection at all the sites. Over 200 health care workers received post-exposure prophylaxis for HIV infection at all the sites offering antiretroviral therapy.

In FY 2009, MJAP plans to procure and distribute ARVs for a total of 20,000 patients attending 19 different treatment service outlets. Four new centres shall be opened in Kampala and Mbarara to decongest the current centres that are overcrowded. The distribution of the treatment slots shall be based on capacity, demand for art and available space. In FY 2009, MJAP will strengthen the uptake of children on to antiretroviral therapy at all the centres where no other partner provides paediatric care namely Mbarara municipal council clinic and Bwizibwera health centre in Mbarara. The program expects to have at least 10% of all the patients on ART at these two sites to be paediatric. The ART drugs for provision of prevention of mother to child HIV transmission shall be obtained from the GFTAM- MOH PMTCT program available at all the centres. MJAP will continue to carry out task-shifting for the management of the ART drugs supply chain with more emphasis being put on using the lower level staff in the quantification and distribution of the products. Over 300 health care workers and 500 women of sexual and gender based violence shall be provided with post-exposure prophylaxis based on the current recommended regimens. MJAP will continue to procure FDA approved generic ART medicines at competitive prices through Medical Access Uganda limited. In addition, the program will continuously monitor the current global pricing mechanisms report to

**Activity Narrative:** ensure value for the commodity procurement and to increase access through increasing treatment slots for every significant price reduction. In order to improve service delivery and build capacity, MJAP will use both task-shifting and pre-service training to build capacity for uptake of ARV drugs at the treatment facilities. MJAP will train newly qualified students from the medical schools of Makerere and Mbarara Universities, and the Mulago paramedical schools. Procured ART medicines shall be received and inspected by a pharmacist of the program together with the procurement officer and stores assistant. The drugs are then entered into a 'goods received' note and other inventory management records. The ART medicines shall all be centrally procured and distributed through the pull logistics system. Stock-taking or physical counts shall be done at monthly intervals for all centres and stores and routine reports made. In addition, MJAP will provide a buffer stock of up to three months for all patients receiving their ART stocks from the Ministry of Health/ Global Fund for Tuberculosis, AIDS and Malaria program during stock-out. In addition, MJAP will continue to strengthen local capacity of the health facilities to take over the provision of ART through training and on-site support. MJAP will upgrade the current logistics and supply-chain management software to be able to handle the increased activities and number of sites. In addition to the ART resources from the GFTAM-MOH program, MJAP will continue to obtain additional ARV drugs for paediatric and adult second line treatment from the Clinton foundation HIV/aids initiative (CHAI) donation program. The CHAI donation program will continue for up to December 2009. The savings that shall be realised from the CHAI donation and shall be used to provide additional treatment options or slots for eligible patients.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13278

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13278	4035.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$4,242,541
8318	4035.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$3,742,541
4035	4035.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$2,725,400

#### Emphasis Areas

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$100,000

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease Control & Prevention



---

**Funding Source:** GHCS (State)

**Budget Code:** HTXD

**Activity ID:** 4415.20800.09

**Activity System ID:** 20800

**Program Area:** ARV Drugs

**Program Budget Code:** 15

**Planned Funds:** \$4,842,541

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trial. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

Between October 1, 2007 and March 31, 2008, 1,725 naive adult clients were initiated on ART bringing the total number of clients who have ever received ARVs to 10,214 through the 12 sites under MU and RO. 410 were trained in HIV/AIDS treatment/ARV services. The drug management at MU is now all electronic with prescriptions entered into a database real time and stock control done using the same system. Two specialist clinics were started. Eye clinic was opened in November 2007 to screen and treat patients with HIV related eye conditions. 21% of the clients seen in the eye clinic are children. Multi-disciplinary hospital and home visits continued. The community programme was introduced in February 2008. Stable children together with their carers are referred for follow up by Mildmay staff in selected near by health facilities, in order to decongest the main clinic. 7 clinics are currently in operation. The trainings run at MU target the use of ARV drugs in resource limited settings. 410 were trained; these were mainly health professionals; doctors and nurses, allied health professionals; counsellors, physiotherapists, occupational therapists, nutritionists and informal caregivers; carers of patients. Training focuses on the side effects and drug interactions of ARVs, when and how to initiate treatment, adherence and the principles of antiretroviral therapy. Trainees come from various health facilities, both rural and urban as well as both government and NGOs. Training courses are typically 5 days to three weeks in duration. The challenges are inadequate space in the pharmacy and store which means that all buffer stock is kept with the supplier and pharmacy staff have limited space to work in.

During FY 2009 MU with RO its sub partner, will continue providing ARVs and training activities at 12 sites of MU and 4 sites of RO. The funds for this programme area will finance the purchase of ARV drugs for both adults and children with HIV and fit within the criteria for starting on ART as per the Uganda National Treatment Guideline. Emphasis will be put on FDA-approved generics and branded ones will only be used where the generic equivalent is not available. More than 90% of the patients are on firstline drugs and therefore these will form the bulk of the ARV drug purchases. However all children and adult patients who need the second line drugs either because of failure on first line or adverse events will also be provided with ARV drugs. The procurement system will be strengthened to ensure sustained supply at all sites and a buffer stock for 4 months will be maintained to avoid any risks. The drugs will be used to manage children and adults who have reached the threshold for starting ART, any pregnant women at risk of transmitting the virus to their unborn babies and victims of rape and sexual assault, health workers exposed to HIV as well as patients on ART moving into the catchment area. The provision of ART will follow a strict preparation exercise where patients will have CD4 tests done and for all adults with values above 250 are treated and children with appropriate CD4 percentages as well as all infected infants are prepared for treatment and family members screened for HIV and those found positive recruited too. This is a continuing activity and

**Activity Narrative:** involvement of rural partners and training will help the sustainability of the activities. MU will continue training at the Centre as well as upcountry in targeted districts to handle the ARV drugs better. Together with EMG, a USAID – funded project MU will also train health practitioners in the private sector in HIV management and use of ARV drugs. MU will train – individuals through formal courses and clinical placements. The targeted population is all people living with HIV/AIDS and health workers working HIV/AIDS organisations within the target area for Mildmay and Reach Out Mbuya plus the military population around Reach Out.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13289

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13289	4415.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$4,842,541
8625	4415.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$4,842,541
4415	4415.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$3,195,003

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

**Table 3.3.15: Activities by Funding Mechanism**

**Mechanism ID:** 5342.09

**Mechanism:** AIDSRelief

**Prime Partner:** Catholic Relief Services

**USG Agency:** HHS/Health Resources Services Administration

**Funding Source:** Central GHCS (State)

**Program Area:** ARV Drugs

**Budget Code:** HTXD

**Program Budget Code:** 15

**Activity ID:** 10137.20733.09

**Planned Funds:** \$3,094,749

**Activity System ID:** 20733

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV- UMSOM), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, , Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nyenga Hospital and Nkozi Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages four of the LPTFs.

In FY 2008, AIDSRelief expanded its services to four new LPTFs. As of July 31, 2008, AIDSRelief in Uganda was supporting 18 LPTFs and 24 satellite sites to provide care and support to 61,859 patients and antiretroviral treatment to 20,590 (18,395 supported by AIDSRelief) HIV-infected people of which 1,726 were children.

AIDSRelief improved supply chain management capacity at all 18 LPTFs. AIDSRelief procured Antiretroviral drugs (ARVs) through a global procurement mechanism which provides very competitive pricing, with delivery, warehousing and distribution through Joint Medical Stores (JMS). Strengthening local capacity at critical points has ensured excellent supply chain management and uninterrupted ARVs provision. To date, AIDSRelief has not experienced any stock-out. The program continues to work closely with the USG in-country team and the Ministry of Health to harmonize and integrate the procurement of ARVs. The choice of regimen has been guided by recent evidence to ensure that the most effective and durable regimen with the minimum toxicity and resistance profile is used. The choice of regimen is based on the more favorable pharmacokinetic and safety profile and is supported by extensive clinical evidence. The choice of regimen is also designed to preserve optimal therapeutic choices for second line regimens. In order to support existing institutions and avoid creating parallel systems, Joint Medical Stores (JMS) a local faith based organization continued to warehouse and distribute ARVs on behalf of the program with continued support from AIDSRelief. Reporting and forecasting of ARVs by LPTFs has been improved with the introduction of the dispensing tool. In FY 2008, AIDSRelief received additional drug support from Clinton Foundation which enabled the program to scale up treatment beyond that supported by FY 2008 funding.

AIDSRelief continued to institutionalize Standard Operating Procedures (SOPs), which were developed in accordance with national guidelines. These guide supply chain activities from product selection and forecasting, procurement, distribution and consumption monitoring. Throughout FY 2008, AIDSRelief institutionalized these SOPs to ensure efficient supply chain management, and thus provided an uninterrupted supply of ARVs to LPTFs.

The program also conducted further trainings for all LPTF staff on the general principles of supply chain management and the ART Dispensing Tool, developed by MSH RPM Plus. This dispensing tool allowed LPTF to capture accurate pharmacy data, forecast drug needs, monitor patient numbers on ARVs and OI drugs, generate accurate pharmacy reports, and initiate appropriate stock replenishment through placing monthly orders. These pharmacy reports tracked stock inventory movement through the supply chain from deliveries by JMS up to the point of use by the patient. This permitted continuous modulation of patient enrollment to reflect ARV drugs availability, and ensured a guaranteed and continuous supply of drugs for each patient initiated on therapy. The use of the dispensing tool has been found to be very helpful in ensuring patient adherence because it maintains a patient diary. This was further enhanced by on site training and one-on-one mentoring during routine Pharmaceutical TA for all LPTFs. Furthermore, AIDSRelief supported LPTFs to establish Therapeutic Drug Committees (TDCs) to assist among others in the pharmaceutical and clinical management of the program.

In FY 2009 AIDSRelief will maintain its support for services at the 18 LPTFs and 24 satellite sites in order to maintain 20,590 patients on ART, of which 2,800 will be children (provided additional funding is made available). AIDSRelief will also provide care and support to 63,620 (55,781 adults, and 7,839 children). The program will continue to leverage ARVs for pediatric patients from the Clinton Foundation, but will cover other ART related support such as purchase of OI drugs, laboratory supplies and technical assistance to the LPTFs. The program will continue to procure adult 1st line, alternative 1st line, and 2nd line therapies for adults and children. The AIDSRelief Supply Chain Management Team will continue capacity building through technical backstopping and on-going training and mentoring in Supply Chain Management.

Technical support to LPTFs to institutionalize standard operating procedures (SOPs) for drug management will continue in COP09. AR will train and retrain the LPTF pharmacists and other health workers including pharmacy technicians or assistants in the development and use of SOPs which are in line with national guidelines. In-depth training of the LPTF staff in the utilization of SOPs, forecasting and quantification for ARVs and general drug management issues will be conducted.

The Pharmaceutical Management Team manages country operations with a Medicines and Therapeutic Committee (MTC/TDC) of clinicians, pharmacists, strategic information advisors and program managers. The MTC/TDC reviews drug utilization patterns across all LPTFs, assesses scale-up progress and develops required technical support plans. The Pharmaceutical Management Team will support the strengthening or establishment of medicines and Therapeutics committees (MTC) at all Local Partner Treatment Facility. The Medicines and Therapeutic committees will have the key responsibility of developing policies for managing medicines use and administration, evaluating the clinical use of drugs and managing a formulary system. The MTC will promote rational use of medicines (RUM) through the medication use reviews, provision of drug information to patients, monitoring medication errors, development and implementation of pharmacovigilance plan and development and implementation of continuing education plans. The AR

**Activity Narrative:** technical team will provide technical assistance through training and on site mentorship for these committees. Technical assistance will be provided to the LPTFs in development and implementation of Pharmacovigilance plan (data gathering activities relating to detection, assessment and understanding of adverse drug events / reactions i.e. ADEs or ADRs and treatment failure). Functional MTC at LPTF level will ensure that the ARV supply chain management is clinically informed and logistically supported. The training and backstopping on the use of electronic tools like the dispensing tool will be continued to further improve the Drug Information Management System of the LPTFs. To facilitate the recruitment and retention of competent pharmacy staff for LPTFs, linkages will continue to be strengthened with pharmacy training institutions with a purpose of recommending graduate students to AIDSRelief LPTFs.

The Institute for Human Virology will participate in the periodic review of National Treatment Guidelines in order to assist in the selection of regimens most appropriate to the Ugandan context guided by the Ministry of Health. Choice of regimen is guided by most recent evidence to ensure that the most effective and durable regimen available within the national guidelines with the least possible toxicity and resistance profile is used. The current choice of primary regimen for AIDSRelief sites consists of Truvada (TVD) combined with Nevirapine (NVP) or Efavirenz (EFV) for patients on Rifampicin containing tuberculosis protocols or intolerant to NVP. Aluvia (lopinavir/ritonavir) is used for those who are intolerant to both NVP and EFV. For those who have renal insufficiency, AZT/3TC will be substituted for TVD. Limited quantities of Stavudine (D4T30) to be combined with Lamivudine (3TC) are also procured to be used for patients with both renal insufficiency and anemia. The choice of regimen is based on the more favorable pharmacokinetic and safety profile and is supported by extensive clinical evidence. The choice of regimen is also designed to preserve optimal therapeutic choices for second line regimens, which in the AR program consists of AZT (or D4T in cases of anemia, or TDF in patients failing AZT or D4T as their primary regimen) coupled with 3TC and Aluvia. All drugs with exception of Aluvia (which is currently not available as generics) are procured in generic form. AIDSRelief provides AZT, 3TC and NVP for children less than 5 years of age, and AZT or D4T, 3TC and EFV/NVP for those above 5 years and ABC as an alternative for those affected by severe anemia.

Constella Futures coordinates the overall monitoring and evaluation of the AIDSRelief program, and will support LPTFs in harmonizing patient numbers for both adults and children, to ensure that accurate reports are produced. This will be done through: updating of the clinical management tools to ensure that they capture relevant pharmacy information; training and targeted TA to staff focusing on identifying and reporting active and terminated patients; and properly documenting clients on each regimen. This will involve emphasizing to clinical staff the relevance of documenting patients switching regimens, and the reasons for the same. Every quarter, this information will be available, and harmonized with that from the dispensing tool, so as to inform forecasting and procurements processes

AIDSRelief initiated the development of its sustainability plan in Year 5 focusing on technical, organizational, funding, policy and advocacy dimensions. To date, the program has been able to increase access to quality care and treatment, while simultaneously strengthening health facility systems through human resource support, equipment, financial training and improvements in health management information. In FY2009, the program will support linkages between LPTFs and the MOH to tap into locally available training institutions. These approaches will ensure continuity of skills training. AIDSRelief will particularly focus on its relationship with indigenous organizations such as the Uganda Catholic Medical Bureau and Uganda Protestant Medical Bureau; Joint Medical Stores to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care services. These strategies will enable AIDSRelief to fully transfer its knowledge, skills and responsibilities to in country service providers.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13259

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13259	10137.08	HHS/Health Resources Services Administration	Catholic Relief Services	6428	5342.08	AIDSRelief	\$3,094,749
10137	10137.07	HHS/Health Resources Services Administration	Catholic Relief Services	5342	5342.07	AIDSRelief	\$3,332,379

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development****Public Health Evaluation****Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

**Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.15: Activities by Funding Mechanism****Mechanism ID:** 5737.09**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS**Prime Partner:** The AIDS Support Organization**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** ARV Drugs**Budget Code:** HTXD**Program Budget Code:** 15**Activity ID:** 4056.20879.09**Planned Funds:** \$6,980,301**Activity System ID:** 20879

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers & 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

By July 31 2008, TASO provided ART to 20,000 clients cared for by the 11 nationally accredited TASO sites (including HBAC Tororo) according to national ART Treatment Guidelines. TASO has been implementing the ART program since July 2004. Of the clients on ART, 99.3% are on first-line regimens and less than 1% are on second line regimens. TASO provides only ARV branded and generic drug supplies approved by the US Food & Drug Administration (FDA). TASO continues to substitute FDA approved branded ARV drugs with generic ARV drugs once they have been approved by the US FDA and are available on market. The cost-savings realized through switching to approved generics were ploughed back into additional treatment slots for clients. TASO procures ARV drugs from Medical Access Uganda, a company established under the UNAIDS Drug Access Initiative to procure drugs from the selected pharmaceuticals. TASO procures all ARV drugs centrally for all 11 sites including HBAC-Tororo in accordance with the TASO Procurement Policy & Procedures. The sites regularly submit monthly consumption reports that form the basis for re-order from the Central Stores at TASO HQ. Four percent of the total TASO ARV drug budget is set aside for an episodic buffer for TASO clients accessing ARV drugs under GFATM in case of temporary stock-outs at public and GFATM supported facilities. This helps prevent treatment interruption of TASO clients receiving ARVs from public facilities thus freeing up slots they would otherwise consume for other TASO clients; it also compliments and strengthens the national ART program. In FY 2008, TASO priorities for ARV Drugs included: ARV drugs procurement for 20,000 clients on treatment; ARV drug procurement for 200 pregnant clients and their newborn babies; maintaining a primary buffer stock of ARV drugs for at least 3 months at each of the 11 TASO sites; maintaining a secondary buffer stock of ARV drugs covering an additional 3 months at the TASO Central Stores; maintaining and regularly updating the 12 month rolling forecast for ARV drugs; ensuring professional stores and stock control system for ARV drugs; running a computerized stores management information system for ARV drugs integrated with patient care information systems; training/re-training pharmacy and stores personnel; and liaising with ARV drug supply partners to keep abreast with critical market trends.

During FY 2009, TASO will carry out activities under ARV Drugs to support HIV treatment services by the 11 Centers located in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso. Each of the Centers will directly serve clients from the host district and up to 6 neighboring districts. The ARV Drugs related activities will comprise: ARV drug procurement for 20,000 continuing clients and 2,640 new clients to be initiated on ART (assuming level funding across the year); ARV drug procurement for prophylaxis for 200 eligible pregnant women and their newborn babies; maintaining a primary buffer stock of ARV drugs covering at least 3 months at each of the 11 TASO sites; maintaining a secondary buffer stock of ARV drugs covering an additional 3 months at the TASO Central Stores; maintaining and regularly updating the 12 month rolling forecast for ARV drugs; ensuring

**Activity Narrative:** professional stores and stock control practices for ARV drugs; maintaining a computerized stores management information system for ARV drugs integrated with drug consumption information systems; training/re-training pharmacy and stores personnel; and liaising with ARV drug supply partners to keep abreast with critical market trends. The ARV Drugs program area is related to the program areas of PMTCT, Palliative Care (Basic), Palliative Care (TB/HIV), Counseling & Testing, ARV Services and Laboratory Infrastructure. The activities under ARV Drugs 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. The activities under this Program Area are also linked to other USG funding through USAID focusing on the Program Areas of Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13229

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13229	4056.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$7,194,288
8360	4056.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	5737	5737.07	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$6,766,294
4056	4056.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$6,263,946



## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Refugees/Internally Displaced Persons

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$15,000

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.15: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7349.09	<b>Mechanism:</b> HHS/CDC CSCS
<b>Prime Partner:</b> US Department of State	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> ARV Drugs
<b>Budget Code:</b> HTXD	<b>Program Budget Code:</b> 15
<b>Activity ID:</b> 18967.20849.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 20849	
<b>Activity Narrative:</b> Follow-on to current Track 1 AIDSRelief activities.	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18967	

## Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18967	18967.08	HHS/Centers for Disease Control & Prevention	US Department of State	7349	7349.08	HHS/CDC CSCS	\$0

**Table 3.3.15: Activities by Funding Mechanism**

---

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** ARV Drugs

**Budget Code:** HTXD

**Program Budget Code:** 15

**Activity ID:** 4020.21221.09

**Planned Funds:** \$887,805

**Activity System ID:** 21221

**Activity 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 phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts namely Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include; an innovative home based and community-based voluntary Counseling and Testing (VCT) program, provision of palliative basic HIV care, antiretroviral therapy (ART), Prevention of Mother to Child Transmission (PMTCT), tuberculosis (TB) care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention. The community-based VCT program is nested within the program's existing annual research activities, whereby persons residing in the study areas are offered counseling and testing in their respective communities. The HIV test results are returned to the clients through program counselors residing within the communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. Through the medical male circumcision service, clients seeking male circumcision service are also offered counseling and testing. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates seventeen (17) outreach clinics in Rakai and Lyantonde districts. These outreach clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. Services offered include: health education, on-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, provision of antiretroviral therapy, prevention for positives, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis (if not contraindicated). The majority of patients currently enrolled on the HIV care program are adults (60% female, 40% male) and only about 5% are children 0-14 years old.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by ELISA and western blot if ELISA is discordant, microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, serology like serum CRAG, chemistry tests like liver and renal function tests and hematology, among others. As an accredited TB treatment center, the program is making efforts to streamline TB diagnostics. In addition to laboratory testing, there is an X-ray facility to support TB diagnosis. Resistance testing for TB is outsourced at a reference laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

The RHSP medical male circumcision program: Three trials of male circumcision (MC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. Men requesting MC are consented for surgery, which is performed under local anesthesia using either the sleeve or dorsal slit procedures. After observation in a recovery room, discharged men are followed at 1-2 and 7-9 days and 4-6 weeks to monitor healing and potential surgical complications. Men and their partners are instructed on wound care and on avoidance of intercourse until wound healing is complete. As part of the MC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their female partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT. The Rakai MMC Program also conducts community-level health education for both men and women regarding HIV Prevention (ABC) and MC. The information is provided through town meetings, sports events, drama groups and videos. Women need to be informed that MC does not guarantee that the male is HIV-negative, that abstinence from sex following the procedure is of great importance regardless of the male partner's HIV status, and that condom use is crucial regardless of MC status if the partner is HIV-positive or of unknown serostatus. Through PEPFAR support, HIV-infected individuals identified through

**Activity Narrative:** MMC service are offered a free Basic Care Package, including cotrimoxazole, insecticide treated mosquito bed nets, clean water containers and hypochlorite tablets. Once they reach eligibility for HAART (CD4 count <250 cells/ml or WHO clinical stage 4), they are offered HAART and clinical monitoring via RHSP mobile and fixed clinics. In order to facilitate safe MMC, RHSP is offering training to different cadres of medical personnel including surgeons, clinicians, counselors and operating room assistants. The Rakai center has been selected by WHO to serve as an East African regional MC training center.

**Progress to-date**

The program purchases antiretroviral (ARV) drugs on a quarterly basis through Medical Access, Uganda Limited (MAUL). The program maintains a 3-months buffer stock to prevent stock-outs that may arise from unpredicted lead times of various drug manufacturers. The ARVs are temporarily stored in a central logistics store in Entebbe before being dispatched to the central pharmacy in the Kalisizo field station. At the pharmacy, these drugs are arranged and stored in shelves, from which smaller quantities are drawn when needed. The drugs are tracked in log books to ensure proper use and keeping track of expiry dates and balances at hand. RHSP is in the process of establishing an electronic drug tracking system which will make drug management and tracking in the pharmacy easier. The ARV drugs that are currently used at the program include first and second line ARV drugs as recommended by the national Treatment guidelines. The first line regimens include zidovudine, lamivudine, nevirapine, efavirenz, tenofovir while second line drugs include Truvada (emtricitabine + tenofovir), Aluvia, didanosine, and abacavir. Stavudine is slowly being withdrawn as a first line drug, following Ministry of Health recommendations. The majority of ARVs are FDA approved generics. The shift to generic drugs has greatly lowered the cost of ART per patient. With the current drug costs, the monthly cost of treatment for a patient on first line regimen is about \$20 as compared to \$ 60 for a second line regimen. Overall, annual ARV cost per person on first line drugs is about \$ 250 and about \$ 750 for patients on second line regimen. Training of logisticians and pharmacy managers in drug forecasting and logistics chain management is conducted at least quarterly by the Infectious diseases Institute and MAUL. The program has successfully maintained a regular ARV drug supply to patients with no stock outs since the start of the program.

In 2009, ARV drug purchase and supply will continue as above. ARV drugs shall be provided to all HIV positive clients with a CD4 count of 250 or below or a WHO stage of IV. These drugs shall be provided to clients registered at the 17 mobile clinics operated by the program and selected MOH facilities within Rakai and Lyantonde districts (the MOH facilities will be selected in consultation with the District Health Team). Medical Access (Uganda) shall remain the key provider of our program's ARV drugs. Purchase of drugs will be done on a quarterly basis. We shall purchase first and second line ARV drugs. (First line regimen: Zidovudine, Lamivudine, Nevirapine, Efavirenz, Tenofovir and second line drugs: (Truvada (emtricitabine + tenofovir), Aluvia, didanosine, abacavir). We shall alter the ARV drug lists as new guidelines come up. We plan to provide ARV treatment to about 2,500 HIV positive persons, with about 150 getting onto second line regimen. The estimated cost of ARV drugs for this year is \$ 740,000 (the rest of the budget will support personnel costs for pharmacy staff and distribution of drugs). Training will continue in order to build capacity for the logisticians, pharmacy technicians, and assistants in planning and management of ARV drugs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13237

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13237	4020.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$887,805
8325	4020.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$887,805
4020	4020.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$637,805

**Emphasis Areas**

Health-related Wraparound Programs

\* Child Survival Activities

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$147,805

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

Estimated amount of funding that is planned for Water \$20,000

Program Budget Code: 16 - HLAB Laboratory Infrastructure

**Total Planned Funding for Program Budget Code: \$18,214,229**

### **Program Area Narrative:**

The goal of this program area is to establish quality-assured, tiered lab services as described in the Uganda National Minimum Health Care Package (UNMHCP). The USG will work towards this goal through improvement of systems management, lab infrastructure, staffing needs, lab and logistics management, quality assurance and informatics. The approach will be in line with the "WHO 2008 Maputo Declaration on Strengthening of Laboratory Systems in Africa."

#### **National Laboratory Structure**

Lab services are available at Health Center (HC) levels III and IV, district and regional hospitals, and national reference labs. The latter include the Central Public Health Laboratory (CPHL), the National Tuberculosis Reference Laboratory (NTRL) and the Uganda Virus Research Institute (UVRI). CPHL acts as the lab support center for rolling-out training, quality assurance (QA) and logistics, in addition to undertaking its more traditional roles in public health. Below the national level, there are lab services at 11 Regional Referral Hospitals. Each district or group of districts has 1 referral hospital, 4-5 HC IVs and 5-10 HC IIIs. There are also labs in the private sector.

#### **Challenges**

There are numerous challenges to improving and maintaining quality lab services:

- 1. Organization and Management:** There is no Division of Laboratory Services within the MOH, and no other single coordinating body for lab services. As a result, management, coordination and supervisory responsibilities are not clearly defined. Public health and clinical services fall under different departments within the MOH. Because there is no other effective unit, CPHL carries out work related to both departments, particularly the supervision of lower-level labs.
- 2. Infrastructure:** Most health-facility labs are old and need renovation if they are to meet recommended standards. Many lower-level facilities were upgraded to HC III and IV levels without improvement in infrastructure, and in 60% of cases, without labs. There is a widespread lack of reliable utilities and mechanisms for waste disposal and infection control at all levels.
- 3. Human Resources:** The inability to recruit and retain qualified staff is the most serious constraint to improving lab services. Technician training schools graduate significant numbers of students each year, but their knowledge and practical skills are weak. It is difficult to deploy and retain staff in public sector labs. Dissatisfaction among lab workers is high due to low pay, lack of respect, poor working conditions and few career opportunities. Many labs do not meet the recommended staffing norms and resort to employing unqualified staff who are not recognized by the Allied Health Practitioners' Council (AHPC).
- 4. Equipment and Supplies:** Lab commodities are procured through the National Medical Stores (NMS). Generally inventory and procurement systems are too weak to ensure an uninterrupted supply. Most facilities experience regular stock-outs of essential commodities, limiting their ability to carry out basic tests. In addition, many labs lack essential equipment such as microscopes and sterilizers. Some equipment, especially when donated, does not meet required standards. Equipment in some facilities either lacks skilled operators or is not adequately maintained. This often occurs because maintenance agreements and training are not included in procurement contracts.
- 5. Quality Assurance:** Weak infrastructure and human resources in equipment and supplies management, and in other lab-related activities, compromise the quality of lab services and lead to a loss of trust in those services by both clinicians and patients. Guidelines and standard operating procedures (SOPs) are not fully disseminated or implemented country-wide; not all labs receive regular supervision due to the limited capacity at the CPHL and District Health Offices (DHO). There is no coordinated system for QA across facilities; follow-up and corrective action of under-performing labs is weak. Record keeping in labs is poor and little attempt is made to standardize or collate data from labs at the district or central levels.
- 6. Informatics:** Currently, information and data are managed manually, and are not used effectively at any health-facility level for reporting and planning. Transmission of information between different levels and sectors is not effective. The use of computerized systems is limited due to funding constraints and the scarcity of skilled staff.
- 7. Regulatory Framework:** The existing regulatory system is weak. AHPC, for example, is mandated to register all lab practitioners and labs, but is understaffed and under-funded. Consequently, many labs and their staff operate without proper registration.
- 8. M&E:** The existing system for M&E within the lab sector is weak and unable to measure the system's performance or its support for the delivery of the UNMHCP.
- 9. Financing:** Health lab services are grossly under-funded. There is no dedicated budget line for lab services, either centrally or within districts; the small amount that is allocated from Primary Health Care funds is often misdirected. PEPFAR remains the major source of funding for the lab sector.

#### **Accomplishments and FY09 Goals**

Against these challenges, the USG has made progress in addressing service delivery at all health facility levels, and improving overall systems management at the central and district levels.

1. Organization and Management: USG is supporting MOH to develop an effective lab management structure that can provide advocacy, stewardship and coordination of services. Working with the National Laboratory Technical Committee, USG drafted the Uganda National Health Laboratory Services Policy and a 5-year Implementation Plan. Funding for a senior Technical Advisor to MOH was set aside in FY08; his duties will include completion of the Policy and Implementation Plan, advocating for and facilitating the re-establishment of a Division of Laboratory Services, liaising with the PEPFAR Laboratory TWG and implementing partners (IP), and integrating IP lab strengthening activities into the National Plan. To promote ownership and sustainability of activities within the districts, IPs are encouraged to support the DHO with funding and technical assistance.

2. Infrastructure: During FY08, 14 HC IV labs, 2 regional blood bank labs, and the NTRL training lab were renovated. Six of the 11 regional hospitals now have access to high-quality labs; in FY09, 2 more will be renovated. Using FY08 funds in the coming year, USG will renovate 20 HC IV labs, 3 regional blood-bank labs, complete the renovations to the NTRL clinical labs and build a new CPHL. The latter will be built adjacent to MOH headquarters to facilitate the transition of CPHL staff into an MOH Division of Laboratory Services.

3. Human Resources: USG provides direct support to training schools. This will be expanded in FY09 to include curriculum review, bursaries for field attachments, and training grants for tutors. USG is sponsoring over 100 technicians and microscopists already working in labs to return to school for 2 years of refresher training. Through the Training Coordination Unit (TCU) at CPHL, the range of courses includes basic diagnostics, equipment maintenance, and lab management. Country-wide training in performing HIV rapid tests is on-going and follow-up of trainees to determine performance is underway; to date, 1,264 health care staff have been trained in HIV rapid testing. By the end of FY09, CPHL will have trained 3,500 staff nationwide to provide HCT. Training in specimen collection for the Early Infant Diagnosis (EID) Program was combined with training in the collection of dried blood spots for HIV rapid testing; staff at 150 sites have been trained in both. The OGAC-Becton Dickinson (BD) partnership supported training of technicians from 64 sites in External Quality Assurance (EQA) for measurement of CD4+ cell counts during 2 workshops; 4 more workshops will be completed this year. BD has also provided technical assistance to NTRL in conducting training in the TB specimen referral system, and in providing two regional trainings using the WHO/CDC/IUATLD AFB Direct Smear Microscopy training package. These activities will continue in FY09. The CPHL TCU is responsible for overseeing all training activities as well as directly initiating some of them, particularly in lab and logistics management. In collaboration with CDC-GAP, the first of 3 workshops piloting the 'Job-Task-Based' approach to training was held in FY08. Additional training in logistics management will be held in FY09 in collaboration with NMS and SCMS for all labs in the country enrolled in the NMS lab credit line.

4. Equipment and Supplies: The procurement of lab equipment is unregulated. Equipment is purchased according to prevailing market prices, usually without associated training or service agreements. Moreover, the lab equipment market is dynamic and new models replace 'obsolete' models every few years, presenting particular problems for service and maintenance. As part of infrastructure improvement, USG continues to support the procurement, training and servicing of equipment appropriate to each health-facility level, with a focus on HC III labs; 80 labs have received lab equipment to date. A credit line was established in 2005 to procure and distribute lab commodities through NMS and the FBO Joint Medical Stores (JMS). Over 40% of the current needs of more than 1,000 facilities are being met; for HIV rapid tests and accessories, funded separately under the PEPFAR CT, PMTCT and integrated TB/HIV program areas, nearly 100% of needs are met. Despite this, stock-outs of HIV rapid test kits continued in FY08. NMS distributes HIV rapid test kits, HIV DNA PCR kits for infant diagnosis, and CD4+ cell count kits for PMTCT donated by the Clinton Foundation. Funding for the latter will continue through 2010. Through expanded efforts in FY08, specimens from 150 health facilities were tested for EID and this will be further expanded in FY09 to 300 facilities covering all regions of the country. NMS will widen its reagent and commodities portfolio to include reagents for CD4+ counting, hematology and serum chemistries. However, TA from SCMS to NMS is needed to establish regional NMS storage depots, and to monitor the supply chain to verify distribution of commodities to district and sub-district facilities.

5. Quality Assurance: MOH has assigned District Laboratory Focal Persons (DLFP) and Regional Laboratory Coordinators (RLC) to oversee lab services at the district and regional levels, respectively. CPHL and the appropriate MOH departments, working with quality-of-care initiatives and EQA programs for HIV, TB and malaria, are taking a more central role in conducting and coordinating national QA initiatives through zonal supervisors. This activity does not yet cover the whole country, however. A common, field-tested assessment tool is in use to evaluate lab service provision, commodities management, and QA of diagnostic testing; SOPs for all phases and levels of lab testing have been distributed. Supervision of district personnel is conducted regularly and each of 1,002 GOU and NGO labs are visited quarterly. EQA for CD4+ counting has been extended to 64 labs, and EQA for hematology and serum chemistries will be introduced in FY09. During regular lab assessment visits across the country, capacity for CD4+ counting, hematology and serum chemistries is noted and the geographical coordinates of those labs with capacity and that are enrolled in EQA programs is recorded using GPS. Mapping of these facilities has been done using GIS to enable facilities to network and maximize the use of limited resources for monitoring ART eligibility and treatment response. Proficiency testing of diagnostics for HIV-related opportunistic infections will be scaled up to cover 400 of the 1,002 government and NGO labs nationwide. A data collection system was established at CPHL in 2006, and MOH now collects and enters monthly data on numbers of tests performed and results, including QA testing at facilities across the country. This system needs to be expanded and integrated into HMIS, and shared with the MOH Epidemiologic Surveillance Division that is responsible for disease control activities.

6. Informatics: The paucity of real-time information from the lab sector is a major constraint to the improvement of lab services in Uganda. Management is critically dependent on the ability to efficiently collect and analyze data from all parts of the country. Data handling capacity at CPHL has been improved by the addition of more staff to analyze data, forecast needs and plan activities. A feasibility assessment of the use of mobile telephones for data information sharing was started in FY08 and will be continued in FY09. To support the expansion in informatics, USG will further strengthen capacity at CPHL to allow analysts and planners at both the central and district levels access to lab databases.

7. M&E: USG will continue to support the strengthening of M&E in the lab sector by implementing the national Performance Monitoring and Management Program. Data on indicators beyond those required by PEPFAR will be collected to better inform planning. CPHL will need TA to manage the data files it is building on infrastructure improvements, technical capacity, technician training and lab management, and which are based on QA activities across the country.

8. Financing: Much of the funding in the PEPFAR lab infrastructure program area that is intended to benefit the lab capacity of the entire country stays within central government entities and is not distributed further. Given central government bureaucratic obstacles, the funding channel via MOH has proved to be an inefficient way to support the implementation of PEPFAR goals. Some funding has to remain at the central level, but an alternative approach is to directly fund DHOs through existing or new IPs. This would promote ownership and sustainability at the district level; DHOs, being more directly accountable to the people who are the intended beneficiaries are likely to be more responsive. Funds could be released to Districts on a competitive basis; continued support would be dependent on performance based on an approved District Health Plan. The IPs could ensure that their own activities, including infrastructure and networks, are fully integrated into district plans. IPs could play an important role both as a conduit for funding and in providing TA and oversight on behalf of the PEPFAR TWGs. Once such a model is established, it may be possible to interest other donors and/or the Ugandan Government to support the approach more widely. The lab sector of PEPFAR-Uganda will pilot this approach in FY09.

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 4408.21235.09

**Planned Funds:** \$2,000,000

**Activity System ID:** 21235



## Activity Narrative: ACTIVITY UNCHANGED FROM FY 2008

The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected/affected persons and their families. Specifically this cooperative agreement supports the MOH to undertake the following five initiatives: 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, 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 HIV counseling and testing 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 HIV testing 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 Central Public Health Laboratory (CPHL) to develop policies, standard operating procedures and quality assurance and quality control processes; 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 HIV/TB/STI surveillance activities and support national and decentralized monitoring and evaluation of HIV/TB/STI programs and population-based studies.

Since FY06, with support under this activity, the MOH has been carrying out activities to strengthen laboratory services in Uganda. The main areas of focus have been: strengthening the capacity of the CPHL to coordinate health laboratory services, early diagnosis of HIV infection among infants (EID), external quality assessment schemes (support supervision/proficiency testing), in-service training in HIV rapid testing, T.B microscopy, and laboratory management; and Laboratory information management systems (LIMS). As part of the support, CPHL has been able to rent office and laboratory premises and has procured reagents, supplies and equipment. In addition, the technical and administrative capacity at CPHL has been strengthened by hiring a Project officer (Laboratories), as a Technical Advisor, Training Coordinator, 2 laboratory assistants, 2 technologists and 10 support staff. The intractable problem of laboratory space will soon be solved by construction of a new CPHL building using a USD 1.5M PEPFAR award. Construction is expected to commence during 08/09. In collaboration with the FIND project, the development of the national health laboratories policy that started in FY06 will be finalized during FY08/09. EID now reaches 150 health facilities and under this program, 15,000 babies have been tested. The program will expand to 220 facilities allowing 28,000 babies to be tested by the end of FY 2008. Support supervision is now conducted regularly in collaboration with district personnel with each of 1002 government and NGO labs visited quarterly. Currently, 120 labs participate in the CPHL administered proficiency testing scheme for HIV testing and for tests for diagnosis of opportunistic infections; the number is expected to rise to 250 by the end of FY 2008. In collaboration with CDC, a proficiency testing scheme is being run for 64 laboratories for CD4+ counting and automated chemistry/haematological tests for HIV monitoring. In FY 2008/09, CPHL will support a maintenance contract for the automated chemistry/haematology equipment in government facilities. To support data collection, an electronic database (LIMS) has been established at CPHL. The system is fed by computers and PDAs installed at districts and by the end of FY 2008/09 a total 50 districts will be covered. Several documents including an HIV rapid testing manual, laboratory SOPs, safety guidelines, a T.B smear microscopy training manual, a laboratory management training manual and laboratory quality assurance guidelines have been developed or customized for use in Uganda. In-service training has been conducted for trainers and service providers. To date, 1264 have been trained in HIV rapid testing with support from this activity and funding from other partners), 105 in laboratory management/quality assurance and 60 in T.B smear microscopy. CPHL will embark on a scheme to promote the capacity of regional laboratories to diagnose opportunistic infections particularly bacterial/fungal cultures through procurement of equipment and supplies, and mentoring of the labs; one regional laboratory is targeted for FY 2008/09. The CPHL has continued to support activities of the National Health Laboratories Advisory and Technical (LTC) sub-committees to advise the ministry on effective management of laboratory services in the country.

During FY 2009, under this activity, the focus of laboratory services and quality improvement activities will be to strengthen EID, LIMS, EQA, in-service training and overall coordination of laboratory activities. Central coordination of national laboratory activities will require funds for renting of premises, utilities, staff costs, transport and communication. The LTC subcommittee will be supported to advise MOH on technical and policy issues of laboratory services. A functional EID program is critical in ensuring timely care for infected babies; it will be scaled up to cover 220 facilities nationwide and reach 28,000 babies during FY 2009. This requires training of facility personnel, courier services and coordination meetings. Supplemental support shall come from the Clinton Foundation and UNICEF. LIMS data is critical for forecasting of laboratory supplies including HIV test kits, reagents for ART monitoring and diagnosis of opportunistic infections. During FY09/10, the number of districts on the electronic data collection and delivery system (PDAs and computers) shall be scaled up to 80. The LIMS database should be integrated in the HMIS. 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 1002 labs nationwide shall be targeted, focusing on HIV testing, logistics management and EID in addition to routine laboratory activities. In collaboration with UVRI, the proficiency scheme for HIV testing and opportunistic infections tests shall be scaled up to cover 400 of the 1002 government and NGO laboratories nationwide. To ensure continuous functioning of automated equipment for HIV monitoring, an equipment maintenance contract and supplies shall be procured for 25 government facilities. CPHL will continue to roll-out HIV rapid testing with 340 service providers trained as we work towards the goal of 3,500 nationwide. Other areas of training shall include T.B smear microscopy (200 personnel) and laboratory management using the 'Job Task Based Approach' (60 personnel), EID (200 personnel). Training shall be done in collaboration with a number of PEPFAR-supported partners including Uganda Health Marketing Group,

**Activity Narrative:** AMREF and the National T.B Reference Laboratory. Regional laboratories shall be strengthened and a laboratory referral network developed that would facilitate supervision and coordination of national laboratory activities; during FY09/10, an additional 2 regional laboratories (Mbale and Gulu hospitals) shall be equipped and mentored for this purpose. Support under this activity directly relates to all other activities supported by the USG through PEPFAR as well as other HIV/AIDS activities supported by other bilateral and multilateral development partners in the country.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13299

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13299	4408.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$2,025,000
8347	4408.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$1,875,000
4408	4408.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$855,000

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$467,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5738.09	<b>Mechanism:</b> Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District
<b>Prime Partner:</b> Makerere University School of Public Health	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 4026.21224.09	<b>Planned Funds:</b> \$450,000
<b>Activity System ID:</b> 21224	

**Activity 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 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 phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 2) The SPH-CDC HIV/AIDS Fellowship Program is an 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. 3) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkin University Center for Clinical Global Health Education (CCGHE).

The comprehensive community based HIV prevention, care and treatment program is implemented by RHSP, a non-government not for profit organization, located in rural Rakai district, South Western Uganda. RHSP is a stakeholder in provision of HIV prevention, care and treatment to HIV positive clients in Rakai and Lyantonde and to a small extent, the neighboring districts like Masaka and Mbarara. Since June 2004, with support from PEPFAR, RHSP has expanded coverage and access to comprehensive HIV/AIDS prevention, care and treatment to the population in and around Rakai District. Activities conducted include an innovative home based and community-based VCT program, provision of basic care, ART, PMTCT, TB care, health education, mitigation of HIV through prevention of domestic violence and medical male circumcision (MMC) for HIV prevention.

The community-based VCT program is nested in the Program's existing annual research activities, where persons residing in the study areas are offered counseling and testing in their respective communities. HIV results are returned to these clients through program counselors who reside in these communities. VCT is also offered at the HIV care clinics and in the homes of HIV positive index persons. Through the medical male circumcision service, clients seeking male circumcision service are also offered counseling and testing. All persons who test HIV positive and accept to learn their HIV status are referred to the program HIV care clinic nearest to their community or nearest to their home. The program currently operates 17 mobile clinics in Rakai and Lyantonde districts. These mobile clinics are located at already existing government centers and are run by a team of medical officers, clinical officers, nurses and counselors on a rotational bimonthly basis. This is part of the integration efforts into the existing health system. Services offered include: health education, On-going HIV counseling, PMTCT, treatment and prophylaxis for opportunistic infections, provision of antiretroviral therapy, prevention for positives, laboratory screening and monitoring of various infections, reproductive health services, provision of basic care packages containing safe water vessel with hypochlorite solution for treatment of water, insecticide-treated bednets, and condoms. All HIV positive patients receive cotrimoxazole prophylaxis.

The RHSP medical male circumcision program: Three trials of male medical circumcision (MMC), including one conducted by the Rakai Health Sciences Program (RHSP) in Rakai District, Uganda, have shown that the procedure reduces male HIV acquisition by 50-60% and has the potential to dramatically curtail the HIV epidemic in areas of Africa where MMC is uncommon and the epidemic most severe. Additional benefits of MC in HIV-negative males include significant reductions in male genital ulcer disease (GUD) and HSV-2 acquisition and in vaginal sexually transmitted infections and genital ulcer disease in female partners. Population-level effects on HIV incidence will be achieved if MMC is provided to and is accepted by men (and their partners), and if there is no increase in sexual risk behaviors (i.e., risk compensation). The RHSP has a state-of-the-art outpatient surgical facility and trained highly experienced surgical teams (doctors, clinical officers, and operating room staff) which can accommodate more than 3,000 surgeries a year. As part of the MMC Service, we provide extensive HIV prevention counseling pre- and post-surgery; offer free condoms; provide information to men, and whenever possible to their women partners, regarding wound healing, wound care and the need to abstain from sex until healing is completed; and offer free individual and couples' VCT.

The RHSP laboratory: RHSP has an established state-of-the-art laboratory infrastructure located at Kalisizo center that supports the evaluation and monitoring of patients on the program. All samples except those collected for rapid field testing like hemoglobin, binax and serum lactate, are transported back to the central Kalisizo laboratory for testing. The range of tests carried out include: HIV testing by 2 ELISA tests and western blot if ELISA is discordant (this algorithm has been validated in our setting and has proven to be superior to rapid tests), microbiology tests like urinalysis, Ziehl Nelsen tests for TB screening, blood cultures etc, Serology like serum CRAG, Chemistry tests like liver and renal function test and hematology, among others. As an accredited TB center, the program is making efforts to streamline TB diagnostics in Rakai. In addition to laboratory testing, there is an X-ray facility to support diagnosis. Resistance testing for TB is outsourced at another laboratory. The RHSP program has refurbished some government facilities to increase clinic space for provision of clinical services.

In FY 2008, RHSP proposed to purchase a chemistry analyzer and this is now fully running. This has made possible patient evaluation of liver and renal function tests.

The laboratory has in this financial year provided several diagnostic and monitoring tests to both HIV positive and negative clients.

Between April 1st 2008 and 25th August 2008, the following tests had been done in the program laboratory: HIV testing: 7524 Elisa tests, 499 Western blot tests, 2510 PCR tests (of these, 1700 were from the HIV clinic and 57 were for infant diagnosis, others from other Rakai studies), 4076 CD4 counts, of which 2806 were for the HIV clinic and 457 for other health centers in the district (Lyantonde and Kitovu hospital). 5370 RPR and 401 TPHA tests for syphilis diagnosis, 310 Elisa for HSV-2 diagnosis, 20 serum CRAG and Hepatitis-B tests.

**Activity Narrative:** The Kalisizo laboratory supports testing of all samples collected from the 17 mobile HIV clinics run in Rakai and Lyantonde districts, community HIV testing and laboratory testing for some patients in Lyantonde hospital.

The program shall continue to utilize the central laboratory based at Kalisizo for all laboratory testing. The various laboratory sections to be utilized include: general section for serology like HIV testing, serum CRAG tests, malaria testing, toxoplasmosis titres, chemistry testing, CD4 counts (using a facs caliber), Hematology section for Complete blood counts and ESR, Microbiology section for urinalysis, blood culture, Gram stain, ZN for identification of Acid fast bacilli (AFBs).Viral load testing shall also be done on all patients receiving antiretroviral therapy at 6 monthly intervals. The program will continue to support laboratory (CD4) testing and training for health units providing ART that lack adequate laboratory support.. We will continue to hold meetings with the DHO (district health officer) to identify health units that will need laboratory improvements through training. These activities will be coordinated with CPHL/MOH

**Early Infant diagnosis:** The program is currently liaising with the MOH EID coordination office to provide HIV DNA testing to babies born to HIV positive mothers. In FY 2009, in consultation with the MOH EID coordination office, we propose to put in place laboratory capacity to perform Early infant diagnosis (EID). In the past, the program has had to out source EID to another laboratory, but the time to result receipt is quite long (2 months). By equipping our laboratory with this capacity (instrumentation, man power, consumables etc) shall diagnose HIV in infants as early as possible. This will enable RHSP and other providers in the district to provide antiretroviral therapy and other preventive measures early enough. With this facility in place, the program hopes to assist other centers in need of EID, with testing of their infant blood samples and overall shall achieve early detection of infant HIV in Rakai, Lyantonde and neighboring districts of Masaka and Mbarara.

**Training of laboratory staff:** With the introduction of new laboratory equipment, shall provide training to staff to ensure proper usage. There will be quarterly retraining of all laboratory staff in the management, care and operation of various laboratory equipment.

**Quality control:** The program shall strengthen laboratory quality control by having a full time laboratory staff dedicated to internal laboratory quality control monitoring of the various activities.

**Technical assistance and Quality assurance:** The program has a rigorous internal quality control program as well as participation and satisfactory status in external proficiency survey (VQA and CAP).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13239

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13239	4026.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$500,000
8330	4026.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$486,000
4026	4026.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$182,400

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$30,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechansim**

**Mechanism ID:** 5793.09

**Mechanism:** National Laboratory System  
Infrastructure Improvement  
Initiative

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 11497.20866.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 20866

**Activity Narrative:** This activity will contribute to the AMREF laboratory strengthening project activities under Laboratory Infrastructure. Since 2004, AMREF has received PEPFAR funding to improve laboratory staffing capacity at Health Center IIIs [HC III] and strengthen laboratory services at Health Centre IVs [HC IV] in Uganda. The primary focus of the AMREF portfolio is to improve national laboratory services. Specific initiatives include: training for district-level for HC III basic laboratory staff cadre to become Laboratory Assistants; strengthening the training capacity at specific laboratory assistant training schools; supply laboratory equipment to district and regional laboratories; and provide in-service training to further develop the capacity of all laboratory staff working at Ministry of Health (MoH) public facilities, uniformed service agencies, and FBO/NGO health facility laboratories.

In FY 2009, "the successful partner" in collaboration with CDC-Uganda will allocate \$1,085,000 for a partnership project with AMREF. The project will consist of the rehabilitation of 20 district laboratories. Using the Ministry of Health (MoH) laboratory service and equipment standards, "the successful partner" will contract with local firm(s) to assess and implement required infrastructure improvements. These improvements will ensure that district laboratory capacity will meet the national 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 related to opportunistic infections diagnosis.

In addition "the successful partner" will direct \$1,500,000 to construct premises for Ministry of Health's Central Public Health Laboratories (CPLH). The CPLH will house the coordination units responsible for different activities in the lab sector.

Finally an additional \$267,265 is programmed in HIV/TB for renovations at NTRL.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15909

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15909	11497.08	Department of State / African Affairs	Regional Procurement Support Office/Frankfurt	7290	5793.08	Technical Assistance for National and District Laboratories Construction and Renovations	\$2,569,000
11497	11497.07	Department of State / African Affairs	Regional Procurement Support Office/Frankfurt	5793	5793.07	RPSO lab	\$535,000

**Emphasis Areas**

Construction/Renovation

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 5737.09

**Mechanism:** Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 17055.20882.09

**Planned Funds:** \$612,320

**Activity System ID:** 20882

**Activity Narrative:** TASO has provided HIV/AIDS services in Uganda since 1987. It is registered with the Government of Uganda as a non-governmental organization and is categorized as having national focus and nationwide coverage. The vision of TASO is "A World without AIDS" and the mission is "To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of individuals, families and communities affected by HIV infection and disease". The values underlying the entire TASO programming are: equal rights, equal opportunities, shared responsibility; obligation to people affected by HIV infection; human dignity; family spirit; and integrity. TASO promotes the philosophy of "Positive Living with HIV" by empowering communities to combat stigma; promote HIV prevention; promote access to care and treatment services; and promoting quality of life of affected people and households. TASO runs 16 direct outlets (11 care centers and 5 training centers) implementing the TASO 2008-2012 Strategic Plan. The outlets reach a catchment population of about 10 million people, of which 81,000 active adult clients and their 300,000 household members are a part. Over 30% of the outlets deliver services to conflict/post-conflict regions of Uganda, where TASO has pioneered HIV/AIDS interventions and continues to play the flag-ship role. TASO proactively addresses challenges faced by refugees/internally displaced persons. The organization also supports 22 partner sites and 100 community-based initiatives to deliver services. The 22 partner sites are public and private facilities supported by TASO through sub-granting and technical support using other funding. TASO is structured in 6 Directorates, namely: Program Management (charged with program development, QA and technical support), Planning & Strategic Information (charged with M&E), Capacity Building (charged with training service providers), Human Resources & Administration, Advocacy & Networking (charged with HIV/AIDS advocacy and networking) and Finance. TASO has over 1,127 program staff and a force of over 4,000 trained community volunteers. Each TASO service outlet has counseling rooms, medical rooms, laboratory, drug store, dispensary, training rooms, resource center, client Day Center, vehicles, ICT systems, as well as adequate staffing organized into: management team, service delivery teams, operational support team and expert client team (peer educators). Each service outlet has linkages with supported community-based service providers comprising of community nurses, community ART support agents, peer support groups and other community HIV/AIDS workers. TASO governance comprises of the Board of Trustees (highest decision-making body); Regional Advisory Councils (Boards overseeing TASO work in each of the four regions of Uganda); Center Advisory Committees (local Boards overseeing each service outlet); Clients' Councils (Clients Boards at each outlet linking clients to all levels of management and governance). All Boards are elected by members regularly at Annual Assemblies as TASO is a membership organization. TASO management and governance is guided by national policy and organizational guidelines. TASO contributes to the national HIV/AIDS strategic plan through: complementing national efforts; engaging in strategic plan development; support to civil society coordination; sharing resources with public health facilities in under-resourced areas particularly laboratory monitoring; and developing human resources for health. Development of appropriate family-friendly and community-friendly service delivery models for low resource settings is part of TASO's core work. These service models are regularly disseminated and provide a backbone for adaptation by other partners, one dissemination forum includes TASO experiential placement training programs focusing on sub-Saharan Africa. TASO has had a successful track record in implementing PEPFAR activities. By FY 2007, TASO contributed 16.5% of Uganda's ART enrolment and 20% of PEPFAR supported enrollment. TASO programming for FY 2009 and the rest of the 2008-2012 period will be influenced by the following broad principles: evidence-based programming; greater focus on the family; greater focus on community empowerment; greater involvement of People Living with HIV/AIDS; 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.

From October 2007 to September 2008, about 100,000 clients were in care by the TASO Centres. All of these index clients and their eligible household members required laboratory services at some time. TASO operated 11 laboratories in the districts of Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso. By September 2008, the key laboratory outputs were: 12,879 HIV antibody tests conducted; 3,061 TB Tests (Smears) conducted; 479 Syphilis Tests conducted; 515 Complete Blood Counts done; 419 Lymphocyte Tests conducted; 2,156 CD4 Count Tests conducted (by TASO Mbarara); 26 Viral Load Tests conducted (by TASO Mbarara); and 78 LFT and/or RFT tests conducted (by TASO Mbarara). Each of the laboratories had linkage to MoH, CDC Uganda and National TB & Leprosy Program Central Laboratories for quality assurance. Other key priorities for laboratory infrastructure were: automating laboratory processes like Hematology and Clinical Chemistry to cope with the high demand for laboratory services; enhancing quality assurance of laboratory services; capacity building for laboratory personnel; ensuring steady supply of laboratory reagents and consumables; reviewing laboratory guidelines and standard operating procedures; enhancing the Laboratory Information Management Information System (LIMBS).

During FY 2009, TASO will support laboratory infrastructure in the 11 centers located in Gulu, Jinja, Kampala, Masaka, Masindi, Mbale, Mbarara, Rukungiri, Soroti, Tororo and Wakiso districts. Laboratory infrastructure will be enhanced through: consolidating automation of laboratory processes like Hematology and Clinical Chemistry; enhancing QA of laboratory services; capacity building for laboratory personnel; ensuring reliable supply chain for laboratory reagents and consumables; reviewing laboratory guidelines and standard operating procedures; enhancing the laboratory information management information system (LIMBS). Deliverables for FY 2009 will include: 20,000 HIV antibody tests; 5,000 TB Tests (Smears); 500 Syphilis Tests; 600 Complete Blood Counts; 500 Lymphocyte Tests; 5,000 CD4 Count Tests; 100 Viral Load Tests; and 150 LFT and/or RFT tests. 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. The activities under this Program Area are also linked to other USG funding through USAID focusing on the Program Areas of Sexual Prevention, Orphans and Vulnerable Children, Strategic Information and Health Systems Strengthening. The USG funded activities in TASO are also backed up by activities funded by other AIDS Development Partners such as DANIDA, DFID and Irish Aid through the Civil Society Fund.



**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17055

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17055	17055.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6420	5737.08	Provision of Comprehensive Integrated HIV/AIDS/TB Prevention, Care and Treatment Services among People Living with HIV/AIDS	\$568,268

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Increasing women's legal rights
- \* Reducing violence and coercion

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 1257.09

**Mechanism:** CDC Base GAP

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GAP

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 4429.20844.09

**Planned Funds:** \$346,606

**Activity System ID:** 20844

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

This funding supports the USG goal of appropriate staffing and level of effort in order to provide technical assistance, programmatic oversight and performance monitoring for all implementing partner (IP) activities. Over 80% of CDC operations and staffing are covered through GAP funding and the balance is covered by GHAI funds. In the lab sector, GHAI funds are used to support implementing partner activities. The HHS/CDC Uganda office is comprised of six units; Operations, Program, Laboratory, Epidemiology, Informatics and Behavior.

In FY 2008, the CDC lab unit continued to provide support for diagnostic testing, logistics management, national and international technical and management training and workshop/conference attendance for CDC projects and for IPs. Diagnostic testing in the CDC lab included 31,361 HIV serological tests, mostly for quality control testing in support of full-access HBCT in two Districts, 5,781 viral load tests, 1,602 HIV DNA tests (for exposed infants), 287 serum chemistries, 19,002 CD4+ counts and 7,498 complete blood counts. The evaluation of immune activation markers as surrogates for viral load became possible with the gift of an LSR II flow cytometer that allows up to 10 phenotypic markers to be investigated on a single immune cell and potentially makes HIV disease monitoring simpler and cheaper. An Ampliprep for automated nucleic acid extraction from plasma, whole blood and dried blood spots was procured for viral load and especially for HIV DNA PCR for infants. This will add capacity to the national Early Infant Diagnosis (EID) program that currently only has 7 testing centers countrywide, allowing faster turnaround times. CDC-Uganda maintained substantial stocks of lab commodities including HIV rapid test kits to offset national stock-outs and also directly supplied a number of partners with CD4+ count tests – currently the National Medical Stores has insufficient capacity to manage diagnostic tests for ART eligibility and disease monitoring. A new approach to the quality assurance of HIV serology in the country was validated by the CDC lab based on dried serum samples. A number of CDC staff completed B.Sc. and M.Sc. graduate courses and CDC and partner lab staff participated in training courses in good lab practice, lab management and technical training to improve their own training skills. The CDC lab, working with the PEPFAR Lab TWG and the national Lab Technical Committee (LTC), continued to strengthen national lab systems by: direct hiring of program staff under the MOH/AIDS Control Program CoAg, including lab personnel, instead of paying existing MOH staff supplementary allowances thus ensuring full-time attention to CoAg activities; assigning two full-time CDC staff to the Central Public Health Laboratory (CPHL) to provide leadership and mentoring for the national Laboratory Training Coordination and Quality Assurance (QA) units – activities included the continued roll-out of the HIV rapid test training package towards the goal of 3,500 technicians trained, the roll-out of the TB smear microscopy training package and the identification of 64 sites with CD4+ count capacity, mapping their locations by GIS for networking of services, enrolling them in an EQA scheme (NEQAS) and training them in its use; providing a senior Technical Advisor to MOH to help finalize and implement the National Laboratory Services Policy and create a Department/Division of Laboratory Services within MOH to oversee its implementation; supporting the national lab commodities credit line at the National Medical Stores (government) and Joint Medical Stores (NGO) that provides basic lab commodities to over 1000 laboratories in the country; overseeing the building and renovation of (20) laboratories at lower health facility levels, (2) blood banks and a new CPHL (not yet started); supporting technical and management training (SMDP) through the OGAC-Becton Dickinson Public Private Partnership and GAP/CDC Atlanta in CD4+ EQA, TB smear microscopy and TB specimen referral; funding the HIV Reference Lab at the Uganda Virus Research Institute (UVRI) to conduct national QA for HIV serology and to validate new HIV serological assays and testing algorithms, facilitating the national QA program for TB smear microscopy and establishing a national TB specimen referral system with POSTA Uganda for re-treatment cases through the National TB Reference Lab (NTRL); renovating the training lab and clinical laboratories at NTRL to provide a safe environment for MDR/XDR culture and resistance testing; establishing a lab information management system (LIMS) at CPHL and in collaboration with the CDC Informatics Unit, providing support to both CPHL/MOH for databases on technicians' training history and lab commodities management and the DHOs, for HMIS and mobile telephony to help coordinate activities within the lab sector and with the MOH Resource Centre and, collaborating with MOH in the design of the 2009 national HIV/Malaria Indicator Survey (UMAIS).

In FY 2009, the CDC-Uganda lab will continue to service CDC and partner lab needs, including the establishment of lab capacity in partner laboratories coupled with continued monitoring by the QA unit at CPHL. Dried blood spot testing by HIV DNA PCR for the national EID program will be expanded and the EID monitoring unit at CPHL strengthened. Immuno-phenotyping to monitor disease progression will be further explored for the Tororo Child Cohort study following the acquisition of an LSR II flow cytometer. The national STI lab will be strengthened through technical and financial support channeled through the CRANE survey. Lab testing for a further two PHEs, one on incidence testing by pooled PCR and the other on 'the last 1000 infections' will be completed. Diagnostic testing capacity at the CDC lab in Tororo Hospital will be expanded to include CD4+ counts, complete blood counts (CBC) and serum chemistries while a new lab, currently under construction, will be completed to support both HBAC and a number of new initiatives including the Pre-Exposure Prophylaxis Study, funded by the Gates Foundation. The College of American Pathologists will inspect the CDC Entebbe lab for accreditation in late 2008. Under national lab systems strengthening activities, there will be renewed emphasis on increasing the District Health Officer's (DHO) engagement with the lab sector – IPs will be encouraged to provide both technical and financial support to the DHO directly which is in line with PEPFAR Uganda's plans for competitive Partnership Compacts. With the hiring of a TA to work alongside the Director of Clinical and Community Health at MOH, the National Health Lab Policy, currently in its second draft, will be completed. The TA will work with senior MOH officials to develop a five-year implementation plan for the policy. A further responsibility for the TA will be to act as a full-time liaison between the PEPFAR Lab TWG and the non-government IPs – the latter have tended to develop vertical programs in the lab sector, duplicating national activities such as procurement, training, quality assurance and infrastructure development which are the responsibility of MOH/CPHL. IPs have now been asked to work more closely with MOH/CPHL and to include in their activity narratives, details of proposed spending on equipment, commodities and salary support for lab-related staff. The strengthened CPHL will house both traditional CPHL activities including environmental health and hygiene, outbreak investigation, etc. and also coordination activities in support of national health lab systems including; infrastructure development (20 additional lower health-facility laboratories will be built/renovated, 3 of the remaining 5 blood banks will be renovated and the building of the new CPHL will be started, GIS mapping of health facilities for the whole country to facilitate networking of services, instrument maintenance contracts with vendors consolidated); human resources (3,500 HIV serological testing

**Activity Narrative:** providers trained, continued roll-out of both the TB smear microscopy and TB specimen referral training and lab management training); logistics management (increased funding to NMS, updated commodities management software tools, national training in logistics management, monitoring lab logistics distribution); quality assurance (extend CD4+ count EQA to all facilities with capacity, expand HIV serological QA to all sites using proficiency testing (DTS PT) panels, introduce EQA for CBC and serum chemistries at sites with capacity); support supervision (facilitate DHO to support Regional Lab Coordinator and District Lab Focal Person, facilitate central and zonal supervisors with vehicles); informatics (implement mobile telephony at lower-level health facilities, provide hardware for CPHL informatics and additional staff, liaise with MOH RC on coordination); infection control (coordinate activities with AMREF). The long-term objective is that staff employed at CPHL to strengthen national health lab systems will naturally transition into a Department/Division of Lab Services within MOH – the positioning of the new CPHL building adjacent to MOH should facilitate this transition. Under the OGAC-BD PPP, the CDC lab will provide continued technical support for CD4+ count EQA and management training to the remaining 30+ sites, support NTRL to roll-out the WHO/CDC national training program in AFB smear microscopy and extend the national TB specimen referral system beyond the Kampala District – a toll-free telephone line to POSTA Uganda will be set up to allow facilities to call in when there are specimens to be collected. The only new activity in 2009 under PEPFAR funding will be support for the HIV Drug Resistance secretariat based at UVRI and for HIVDR surveillance, funded through an existing CoAg with UVRI. The CDC-Uganda lab will continue to play an active role in the preparation, funding and implementation of the 2009 UAMIS. New developments at UVRI in 2008/9 are the collaboration between CDC (NCZVED) and UVRI on the establishment of a center for Infectious Diseases Ecology that will encompass prevention, detection, surveillance and control of new and emerging infectious agents including plague, arboviruses, influenza, hepatitis E and viral hemorrhagic viruses and, the proposed biotechnology unit, a collaboration between Inverness Medical Innovations and UVRI, for both of which, CDC-Uganda staff will provide TA.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13341

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13341	4429.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6446	1257.08	CDC Base GAP	\$981,732
8376	4429.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4820	1257.07	CDC Base GAP	\$1,400,000
4429	4429.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3347	1257.06	CDC Base GAP	\$1,315,300

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

Workplace Programs

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 3440.09

**Prime Partner:** Uganda Virus Research  
Institute

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 4709.20888.09

**Activity System ID:** 20888

**Mechanism:** Laboratory Quality Assurance-  
Cooperative Agreement

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$550,000

**Activity Narrative:** UVRI is a department within Ministry of Health (MOH), & has been dedicated to conducting research on viral diseases since 1936. It conducts research on the isolation & characterization of HIV strains, & on the epidemiology & molecular epidemiology of HIV before & after the introduction of ART; evaluates HIV vaccines & microbicides; & compares modalities of delivering ART & PMTCT programs. UVRI also helps implement national sero-behavioural surveys, & provides the MOH with HIV surveillance data from ANC & STI clinics. UVRI is mandated by MOH to provide QA to all public & private HIV serological testing sites. With USG funding, the HIV Reference & QA Lab at UVRI has established a national lab QA program for HIV serologic testing. This activity focuses on ensuring that the lay, community health workers, counselors & lab staff that obtain samples for testing are providing quality services, obtain & provide quality samples following biosafety guidelines.

The UVRI cold room has been equipped; 78 of 93 staff (RLC & DLFPs) were trained in QA/QC because 15 were not available. 5 SOPs for lab safety, sample processing, rapid HIV lab testing, Elisa HIV testing, rapid syphilis testing & PT panel preparations for HIV were reviewed, updated & distributed. 700 PT panels were prepared & distributed to 216 USG & non USG supported testing sites. 135 internal controls were prepared & 15 test runs performed where they have been incorporated. Re-testing was carried out on 1,435 samples from 34 sites ranging from national, regional, district hospitals to HC IVs & III & private facilities; results were returned in 6 weeks. We compiled an HIV testing inventory, distributed PT panels, collected PT results & provided corrective action, provided support supervision with RLCs & DLFPs, distributed other information tools, provided formal dissemination on support supervision to 216 testing sites. Sites were further assessed for compliance with GCLP, waste disposal & availability of requirements to conduct HIV testing. Strategies to increase HCT include both client & provider initiated HIV CT & MOH plans to scale up HIV CT to all HC IIIs by 2010. There is need to further scale up training of service providers & ensuring quality control for HIV testing.

While the existing M&E plan will guide implementation of activities, partnerships will be established with government structures at district level through the health facility hierarchy including NGOs & uniformed services. This will entail combined training of both lab & non lab including lay & community health workers, support supervision visits, provision of DTS as PT panels & continuous assessment of labs for QA/QC services in labs testing for HIV, TB, STI & malaria, thus supporting the TB & malaria National Strategic Plans. MOH in collaboration with UAC has launched new preventive strategies to drive the HIV prevalence below 6.4% & prevent an increase in new infections. There is now an urgent need to have high-quality HIV serological testing in all labs across the country, including UNHCR sites, funded by WHO. Working with MOH, particularly the QA Unit, the training coordination unit at CPHL & lab supervisors, we shall continue to identify labs currently conducting HIV serological testing & the tests/algorithms used, at HCT, ANC & PMTCT programs, in the private & public sector. Based on the inventory of HIV-testing labs, we shall develop a QA plan that takes advantage of supervisory visits conducted by CPHL, NTLP, QA Unit of MOH, Area Supervision Teams & other stakeholders to distribute DTS PT panels, & to meet reporting requirements. Labs failing to meet QA criteria will be visited & remedial action taken. Testing algorithms for use in the field & for QC at UVRI will be continuously monitored & new algorithms evaluated. With the expanded LIMS & linked to databases at CPHL & MOH sharing of information, logistics management & training needs will be easily coordinated, in line with the Uganda National Quality System Guidelines.

Activities include the preparation & distribution of PT panels, resolving discordant results & evaluation of new HIV testing kits & algorithms. We shall work with the MOES to include quality assurance of HIV testing in the curriculum of lab training institutions. Apprenticeships will be provided to both counselors & lab trainees at the UVRI clinic. We shall work with the DLFPs to ensure that their activities are incorporated in the annual district plan. Medical waste at UVRI will be disposed of using disinfectants, incineration & sharps containers as appropriate. In collaboration with MOH & CPHL sites will be requested to support other testing centers in their area of jurisdiction for incineration of medical waste. These issues will be emphasized during training & support supervisory visits. UVRI shall work with MOH & HSC to recruit project staff into Public Service thus allowing long term sustainability of QA/QC for the country; other efforts include training provided to RLCs & DLFPs, supervisory visits, training in preparation & characterization of DTS PT panels, their distribution & interpretation of the results. We shall coordinate activities with CPHL for training in rapid HIV testing, EID & support supervision; & with NMS to ensure the availability of supplies. 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, & allow for dialogue about recent news & innovations in HIV lab services. Working together with national regulatory authorities especially NDA, we shall expedite the approval of new HIV rapid tests, including saliva-based tests. We shall procure new HIV serologic assays & related instruments, evaluate their performance, & disseminate the findings. This funding will increase gender equity by ensuring that both male & female lab staff are equally represented in the various activities, & courses promote females who are currently fewer in the lab profession in the country.

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. The major principles of containment of HIVDR include: appropriate ARV drug access, proper prescribing & usage, drug adherence, reduction of HIV transmission, & appropriate programmatic response based on the results of monitoring & surveillance. The WHO plan also 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. A consensus workshop on the prevention of DR was held in

**Activity Narrative:** Kampala in January 2007. A National HIVDR Monitoring Plan, developed with support from WHO, has been endorsed by MOH & UAC. Under the plan, UVRI, working closely with the MOH-ACP & other partners, was mandated to coordinate these activities, which include: 1) creation of a National HIVDR Data Center in collaboration with MOH Resource Reference Center; 2) establishing a National Drug Resistance Reference Lab 3) program management, data coordination, & administration; 4) establishing a National HIVDR Working Group (HIVDR WG) within the MOH & as part of the National ART Committee. The plan addresses key areas within the National Strategic Plan for HIV/AIDS, 2007/8-2011/12, & is relevant to PEPFAR goals. The national HIVDR WG is comprised of MOH, CDC, MRC, WHO, UVRI & PEPFAR-supported treatment partners including JCRC, IDI, CRS, TASO & MJAP. With funding from WHO, the HIVDR WG conducted a pilot survey in 2007 to collect EWI at 41 treatment sites. The sites were selected from different geographical regions, represented different levels & modes of ART service delivery, & were supported by a range of funders. The indicators evaluated included prescribing practices, proportion of patients lost to follow-up, number of patients on first line ART, appointment keeping, adherence, & drug supply continuity. The results of this pilot were presented at the Uganda National AIDS Conference the WHO-AFRO HIV DR meeting in Namibia, & to various key partners, including the PEPFAR country team. UVRI, through support from WHO & MRC, conducted a study in Entebbe to determine whether resistant viruses were transmitted to recently infected individuals. No resistant viruses were identified. These results were published & presented at various meetings including UAC & the International AIDS Society meeting in Sydney, 2008. The HIVDR WG recommended that this activity be repeated in 2008. Plans exist for these threshold surveys to be conducted among teenage pregnant females in Kampala & funding is being sought from PharmAccess. With funding from MRC & GFATM, UVRI established the National HIV Drug Resistance Reference Lab which was accredited by WHO. This is one of few accredited labs in Africa, & plans are underway to make it a regional reference lab. With support from WHO, MRC, & the European Developing Countries Partnership (EDCTP), the facilities & equipment have been upgraded, including the purchase of an additional Beckman Coulter capillary sequencer & DNA/RNA extractor, & an ABI sequencer. The UVRI lab has provided training in drug resistance testing for other technicians & scientists, including one from Zambia, & has also provided testing of samples from other sub-Saharan African countries.

The DR WG continues to make efforts to secure funding from other sources to support HIVDR lab services, & for expansion of EWI & acquired resistance surveys. One of the major challenges to implementation of the national plan has been the absence of a dedicated HIVDR secretariat or center that can develop, implement, & coordinate efforts, & a lack of adequate funding to perform EWI surveys & DR monitoring. This funding will support dedicated staff & provide resources to coordinate national activities & enable drug resistance prevention & monitoring. The proposed activities include: coordinating HIVDR prevention, monitoring & surveillance at both national & institutional levels, supporting the national HIVDR Working Group, monitoring emerging & transmitted HIVDR, & supporting the National HIVDR Reference Lab & other labs to perform HIVDR testing, surveillance & monitoring. A Coordinating Center for HIVDR Prevention, Monitoring & Surveillance shall be established at UVRI in close collaboration with the MOH-ACP. The terms of reference of the HIVDR WG include: 1) to coordinate & implement of the National HIV Drug Resistance (HIVDR) Prevention, Surveillance & Monitoring Plan; 2) to collect & analyze HIVDR EWIs; 3) to develop & coordinate implementation of the country protocol for monitoring HIVDR in representative sentinel ART sites; 4) to regularly perform HIVDR threshold surveys to evaluate transmitted resistance in specific geographic areas; 5) to continue building capacity for genotyping & other activities to support HIV DR surveillance & monitoring within the country; 6) to provide to other countries an example of implementation of a national HIVDR strategy, including elements recommended by WHO; 7) to develop & collect information on activities & programs which will contribute to minimizing HIVDR; 8) to collect & disseminate information on, & help coordinate all HIVDR public health & research activities in the country; 9) to ensure all activities follow country & international ethical standards designed to promote the well-being & health of individuals & communities; 10) to prepare & disseminate annual HIVDR reports & recommendations. An important component of the WHO & National Plan is the sentinel monitoring of HIVDR emerging during treatment, & the relationship of resistance to ART program factors. We plan to follow WHO protocol guidelines by evaluating adult cohorts from time of initiation of ART up to 12 months later, or at viral failure or switch to a second line regimen. An assessment of routinely collected adherence measures will be made. In FY2009, we will perform monitoring at 3-5 pilot sites, with possible expansion in subsequent years subject to availability of funds. According to WHO protocols, 100 individuals newly initiating ART at each site will be followed. Site selection will be made by the HIVDR working group based on geographic region, type or level of clinical service, & funder (PEPFAR, GFATM, MOH, other). A protocol will be developed following WHO guidelines, & reviewed by relevant IRB's. DR survey results will be used to develop recommendations for improvement of outcomes & program planning, to help inform recommendations for optimal first & second line regimens, & develop criteria for drug switching. This funding will support the National HIVDR reference lab through continued participation in testing proficiency panels, QA/QC, provision of supplies, training of lab staff & preparation for accreditation in genotypic testing using DBS. The lab will develop SOPs for training, specimen collection, handling, shipment & storage; ensure observance of GCLP, & assist in accreditation of other labs. The lab team will create a National Data base for resistance marker sequencing, by working with WHO HIVResnet. Initially, viral loads will be determined in the labs of the different partners at UVRI with the aim of establishing viral load measurements within the National HIVDR Reference Lab.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13323

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13323	4709.08	HHS/Centers for Disease Control & Prevention	Uganda Virus Research Institute	6443	3440.08	Laboratory Quality Assurance-Cooperative Agreement	\$325,000
8367	4709.07	HHS/Centers for Disease Control & Prevention	Uganda Virus Research Institute	4816	3440.07	Laboratory Quality Assurance-Cooperative Agreement	\$325,000
4709	4709.06	HHS/Centers for Disease Control & Prevention	Uganda Virus Research Institute	3440	3440.06	Laboratory Quality Assurance-Cooperative Agreement	\$170,000

### Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$210,743

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Table 3.3.16: Activities by Funding Mechanism

**Mechanism ID:** 629.09

**Mechanism:** Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services

**Prime Partner:** National Medical Stores

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 4027.20820.09

**Planned Funds:** \$3,400,000

**Activity System ID:** 20820

**Activity 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 health facilities throughout Uganda. NMS has developed a countrywide distribution supply chain for essential medicines and supplies; as well as providing HIV/AIDS-related Laboratory materials which are supported by PEPFAR funding. Health facilities and HIV Counseling and Testing Centers (HTC), can access these commodities through the established laboratory credit line system, at both NMS and Joint Medical Store (JMS) a subsidiary partner. Following the national credit line for essential medicines, the Ministry of Health (MOH) provides a 20% contribution to JMS for faith-based and mission health facilities and NMS also allocates 20% of PEPFAR funding for JMS to procure, store, and distribute HIV/AIDS-related laboratory commodities.

Since, starting the project in 2004, all eligible functional laboratories (public, NGO / FBO, private and armed forces health facilities) across the country have received HIV/AIDS-related laboratory reagents and commodities from NMS and JMS. Currently, HIV/AIDS-related laboratory reagents and supplies are currently being distributed to 1,280 accredited laboratories throughout the country. The NMS/JMS laboratory material list includes: HIV/AIDS related 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. These laboratory resources have enabled health facilities countrywide to perform needed HIV testing and HIV/AIDS patient monitoring. The established laboratory credit line system, allows laboratories to draw down commodities on a quarterly basis as follows: Health Centre IIIs can order commodities worth Sh980,000; Health Centre IVs laboratory credit line limit is Sh1,200,000; District Hospitals' credit lines is Sh1,800,000; Regional Hospitals' credit allows for Sh2,600,000; and the Armed Forces Hospital's laboratory credit line is Sh1,400,000. NMS and JMS track quarterly draw downs by health sub-district and hospital levels. The tracking system monitors the appropriate utilization of commodities, ensuring that facilities do not surpass their credit line ceiling. As of June 30, 2008, HIV/AIDS-related laboratory commodities worth Sh3.2 billion have been distributed. Additionally, NMS partnership with the Clinton Foundation, lead to a sizeable donation of CD4/8 reagents worth Sh650,000,000; this supply of reagents supports NMS distribution to the 956 Health Centre IIIs, 162 Health Centre IVs, and 104 Hospitals including the Armed Forces.

In FY 2009, NMS and JMS will continue to supply the laboratory credit line to ensure consistent availability of HIV/AIDS-related laboratory reagents and supplies. However, current funding covers only 46% of the national laboratory testing requirements for HIV/AIDS testing and patient monitoring in Health Centre IIIs to perform rapid HIV testing, complete blood counts, and STI testing for HIV+ patients. Health Centre IVs will be able to perform all HIV/AIDS-related laboratory testing, and early infant sample collection for PCR testing. All Regional Hospitals, District Hospitals, and Armed Forces health facilities will continue to perform all HIV/AIDS related laboratory testing for adults and pediatric cases; including basic hematological and clinical chemistry including CD3/CD4/CD8 remunerations. NMS will also provide training in logistics management to the 83 District Stores and home-based HCT initiatives in the country. As a result of the procurement and distribution of HIV laboratory reagent and related supplies provided by PEPFAR, the demand for HIV/AIDS-related laboratory services in health facilities has increased from the 552 laboratories served in FY 2004 to 1,200 labs in FY 2008.

In addition, both NMS and JMS will support training their management and support staff in order to build internal human resource capacity and improve the supply chain system. NMS has also received support from DANIDA in several areas, most recently for the construction of a 20,000 m3 volume extension to the main warehouse in Entebbe. This additional space will eliminate the need for rented warehousing. The World Health Organization (WHO) is also supporting NMS, by conducting a business process and information systems assessment review. This WHO technical assistance will also identify gaps, outline strategies, and improve NMS management capacity to fully implement the national supply chain system. Finally, JMS had recently been supported by the PEPFAR funded Supply Chain Management System (SCMS) project to conduct a business process review, and assist JMS with the acquisition of a new logistics management information system.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13305



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13305	4027.08	HHS/Centers for Disease Control & Prevention	National Medical Stores	6435	629.08	Purchase, Distribution & Tracking of Supplies to Support HIV/AIDS Related Laboratory Services	\$3,400,000
8350	4027.07	HHS/Centers for Disease Control & Prevention	National Medical Stores	4810	629.07		\$3,200,000
4027	4027.06	HHS/Centers for Disease Control & Prevention	National Medical Stores	3178	629.06		\$1,950,000

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$125,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3481.09	<b>Mechanism:</b> CDC GHAI
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 15738.20832.09	<b>Planned Funds:</b> \$1,633,364
<b>Activity System ID:</b> 20832	

**Activity Narrative: ACTIVITY UNCHANGED FROM FY 2008**

The HHS/CDC Base GAP funding supports the USG goal of appropriate staffing and level of effort in order to provide technical assistance, programmatic oversight and performance monitoring for all implementing partner (IP) activities. Over 80% of CDC operations and staffing are covered through GAP funding and the balance is covered by GHAI funds. In the laboratory sector, GHAI funds are used to support implementing partner activities. The HHS/CDC Uganda office is comprised of six units; Operations, Program, Laboratory, Epidemiology, Informatics and Behavior.

In FY 2008, the CDC laboratory unit continued to provide support for diagnostic testing, logistics management, national and international technical and management training and workshop/conference attendance for CDC projects and for IPs. Diagnostic testing in the CDC laboratory included 31,361 HIV serological tests, mostly for quality control testing in support of full-access HBCT in two Districts, 5,781 viral load tests, 1,602 HIV DNA tests (for exposed infants), 287 serum chemistries, 19,002 CD4+ counts and 7,498 complete blood counts. The evaluation of immune activation markers as surrogates for viral load became possible with the gift of an LSR II flow cytometer that allows up to 10 phenotypic markers to be investigated on a single immune cell and potentially makes HIV disease monitoring simpler and cheaper. An Ampliprep for automated nucleic acid extraction from plasma, whole blood and dried blood spots was procured for viral load and especially for HIV DNA PCR for infants. This will add capacity to the national Early Infant Diagnosis (EID) program that currently only has 7 testing centers countrywide, allowing faster turnaround times. CDC-Uganda maintained substantial stocks of laboratory commodities including HIV rapid test kits to offset national stock-outs and also directly supplied a number of partners with CD4+ count tests – currently the National Medical Stores has insufficient capacity to manage diagnostic tests for ART eligibility and disease monitoring. A new approach to the quality assurance of HIV serology in the country was validated by the CDC laboratory based on dried serum samples. A number of CDC staff completed B.Sc. and M.Sc. graduate courses and CDC and partner laboratory staff participated in training courses in good laboratory practice, laboratory management and technical training to improve their own training skills. The CDC laboratory unit, working with the PEPFAR Laboratory TWG and the national Laboratory Technical Committee (LTC), continued to strengthen national laboratory systems by: direct hiring of program staff under the MOH/AIDS Control Program Cooperative Agreement (CoAg), including laboratory personnel, instead of paying existing MOH staff supplementary allowances thus ensuring full-time attention to CoAg activities; assigning two full-time CDC staff to the Central Public Health Laboratory (CPHL) to provide leadership and mentoring for the national Laboratory Training Coordination and Quality Assurance (QA) units – activities included the continued roll-out of the HIV rapid test training package towards the goal of 64 sites with CD4+ count capacity, mapping their locations by GIS for networking of services, enrolling them in an EQA scheme (NEQAS) and training them in its use; providing a senior Technical Advisor (TA) to MOH to help finalize and implement the National Laboratory Services Policy and create a Department/Division of Laboratory Services within MOH to oversee its implementation; supporting the national laboratory commodities credit line at the National Medical Stores (government) and Joint Medical Stores (NGO) that provides basic laboratory commodities to over 1000 laboratories in the country; overseeing the building and renovation of (20) laboratories at lower health facility levels, (2) blood banks and a new CPHL (not yet started); supporting technical and management training (SMDP) through the OGAC-Becton Dickinson Public Private Partnership and GAP/CDC Atlanta in CD4+ EQA, TB smear microscopy and TB specimen referral; funding the HIV Reference Laboratory at the Uganda Virus Research Institute (UVRI) to conduct national QA for HIV serology and to validate new HIV serological assays and testing algorithms, facilitating the national QA program for TB smear microscopy and establishing a national TB specimen referral system with POSTA Uganda for re-treatment cases through the National TB Reference Laboratory (NTRL); renovating the training laboratory and clinical laboratories at NTRL to provide a safe environment for MDR/XDR culture and resistance testing; establishing a laboratory information management system (LIMS) at CPHL and in collaboration with the CDC Informatics Unit, providing support to both CPHL/MOH for databases on technicians' training history and laboratory commodities management and the DHOs, for Health Management Information Systems and mobile telephony to help coordinate activities within the laboratory sector and with the MOH Resource Centre and, collaborating with MOH in the design of the 2009 national HIV/Malaria Indicator Survey (UMAIS). In FY 2009, the CDC-Uganda laboratory will continue to service CDC and partner laboratory needs, including the establishment of laboratory capacity in partner laboratories coupled with continued monitoring by the QA unit at CPHL. Dried blood spot testing by HIV DNA PCR for the national EID program will be expanded and the EID monitoring unit at CPHL strengthened. Immuno-phenotyping to monitor disease progression will be further explored for the Tororo Child Cohort study following the acquisition of an LSR II flow cytometer. The national STI laboratory will be strengthened through technical and financial support channeled through the CRANE survey. Laboratory testing for a further two PHEs, one on incidence testing by pooled PCR and the other on 'the last 1000 infections' will be completed. Diagnostic testing capacity at the CDC laboratory in Tororo Hospital will be expanded to include CD4+ counts, complete blood counts (CBC) and serum chemistries while a new laboratory, currently under construction, will be completed to support both HBAC and a number of new initiatives including the Pre-Exposure Prophylaxis Study, funded by the Gates Foundation. The College of American Pathologists will inspect the CDC Entebbe laboratory for accreditation in late 2008.

Under national laboratory systems strengthening activities, there will be renewed emphasis on increasing the District Health Officer's (DHO) engagement with the laboratory sector – IPs will be encouraged to provide both technical and financial support to the DHO directly which is in line with PEPFAR Uganda's plans for competitive Partnership Compacts. With the hiring of a TA to work alongside the Director of Clinical and Community Health at MOH, the National Health Laboratory Policy, currently in its second draft, will be completed. The TA will work with senior MOH officials to develop a five-year implementation plan for the policy. A further responsibility for the TA will be to act as a full-time liaison between the PEPFAR Laboratory TWG and the non-government IPs – the latter have tended to develop vertical programs in the laboratory sector, duplicating national activities such as procurement, training, quality assurance and infrastructure development which are the responsibility of MOH/CPHL. IPs have now been asked to work more closely with MOH/CPHL and to include in their activity narratives, details of proposed spending on equipment, commodities and salary support for laboratory-related staff. The strengthened CPHL will house both traditional CPHL activities including environmental health and hygiene, outbreak investigation, etc. and also coordination activities in support of national health laboratory systems including; infrastructure

**Activity Narrative:** development (20 additional lower health-facility laboratories will be built/renovated, 3 of the remaining 5 blood banks will be renovated and the building of the new CPHL will be started, GIS mapping of health facilities for the whole country to facilitate networking of services, instrument maintenance contracts with vendors consolidated); human resources (3,500 HIV serological testing providers trained, continued roll-out of both the TB smear microscopy and TB specimen referral training and laboratory management training); logistics management (increased funding to NMS, updated commodities management software tools, national training in logistics management, monitoring laboratory logistics distribution); quality assurance (extend CD4+ count EQA to all facilities with capacity, expand HIV serological QA to all sites using proficiency testing (DTS PT) panels, introduce EQA for CBC and serum chemistries at sites with capacity); support supervision (facilitate DHO to support Regional Laboratory Coordinator and District Laboratory Focal Person, facilitate central and zonal supervisors with vehicles); informatics (implement mobile telephony at lower-level health facilities, provide hardware for CPHL informatics and additional staff, liaise with MOH RC on coordination ); infection control (coordinate activities with African Medical & Research Foundation – AMREF). The long-term objective is that staff employed at CPHL to strengthen national health laboratory systems will naturally transition into a Department/Division of Laboratory Services within MOH – the positioning of the new CPHL building adjacent to MOH should facilitate this transition. Under the OGAC-BD PPP, the CDC laboratory will provide continued technical support for CD4+ count EQA and management training to the remaining 30+ sites, support NTRL to roll-out the WHO/CDC national training program in AFB smear microscopy and extend the national TB specimen referral system beyond the Kampala District – a toll-free telephone line to POSTA Uganda will be set up to allow facilities to call in when there are specimens to be collected. The only new activity in 2009 under PEPFAR funding will be support for the HIV Drug Resistance secretariat based at UVRI and for HIVDR surveillance, funded through an existing CoAg with UVRI. The CDC-Uganda laboratory will continue to play an active role in the preparation, funding and implementation of the 2009 UAMIS. New developments in FY 2009 are the collaboration between CDC (NCZVED) and UVRI on the establishment of a center for Infectious Diseases Ecology that will encompass prevention, detection, surveillance and control of new and emerging infectious agents including plague, arboviruses, influenza, hepatitis E and viral hemorrhagic viruses and, the proposed biotechnology unit, a collaboration between Inverness Medical Innovations and UVRI, for both of which, CDC-Uganda staff will provide TA.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15738

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15738	15738.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$1,041,237

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

Workplace Programs

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 1298.09

**Prime Partner:** Mildmay International

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 4416.20803.09

**Activity System ID:** 20803

**Mechanism:** HIV/AIDS Project

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$245,000

**Activity Narrative:** As of 1st July 2008 The Mildmay Centre (TMC) merged with her sister programme Mildmay Paediatric Care Centre (MPCC) to form Mildmay Uganda. 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 28% 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 runs one main clinic site in one subcounty in Wakiso district which also serves as a referral center for clients outside the catchment area, and eight rural clinics i.e. in one subcounty in Kamwenge district, two subcounties in Luwero district, two subcounties in Mityana district, one subcounty in Mpigi district, two subcounties in Mukono district. Since opening, MU has registered over 20,000 patients, of whom more than 13,000 are actively in care. 6,465 patients receive antiretroviral (ARV) drugs through PEPFAR, >500 through MOH (Global Fund), and 300 receive ART paying privately, but are supported to access the free palliative basic care package and laboratory services i.e. CD4 counts and other laboratory tests, Cotrimoxazole prophylaxis, a safe water vessel, free mosquito nets for malaria prevention, and other palliative care services i.e. morphine and chemotherapy for HIV related cancers and management of opportunistic infections including TB. More services to the patients including cervical cancer screening, reproductive health and family planning, screening and treatment of HIV related eye diseases, dental care for children and mental health care are now offered at MU and the rural sites (only eye clinic at rural sites). In order to decongest the main site, MU started a community programme that covers two districts of Wakiso (6 subcounties) and Kampala (1 subcounty). Reach Out Mbuya (RO) is a sub-partner with MU in the provision of holistic HIV care services and it has 3 sites in one subcounty in Kampala District. It is an initiative of Mbuya Parish in Kampala archdiocese, serving the urban poor. RO started in May 2001 with 14 patients using a community-based approach implemented by volunteers and people living with HIV. By the end of June 2008, RO had 2,848 patients in palliative care including 221 children. Of the 1,574 (60%) clients on ART; 69 are children, 789 PEPFAR funded, 741 MOH funded and 44 by JCRC/DART clinical trail. 124 were on TB treatment. By June 2008 RO had expanded to Kasaala in Luweero where needs assessment has already been conducted. Training at MU is a key component of the programme, targeting doctors, nurses, HIV/AIDS counsellors, pharmacists, laboratory personnel, nursing assistants, community health workers, school teachers, religious leaders, community leaders and carers of patients. MU views care and training as complementary processes when offering HIV/AIDS services. The training programme reaches participants throughout Uganda via a work-based training programme, mobile training teams (MTTs), clinical placements and short courses. Courses include: HIV Programmatic issues; Use of ART in Children and Adults; Management of Paediatric HIV/AIDS; HIV/AIDS Palliative Care; Laboratory Skills in an HIV/AIDS Context; Management of Opportunistic Infections and others. MTT trains health workers from targeted rural districts of Uganda through modular work based programmes. The work-based training programme targets health managers/policy makers nationally from government facilities, faith-based organisations and other NGOs. The work-based programme comprises a modular programme with six staggered residential weeks over an 18-month period but students have the option of undertaking extra 18 months of study for the award of the degree. In between the training modules of the work-based programme, students are expected to practice what they have learnt and to complete their assignments. The time between modules in the work-based programmes is spent at the workplace doing assignments and putting into practice what has been learnt. MU and RO both have electronic systems for capturing their data, analysis and reporting including an M&E system for monitoring performance. The activities are regularly reported on coupled with very good public relations. Further the support directorates of resources and quality assurance support more all the care, treatment and training activities.

MU currently supports laboratory services at all the sites. MU's laboratory has the capacity to perform HIV tests, CD4 tests, Full Blood Counts (FBC), diagnostic tests for opportunistic infections (OI), and chemistry analysis for liver and renal function. Links are maintained with facilities such as the CDC laboratory in Entebbe and the National TB laboratory. Quality assurance measures include regular servicing of all equipment in the laboratory through contracts with machine manufacturers or properly qualified technicians. Quality control systems for all laboratory tests are maintained through contacts with the CDC lab in Entebbe, the Ebenezer laboratory, and the National TB and Leprosy Laboratory for TB. Training of laboratory staff from MU and all supported sites is conducted regularly. This ensures that a comprehensive service is provided for patients and a quality assurance programme to monitor the services in place. The laboratory supports patients recruited through CT (10,000 planned in FY 2007), those in palliative care (over 8,000 planned for FY 2007), and those accessing ARV services (more than 5,000 in FY 2007). Laboratory staff at all MU sites, and other health units in Uganda, have been trained through practical and laboratory specific short courses, and clinical placement schemes. The laboratory performs all tests required to support an HIV clinic including HIV tests, haematological tests, clinical chemistry tests, CD4 counts, diagnostic tests for TB and for other opportunistic infections, and other immunological tests. Histology, diagnostic PCR and viral load are offered as well. The laboratory serves patients in all MU supported sites including the rural sites and RO.

Equipment for which service contracts are maintained includes, a FACS Callibur and a FACS Count for CD4 counts, 3 chemistry analysers, 2 coulter counter machines, an Elisa machine and reader, an interscope for viewing TB sputum smears, microscopes and other general laboratory equipment. We are now able to perform blood cultures.

Reach Out laboratory carries out HIV and TB testing using the National testing algorithm, and client monitoring including follow-up CD4 cell counts, sputum analysis, biochemistry and any other tests depending on the needs of the individual clients. We conduct about 800 sputum analyses (TB), 100 serum crag (Cryptococcal Meningitis), 100 bio-chemistry tests, and 300 blood slides for Malaria parasites per month. Between October 1, 2007 and March 31 2008, 36 individuals were trained in laboratory services. The following laboratory tests were carried out, HIV (1,836), TB (1,964), Syphilis (1,684) and HIV Disease monitoring (12,634). There were 9 laboratories under MU. The main laboratory acquired an automated blood culture system (BACTALERT), which can also be used for TB cultures. An order has also been placed for viral load and diagnostic PCR equipment (COBAS TaqMan 48 and AmpliPrep) that are expected to be delivered soon. This will help with diagnosis of HIV in infants which results have always been delayed. All this lab infrastructure strengthening has led to an improved management of HIV patients in all aspects of prevention, care and treatment.

**Activity Narrative:** In FY 2009 MU plans to increase to 15,000 the number of patients receiving ARV services, each having an average of 2 CD4 counts a year, 3 full blood counts, and 2 liver function tests, 2 renal function tests and 1 lipid profile a year. MU also expects to carry out 700 pregnancy tests, 25,000 HIV tests, 30,000 CD4 tests and 1,000 viral loads (particularly aimed at treatment-experienced patients who may need to switch to a new regimen). Some 3,000 patients will require diagnostic tests for OIs and other monitoring tests. RO expects to carry out 3,600 HIV tests, 9,000 TB diagnostic tests, 300 syphilis tests, 3,300 disease monitoring tests, 6,000 CD4 tests and 1,500 X-Rays (TB diagnosis). The total number of tests will be 63,700 (40,000 for MU and 23,700 for RO). Funds will be used for the purchase of reagents and test kits, maintaining laboratory equipment, quality assurance costs, human resources, training of laboratory workers in HIV related diagnostic skills, and transportation of samples from rural sites to MU and other testing centres as necessary. MU plans to train 50 laboratory staff from various health centres across Uganda in HIV-related laboratory practice. MU plans to equip two rural clinics to be able to perform CD4, FBC, TB diagnosis and clinical chemistry. RO will expand its client laboratory monitoring from basic test to standard tests. It is targeting to analyze 2,590 sputum samples, (TB diagnosis and follow-up), 600 serum Toxo screening, 600, serum Cryptococcal Antigen, 4500, HB, 400 syphilis, 10,000 CD4 cell count, 100 Viral Load, 150 HIV DNAPCR, 300 blood chemistry at both RO and TMC laboratories. As part of the quality improvement we shall build the capacity of 12 laboratory/ and clinical staff in Laboratory services. MU will continue training at the Centre as well as upcountry in targeted districts. Together with Emerging Markets Group, a USAID – funded project MU will also train health practitioners in the private sector in HIV management. MU will train 50 individuals through the short courses. The targeted group are people living with HIV/AIDS and health workers providing care, treatment and training in HIV/AIDS.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13291

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13291	4416.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$250,000
8335	4416.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$190,000
4416	4416.06	HHS/Centers for Disease Control & Prevention	Mildmay International	3344	1298.06	HIV/AIDS Project	\$189,200

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 1107.09

**Mechanism:** Mulago-Mbarara Teaching Hospitals - MJAP

---

**Prime Partner:** Makerere University Faculty of  
Medicine

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 4037.20770.09

**Activity System ID:** 20770

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$800,000

**Activity Narrative:** Makerere University Faculty of Medicine was awarded a cooperative agreement titled "Provision of routine HIV testing, counseling, basic care and antiretroviral therapy at teaching hospitals in the Republic of Uganda" in 2004. The program named Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP) implements HIV/AIDS services in Uganda's two major teaching hospitals (Mulago and Mbarara) and their catchment areas in close collaboration with the national programs run by the Ministry of Health (MOH). MJAP also collaborates with the national tuberculosis and leprosy program (NTLP), and leverages resources from the Global fund. MJAP provides comprehensive HIV/AIDS services including: 1) hospital-based routine HIV testing and counseling (RTC), 2) palliative HIV/AIDS basic care, 3) integrated TB-HIV diagnosis with treatment of TB-HIV co-infected patients, 4) antiretroviral treatment, and HIV post-exposure prophylaxis, 5) family based care (FBC) which includes services for orphans and vulnerable children (OVC), in addition to home-based HIV testing and prevention activities (HBHCT), and 6) capacity building for HIV prevention and care through training of health care providers, laboratory strengthening, and establishment of satellite HIV clinics. Mulago and Mbarara hospitals are public referral institutions with a mandate of training, service-provision and research. Annually 3,000 health care providers are trained and about one million patients seen in the two hospitals (500,000 outpatients and 130,000 inpatients for Mulago, and 300,000 in and outpatients for Mbarara). Approximately 60% of medical admissions in both hospitals are because of HIV infection and related complications. Within Mulago, MJAP works closely with the Infectious Diseases Institute (IDI). IDI is an independent institute within the Faculty of Medicine of Makerere University with a mission to build capacity for delivering sustainable, high-quality HIV/AIDS care, treatment and prevention in Africa through training and research. At IDI health care providers from all over sub-Saharan Africa receive training on HIV care and antiretroviral therapy (ART); people living with HIV receive free clinical care including ART at the Adult Infectious Diseases Clinic (AIDC) - the clinic is integral with Mulago teaching hospital. The main HIV clinics in Mbarara and Mulago teaching hospitals are the Mbarara ISS (HIV) clinic, Mulago ISS, and AIDC respectively; MJAP supports HIV care and treatment in all the three clinics. Since 2005, MJAP has established 12 satellite clinics due to the rapidly increasing number of HIV positive patients; increasing the total number of treatment sites to 15. The twelve satellite clinics include Kawempe, Naguru, Kiswa, Kiruddu, Kisenyi, Kawaala, Kitebi and Komamboga (under Kampala City Council – KCC), Mbarara municipality clinic (under the Mbarara municipal council), Bwizibwera health centre IV (under MOH and Mbarara local government), Mbarara TB/HIV clinic, Mulago TB/HIV clinic, which provides care for TB-HIV co-infected patients. The satellite clinic activities are done in collaboration with several partners including KCC, Mbarara Municipal Council, IDI, Baylor-Paediatric Infectious Disease Clinic (PIDC), Protection of Families against AIDS (PREFA), MOH, and other partners.

MJAP currently supports 19 laboratories. The main areas of support include training of staff, improving of laboratory space, procurement and maintenance of equipment and reagents, support for infection control and quality assurance. All the program supported sites are now able to provide HIV testing, TB sputum microscopy, syphilis and malaria diagnosis. Five laboratories (Mulago Hospital, Mulago IDC, Kiswa, Kiruddu and Mbarara Municipal Council) have capacity to provide ART laboratory monitoring tests. Mulago, which supports CD4 tests for all the Kampala based sites, has two Facs Calibur machines. CD4 tests for patients from the Mbarara ISS clinic are performed by the Mbarara referral hospital laboratory, supported by JCRC. In FY 2007 and FY 2008, all the regional referral hospital laboratories Jinja, Soroti, Hoima, Masaka and Fort Portal were equipped with hematology and chemistry analyzers, biosafety hoods and calorimeters in order to support TB/HIV integration activities. The program shares costs with the hospitals for reagents and maintenance of the equipment. The program also conducts CD4 tests for other programs such as PIDC. External quality control (QC) for HIV testing is done at the MU-JHU laboratory. The Quality Control for sputum microscopy is done at the NTLP laboratory. For CD4 testing, selected samples are sent to the CDC laboratory in Entebbe. MJAP Laboratory also participates in the proficiency testing scheme that is implemented by the HIV reference laboratory at Uganda Virus Research Institute (UVRI). In order to improve on space, the program put up two prefabricated structures to house the laboratory in Mbarara satellite clinics; these have adequate space for equipments installation and performing routine work. The introduction of RTC services has contributed to the increase in the quantity of waste being generated therefore; appropriate biohazard disposal mechanisms have been put in place in order to strengthen existing infection control systems. Laboratory staff has received the relevant training in infection control. In this regard, bins with pedals and liners were provided in the entire program supported sites, and Bio-safety hoods were installed at all the TB screening units. In order to improve the performance of the lab staff, MJAP conducted several training using standard MOH guidelines. The laboratory and data staff was also trained eDOTS, a soft ware for tracking laboratory and clinical information for patients under treatment for tuberculosis. In order to strengthen capacity for internal support supervision, MJAP recruited two supervisors, one for each arm of the program. In spite of the above achievements, the available equipment and personnel are inadequate to meet the ever-increasing program needs. Another major challenge experienced is the delay in receiving infant DNA PCR results from partners where samples are processed. The current turn around time for DNA PCR results is one month for Mbarara and four months for regional referral hospitals. This means that in case of HIV positive infants, there is a delay in initiation of the appropriate care and treatment. The absence of an interface information management system makes retrieval of results and specimen storage difficult. There is therefore need to introduce a laboratory electronic information system. Finally, the increasing number of samples has impacted negatively on the only 5-parts differential Coulter machine in Mulago and leads to frequent breakdowns due to overload.

In FY 2009 four new satellite care (HC1V) and treatment sites will be opened (increasing the number of treatment sites to 19). MJAP will provide ART laboratory screening and monitoring support to over 70,000 patients (this includes patients accessing Global Fund ARV drugs). In the new treatment sites, MJAP will provide support in terms of space modification, staff training, provision of equipment and reagents, quality assurance and infection control according to identified gaps. To ensure sustainability, MJAP will continue to support the improvement of existing infrastructure and systems within the facilities. Funds will go towards training and support for laboratory monitoring including CD4 counts. MJAP ART laboratory infrastructure will support all ART patients within health units in which MJAP is operating thereby leveraging resources. The program will maintain the baseline tests, additional tests for improvement in diagnosis of opportunistic infections will be added basing on costs evaluation and significance as may be required by the clinical team. Additional equipment will be procured for the two new health centres of Kitebi and Komamboga. This will reduce costs and improve the turn around time for results. The program will provide supplies and



**Activity Narrative:** maintenance for all the equipment. Due to the expansion and setting up of several centres, a quality monitoring section with two staff will be set up to monitor the quality of laboratory performance, regional referral hospitals inclusive. The internal and external quality procedures that are in place will be strengthened. The two main central laboratories in Mulago and Mbarara will be listed for International Standards Organisation accreditation (ISO) by reputable bodies. The primary target is to come up with workable and sustainable laboratory quality standards and implement good laboratory practice, in delivery of reliable, accurate and timely HIV related laboratory services. Safety practices and infection control will be strengthened. Basic disposal materials like waste bins and waste liners will be replenished and staff will be trained in infection control as needed. The program will upgrade tuberculosis (TB) screening from ZN sputum smear to Fluorescent microscopy technique to improve case detection across all regional referral hospitals. Periodic monitoring, supervision and training will be done in order to maintain the desired quality. In order to improve on the turn around time for infant DNA PCR results, MJAP will hold discussions with the supporting partners in order to address the obstacles encountered. A laboratory training curriculum targeting laboratory technicians and laboratory managers that is under development will be implemented. In order to improve service delivery and build capacity, MJAP will use both task shifting and pre-service training to build capacity in expansion of laboratory services at the University teaching hospitals. Support supervision will be strengthened, this will be in-line with the national health structure, which is: National referral to regional referral then to lower level laboratories, and this will improve follow up of TB patients. Laboratory personnel involved in HIV screening will be constantly supported, through capacity building and exchange visits to partner laboratories.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13280

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13280	4037.08	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	6431	1107.08	Mulago-Mbarara Teaching Hospitals - MJAP	\$900,000
8320	4037.07	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	4805	1107.07	Mulago-Mbarara Teaching Hospitals - MJAP	\$900,000
4037	4037.06	HHS/Centers for Disease Control & Prevention	Makerere University Faculty of Medicine	3182	1107.06	Mulago-Mbarara Teaching Hospitals - MJAP	\$439,270

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$496,447

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Mechanism:** Makerere University Walter Reed Project (MUWRP)

**Prime Partner:** Walter Reed

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 4514.20039.09

**Planned Funds:** \$370,939

**Activity System ID:** 20039

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and an array of counseling and testing and prevention programs.

The laboratory program described below continues to be part of a comprehensive program and activities do link to other program areas. Specific program activities that are included in this comprehensive program include Counseling and Testing, Strategic Information, Adult and Pediatric Care and Treatment, ARV drugs, and OVC services. During FY2008, MUWRP succeeded in giving full capacity to the Kayunga District Hospital laboratory. This facility is now processing and reporting CD4 enumeration, chemistry, and hematology for all HIV samples in Kayunga District. The lessons learned by MUWRP in the achievement of this goal were presented at the 2008 International AIDS Conference in Mexico City. Throughout FY2008 MUWRP continued to support laboratory services in Kayunga District with external quality assurance schemes, reagents, daily supportive supervision, staffing support, task shifting programs, power solutions, perishables, trainings, and an equipment maintenance contract.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

During FY2009, MUWRP will need to keep up with increasing demand for laboratory services by supporting more staffing, reagents, trainings, additional diagnostic capacities, electronic data capacity, task shifting programs, and the provision of laboratory equipment. MUWRP intends to expand HIV services to one additional health facility in Kayunga and also expand services to the District of Mukono South sub-district. These expansions will have an impact on laboratory services. Furthermore, in FY2009 MUWRPs intends to make assessments of two health center IV (Kangulamira and Baale) and one health center III (Galyiria) laboratories. Capacity improvements will be made to those laboratories so that they can perform routine assays. Again, this will include training, provision of reagents/perishables, supportive supervision, staffing support and possibly some infrastructure remodeling at the Galyiria Health Center III. In June 2008, the chemistry analyzer at the Kayunga District Hospital was replaced so as to allow the laboratory technicians the ability to process more specimen's thereby reducing staff time. However, the reagents used by this new machine are more expensive and will need to be budgeted for in FY2009. The data system of the District Hospital laboratory, which processes and reports all of the HIV samples for Kayunga District, needs to be addressed and automated. Presently, that laboratory is operating on a paper-based system. Finally during FY2009, MUWRP, as part of its comprehensive HIV program, would like to offer viral load assessments for all patients receiving HIV care. Beginning with a baseline viral load, measurements would be repeated every 6 months. The cost of these assays will have a large impact on the laboratory budget.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15714

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15714	4514.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$368,267
8528	4514.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$350,000
4514	4514.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$232,666

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$117,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5739.09	<b>Mechanism:</b> Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers
<b>Prime Partner:</b> Baylor College of Medicine Children's Foundation/Uganda	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 8745.20066.09	<b>Planned Funds:</b> \$450,000



**Activity Narrative:** 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 paediatric & 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 at Houston, Texas, USA. Baylor – Uganda started in 2003 with support to the Paediatric Infectious Diseases Clinic (PIDC), an integral service of the Department of Pediatrics and Child Health at Mulago Hospital/Makerere University. With support from Bristol-Myers Squibb Foundation, BIPAI, and Government of Uganda; a new Children's Centre of Excellence has been constructed and is due to open in October, 2008. This Centre will provide additional space for HIV/AIDS services provision to children and families, training and research in collaboration with Department of Pediatrics & Child Health of Mulago Hospital/Makerere University. Baylor – Uganda has been receiving some support from UNICEF and Clinton Foundation for specific paediatric HIV/AIDS programs in Eastern (Soroti) and Western (Kasese) Uganda, and is due to initiate one site in Kitgum. Other collaborating partners include Feed the Children- Uganda supporting the nutrition program, Pediatric AIDS Canada providing support for 250 children and adults, Save the Children in Uganda, Christian Children's Fund, Plan International and AIDS Information Centre. Baylor – Uganda is the largest provider of paediatric ART services in Uganda. By June 2008, 4,918 children (0 – 14 years) and 1,254 adults (15+ years) were directly receiving ART from Baylor – Uganda sites, and indirectly 281 children were on ART through the supported 32 upcountry public health facilities. 4,240 adults were being served indirectly from the upcountry public health facilities with drugs for OI management, systems strengthening, etc. In total 6,330 children and 3,122 adults were receiving HIV/AIDS related care & support (this includes those on ART) from direct services delivery sites; while 13,647 adults and 1223 children were in care from the indirectly supported upcountry sites. From direct services delivery sites, the HIV positive child is the index and point of entry for testing care givers & other family members. Depending on HIV test result, the adults are appropriately enrolled into HIV/AIDS prevention, care &/or treatment. Baylor – Uganda uses two services delivery modes:

(a) Direct services provision through 11 separate health facilities: Pediatric Infectious Diseases Clinic (PIDC); 4 Regional Centres of Excellences (COEs) in Soroti (Lwala Hospital & Kaberamaido HCIV) and Kasese (Kilmebe Mines & Bwera Hospitals) areas; and six satellite clinics [Naguru, Kirudu, Kawempe and Kitebi Kampala City Council – KCC clinics; Kanyanya TASO Centre and Post Natal Clinic at Mulago Hospital] run as family care consortium with KCC and other partners: Makerere University John Hopkins University Research collaboration (MUJHU); Infectious Diseases Institute (IDI), Mulago-Mbarara Joint AIDS Program (MJAP) and The AIDS Support Organization (TASO). A comprehensive package of paediatric and family HIV care and treatment services are provided through the PIDC and its satellite clinics. This 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) Baylor – Uganda provides indirect services through integration of paediatric and family-centered HIV/AIDS services into existing ART accredited public health facilities in upcountry parts of Uganda. Within 3 months of the first project year, Baylor – Uganda has supported 33 public health facilities (32 upcountry & 1 Kampala satellite clinic – Kitebi HCIV) to integrate paediatric HIV/AIDS services, and plans to roll out in 100 additional facilities over the remaining 4 years. From the 32 upcountry health facilities, 104 children (0 – 14 years) and 1,200 (adults & children) receive ART

In addition to clinical services, a specialized paediatric HIV data management system has been developed and is in use at COE and Satellites to manage vital patient information. Support for strengthening Health Management Information System (HMIS) in the targeted health facilities and their District Health Offices is on-going based on the national Health Management Information System (HMIS). In October 2008, the COE will roll out Electronic Real Time Medical records and with support of CDC, we plan to modify and roll it out to the targeted health facilities over the project period. We hope these will lead to development of paediatric HIV/AIDS database in Uganda.

#### Progress to-date and outline activities and achievements

Baylor – Uganda performs a number of laboratory services for diagnosis and monitoring of patients with HIV/AIDS and related conditions. Laboratory services provided include diagnosis of HIV using antibody tests for adults and children aged 18 months or older, and DNA-PCR for infants below 18 months of age; diagnosis of opportunistic infections (including TB), assessment for ART eligibility and monitoring treatment using CD4, Complete Blood Count (CBC) and serum chemistry. Some of the tests are performed directly from our sites, while others are done in partnership with other providers: MJAP, MUJHU, JCRC and private providers such as Ebenezer Laboratory. By June 2008, Baylor – Uganda had performed 4706 and supported 439 DNA-PCR tests from her direct and indirect services delivery sites. About 60661 HCT were performed. In 2008, Baylor – Uganda acquired a CD4 test machine and CBC as well as Chemistry Analyzer which will be installed in the new Baylor-Uganda COE located at Mulago. All the 11 direct and 32 indirect services delivery sites and 10 new sites to be initiated in FY2009 will require continuous support with appropriate laboratory reagents and supplies, as well as support for transportation of samples for the tests from the Baylor – Uganda's supported health facilities to health facilities with appropriate testing equipment. To facilitate this process and ensure a lower negotiated rate, Baylor – Uganda has secured free tests for DNA-PCR and CD4 from JCRC under MOH supported initiative of Early Infant Diagnosis. However, tests for CBC, blood chemistry, etc. need to be paid for. While Baylor – Uganda promotes use of WHO staging criteria for initiation of ART especially in rural resource- constrained environment, support will be provided for transportation of samples collected from children, adolescents and family members for HIV diagnosis and monitoring to various testing centres. Baylor – Uganda uses Ministry of Health's approved tools and systems for this work, and will not introduce new systems. By March 2008, Baylor-Uganda had trained 243 individuals in the provision of laboratory-related activities.

FY 2009 activities: Baylor – Uganda will provide the following laboratory related services with a 10% increase every year

- Support for laboratory monitoring, including transportation of samples for CD4 count, DNA-PCR, etc. from

**Activity Narrative:** 23 upcountry health facilities and 6 Satellite clinics. We expect to perform at least 2 CD4 tests for more than the 6,330 children and 3,122 adults enrolled in care by June, 2008. More than 5145 children/infants will be provided with DNA-PCR services.

- Provision of mentorship and support supervision to laboratory personnel in all the program sites.
- On-going training in Dry Blood Spot and Good Laboratory Clinical practices in 10 new sites.
- Home based services to children on ARVs and their families in an effort to support adherence. For the bedridden patients, those that miss scheduled appointments, those with poor adherence and to extend VCT and other HIV services to the family members of the index client.
- Development/improvement in Standard Operating Procedures for laboratory practices will also be done.
- Providers training in pediatric HIV/AIDS management will also have some component of laboratory monitoring.
- Personnel support for laboratory staff at Baylor – Uganda’s COE as well as partial contribution for administrative/support staffs that support laboratory functions such as procurement officers and data entrants, executive director, etc.

ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

- Procurement & distribution of laboratory equipment (CD4 count machine, centrifuge, etc.), supplies & reagents for the COE & upcountry public health facilities. Baylor – Uganda will continue extending some support for laboratory supplies for these health facilities where it is working indirectly to increase access to paediatric HIV/AIDS care and treatment.
- Development of external & internal laboratory quality assurance mechanisms for all Baylor – Uganda supported sites, in line with Ministry of Health’s approved protocols.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13249

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13249	8745.08	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	6422	5739.08	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$500,000
8745	8745.07	HHS/Centers for Disease Control & Prevention	Baylor College of Medicine Children’s Foundation/Uganda	5739	5739.07	Expansion of National Pediatric HIV/AIDS Prevention, Care and Treatment Services and Training of Service Providers	\$450,000

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Child Survival Activities

- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$120,105

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 583.09

**Prime Partner:** African Medical and Research Foundation

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 4012.20030.09

**Activity System ID:** 20030

**Mechanism:** Laboratory Services Strengthening at Health Center IV and Above

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$641,000

**Activity Narrative:** In 2004, AMREF received PEPFAR funds through CDC for strengthening laboratory services at Health Center IV (HC IV) and above in Uganda. Activities include: identifying laboratory infrastructure for rehabilitation by working with Regional Procurement and Support Office [RPSO] and Ministry of Health [MOH]; equipping laboratories with essential equipment for managing OIs; strengthening health care workers' skills through training; strengthening laboratory quality assurance and enhancing stakeholder support for health laboratory services.

To-date, 21 health unit laboratories have been rehabilitated and are now functional namely: Atiak, Baale, Bugiri, Bufumbo, Busesa, Butenga, Bwijanga, Buyinja, Kawempe Kityerera, Kiyunga, Kotido, Kyanamukaaka, Lyantonde, Magale, Muyembe, Moroto, Namayumba, National TB Reference Laboratory, Pader, Pajule, Rakai. The rehabilitation has improved quality of laboratory services, attitude of patients and clinicians to lab services and morale of lab staff. 151 labs have been provided with essential lab equipment including: microscopes, centrifuges, haemoglobinometers, counting chambers for white blood cells, microlitre pipettes, water filters, spirit lamps, tally counters (single and multi-key); wire loop holders, nichrome wire and cold boxes. The equipment has improved quality of results and access to lab services. 10 CD4 machines at 10 Regional Referral Hospitals were repaired, and has enabled the clinicians to start eligible patients on ART, while monitoring their progress. A total of 12 water tanks and one set of invertors were provided to Kiwoko, Jinja, Ishaka and Rubaga Laboratory Training Schools, which has improved the sanitation standards and availability of regular electricity at the schools for practical teaching and library use. Kiwoko, Jinja, Ishaka, Lacor, Kitovu, Nsambya, Mengo, Mulago and Rubaga Laboratory Training Schools were provided equipment {11 computers, 34 microscopes, 5 Centrifuges, 18 Sahli haemoglobinometers}, diagnostics (18 Liver function test kits, 8 Pancreatic function test kits, 60 Blood grouping sera sets comprising anti A, anti AB, anti B and anti D) plus a range of essential chemicals to support practical training. These schools also received an assortment of 719 text books in 15 different titles to support teaching and learning. As a result, the average success rate in final exams at these schools has increased from 40 to 50%. Capacity has been built for 74 District Laboratory Focal Persons [DLFPs] through TOT lab management and supportive supervision; these were drawn from districts, Catholic Medical Bureau, Protestant Medical Bureau and Muslim Medical Board. These currently form the core National Training Team for this activity and they support district health authorities and other development partners to train health workers in support of HIV care and management. A curriculum for In-Service training of lab staff, SOPs for lab staff Performance Monitoring Tools were developed. Refresher training based on MOH's national standards has been conducted for 231 lab staff, 181 Doctors and Clinical Officers and 225 Counselors. This has enhanced skills and team work amongst the cadres improving on the care and management of HIV and related conditions at the health units. 395 reference books, in 3 titles, have been provided to 147 labs to consolidate technical skills at these sites. 30 microscopists [(un-trained staff working in labs at Health Center III) from the post-conflict districts of Amuru, Gulu, Kitgum and Pader, have benefited from training in testing for HIV, Syphilis, Tuberculosis and Malaria. This has improved the staff's work approaches, their patient relations and the quality of test results has continued to improve. 29 students are being sponsored for the three year diploma course in Laboratory Technology at eight schools in country; 11 of these will sit for their final exams in September 2008. 159 microscopists have been sponsored for two year certificate course in laboratory technology; 20 have qualified and have reported back to their respective health units where they were previously working. Five Lab School Trainers are being sponsored for the two year Diploma course in Health Tutorship; two will sit for their final exams in September 2008. In consultation with the Infrastructure Division of MOH and the Central Public Health Laboratory [CPHL], the AMREF plan for a basic laboratory was accepted as a good standard reference plan and it is being used by RPSO and MOH as a foot print to rehabilitate existing laboratories and construct new ones. AMREF participated in the review of the East African Regional External Quality Control (EAREQAS) Protocols that were developed by the MOH of Health of Kenya, Tanzania and Uganda with support from AMREF. They have been adopted to prepare proficiency panels for national laboratory QC. AMREF is promoting internal QC by using on site training during support supervision. CPHL is aware and the difference is that CPHL is emphasising external QC of mainly bacteriological cultures and CD4 counts. Diagnostics are procured from Joint Medical Stores. Internal QC conducted on spot during support supervision, following the NTLF protocol emphasizes the need for application of internal lab QC which is a good laboratory practice. CPHL has worked with AMREF to strengthen the capacity of DLFPs [including the Faith Based hospitals] to effectively conduct support supervision at laboratory units under their jurisdiction through the utilization of a support supervision tool, that is being used countrywide. Lab performance was monitored through support supervision together with the DLFPs [public and faith based], District HIV Focal Persons and Counselor Supervisors. It was established that in 67 districts that participated, 87 of 171 labs had the capacity to perform HIV monitoring tests. This is attributed to lack of equipment, diagnostics and untrained lab staff. The average lab utilization by clinicians was 27%; based on accuracy and completeness of records at 99 health units. Utilization rate at Faith Based health units was seen to be better than at public health units. Labs in new districts were utilized much less than those in the mother districts. This may have resulted from a much less established supply chain or reagents and supplies and more inadequately staffed health facilities. In order to improve quality of the performance of laboratory equipment, 15 lab staff; (11 from Regional Referral Hospitals, 2 from CPHL and 2 from AMREF) were trained in basic repair and maintenance of lab equipment. They each were provided with a tool kit and four have assisted labs to repair microscopes, centrifuges and refrigerators. Ten lab staff at hospitals with CyFlow CD4 counting equipment were trained in proper use and maintenance of the equipment; support supervision was provided at their sites and they were re-oriented in general maintenance of these machines and repositioning diagnostics for these machines from the National Medical Stores. 23 lab staff from Regional Referral Hospitals, Jinja Lab Training School, and the Faith Based health units were trained in the maintenance and basic repair of haematology analysers. MOH would like this activity to be extended to lab staff working at lower level health units so as to minimize failure of critical equipment. DLFPs in the post-conflict districts of Amuru, Gulu, Kitgum and Pader were trained on basic preparation of internal QC materials-the QC test results of the 25 functional labs has improved from 5% correct to an average of 60%. To further improve QC monitoring, CPHL was provided with a vehicle, and a computer network was installed at the office. AMREF has worked with MOH and the Ministry of Education and Sports to follow up the sponsored students who are at the schools, during the school term. Consultative meetings were held in 13 districts - Bukwo, Jinja, Kabale, Kampala, Kapchorwa, Kitgum, Kisoro, Mbarara, Masindi, Mbale, Mukono, Pader and Wakiso districts. The District Health Officers and Secretaries for Health pledged to promote the laboratory services in annual district development plans.



**Activity Narrative:** The DLFPs need to acquire computer skills in order to use computer facilities at the district offices for record keeping and report writing. Challenges include: low numbers of tutors at the training schools; the field attachments required to complete the course are increasing the costs to the schools and students; some of the mature-entrant students are not able to cope with the intensity of the course. They have been out of school for so long and this has affected their performance; the dynamics of the global economy has increased affected the students.

In FY 2009, AMREF will assess lab infrastructure and identify approximately 20 labs for rehabilitation through RPSO during support supervision of lab staff and document the state of repair for RPSO. AMREF will also provide laboratory technical support to A&E firms in designing laboratory plans for remodeling. This will be nationwide and the rehabilitated labs benefit the communities/clients served at the lab through improved patient flow, privacy and confidentiality plus the lab staff by working in a safer and more lab work tailored environment. Supplementary equipment will be provided to labs at HC IV, District and Regional Referral Hospitals. Equipment distributed will be based on gaps identified during support supervision, and MOH's equipment norms for health units. 10 district hospitals [Moroto, Kitgum, Anaka, Kalangala, Adjumani, Kamuli, Bukwo, Nakasongola, Kisoro, Sironko] and one Prisons health unit will be provided with supplementary equipment to conduct CD4, liver, kidney and pancreas function tests. CPHL will train 40 DLFPs or their deputies and 10 RLFPs in good lab management practice; this will enhance their management skills and participation during the district planning sessions. AMREF will work with MoH's HR Department to establish the Health Laboratory Practice Course through distance learning. In addition, 20 Laboratory Assistants from the districts of Bukwo, Kisoro, Kotido, Adjumani, Yumbe, Sembabule, Pallisa, Ntungamao Kampala, Mukono, Bundibugyo, Tororo and Kamuli will be sponsored in fulfillment of the continued professional development strategy of the MoH. Refresher trainings will be conducted to strengthen skills for 40 laboratory staff in essential technology for testing HIV and related conditions; these participants will be drawn districts previously supported by the AIM project. 30 clinicians from the same districts will also benefit from training on appropriate utilization of and planning for laboratories. In collaboration with MOH and District Health Officers, long term training will be offered to 30 lab technician students and 92 lab assistant students. In addition, 30 new Microscopists serving at HC III will be sponsored for the 2 year Certificate course; they will be selected from districts [including AIM project supported districts] that have had few microscopists sponsored such as Amolatar; Amuria, Bushenyi, Butaleja, Budaka, Katakwi, Koboko, Kumi, Mityana, Tororo, Yumbe, Moyo, Nebbi, Jinja, Arua, Soroti, Kaberamaido, Lira, Pader, Masaka, Rakai, Mubende, Kaliro and Busia plus Uganda Prisons, Uganda Police and Uganda Peoples Defence Forces. Training opportunities will increase gender equity by ensuring that both male and female participants are selected for the courses. In addition, the long term courses promote females who are currently fewer in the laboratory profession in the country. Lab Technologists from district hospitals will receive training in maintenance and repair of health lab equipment. The training emphasizes preventive maintenance. Failure of lab equipment has been caused mainly by limited user skill to prevent simple faults from growing into major ones. A needs assessment for the training of workshop staff for repair of lab equipment will be carried out to ascertain the required scope of training; 42 staff who were trained from the Regional Referral Hospitals will be supported financially to assess the status of equipment at district hospitals. Those who were trained from the districts will assess the status of equipment at HC IV labs and mobilize technical assistance for major repairs within the regions. Technical assistance will be drawn from the district staff. Each group will be expected to carry out minor service and repair of some equipment like microscopes, centrifuges and colorimeters. They will liaise with regional maintenance departments to procure the required spare parts. 8 lab training schools will be supported to set up a QC system and prepare select QC materials (Glucose, RPR, HIV, TB, total Protein, WBC counts, Haemoglobin, Intestinal Parasites, Blood parasites, Cryptococcus). They will also be provided with essential semi-automated supplementary equipment like haematology analyser, Flow cytometer, spectrophotometers plus diagnostics to improve practical training. AMREF will collaborate with CPHL in monitoring performance of lab services through sharing technical input on lab systems development and monitoring, validating quality of reagents provided to health units through sampling and testing selected reagents for quality and quantity of specified characteristics. Through this programme, 70 DLFPs will conduct lab technical consultative meetings with lab staff in the districts twice a year to review and set approaches of improving performance. They will also conduct a joint support supervision with 70 HIV Focal Persons, 70 Counselor Supervisors and 70 District Health Officers twice a year to consolidate good lab practices. AMREF will work with the Commissioners of Disease control, and Clinical Services and CPHL to conduct one consultative meeting for lab services with Regional Hospital Medical Superintendents, and RLFPs to enhance stakeholders support so as to promote sustainability. AMREF will collaborate with UVRI in assessing the quality of lab services through production of QC materials, analysis of results from the labs, giving feed back, carrying out remedial action(s) and involving UVRI staff in facilitating courses. The Programme will support MOH to finalize the development of an abridged in-service course for microscopists who lack entry requirements to the lab certificate course. AMREF will support the national Health Tutors College to conduct short in-service courses for Lab Trainers and Instructors, at lab schools, who may not have the academic entry requirements to the Health Tutors Course.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13255

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13255	4012.08	HHS/Centers for Disease Control & Prevention	African Medical and Research Foundation	6425	583.08	Laboratory Services Strengthening at Health Center IV and Above	\$583,000
8277	4012.07	HHS/Centers for Disease Control & Prevention	African Medical and Research Foundation	4796	583.07		\$703,000
4012	4012.06	HHS/Centers for Disease Control & Prevention	African Medical and Research Foundation	3173	583.06		\$1,238,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

Military Populations

Refugees/Internally Displaced Persons

Workplace Programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$310,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1290.09	<b>Mechanism:</b> AIDSRelief
<b>Prime Partner:</b> Catholic Relief Services	<b>USG Agency:</b> HHS/Health Resources Services Administration
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 4390.20747.09	<b>Planned Funds:</b> \$600,000
<b>Activity System ID:</b> 20747	

**Activity Narrative:** AIDSRelief provides a comprehensive care and treatment program emphasizing strong links between PLHAs, 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. AIDSRelief is a consortium of five organizations which includes Catholic Relief Services (CRS) working as the lead agency, the Institute of Human Virology (IHV), Constella Futures Group (CF), Catholic Medical Mission Board (CMMB) and Interchurch Medical Assistance World Health (IMA); AIDSRelief services are offered through 18 Local Partner Treatment Facilities (LPTFs), distributed throughout Uganda working in some of the most underserved and rural areas, including Northern Uganda. These include St. Mary's Lacor, St Joseph Kitgum, Nsambya Hospital, Kamwokya Christian Caring Community, Family Hope Center Kampala, Family Hope Center Jinja, Virika Hospital, Villa Maria Hospital, Kabarole Hospital, Bushenyi Medical Center 1- Katungu, Bushenyi Medical Center 2- Kabwohe, Kyamuhunga Comboni Hospital, Kasanga Health Centre, Kalongo Hospital, Amai Hospital, Aber Hospital, Nkozi Hospital, and Nyenga Hospital. In order to get services closer to the communities it serves, AIDSRelief supports 24 satellite sites in selected LPTFs. The Children's AIDS Fund is a sub-grantee in AIDSRelief and manages a number of the LPTFs.

As of July 31st, 2008, AIDSRelief in Uganda was providing care and support to 55,781 adult patients 18 years and older, and antiretroviral treatment to 16,833 HIV-infected patients 15 years and older. In addition it was providing care and support to 5,144 infected children under the age of 18, and antiretroviral treatment to 1726 children under the age of 15. 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, cryptococcal 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 QA/QI, and referral CD4 testing, and AIDSRelief LPTF laboratories participated in UKNEQAS external assessment scheme for CD4 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. 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 and continuing medical education trainings 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 TB smear Microscopy, HIV rapid testing, basic flow cytometry 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 24 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 to be performed at identified 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 tools to ensure collection and compilation of laboratory data for all HIV patients.

In FY 2009, AIDSRelief will maintain its services at the 18 LPTFs and 24 satellite sites with the goal to maintain 20,000 patients on ART, of which 2,800 will be children, and 63,620 patients in care and support. The FY 2009 request will include provision for lab supplies and technical assistance to the LPTFs. In FY 2009, AIDSRelief laboratory support will continue to include the procurement and distribution of necessary reagents from local distributors (HIV test kits, reagents for the identification of opportunistic infection). AIDSRelief will further strengthen LPTFs laboratory capacity to diagnose TB, malaria and other opportunistic infections through additional equipment and supplies and technical assistance. Laboratory staff skills in forecasting will be strengthened. There will be some provision for viral loads measurements. Tools and reference materials to monitor OIs and ARV drug toxicities will also be provided. 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. AIDSRelief will also ensure that service contracts for laboratory equipment remain in place, and that routine preventative service visits and prompt maintenance occurs. The program will also maintain support for the maintenance of solar back up power systems and surge protectors. To enforce sustainability the program will build local capacity in country to perform equipment maintenance/ service by collaborating with private service providers.

AIDSRelief will again provide refresher trainings for 96 laboratory personnel to emphasize standard operating procedures, good laboratory practices, reagents forecasting and procurement and quality control to ensure a safe working environment, personal safety and reliable laboratory test results. Additionally, in order to address the shortage of laboratory personnel, the program will train nurses and midwives to conduct HIV rapid tests and link them to MOH and CDC for quality assurance support and laboratory training schools to increase the number of qualified staff. 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 24 satellites laboratories. This includes continued training for these sites in rapid HIV testing, malaria smears, TB smears and other diagnostic tests and in the collecting and processing of specimens for other tests to be performed at an identified referral laboratory. Laboratory services will also be further extended to include home based HIV testing and mobile laboratories in case sufficient funding is made available for this.

In FY 2009, AIDSRelief will engage the Ministry of Health to ensure that AR 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

**Activity Narrative:** for QA/QI, and referral CD4 testing. AIDSRelief LPTF laboratories will continue to participate in UKNEQAS external assessment scheme for CD4 testing with support from CDC. Through Constella Futures, 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.

Sustainability lies at the heart of the AR program, and is based on durable therapeutic programs 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 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, AR will strengthen the selected indigenous organizations according to their assessed needs, while continuing to strengthen the health systems of the LPTFs. In FY2009, 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 and Uganda Protestant Medical Bureau to build their institutional capacity to support LPTFs integrate ART and other care and support programs into their health care.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13269

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13269	4390.08	HHS/Health Resources Services Administration	Catholic Relief Services	6429	1290.08	AIDSRelief	\$750,000
8290	4390.07	HHS/Health Resources Services Administration	Catholic Relief Services	4799	1290.07	AIDSRelief	\$755,871
4390	4390.06	HHS/Health Resources Services Administration	Catholic Relief Services	3330	1290.06	AIDSRelief	\$755,871

**Emphasis Areas**

Health-related Wraparound Programs

- \* Child Survival Activities
- \* Malaria (PMI)
- \* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$206,250

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4961.09	<b>Mechanism:</b> TBD/Drug Logistics
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 8984.21817.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21817	

**Activity Narrative:** USAID is consolidating its support to Uganda's supply chain management system into a single procurement mechanism to improve coordination and build upon the work of two implementing partners (SCMS, DELIVER) currently providing procurement services and technical support in this area. The new mechanism will provide technical assistance to key Government of Uganda entities (Ministry of Health (MOH), National Medical Stores (NMS), National Drug Authority (NDA), district health offices, Joint Medical Stores (JMS), and in-country and international partners to ensure the availability of quality ARVs and other health commodities to meet the care and treatment needs of people living with or affected by HIV and AIDS. This includes improved forecasting and quantification of overall country program needs and the needs of implementing partners; transparent procurement of the right products in a timely manner; quality assurance of commodities; proper storage and timely distribution to the end user health facilities; and complete and accurate information at all levels of the supply chain.

This activity is linked to Adult Care and Treatment, Pediatric Care and Treatment, Counseling and Testing, PMTCT, Strategic Information, and Health Systems Strengthening.

With the MOH priority focus on improving and expanding laboratory services for HIV/AIDS, TB and other diseases, the number of MOH and NGO-supported laboratories has increased from 579 to over 1,000 facilities in the last two to three years. With support from SCMS, the Central Public Health Laboratory (CPHL) and National Medical Stores established a national logistics management system and credit line for laboratory supplies to maintain a regular chain of supplies to the rapidly expanding number of laboratories. Laboratory supply requirements continue to increase with the scale-up of HIV counseling and testing, ART and TB prevention and treatment services and SCMS provides technical support to CPHL in preparing annual specifications and quantifications for laboratory consumables and reagents based upon consumption and other service data collected through a laboratory logistics management information system. Work has been initiated to build the capacity of the Laboratory Technical Committee to improve procurement by enabling them to do conduct future quantifications. SCMS conducted pre-service training for 586 final year students from 13 accredited laboratory training schools (private and public) country wide in an effort to strengthen laboratory logistics capacity and as part of a plan to institutionalize logistics management in the national laboratory training curriculum. SCMS, in collaboration with CDC, is supporting a national laboratory logistics training program to improve skills of lab personnel in logistics management, ordering and reporting. SCMS, in collaboration with CPHL and the Laboratory Technical Committee, carried out a logistics assessment for automated equipment supplies (CD4, clinical chemistry and hematology) in 20 MOH health facilities. Data from the assessment will be used to redesign a more effective laboratory automated equipment supplies logistics system for the MOH. Support for regular supervisory visits to lab personnel is provided with an emphasis on logistics management and commodity availability.

In FY 2009, TBD will continue to work in collaboration with WHO, UNAIDS, GFATM and other stakeholders to provide technical support to the MOH to strengthen laboratory services. Ensuring the availability of laboratory supplies for diagnosis, treatment and care is fundamental to the effectiveness of the HIV/AIDS and TB activities. The MOH and CPHL will receive assistance in forecasting and quantification of national laboratory needs, procurement planning and coordination, monitoring of stock levels, and training of new laboratory staff in inventory management. To improve central level management and distribution of laboratory commodities, TBD will work the NMS and other donors to implement the key recommendations of numerous NMS assessments including installation and training on new systems software, and hardware procurement (e.g. computers, software, warehousing equipment, odometer readers) to improve efficiency and cost-effectiveness of operations. JMS will also receive technical support as needed to complete implementation of their new warehousing systems. At the policy level, TBD will work with the MOH, NMS and other GoU ministries, e.g. Ministry of Finance, to address the well-documented legal, regulatory, and financial issues that negatively affect the national supply chain system. An important area of focus will be to improve accountability and enforcement of procedures, laws and regulations regarding leakage of public health commodities. At the district and lower level, more TBD technical assistance will be focused on on-job training and support to DHO, HSD and health facility staff in carrying out their logistics management operations including planning and tracking their expenditures and submit timely reports to keep the system moving. A special area of focus will be the development and testing of a scalable model to improve "last-mile" distribution to health centers in selected districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14236

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14236	8984.08	U.S. Agency for International Development	John Snow, Inc.	6746	4961.08	Partnership for Supply Chain Management	\$650,000
8984	8984.07	U.S. Agency for International Development	Partnership for Supply Chain Management	4961	4961.07	Partnership for Supply Chain Management	\$650,000

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 9320.09

**Mechanism:** Community-based Care and Support/TASO Follow on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 21640.21773.09

**Planned Funds:** ██████████

**Activity System ID:** 21773

**Activity Narrative:** This is follow-on to USAID support to HIV/AIDS prevention, care and support activities through its cooperative agreement with The AIDS Support Organization (TASO) which is ending in December 2008. This activity ensures consistent availability of life saving services to clients supported through the existing mechanism while availing resources for new clients in the same or expanded geographic coverage. This activity will build on lessons learned during two decades of international HIV/AIDS response and the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

USAID has been supporting HIV/AIDS care, prevention and treatment services through indigenous organizations over the last 15 years. During this period USAID made significant progress in developing indigenous response, partnership and ownership through its support to Government of Uganda and private/Civil society organizations including TASO, AIC, IRCU and JCRC to mention a few. In addition, USAID has been supporting a large number of indigenous organizations through a subgrant mechanism through UPHOLD, International HIV/AIDS Alliance, AIM, and others. USAID has built the technical, financial, management and administrative capacity of these organizations by using US based international implementing partners as mentoring organizations. A number of indigenous organizations including TASO, JCRC, IRCU, AIC have demonstrated the capacity to manage USAID programs as prime partners.

In FY 2007 USG has reached more than 80,000 clients with HIV/AIDS care and support services through TASO.

USAID/PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which demonstrated competency and leadership in these technical areas. These partnerships are envisaged to continue as mechanisms for building local partnership, response, ownership and sustainability. While doing so USAID envisions moving from a sole sourcing or subgrant approach to a direct cooperative agreement and open competition among indigenous partners. Competition will prompt local partners on the need to be competitive and the requirement to develop their own capacity on designing and developing of high quality and competitive proposals and programs.

In order to provide good quality basic health care services, healthcare workers need a well functioning laboratory to help in the diagnosis of opportunistic infections. Therefore, strengthening laboratory infrastructure and capacity is a key component of adult and pediatrics HIV/AIDS care.

This mechanism will support a minimum set of laboratory services required to support diagnose of HIV and key opportunistic diseases and for disease monitoring. The tests include malaria testing, TB microscopy, HIV testing, syphilis, CBC, and basic chemistry tests.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21640

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21640	21640.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$50,000

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

\* TB

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 4706.21731.09

**Activity System ID:** 21731

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$300,000



**Activity Narrative:** Introduction and overview of the organization and project:

This activity relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Palliative care: Basic health care, Counseling and testing, ART, Strategic Information and policy analysis system and strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

**Progress to date and outline of activities and achievements:**

In FY 2008 NUMAT embarked on the process of refurbishing selected laboratories at HC III in the nine districts to meet the standards set by the Ministry of Health. Following an in-service training curriculum 59 practicing laboratory personnel were trained on tests for diagnosis and management of HIV/AIDS/TB and malaria; 17 clinicians attended a Training of Trainers' (ToTs) course on rational utilization of laboratory services - capacity building for the district personnel in preparation for the roll out of the re-orientation of clinicians on rational laboratory utilization in the districts; Seven students from the project districts have been sponsored in various laboratory training schools for a two year Laboratory Assistants' course; these students are bonded to districts and after completion of training will have to serve in the districts; select equipment such as Microscopes, Manual centrifuges, Refrigerators, Colorimeters, Water filters, Microlitre pipettes, Counting chambers, Tally counters have been provided to 29 health facilities based on the gaps identified; these 29 laboratories have capacity (personnel and equipment) to provide both HIV testing and HIV disease monitoring tests. A total of 64 health unit laboratories were supervised by District Laboratory Focal Persons (DLFPs), National trainers/supervisors and Central Public Health Laboratories (CPHL) staff and an improvement in the quality of laboratory services was registered. Nine DLFPs from the project area were attached to Uganda Virus Research Institute – HIV Reference Laboratory for five days for mentoring and enhancement of their competencies in quality control for HIV/AIDS diagnosis and monitoring clients on ART; Reference text books (District Laboratory Practice in Tropical countries, Part 1 and 2 by Monica Cheesebrough, Microscopy of Tropical Diseases – Colour plates learning bench aid series) were provided to 64 health facilities with functional laboratories to provide back up to enhance quality day to day service provision as most laboratories are run by one staff. An estimated 80,000 HIV tests; 8,100 tests for TB; 14,000 Syphilis tests and 1,500 HIV monitoring test were performed during the reporting period.

**Activities for FY2009:**

In FY 2009, for the laboratory infrastructure program area, NUMAT project will continue building on the achievements gained through the joined efforts of partners and agencies such as CDC, UNICEF, UNOCHA, WHO supporting the laboratory sector. This will be through strengthening the laboratory capacity at the lower level of the health systems, particularly HC III. ALL ACTIVITIES ARE UNCHANGED FROM FY 2008

1. Renovating infrastructure to meet the minimum standards set by Ministry of Health- NUMAT working closely with district authorities will identify priority health laboratory facilities for refurbishment, conduct an assessment of the state of the laboratories and counseling rooms then remodel the laboratories to meet the standards set by the Ministry of Health. In FY 2009 NUMAT will complete the refurbishment works started in 20 laboratories in FY2008.
2. Training of personnel – NUMAT through the districts, will conduct refresher training of 50 laboratory staff that have not yet received the refresher training. The laboratory personnel will undergo a two week in-service training in HIV rapid testing, sputum smears microscopy, total and differential white blood cell counting, hemoglobin estimation, blood smear examination for malaria and other haemoparasites, diagnosis of other opportunistic infections common in HIV/AIDS, Laboratory management and Laboratory disease surveillance. The training will be based on an in-service training curriculum revised in FY2008. NUMAT will support the re-orientation training of 180 clinicians in best practices in utilization of laboratory services, this activity will be conducted by the Trainers that under went a Training of Trainers course that was conducted in FY2008. This activity will be conducted at district level.
3. Procure/Provide select supplementary equipment and supplies that will enable units to undertake appropriate laboratory tests for the diagnosis and treatment of HIV, TB and malaria. Based on the gaps identified during performance monitoring visits to the health facilities, NUMAT will quantify, procure and deliver the equipment to the health facilities. The select equipment will include but not be limited to Microscopes, Autoclaves, Counting chambers, Cool boxes and other supplies.
4. Strengthen the capacity of higher level laboratories to conduct specialized tests such as CD4 count, Liver Functional Tests (LFTs) and Renal Functional Tests (RFTs). NUMAT by networking with other partners will support training of personnel in the performance of CD4 counts, LFTs and RFTs while ensuring availability of laboratory supplies that support the tests at the facilities.
5. Strengthen specimen referral from the lower facilities to higher levels through supporting the health facilities to obtain specimen packaging and transportation materials from Central Public Health Laboratories (CPHL) and from the National Medical stores (NMS).
6. Strengthen laboratory quality assurance systems through supportive supervision by the DLFPs, National trainers/supervisors and staff from CPHL. NUMAT will facilitate the supervisors to conduct regular technical support supervision visits for the laboratory staff at their work places. The laboratory personnel will receive on-site training and mentoring during the visits. Standard Operating Procedures (SOPs) will be printed, laminated and distributed to laboratories to further enhance provision of quality laboratory services.
7. In line with the MoH's Human Resource Development strategy of increasing availability of qualified laboratory personnel at the health facilities particularly in severely Humana resource constrained districts like in the North, NUMAT will continue to work closely with the districts to identify and sponsor an additional 18 currently unqualified staff (Microscopists) that have the minimum requirements for Laboratory Assistant's courses as well as continue to support the 7 that are already in school. The sponsored students on qualifying will be expected to serve the district for a period of time as agreed upon in the bond agreement signed between them and the district before the commencement of the course.
8. NUMAT will document and disseminate innovative approaches to integrating HIV, TB and malaria

**Activity Narrative:** diagnosis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15490

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15490	4706.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$300,000
8473	4706.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASSO; AIC; Conflict	\$300,000
4706	4706.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$300,000

**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

\* TB

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$31,760

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 7207.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 15914.21553.09

**Activity System ID:** 21553

**Mechanism:** TREAT (Timetable for Regional Expansion of ART)/JCRC Follow on

**USG Agency:** U.S. Agency for International Development

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** [REDACTED]

**Activity Narrative:** The USG has been supporting the provision of ART services in Uganda through the Joint Clinical research Center (JCRC) since 2003. Today, JCRC is the leading provider of ART in Uganda with over 40,000 patients, providing ART in 51 static and 25 outreach sites across the country. The static and outreach sites are supported through six regional centers of excellence (RCE) located in Jinja, Mbale, Gulu, Mbarara, Kabale and Fort Portal. In FY 2008, JCRC initiated treatment to over 10,000 new clients bringing the total number of clients on ART to over 40,000. Currently JCRC is the largest single provider of pediatric ART with over 7,600 children accessing treatment. In FY 2008, over 4,000 health workers were trained in clinical care, laboratory services, logistics, community mobilization and pediatric HIV/AIDS care.

Between October 2007 and June 2008, JCRC conducted 216,837 CD4 tests, 15000 DNA PCR tests, and 204,946 chemistry tests through six regional centers of excellences and JCRC centers in Kampala. JCRC is the lead partner in providing laboratory support for the Ministry of Health (MOH) EID program; in providing viral load and CD4 tests for monitoring treatment response and drug failure; and DNA sequencing for HIV Drug resistance testing. The JCRC advanced laboratory is being used as major referral center for Uganda and several African countries in the Great Lakes Region and reports to the national HIVDR Coordinating Center at UVRI.

The cooperative agreement with JCRC has been extended to September 2009 and PEPFAR will continue to support HIV/AIDS prevention, care and support activities through indigenous partnerships which have demonstrated competency and leadership in respective technical areas. During the extension phase, JCRC will transition the majority of the sites beyond the eleven regional referral hospitals to the new district-based mechanism, other PEPFAR partners who overlap in the same facilities and to MOH. To ensure continuity of services, the new mechanism will be awarded by June 2009 to ensure a smooth transition between the current JCRC program and the TBD mechanism.

With more that 140,000 Ugandans on ART and as PEPFAR transitions from an emergency phase to a sustainable program, it is imperative to address quality issues through regular CD4+ monitoring of patient pre-ART and ART phase, annual viral load tests for patients on ART to monitor treatment responses; there is also a need to rapidly increase access to DNA-PCR for early infant diagnosis. Through the TBD mechanism USG will continue to support access to early infant diagnosis. In FY 2009, the program will provide support to nine regional hospital laboratories to provide services for improved laboratory testing for diagnosis of HIV infection and other opportunistic infections and for monitoring patients during care and treatment. The program will support the establishment of effective laboratory networks in districts hosting regional referral hospitals. The program will build the capacity of the district hospitals to provide level appropriate laboratory support to lower health centers (HCIV and HCIII) through referral testing and support supervision; in this JCRC will work closely with the MOH Central Public Health Laboratory. The program will build capacity of regional referral hospitals to provide advanced HIV diseases monitoring services in a consistent manner. The program receives reagents for EID from the Clinton Foundation, a donation to MOH.

Additional resources are required in the subsequent fiscal years for this activity to achieve the objectives highlighted above and to continue to provide the services that are being provided by JCRC including supporting MOH, PEPFAR and non-PEPFAR partners in CD4+ counting, serum chemistries and hematology, DNA and RNA PCR. The need for such lab services will increase exponentially with the rapid scale up of ART services and as the MOH plans to link more service outlets to the EID network which is mainly serviced through JCRC laboratories.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15914

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15914	15914.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$1,400,000

**Emphasis Areas**

Health-related Wraparound Programs

\* TB

Military Populations

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development



**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 21145.21580.09

**Activity System ID:** 21580

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International Development

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$153,333

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, ARV drugs, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to six districts in the East Central region of Uganda including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba. Whereas these districts are estimated to have more than 74,000 people living with HIV, they are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

In the 8 focus districts, the program will provide support to the Directorates of District Health Services (DDHS) and over 16 primary health centers to provide laboratory services for improved laboratory testing for diagnosis of HIV infection and other opportunistic infections and for monitoring patients during care and treatment. Through the DDHS office, the program will support the establishment of effective laboratory networks in the 12 focus districts. The program will build the capacity of the district hospitals to provide laboratory support to lower health centers (HCIVs, HCIII and HCII) through referral testing and support supervision. The program will build capacity of the district hospital to provide quality assurance and train laboratory personnel.

Through support to the districts the program will generate support from the local government structures and provide an environment for a sustainable long-term impact. The program will provide financial and technical support to the District Directorate of Health Services (DDHS) to provide support supervision to health workers in the district and monitor establishment of tiered-quality-assured laboratory networks in the respective districts. Lab strengthening activities will be coordinated with CPHL/MOH activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

## Emphasis Areas

### Gender

- \* Increasing gender equity in HIV/AIDS programs

### Health-related Wraparound Programs

- \* Family Planning
- \* Malaria (PMI)
- \* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$50,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.16: Activities by Funding Mechanism

<b>Mechanism ID:</b> 11128.09	<b>Mechanism:</b> TASO
<b>Prime Partner:</b> The AIDS Support Organization	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 21640.26798.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26798	
<b>Activity Narrative:</b> ACTIVITY UNCHANGED AND ENDING IN DECEMBER 2008. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.	
This activity will focus on community mobilization activities to promote positive behaviors such as: gender equity; couple dialogue; partner counseling and testing; disclosure; and accessing treatment together. Community mobilization activities will also be directed towards elimination of negative behaviors that bring about stigma and discrimination associated with HIV/AIDS. TASO will support to strengthening/setting up of PLHA networks through training and logistics support in 28 districts of Uganda. PLHA networks will increase community mobilization, address stigma, denial and discrimination among PLHAs and their communities, and facilitate referral for treatment. This support is expected to increase the overall capacity of PLHA networks to access additional funding opportunities.	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 21640	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21640	21640.08	U.S. Agency for International Development	The AIDS Support Organization	9320	9320.08	TASO	\$50,000

**Table 3.3.16: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11125.09	<b>Mechanism:</b> IRCU
<b>Prime Partner:</b> Inter-Religious Council of Uganda	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 9455.26787.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26787	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN JUNE 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Inter-Religious Council of Uganda (IRCU) is an indigenous, faith-based organization uniting the efforts of five major religious institutions of Uganda including Catholics, Anglican Protestants, Muslims, Orthodox and Seventh Day Adventists to address mutually identified development challenges. IRCU also works with other religious organizations including Pentecostal and other independent churches. IRCU coordinates the largest network of faith-based health units in Uganda, which together deliver close to 50% of the health care services in Uganda. In June 2006, IRCU initiated a program to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment through the network of faith-based organizations and community-based organizations. This program is funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR).

In general, laboratory services are a crucial part of health care. Without laboratories to diagnose correctly, medical personnel would be challenged to prescribe the right treatment for patients. Yet this aspect of the diagnostic process can be undervalued, resulting in laboratories being under equipped and staff unexposed to continuous process of training in the workplace.

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 care 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.

In FY 2006, IRCU worked with 18 health facilities to establish the infrastructure to enable them carry out basic tests that enhance HIV/AIDS care and support including procuring basic laboratory equipment, Limited refurbishment, training of lab staff and reinforcing the human resource need to carry out the lab tests. Of these 18 labs, 12 are hospital labs while the remaining six are lower health center labs. Through these laboratories, the following test were carried out: 90,000 HIV screening tests, 5,000 TB screening microscopic and radiologic tests, 40,000 baseline syphilis screening tests and 2,000 pregnancy tests. By the end of FY 2008, IRCU will have built the capacity of 28 labs to perform 160,000 HIV screening tests, 20,000 TB screening tests, at least 90,000 CD4 tests, 80,000 syphilis tests, 3,000 pregnancy tests, and 60,000 organ functions tests (Liver and Renal). With the support from Supply Chain Management Systems (SCMS) and Joint Clinical Research Centre (JCRC), IRCU plans to train 112 laboratory staff in: ordering and forecasting of laboratory reagents; logistical inputs to ensure a reliable supply; HCT and other HIV/ART monitoring tests and finally good lab practices. Routine reliability and quality assurance checks will be undertaken to ensure that lab services conform to nationally acceptable standards.

IRCU currently has 24,000 clients enrolled on palliative care and targets to enroll another 20,000 in FY 2007. An additional 31,000 individuals are targeted to receive care in FY 2008. This implies that by the end of FY 2008, IRCU will have over 75,000 PHA receiving care. All these individuals will require routine baseline CD4 tests, lymphocyte counts and hemoglobin levels 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 5,000 patients currently enrolled on ART will continue to have quarterly hemoglobin and lymphocyte estimates and bi-annual CD4 cell counts. Most of the IRCU related labs are limited to performing 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 while these tests are a key ingredient to an efficient ART service.

Therefore, IRCU entered into a Memorandum of Understanding with JCRC to out source laboratory services 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.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14213

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14213	9455.08	U.S. Agency for International Development	Inter-Religious Council of Uganda	6740	3327.08	IRCU	\$350,000
9455	9455.07	U.S. Agency for International Development	Inter-Religious Council of Uganda	4836	3327.07	IRCU	\$300,000



**Table 3.3.16: Activities by Funding Mechansim**

**Mechanism ID:** 11126.09 **Mechanism:** TREAT (Timetable for Regional Expansion of ART)  
**Prime Partner:** Joint Clinical Research Center, Uganda **USG Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State) **Program Area:** Laboratory Infrastructure  
**Budget Code:** HLAB **Program Budget Code:** 16  
**Activity ID:** 15914.26793.09 **Planned Funds:** \$0  
**Activity System ID:** 26793

**Activity Narrative:** ACTIVITY UNCHANGED AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS ARE PLANNED FOR THIS ACTIVITY.

In FY 2008, this activity will focus on training health workers, strengthening and mentoring regional hospitals, districts, private sector including faith-based institutions and other anti-retroviral therapy (ART) providers to scale-up ART services district-wide, and infrastructure development for increased clinical space for ART in rural health centers and improved laboratory infrastructure and services for diagnosis and monitoring of treatment for tuberculosis (TB) and HIV.

In the 25 focus districts, the program will provide support to the Directorates of District Health Services (DDHS), six regional hospital laboratories and over 60 primary health centers to provide laboratory services for improved laboratory testing for diagnosis of HIV infection and other opportunistic infections and for monitoring patients during care and treatment. Through the DDHS office, the program will support the establishment of effective laboratory networks in the focus districts. The program will build the capacity of the district hospitals to provide laboratory support to lower health centers (HCIVs, HCIII and HCII) through referral testing and support supervision. The program will build capacity of the district hospital to provide quality assurance and train laboratory personnel.

At least 10 of the 60 health facilities will be designated as regional referral hubs for CD4+ testing and infant diagnosis and two centers for viral load and TB culture. In addition the program will support at least six regional centers to a status of a Regional center of Excellence to provide highly specialized HIV and TB diagnostic testing and support supervision. In FY2008, the program will train over 100 non-laboratory technicians to carry out microscopy work in the laboratories and also provide in-service training for 100 laboratory technicians.

Through support to the districts the program will generate support from the local government structures and provide an environment for a sustainable long-term impact. The program will provide financial and technical support to the District Directorate of Health Services (DDHS) to provide support supervision to health workers in the district and monitor establishment of a tiered-quality-assured laboratory networks in the focus districts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15914

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15914	15914.08	U.S. Agency for International Development	Joint Clinical Research Center, Uganda	7207	7207.08	TREAT (Timetable for Regional Expansion of ART)	\$1,400,000

**Table 3.3.16: Activities by Funding Mechansim**

**Mechanism ID:** 7253.09 **Mechanism:** TBD - Districts South-Southwest  
**Prime Partner:** To Be Determined **USG Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (State) **Program Area:** Laboratory Infrastructure  
**Budget Code:** HLAB **Program Budget Code:** 16

Activity ID: 15924.24029.09

Planned Funds: [REDACTED]

Activity System ID: 24029

Activity Narrative: This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult and pediatric), TB/HIV, ARV drugs, Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to nine districts in the West and South Western regions of Uganda including Bulisa, Kibaale, Kamwenge, Kyenjojo, 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. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services. This activity will expand to other underserved districts in subsequent years.

In addition to supporting expanding delivery of HIV/AIDS services, this activity will also support capacity of decentralized health delivery system 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.

In the 8 focus districts, the program will provide support to the Directorates of District Health Services (DDHS) and over 17 primary health centers to provide laboratory services for improved laboratory testing for diagnosis of HIV infection and other opportunistic infections and for monitoring patients during care and treatment. Through the DDHS office, the program will support the establishment of effective laboratory networks in the 12 focus districts. The program will build the capacity of the district hospitals to provide laboratory support to lower health centers (HCIVs, HCIII and HCII) through referral testing and support supervision. The program will build capacity of the district hospital to provide quality assurance and train laboratory personnel.

Through support to the districts the program will generate support from the local government structures and provide an environment for a sustainable long-term impact. The program will provide financial and technical support to the District Directorate of Health Services (DDHS) to provide support supervision to health workers in the district and monitor establishment of tiered-quality-assured laboratory networks in the respective districts. Lab strengthening activities will be coordinated with CPHL/MOH activities.

New/Continuing Activity: Continuing Activity

Continuing Activity: 15924

Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15924	15924.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	[REDACTED]

### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development



### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

Table 3.3.16: Activities by Funding Mechanism

**Mechanism ID:** 7204.09

**Prime Partner:** Management Sciences for Health

**Funding Source:** GHCS (State)

**Budget Code:** HLAB

**Activity ID:** 21647.24019.09

**Activity System ID:** 24019

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**USG Agency:** U.S. Agency for International Development

**Program Area:** Laboratory Infrastructure

**Program Budget Code:** 16

**Planned Funds:** \$153,333

**Activity Narrative:** This activity relates to PMTCT, VCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), Health systems strengthening, and Strategic information.

The activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP08.

The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

In FY 2009, this activity will focus on increasing rural access to HIV/AIDS care and treatment through support to eight districts in the Eastern region of Uganda including Busia, Budaka, Bududa, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. These districts are among those districts underserved by USG and non-USG funded partners. This 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 to strengthen care and treatment service delivery systems at health center IV's, III's and build community outreaches that serve to provide intermediate care and generate demand for facility based services. The program will also 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, coverage of and utilization of care and treatment services.

In the 8 focus districts, the program will provide support to the Directorates of District Health Services (DDHS) and over 16 primary health centers to provide laboratory services for improved laboratory testing for diagnosis of HIV infection and other opportunistic infections and for monitoring patients during care and treatment. Through the DDHS office, the program will support the establishment of effective laboratory networks in the 12 focus districts. The program will build the capacity of the district hospitals to provide laboratory support to lower health centers (HCIVs, HCIII and HCII) through referral testing and support supervision. The program will build capacity of the district hospital to provide quality assurance and train laboratory personnel.

Through support to the districts the program will generate support from the local government structures and provide an environment for a sustainable long-term impact. The program will provide financial and technical support to the District Directorate of Health Services (DDHS) to provide support supervision to health workers in the district and monitor establishment of tiered-quality-assured laboratory networks in the respective districts. Lab strengthening activities will be coordinated with CPHL/MOH activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21647

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21647	21647.08	U.S. Agency for International Development	To Be Determined	10369	10369.08	Districts East	████████

### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning

- \* Malaria (PMI)

- \* TB

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$50,000

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 3327.09

**Mechanism:** HIV/AIDS Service Delivery Through FBOs/IRCU Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 23917.09

**Planned Funds:** ██████████

**Activity System ID:** 23917

**Activity 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 care 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 are 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. As at March 2008, the following test were carried out through these laboratories: 58,115 HIV screening tests, 3,769 TB screening microscopic and radiological tests, 7,008 baseline syphilis screening tests and 11,641 HIV disease monitoring tests.

USAID/Uganda's partnership with IRCU ends in June 2009. USAID/Uganda plans to initiate a follow on program 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 45,000 clients enrolled on palliative care and this number is projected to rise to 55,000 by June 2009 when then current program ends. By the end of FY 2009, it is estimated that IRCU will have enrolled over 60,000 individuals (adults and children) in care and treatment. All these individuals will require routine medical tests to better inform basic palliative care management options, particularly with respect to OI management. 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 3,000 patients currently enrolled on ART will continue to have quarterly hemoglobin and lymphocyte estimates and bi-annual CD4 cell counts.

Most of the IRCU related labs are limited to performing 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 while 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.

Based on the projected number of clients to be served, it is estimated that by the end of FY 2009, the IRCU follow on program will have further built the capacity of the existing labs to perform 78,000 HIV screening tests, 5,000 TB screening tests, at least 15,600 CD4 tests, 9,500 syphilis tests, 1,000 pregnancy tests, and 0 organ functions tests (Liver and Renal).

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.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

\* TB

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.16: Activities by Funding Mechanism

**Mechanism ID:** 3481.09

**Mechanism:** CDC GHAI

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 27236.09

**Planned Funds:** \$380,000

**Activity System ID:** 27236

**Activity Narrative:** This activity is not new - according to the FY 2009 COP Guidance Clarifications [October 24, 2008], third party company contractors such as CTS Global (COMFORCE) should be teased out. The 261 staff total includes 8 non-personal services contractors, who have been hired through a contract with COMFORCE. CDC Atlanta issued a cost-reimbursement agreement to COMFORCE in March 2006 to provide field offices with a mechanism to hire individuals to provide much needed technical expertise in-country.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 17 - HVSI Strategic Information

**Total Planned Funding for Program Budget Code: \$17,523,972**

## Program Area Narrative:

The USG SI Program Area provides technical oversight and expertise in: 1) support for M&E of overall PEPFAR country performance; 2) strengthening national surveillance activities; 3) supporting the development and maintenance of HIV/AIDS management information systems (MIS) within GOU and USG IPs; 4) SI capacity building for the MOH, Uganda AIDS Commission (UAC) and Ministry of Gender, Labour, and Social Development (MoGLSD); 5) data support and statistical analyses

of PEPFAR funded activities; and 6) participation in PHEs with dissemination of primary findings.

In order to more fully implement these activities, a full-time SI Liaison was recruited in FY08 as a key member of the PEPFAR Coordinator's office. This individual will help coordinate and facilitate all SI and related activities and ensure that a coherent strategy is implemented. The SI team includes staff from USG agencies with expertise in M&E, epidemiology, surveillance, Management Information Systems and PHEs. This team works with other PEPFAR TWGs to strengthen their SI related activities, reinforce planning, implementation and coordination of IP activities.

#### Country Context

A key objective of Strategies for Strengthening Systems within the National HIV/AIDS Strategic Plan, 2007/8-2011/12 (NSP) is "to effectively coordinate collection, analysis, use, and provision of information that will enable tracking the progress made in the national response to HIV/AIDS." In order to determine progress of the NSP, the Performance Measurement and Management Plan (PMMP) was finalized in FY08. This is a major step towards ensuring a single country-level M&E system for HIV/AIDS. The goal of the Plan is to harmonize existing systems of data collection, reporting and review, and facilitate M&E and data use in policy-making, implementation and resource allocation. The National Joint AIDS Review (JAR) held in October 2008 recommended that national data systems within all sectors be strengthened to capture HIV/AIDS, social and health indicators. It also recommended that the Uganda National Research Organization and Makerere University Institute of Social Research take a lead in strengthening the national capacity to undertake and coordinate priority HIV and AIDS-related research to inform strategy and programming.

The UAC Report on the Implementation of the NSP October 2008 highlights last year's achievements:

1. Irish AID provided a 3-year grant to the Ministry of Local Government to improve data management within 50 districts.
2. Facility level data management and reporting improved: 77% of facilities were reporting by mid 2008 compared to 52% in June 2006.
3. Data quality assurance of routine HMIS reporting is improving, although additional financial and technical support for the Resource Center (RC) are still needed
4. MOH established the HIV Drug Resistance Working Group (HIVDR WG) to implement the National Plan for ARV Drug Resistance Monitoring. Last year, the HIVDR WG conducted a survey on Early Warning Indicators (EWI) at 41 ART sites and a threshold DR survey.

The UAC cited the following challenges:

1. Weak, slow and unreliable information and reporting systems at local and national levels, despite investments in the MOH and MoLGSD.
2. Poor coordination, harmonization and data quality of HIV/AIDS and health indicators within the various government sectors and among donors.
3. Local government M&E systems are extremely weak, and lack both human and physical infrastructure.
4. Lack of dedicated M&E staff at the majority of ART sites.
5. Coordination among multiple donors at sites is poor, resulting in both multiple and inadequate reporting to HMIS. Systems and reporting are often based on individual agency needs.
6. Limited demand for data use at all levels.
7. Limited capacity at the local level to make use of data, coupled with lack of data feedback to sites generating the data.
8. No national system for M&E of HIV/AIDS social support services. There is limited financial support and technical guidance for M&E of social support activities at all levels.

The SI TWG also notes the following challenges:

1. Lack of adequate M&E capacity within many IPs. Most partners have M&E staff, although many are not appropriately trained or supervised.
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.

UAC developed a 2-year operational plan, the National Priority Action Plan (NPAP), to guide all stakeholders and which makes the following recommendations:

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; harmonize M&E indicators from NSP, 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

#### FY08 Accomplishments:

HMIS: The SI team formed an HMIS sub-working group to develop a strategy to help address the many issues facing the national HMIS system. The USG worked with the MOH Resource Center (RC) to convene a series of meetings aimed at mapping and coordinating the activities of the multiplicity of stakeholders and donors involved. Several HMIS reviews were performed by donors e.g. Belgian Technical Cooperation and DANIDA, which also assisted the MOH/RC to develop a central server and data base. USG requested and received support from the OGAC HMIS Working Group to work with the SI TWG, WHO and other stakeholders to review the HMIS strategy. This resulted in a strategic plan called Vision 2012, that outlines activities the RC needs to implement to develop and operationalize a vibrant HMIS. The Laboratory MIS for MOH and Central Public Health Laboratory was supported by USG and DANIDA to effectively monitor needs of service delivery sites and track lab and drug commodities. PEPFAR continued to work with the Uganda People's Defense Force to strengthen their HMIS and institute quality assurance systems for improved HIV service delivery.



The SI TWG performed reviews to inform FY09 programming. This included participation in a health facility mapping workshop, efforts towards coding facilities and harmonizing indicators for health facility assessments, and site visits to evaluate HMIS capacity. USG reviewed and will continue to support the various HMIS data management and reporting systems used by USG and its partners, including web-based systems and Epi-Info.

**Surveillance:** The protocol for the joint Malaria and AIDS Indicator Survey was developed and submitted for IRB clearance, with logistical preparations in the final stages. Annual ANC sentinel surveillance was conducted at 30 sites. Testing of samples is taking place, after which data analysis and dissemination of results should occur.

Secondary analysis of the UDHS (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. The Most at Risk Populations (MARP) survey was conducted with excellent recruitment of clients using Respondent Driven Sampling and Audio Computer Assisted Self Interview (ACASI) methods. USG actively participated in the HIVDR WG that was established as a subgroup of the National MOH ART TWG. The WG conducted surveys on Early Warning Indicators and transmitted HIV drug resistance.

To inform GOU and PEPFAR with specific information on key program issues, USG supported the following PHEs. Details are described in the activity narratives.

- 1) The "Last 1000 infections", to evaluate the utility of re-testing HIV-negative VCT clients to identify "window period" infections. Laboratory testing began and will continue in FY09.
- 2) Continuation of HBAC I, to evaluate the relative utility of viral load versus CD4 cell monitoring.
- 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. Field work will be completed by end calendar 2008.
- 5) Evaluating home-based confidential counseling and testing in Kumi and Bushenyi Districts. Field activities have ended; current efforts focus on data cleaning.
- 6) PHAs 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.
- 8) Assessing the relationship between intimate partner violence and HIV status disclosure in Rakai District. This activity is awaiting IRB approval.
- 9) Evaluating two types of male circumcision procedures. Protocol revision is taking place based on comments from OGAC.

**M&E.** The functionalities of the dedicated SQL database to collect and consolidate PEPFAR indicator data from all partners were enhanced. This system was 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 understanding of indicator reporting requirements and improve M&E capacity. Data Quality Assessments and site visits were conducted for PMTCT, Care, ART, TB, SI; training on data management occurred within all program areas. USG continued to work with MoGLSD to develop a national M&E system for OVC. USG shared PEPFAR results for FY08 SAPR and APR with the GOU, UNAIDS, UNICEF, WHO and other major stakeholders.

Efforts to improve the ability of partners to collect and analyze their program data continued. Training was provided to implementing partners on STATA, Epi-Info, and electronic registries. Evaluation of various Electronic Medical Record (EMR) systems was undertaken, and assistance provided to IPs in either developing an EMR or ensuring that their current system was appropriate. The development of an electronic registry system was completed and installed at several partner sites, improving their ability to track visits and triage clients

USG supported the piloting of new technologies for data collection including a review of various portable devices such as mobile phones and personal digital assistants (PDA). It is expected that PDAs will be used for reporting facility-based data, helping to overcome the problems with lack of computer infrastructure and support. ACASI technology is also being used. An evaluation of Health Commodities Distribution Systems was completed and included an assessment of MIS of the National Medical Stores.

#### FY09 Plans:

**HMIS:** In FY09, USG will actively participate in the scheduled revision of HMIS tools and indicators. The USG strategy to support the Vision 2012 and HMIS activities will be developed and guided by the strategic vision of MOH. In support of national reporting, an SI meeting with IPs will be convened to discuss obstacles and barriers to reporting to HMIS, and to ensure that IPs report to the District level using appropriate HMIS forms. The goal of having single rather than multiple reports from each facility will be stressed.

USG will support the roll-out of the PMMP, assist UAC in disseminating the Plan, and work with IPs to report on PMMP indicators. Special effort will be made to support the collection, collation and analysis of data on community based activities. In addition, the USG will continue to participate in the National M&E Technical Working Group.

**M&E:** SI will work closely with PEPFAR TWGs to review partner targets, provide on-going technical assistance to guarantee adequate understanding of PEPFAR indicators and reporting requirements, and to minimize double counting within and across IPs. Challenges include comparing trends in PEPFAR I to PEPFAR II indicators, and trying to reconcile the PEPFAR definition of palliative care with the national and international recognition of HCT as part of prevention.

Efforts to increase data use for planning and decision making among PEPFAR funded IPs will continue to be a major activity. The SI TWG will work with other TWGs to help build institutional M&E capacities. This requires an evaluation of M&E staffing and skill levels, and greater technical assistance, training, and support supervision in data management and analysis. The SI TWG will work towards harmonizing USG program reporting and indicators to reduce reporting time and improve data quality. In addition, SI will assist programs to generate and analyze data that can inform planning and indicate the extent to which PEPFAR programs are making an impact. A situation analysis of service delivery models for OVC will be conducted.

Surveillance: USG will continue to support the implementation of ANC sentinel surveillance, and the timely availability of data and reports. Surveillance of MARP will continue, with completion of recruitment of all groups, except for female partners of MSM, who have proven more difficult to access. Uganda's second AIS will be merged with the Malaria Indicator Survey and completed. Part of this survey will include the piloting of ACASI as a data collection tool for national surveillance activities. USG will work with MOH to develop a national strategic surveillance plan for HIV/AIDS, particularly with respect to the timeline, scope and frequency of key surveillance activities. A pilot evaluation of incidence-based HIV surveillance will take place using PMTCT program data and lab-based incidence testing. A bio-behavioral surveillance activity to evaluate determinants for HIV acquisition in a routine VCT setting is also planned. 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. .

PHEs: In FY09, of the nine active PHEs, five will be continued and four completed. Several new multi-country and country-specific PHEs have been proposed and are pending approval by OGAC.

**Table 3.3.17: Activities by Funding Mechansim**

<p><b>Mechanism ID:</b> 8655.09</p> <p><b>Prime Partner:</b> To Be Determined</p> <p><b>Funding Source:</b> GHCS (State)</p> <p><b>Budget Code:</b> HVSI</p> <p><b>Activity ID:</b> 4424.26515.09</p> <p><b>Activity System ID:</b> 26515</p>	<p><b>Mechanism:</b> Teachnical Assistance for data use/M&amp;E systems strengthening for Implementing Partners</p> <p><b>USG Agency:</b> HHS/Centers for Disease Control &amp; Prevention</p> <p><b>Program Area:</b> Strategic Information</p> <p><b>Program Budget Code:</b> 17</p> <p><b>Planned Funds:</b> ██████████</p>
---	--

**Activity Narrative:** In FY 2009 the university technical assistance (UTA) mechanism will be competed to continue provision of high quality expert technical support for PEPFAR programs in Uganda. The focus of this assistance will be in three key program areas.

Treatment services technical assistance will be concentrated on enhancing comprehensive care and treatment interventions to strengthened partners' clinical programs. In FY08 the primary focus will be to review patient management and record keeping systems at treatment sites and identify areas and implement improvements in the clinic operations to substantially improve patient outcomes.

The strategic information component of UTA will be to assist the PEPFAR program in using the substantial amounts of program area data collected over the past five years in combination with country surveillance data to provide a better understanding of PEPFAR outcomes and contributions to the national portfolio. Examining the data from multiple sources will provide the country team will a more comprehensive analysis to assist with future programming directions.

In addition, this component of the follow-on will focus on—1) To assist in providing training and technical assistance to develop the capacity of Implementing Partners (IP) to perform meaningful quantitative program monitoring and evaluations, and 2) to assist Implementing Partners to perform HIV care and ART outcome evaluations.

The need for this technical assistance is based on the uneven skill level of PEPFAR supported IPs to perform M&E particularly program impact evaluations, the range of data collection and management systems being used from paper-based to highly sophisticated web-based platforms, and the large number of IPs and sites that require assistance. In addition, the ability to determine the impact of PEPFAR programming requires moving beyond aggregate indicator reporting, to more detailed evaluations of individual program outcomes. This is particularly true for care and treatment programs, in which the loss to follow-up, mortality rate, morbidity, and adherence to medications are not known for the vast majority of partners. These outcomes are critical for individual programs to assess how well they are meeting the clinical and treatment needs of their clients, to determine the extent of loss to follow-up and how to address it, and to determine whether the choice of treatment regimens being used are appropriate for their context. Measures of adherence are inconsistently applied and difficult to interpret. Finally, there are currently numerous reporting requirements of IPs including the CDC quarterly report, PEPFAR aggregate indicator reporting, the MOH HMIS reports and ART cards, HIVQUAL assessments for those facilities being evaluated, and early warning indicators (EWI) for drug resistance, surveys of which are being performed by the MOH HIV Drug Resistance Working Group. All these reporting requirements and most indicators are overlapping but are currently assessed individually, resulting in inefficient use of IP data management capacity, incomplete reporting of indicators across sites, and variable data that is difficult to compare. Ideally, almost all indicators could easily be collected with routine data collection instruments, and reports and outputs programmed in advance so that data are generated routinely and without undue and costly time inputs.

The selected partner providing this technical assistance will work closely with and under the guidance and supervision of both the CDC Program Unit and the Informatics Unit. The partner will have technical experience and capacity in data management, systems and statistical analysis; M&E; epidemiology; providing training, workshops and support supervision; be familiar with the country context; understand the components of program evaluations and relevant HIV clinical outcomes; be familiar with IRB and NRD protocol requirements and reviews.

Specifically, the partner will provide technical assistance to CDC Uganda in the following. 1) Review and evaluation of current data management capacity of IPs with recommendations for needed staffing, training, and support supervision. 2) Assist in the review of all indicators across reporting formats; assist in the harmonization of those indicators to reduce reporting burden, and improve consistency and data quality. 3) Provide workshops, training, and hands-on support supervision to IPs on data collection, management and analysis; routine M&E; and program evaluations, including protocol development and ethical issues. 4) Develop and implement a method of assessing the utility and impact of these trainings, revising them based on these assessments. 5) Assist CDC-Uganda and selected IPs with adequate capacity to develop and implement protocols for HIV care and treatment (ART) outcome evaluations, including submission for clearance to appropriate review boards.

For systems strengthening/policy development the UTA technical expertise will be transferred to local partners through a series of in-country workshops for advanced data analysis and triangulation and training on how to interpret the results for policy guidance and program direction; and, training on how to prepare technical presentations and manuscripts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13326

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13326	4424.08	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	8655	8655.08	UCSF	\$600,000
8372	4424.07	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	4818	1273.07	University of California San Francisco - UTAP	\$490,000
4424	4424.06	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	3345	1273.06	University of California San Francisco - UTAP	\$490,000

**Table 3.3.17: Activities by Funding Mechansim**

**Mechanism ID:** 1270.09  
**Mechanism:** Randomized Trail of Home or Facility - Based AIDS Care  
**Prime Partner:** Medical Research Council of Uganda  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State)  
**Program Area:** Strategic Information  
**Budget Code:** HVSI  
**Program Budget Code:** 17  
**Activity ID:** 4691.24362.09  
**Planned Funds:** \$0  
**Activity System ID:** 24362  
**Activity Narrative:** This PHE activity 'Comparison of Facility and Home-Based Antiretroviral Therapy Delivery Systems in Uganda' was approved for inclusion in the COP. The PHE tracking ID associated with activity is 'UG.07.0158'.  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 13282

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13282	4691.08	HHS/Centers for Disease Control & Prevention	Medical Research Council of Uganda	6432	1270.08	Randomized Trail of Home or Facility - Based AIDS Care	\$650,000
8331	4691.07	HHS/Centers for Disease Control & Prevention	Medical Research Council of Uganda	4807	1270.07		\$550,000
4691	4691.06	HHS/Centers for Disease Control & Prevention	Medical Research Council of Uganda	3438	1270.06		\$450,000

<b>Emphasis Areas</b>	
<b>Human Capacity Development</b>	
<b>Public Health Evaluation</b>	
Estimated amount of funding that is planned for Public Health Evaluation	\$0
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>	
<b>Food and Nutrition: Commodities</b>	
<b>Economic Strengthening</b>	
<b>Education</b>	
<b>Water</b>	

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 23938.09

**Planned Funds:** \$250,000

**Activity System ID:** 23938

**Activity Narrative:** This PHE activity 'Evaluating Two Types of Male Circumcision Procedures' was approved for inclusion in the COP. The PHE tracking ID associated with this activity is 'UG.08.0166'.

This is not a new activity but a continuation of Activity ID 10102.08, which is not brought in the list of continuing activities when I click on the "Modify Continued Activity Information" tab below.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$250,000

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechansim**

**Mechanism ID:** 3481.09

**Mechanism:** CDC GHAI

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 4821.23946.09

**Planned Funds:** \$2,400,000

**Activity System ID:** 23946

**Activity Narrative:** This PHE activity 'Home Based AIDS Care Project' was approved for inclusion in the COP. The PHE tracking ID associated with this activity is 'UG.07.0159'.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13331

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13331	4821.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$2,400,000
8373	4821.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4819	3481.07		\$3,451,142
4821	4821.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3481	3481.06		\$1,757,445

**Emphasis Areas****Human Capacity Development****Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$2,400,000

**Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water****Table 3.3.17: Activities by Funding Mechanism****Mechanism ID:** 1284.09**Mechanism:** Full Access Counseling and Testing**Prime Partner:** Kumi Director of District Health Services**USG Agency:** HHS/Centers for Disease Control & Prevention**Funding Source:** GHCS (State)**Program Area:** Strategic Information**Budget Code:** HVSI**Program Budget Code:** 17**Activity ID:** 10038.24048.09**Planned Funds:** \$0**Activity System ID:** 24048**Activity Narrative:** This PHE activity 'Evaluating Home-Based Counseling and Testing in Kumi and Bushenyi Districts, Uganda' was approved for inclusion in the COP. The PHE tracking ID associated with activity is 'UG.07.0156'.**New/Continuing Activity:** Continuing Activity**Continuing Activity:** 15907**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15907	10038.08	HHS/Centers for Disease Control & Prevention	Kumi Director of District Health Services	7288	1284.08	Full Access Counseling and Testing	\$50,000
10038	10038.07	HHS/Centers for Disease Control & Prevention	Kumi Director of District Health Services	4804	1284.07	Full Access Counseling and Testing	\$110,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$0

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Prime Partner:** To Be Determined

**Funding Source:** GHCS (State)

**Budget Code:** HVSI

**Activity ID:** 24414.09

**Activity System ID:** 24414

**Mechanism:** TBD - Districts South-Southwest

**USG Agency:** U.S. Agency for International Development

**Program Area:** Strategic Information

**Program Budget Code:** 17

**Planned Funds:** [REDACTED]



**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and health systems strengthening.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – West/South West will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus support to 9 districts in the Western region of the country. As a follow up to previous efforts by UPHOLD, UNICEF and Uganda AIDS Control Programs (UACP), the district based HIV/AIDS/TB program – West/South West will continue focusing on activities aimed at promoting evidence-based planning and decision making at district and lower levels. The districts to be covered by this project will include Bulisa, Kibaale, Kamwenge, Kyenjojo, Isingiro, Kanungu, Ibanda, Kisoro and Kiruhura. Evidence-based planning and decision making will be achieved through regular measurement of program performances and progress in all the districts that this program will operate. 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 other civil society reporting tools developed under the new civil society fund as well as through the annual Lot Quality Assurance Sampling (LQAS) survey. Up to FY 2008, LQAS has been carried out in 43 UPHOLD and NUMAT districts as well as some UNICEF districts. LQAS was previously supported through the World Bank MAP project in selected other districts. Under the FY 2009 activity (new design), the mission will work closely with the GOU to determine the best way to transfer ownership and management of the annual survey. From FY 2009 onwards under the three new district-based activities, LQAS survey will be conducted annually in approximately 50 districts in order track coverage and utilization of key indicators related to program performance. LQAS will be supported at the national level by one of the HIV/AIDS/TB projects to provide one major source of data/information for the USG programs. Key stakeholders such as line ministries, local government authorities, civil society organizations and other implementing partners will be involved in the development of questionnaires of this survey. 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. LQAS will also track indicators under the President's Malaria Initiative (PMI).

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7204.09	<b>Mechanism:</b> Eastern Region - HIV/AIDS & TB Program
<b>Prime Partner:</b> Management Sciences for Health	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 24061.09	<b>Planned Funds:</b> \$251,745
<b>Activity System ID:</b> 24061	

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and health systems strengthening.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program - Eastern will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

This activity that will focus support to 8 districts in the Eastern region of the country. As a follow up to previous efforts by UPHOLD, UNICEF and Uganda AIDS Control Programs (UACP), the district based HIV/AIDS/TB program – Eastern will continue focusing on activities aimed at promoting evidence-based planning and decision making at district and lower levels. Districts to be covered in this region include: Busian, Budaka, Bukwa, Butaleja, Kapchorwa, Pallisa and Sironko. Evidence-based planning and decision making will be achieved through regular measurement of program performances and progress in all the districts that this program will operate. 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 other civil society reporting tools developed under the new civil society fund as well as through the annual Lot Quality Assurance Sampling (LQAS) survey. Up to FY 2008, LQAS has been carried out in 43 UPHOLD and NUMAT districts as well as some UNICEF districts. LQAS was previously supported through the World Bank MAP project in selected other districts. Under the FY 2009 activity (new design), the mission will work closely with the GOU to determine the best way to transfer ownership and management of the annual survey. From FY 2009 onwards under the three new district-based activities, LQAS survey will be conducted annually in approximately 50 districts in order track coverage and utilization of key indicators related to program performance. LQAS will be supported at the national level by one of the HIV/AIDS/TB projects to provide one major source of data/information for the USG programs. Key stakeholders such as line ministries, local government authorities, civil society organizations and other implementing partners will be involved in the development of questionnaires of this survey. 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. LQAS will also track indicators under the President’s Malaria Initiative (PMI).

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.17: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3456.09	<b>Mechanism:</b> MEEPP (Monitoring and Evaluation of the Emergency Plan Program)
<b>Prime Partner:</b> Social and Scientific Systems	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 4766.26794.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26794	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN DECEMBER 2009. NO FY 2009 FUNDS GOING TO ACTIVITY.

The Monitoring and Evaluation of the Emergency Plan Progress (MEEPP) was launched in January 2005. The purpose of this program is to design, implement and maintain a comprehensive PEPFAR performance management, monitoring and reporting system. The MEEPP program is similarly charged with supporting the USG PEPFAR team and its implementing partners (IPs), using performance improvement processes and targeted technical assistance, to report high quality data in a timely and efficient manner in accordance with OGAC's strategic information requirements. The programme is also required to establish strong linkages with host country institutions that are involved in the monitoring of HIV / AIDS activities in the context of the national response. This activity is a continuation from FY 2007 and has been updated for FY 2008.

MEEPP has now fully institutionalized a web-based database that has facilitated PEPFAR data aggregation, analysis and use through five reporting cycles. The database is fully operational and is continuously upgraded to respond to changes in PEPFAR requirements and to increase the user friendliness for both Emergency Plan (EP) implementing partners and the USG PEPFAR team. MEEPP staff has been busy working with the EP strategic information team to improve existing data gathering tools and to train PEPFAR implementing partners in the use of these tools and the new database to standardize data reporting across all 70 or so Emergency Plan partners in accordance with OGAC guidance. MEEPP has also established effective communication and networking channels between partners facilitating the sharing of best practices and lessons learned in M&E. In this way, MEEPP has played a critical role in the preparation of the EP Semi-Annual and Annual Reports as well as validating the reported data. As of 30th March 2007, MEEPP had conducted participatory Data Quality Assessment and Validation with 31 Prime Partners at a total of 269 service outlets. The outcome of this exercise has been an improvement in the quality of data as manifested in the subsequent reporting cycles. During the SAPR 2007, the 31 Prime Partners contributed 97 % of the HCT, 93 % of the ART, 98 % of the PMTCT, 95 % of the Palliative Care and 95 % of the OVC data.

MEEPP has worked closely with the EP strategic information team to use the results of these assessments and validations to target MEEPP technical assistance to particular implementing partners facing M&E challenges and improving/upgrading their information management systems and thus the quality and timeliness of data reported. In addition to the special studies that had been undertaken to support improved ART programming including a mapping of all USG ART sites in Uganda and a comprehensive ART program review, MEEPP has been integrally involved in five Special Studies that focused on assessing the factors underlying discrepant reporting by IPs at the same service outlet; assessing the level of overlap of clientele across ART and Palliative Care service outlets; validating the USG indirect OVC support for SAPR 07; validating ART indirect USG support for APR 06 and SAPR 07 and validating HCT and PMTCT indirect USG support for APR 06 and SAPR 07. The preliminary results from these studies are already pointing at specific action points that need to be taken to register further improvement in the quality of both direct and indirect EP data at the aggregate level as well as the national host country level.

In support of FY 2006 and FY 2007 planning meetings, MEEPP prepared - and subsequently updated - a series of data analyses providing important insights regarding progress against set targets and coverage of PEPFAR supported interventions identifying opportunities for improved collaboration among partners. These documents included HIV burden by districts worksheets and comparative analyses of reported achievements against FY 2004, FY 2005, FY 2006 and, FY 2007 targets across all implementing partners in all 14 PEPFAR program areas. These documents are the main tools for the target setting refresher trainings organized by MEEPP and engaging all USG PEPFAR Technical Working Groups and training program managers in the use of detailed data trend tools to better support their IPs in target setting/estimation. An updated set of these tools was prepared and utilized for the FY 2008 Country Operational Planning exercise. The main objective of these data trend orientation and "how-to" target setting sessions is to introduce MEEPP generated Country Operational Planning resource materials, jointly analyze performance data trends, raise awareness on key findings related to HIV burden and important results of the Uganda HIV/AIDS sero-behavioral survey, identify "windows of opportunity" to adjust programs to maximize data driven programming and encourage constructive dialogue between Cognizant Technical Officers (CTOs) / Project Officers and their respective implementing partners on areas of programmatic and/or target setting concerns.

In response to increasing demand for MEEPP services from the USG PEPFAR team to support the M&E needs of the growing PEPFAR/Uganda portfolio and its numerous continuing and new implementing partners, MEEPP was facilitated to hire additional staff. In FY 2006, the USG PEPFAR team was supported by OGAC to increase funding to MEEPP in order to hire an additional M&E specialist, a data manager/analyst and a program assistant. This increase in staff has been instrumental in enabling MEEPP to further the implementation of its comprehensive performance management, monitoring and reporting system and to maintain – and upgrade as necessary - the functionality of the online database. This human resource strength will be further utilized to strengthen the Emergency Plan M&E capacity and also the capacity of the relevant host country institutions during FY 2008.

In FY 2008, MEEPP will continue to work with all PEPFAR implementing partners to build capacity in monitoring and evaluation, especially so for those that have suffered marked attrition of M&E personnel, and to ensure that quality data collection and reporting systems are in place. All key M&E staff within implementing partner organizations will be trained or retrained in data quality assessment, reporting readiness and in the use of data for performance improvement. MEEPP will conduct Data Quality Assessments and data validations in collaboration with ten additional prime partners and will place particular attention on validating reported training data in order to maintain high quality and timely reporting for PEPFAR. A total of five Special Studies will be conducted in response to the programmatic and performance improvement questions identified by the USG PEPFAR strategic information team and the Technical Working Groups. MEEPP will take advantage of the growing volume of Emergency Plan data for a series of in-depth trend analyses to inform the individual IPs and the PEPFAR team in strategic

**Activity Narrative:** information management and overall planning and performance monitoring. Accordingly, MEEPP will continue to support the target setting and analytical agenda of each of the USG PEPFAR technical working groups in order to ensure timely attainment of Uganda's PEPFAR targets and increasingly fine tune PEPFAR programming to effectively and efficiently address key drivers of the HIV/AIDS epidemic in Uganda. As importantly, MEEPP will continue to support the analytical agenda of the EPT for gender related issues. MEEPP's on-line data collection and reporting system facilitates examination of gender issues across prevention, care and treatment programming within the USG EP response in Uganda.

In response to the findings of the recently conducted special studies on validation of the USG Indirect support, MEEPP, in close consultation with AIDS Capacity Enhancement program (ACE), will work closely with the Monitoring and Evaluation teams of the Ministries of Health (AIDS Control Programme) and Gender and Social Development (OVC Secretariat) to strengthen Data Quality Assessment (DQA) and Validation for the Indirect outputs (HCT, PMTCT, ART, PC (Including TB/HIV) and OVC. The expected output will be strengthened HIV/AIDS and OVC M & E systems in the respective ministries. MEEPP will also assist in the dissemination of the best practices amongst implementing partners, host country counterparts and development partners through a variety of dissemination modalities including technical meetings, seminars, trainings and a series of communication products including contributions to a quarterly newsletter by the Uganda AIDS Commission, as appropriate. In addition, MEEPP will continue to work closely with the PEPFAR supported implementing partner, AIDS Capacity Enhancement program (ACE) in its work with the Uganda AIDS Commission to advance HIV/AIDS stakeholders toward the application of and adherence to "One Monitoring and Evaluation System" through the operationalization of Uganda's HIV/AIDS National Strategic Plan 2007/2008-2011/2012 (NSP). MEEPP will also coordinate closely with the CDC informatics Team and ACE in their work to support the MOH/Resource Center's strengthening / expansion of the HMIS and ensure that all USG PEPFAR implementing partners upgrade and/or build HIV/AIDS information management systems that can easily link to the HMIS and provide the GOU with key HIV/AIDS information. The emphasis on closer participatory involvement in strategic information activities between MEEPP and the host country institutions responsible for monitoring the national HIV/AIDS response is yet another step in strengthening the sustainability of this vital component of portfolio management at the national level.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14242

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14242	4766.08	U.S. Agency for International Development	Social and Scientific Systems	6752	3456.08	MEEPP (Monitoring and Evaluation of the Emergency Plan Program)	\$2,250,000
4766	4766.06	U.S. Agency for International Development	Social and Scientific Systems	3456	3456.06	Monitoring and Evaluation of the Emergency Plan Program	\$1,850,000

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09 **Mechanism:** CDC GHAI  
**Prime Partner:** US Centers for Disease Control and Prevention **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State) **Program Area:** Strategic Information  
**Budget Code:** HVSI **Program Budget Code:** 17  
**Activity ID:** 27233.09 **Planned Funds:** \$420,000

**Activity System ID:** 27233

**Activity Narrative:** This activity is not new - according to the FY 2009 COP Guidance Clarifications [October 24, 2008], third party company contractors such as CTS Global (COMFORCE) should be teased out. The 261 staff total includes 8 non-personal services contractors, who have been hired through a contract with COMFORCE. CDC Atlanta issued a cost-reimbursement agreement to COMFORCE in March 2006 to provide field offices with a mechanism to hire individuals to provide much needed technical expertise in-country.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3370.09	<b>Mechanism:</b> AIDS Capacity Enhancement Program (ACE)
<b>Prime Partner:</b> Chemonics International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 4531.26767.09	<b>Planned Funds:</b> \$0
<b>Activity System ID:</b> 26767	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program to provide organizational development technical assistance and engage highly specialized local consultants to build the capacity of targeted Ugandan institutions for improved HIV prevention, care and treatment program outcomes. This program also aimed at strengthening administrative and managerial systems to fortify in a sustainable manner the targeted institution's ability to respond effectively to emerging opportunities resulting from the vast increases in HIV/AIDS funding. The program, named AIDS Capacity Enhancement (ACE) currently works with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), and the Ministry of Health Resource Centre (MOH RC) among others. Three organizations, JCRC, HAU, and IRCU play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda. UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The Chemonics/ACE will continue to consolidate its achievements to date and will support the target organizations through the entire first phase of PEPFAR. ACE has made substantial progress in building the capacity of the targeted organizations.

Over the last two years, ACE assisted UAC in the evaluation of the previous National Strategic Framework for HIV/AIDS and the development of Uganda's HIV/AIDS National Strategic Plan 2007/2008- 2011/2012 (NSP), which is currently almost complete. ACE also supported UAC to develop the new long term institutional arrangements which will govern the Global Fund process in Uganda, particularly HIV/AIDS funds. In FY 2007, ACE will support UAC to improve coordination of the HIV/AIDS response through the operationalization of both the NSP and the accompanying Performance Measurement and Management Plan (PMMP). In addition, ACE will continue to support UAC in the development of the national HIV/AIDS comprehensive communications strategy that will provide guidance to partners implementing HIV/AIDS activities under the NSP.

Beyond FY 2007, UAC will require assistance to track the progress of the national HIV/AIDS response. This will entail helping UAC coordinate a strong network of all stakeholders, civil society organizations and the districts, and to ensure that their systems have indicators that can contribute to the PMMP. ACE will support the UAC to take the PMMP operational plan and handbook to district leaders and work with them to ensure they are participating in the PMMP and that they are both contributing data according to the needs of the NSP and that they are benefiting from the information gathered by receiving reports for analysis and application of any new strategies or lessons gleaned from the data.

At the MOH resource center, ACE is contributing to improved management and analysis of health information through the development and initiation of several new systems. Using FY 2006 funds, ACE developed a new national-level web-enabled Health Management Information System (HMIS). This system will allow the MOH RC to collect, monitor, and report key health sector information, giving them a new platform to keep government, donors, citizens, and other stakeholders abreast of health trends in Uganda. In addition, ACE has helped the MOH RC to redesign its website, making it more interactive and user-friendly, and has linked the site to a new digital library of MOH reports and other documents. Together these systems give the public greater access to health information, and provide opportunities for sharing best practices in the health sector, new findings from research and operational studies, evaluations, and new approaches for health care delivery. Finally, to provide a strong platform to support these systems, ACE has provided all the necessary equipment for a new local area network (LAN) at the MOH RC.

In FY 2007, ACE will work in close collaboration with the CDC Informatics team and MOH RC staff on the district rollout of the electronic HMIS systems; both web-enabled and Epi-Info. To ensure sustainability of these electronic systems, ACE and CDC are developing a plan to ensure there is follow up training and support supervision at the district level both from MOH RC staff and by identifying regional IT firms who can be resources for districts using the new electronic systems. ACE will also continue to strengthen the center's ability to oversee and manage health information by following up on the systems installed this year, ensuring they are working effectively and contributing to the ability of the MOH RC to perform its core functions. In addition, ACE will continue to improve the HMIS so that there is a smooth flow of data from the districts to the center and an effective reporting system which allows MOH RC staff to share the data collected widely and improve their planning and decision making. ACE will facilitate linkages between the MOH HMIS and other systems that have been developed by other donors. Deliberate plans will be made to ensure that the HMIS and the newly developed PMMP of the NSP are linked. Additionally, all HMIS stakeholders will be able to meet at least twice a year in order to discuss priority areas for programming, collaborations, overlapping areas, and gaps.

Web-based monitoring is a new initiative within the MOH and hence staff at central and district level will require substantial training and support to internalize the system. In FY 2008, ACE will work with MOH in training the relevant staff to orient them to the new system. Further training will also be needed in data analysis and in the development of a functional reporting system of the MOH database. This will allow the MOH RC to use the data generated by the new system to perform high level analysis of health trends and report clearly to the public and other health stakeholders on health trends in Uganda. ACE will also support the continued roll out of the electronic HMIS systems to more districts, and will continue to provide follow-up technical assistance to districts using the electronic systems. Working in collaboration with the CDC Informatics Unit and the MOH RC, ACE will ensure that there is a sustainable plan in place at the MOH RC for upkeep of the system and TA provision to the districts.

With its other partner organizations, ACE is supporting the development of monitoring and evaluation tools and systems as well as information technology systems that will help gather, manage, and analyze information. At IRCU, ACE worked closely with IRCU to ensure they have the means to measure their progress against their targets. Working with the Religious Coordinating Bodies (RCBs) and the grantees, ACE developed, tested, and rolled out reporting tools for palliative care and ART. A tool for tracking results in their OVC program is currently being tested and ACE is advising IRCU in the procurement of the required

**Activity Narrative:** IT infrastructure to effectively manage all the data that will be forthcoming. ACE also worked with JCRC and HAU, providing support in their reporting to PEPFAR and in developing M&E tools. As FY 2006 comes to an end, ACE is working closely with both of these partners to develop M&E frameworks. Through consultations and participatory workshops, ACE has helped both organizations create the foundations for effective organization-wide M&E systems.

In FY 2007, ACE will continue to consolidate and improve strategic information systems at these three partners. At IRCU, ACE will complete the rollout of the OVC data collection tool and will work with the IRCU M&E department in developing a data collection tool for prevention activities. IRCU will then have a thematic tool for each of their three core technical areas and the grantees and RCBs will have the means to report thoroughly and correctly. To consolidate all the work done so far, ACE will ensure that a master database is functioning that can accommodate all the incoming data and that the IRCU staff are fully able to manage the database and the data collection and analysis process. ACE is also providing ongoing support to HAU in developing an M&E plan and related tools for the organization. In FY 2008, ACE will work with these indigenous partners, particularly in aspects of analysis and reporting of the data collected, documentation and publication of their best practices.

With JCRC, ACE is providing ongoing support in the development of a new M&E framework and plan that will encompass all of JCRC's activities. In addition, ACE is assessing the current database in use and reporting systems to recommend how the satellite sites should work with the Regional Centers of Excellence (RCEs) and the center in collecting data. Based on the results of this assessment, ACE will work with JCRC staff to implement an improved reporting system. In FY 2008, ACE will continue to work with JCRC on improving their data management and reporting. Based on the results of the analysis performed in FY 2007 and on consultations with JCRC, ACE may assist JCRC to put in place a new data base system that links the satellite sites, RCEs, and headquarters. This system could be web-enabled, using an SQL platform to link all the reporting sites to one system. Additionally, the possibilities for web based reporting for JCRC and its branches will be explored. This would open up opportunities for real time reporting and accuracy of data collected.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15630

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15630	4531.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$1,205,630
8460	4531.07	U.S. Agency for International Development	Chemonics International	4850	3370.07	AIDS Capacity Enhancement Program, ACE	\$1,275,000
4531	4531.06	U.S. Agency for International Development	Chemonics International	3370	3370.06	Capacity Building of Indigenous Institutions	\$525,000

**Table 3.3.17: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3481.09	<b>Mechanism:</b> CDC GHAI
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 27232.09	<b>Planned Funds:</b> \$356,275
<b>Activity System ID:</b> 27232	

**Activity Narrative:** This is not a new activity but a continuation of Activity ID 4703.08

The CDC Informatics Unit provides technical assistance for the development and implementation of strategic information systems to the country office and national prevention, care and treatment implementing partners. These service providers, who are key recipients of PEPFAR funds, are given direct, hands-on support by the informatics team to design strategic information systems tailored to meet the specific needs of the programs and to build institutional capacity across the organization. The team actively engages partner management and clinic staff at all levels to build consensus and develop applicable standards for effective information system development. Strategic information program interventions range from the design of patient care records, and clinic management and logistics system to the integration of monitoring and evaluation of national indicators between the MOH HMIS and the PEPFAR program.

The Informatics Unit develops computer-related capabilities such as biological patient recognition, computer power sources, and hand held computer applications which support our public health partners. The unit supports the MOH resource center for development of computer capacity for national data collection and reporting; connectivity and computer infrastructure from internet access to specific network topology design and implementation. The Unit provides application development for standard information systems and tools for clinics, development and design of SI collection instruments; data entry and management; analysis and reporting of SI; and, information and infrastructure security and maintenance.

Training in each of these areas will also be developed and supported either directly by the CDC Informatics team or through utilization of outside resources and partners. The goal of training and technical support provided will be to build capacity in partners to implement and maintain their own HMIS with limited on-going technical support from CDC. Technical assistance will also be provided in the interconnectivity of MIS for all partners into the national HMIS and USG systems where required or relevant. Finally, the CDC Informatics Unit will conduct on-going SI needs assessments of partners to ensure informatics resource growth to match needs necessitated by increasing care and prevention activities. The increases in demand reflect the success in implementing initial programs since the partners have used these initial systems and by passed the systems capacity. This activity works closely with MEEPP to maximize synergies and avoid duplication.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9221.09	<b>Mechanism:</b> STAR-EC
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 21145.21581.09	<b>Planned Funds:</b> \$251,745
<b>Activity System ID:</b> 21581	



**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and health systems strengthening.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – East Central will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

The FY 2009 activity will focus support to 6 districts in the Eastern region of the country. As a follow up to previous efforts by UPHOLD, UNICEF and Uganda AIDS Control Programs (UACP), the district based HIV/AIDS/TB program – East Central will continue focusing on activities aimed at promoting evidence-based planning and decision making at district and lower levels. Districts for this region will include: Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutamba. Evidence-based planning and decision making will be achieved through regular measurement of program performances and progress in all the districts that this program will operate. 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 other civil society reporting tools developed under the new civil society fund as well as through the annual Lot Quality Assurance Sampling (LQAS) survey. Up to FY 2008, LQAS has been carried out in 43 UPHOLD and NUMAT districts as well as some UNICEF districts. LQAS was previously supported through the World Bank MAP project in selected other districts. Under the FY 2009 activity (new design), the mission will work closely with the GOU to determine the best way to transfer ownership and management of the annual survey. From FY 2009 onwards under the three new district-based activities, LQAS survey will be conducted annually in approximately 50 districts in order track coverage and utilization of key indicators related to program performance. LQAS will be supported at the national level by one of the HIV/AIDS/TB projects to provide one major source of data/information for the USG programs. Key stakeholders such as line ministries, local government authorities, civil society organizations and other implementing partners will be involved in the development of questionnaires of this survey. 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. LQAS will also track indicators under the President's Malaria Initiative (PMI).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 9326.09 **Mechanism:** Monitoring and Evaluation Agent/Civil Society Fund

**Prime Partner:** Chemonics International **USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State) **Program Area:** Strategic Information

**Budget Code:** HVSI **Program Budget Code:** 17

**Activity ID:** 21478.21587.09 **Planned Funds:** \$300,000

**Activity System ID:** 21587

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities; with another 90 expected in be awarded at the end of FY 2008 in both the areas of prevention and OVC service delivery. The monitoring and evaluation component of the CSF will function similar to the MEEPP project for the USG PEPFAR program in Uganda and will help the CSF grantees to set reasonable targets and report on their progress. The participating development partners, UNAIDS and the Uganda AIDS Commission are currently mapping out the best way to manage and support this M&E function under the new national M&E plan but it is anticipated that these results will feed into the larger information system at the Uganda AIDS Commission. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts and their funds are often not able to pay for M&E costs. This mechanism was a unique way to streamline and broaden their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Tracking the impact of HIV programs remains a challenge within civil society and resources will continue to be used to provide capacity building support to CSOs competitively selected to receive grants. Upon award in FY08, the Monitoring and Evaluation Agent will immediately be responsible for measuring the impact of the CSF through monitoring the 200+ grantees performances, and improving the capacity of these grantees to collect better data and use such data for future decision-making. These activities will not change in FY09. The requested resources will be used to support a portion of the management fees (along with funding from other key program areas such as Sexual Prevention and OVC) for the Monitoring and Evaluation Agent, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF. They will work in close partnership with the Technical and Financial Management Agents, in addition to providing technical support to the Steering Committee. It is expected that as the CSF becomes more established and institutionalized, other development partners will put funds into the CSF. The long term financial needs of the M&E component will continue to be assessed on a regular basis.

The targets reached through direct service delivery in prevention and OVC will be reported by Deloitte and Touche, the Financial Management Agent.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21478

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21478	21478.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$600,000

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 690.09

**Mechanism:** N/A

**Prime Partner:** US Department of Defense

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 3969.21602.09

**Planned Funds:** \$100,000

**Activity System ID:** 21602

**Activity Narrative:** The UPDF is Uganda's national Army. As a mobile population of primarily young men, they are considered a high-risk population. As Commander in Chief of the armed forces, the President mandated the UPDF's AIDS Control Program to oversee and manage prevention, care and treatment programs through out the forces. Although the exact HIV prevalence in the military are unknown, it is estimated that approximately 10,000 military are living with HIV with up to an additional 10,000 HIV infected family members. Additionally, the UPDF medical clinics are accessed by civilians not affiliated with the military, and there has been a trend of increased utilization, representing up to 50% of patients in some of the clinics and sick bays. This activity supports an HIV sero-behavioral survey of UPDF personnel, with shared variables from the national MOH survey, in order to determine an accurate estimate of HIV sero-prevalence in the UPDF. The existing UPDF data capturing and management system is in need of improvement. It is mainly paper based with frequent stock-out of the relevant data capturing stationery. The personnel charged with medical data capturing do not have the required training in Health Management Information Systems. Ultimately, after establishing an effective hard paper system, a computer based HMIS will be developed with acquisition of necessary hardware, software, and training of data staff necessary to support this.

In FY 2008, the HIV sero-behavioral survey was conducted. This survey targeting 3,000 randomly selected combatants on 5 military bases across the country. A BED assay to identify newly infected individuals will be done through collaboration with CDC. The information from this survey will assist in guiding the Prevention and Clinical Care programs of the UPDF. Data analysis is in its final stages. The USG conducted site visits to UPDF Bombo Barracks Hospital and two additional clinics. Specific recommendations were made, including training for UPDF data staff. Implementation is underway, with development of a proper medical information system that is meets Ministry of Health national standards and PEPFAR reporting. To improve on the data capturing reporting in the UPDF, three health facilities (Bombo, Nakasongola and Gulu) were selected to pilot an improved HMIS. From these centers a total of 24 Nursing Assistants were trained and equipped with skills in data collection, analysis and reporting. From these we selected six Medical Records Clerks and 6 HMIS Focal Persons. An additional 30 health workers involved in the generation of medical data (Medical doctors, Clinical Officers and Nursing Staff) have also attended Ministry of Health Modular training in HMIS and Integrated Disease Surveillance. For the selected centers relevant medical data capturing tools and related medical stationery were procured including, OPD and In-patients registers, medical forms, clinical notes sheets, patients records files, x-ray and laboratory request forms, laboratory registers, patient appointment cards and standard HMIS reporting forms. Internet has been established at Bombo Barracks Hospital and Clinic.

Activities initiated in FY 2008 will continue in FY 2009. New activities will include the of completion of the model HMIS system, and expansion of this to the other 8 ART centers, as well as extension of internet.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16073

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16073	3969.08	Department of Defense	US Department of Defense	7336	690.08		\$100,000
8387	3969.07	Department of Defense	US Department of Defense	4821	690.07		\$100,000
3969	3969.06	Department of Defense	US Department of Defense	3156	690.06		\$50,000

**Emphasis Areas**

Military Populations

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** HVSI

**Activity ID:** 4712.21733.09

**Activity System ID:** 21733

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Strategic Information

**Program Budget Code:** 17

**Planned Funds:** \$400,000

**Activity Narrative:** This activity is a continuation from FY2008. This activity also relates to Prevention /Abstinence and Being Faithful, Prevention/ Other, PMTCT, Palliative care: Basic health care, Counseling and testing, ART, Improve Laboratory Capacity/ Laboratory Infrastructure and Other/ Policy analysis and system strengthening. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning

In FY 2008 NUMAT focused on capacity building and 65 individuals (HMIS focal persons and record clerks) were trained in strategic information. Other key achievements in FY 2008 included support to the strengthening of the Health Management Information System (HMIS) through training, support supervision in data management and executing data quality assessments in selected health units. Data collection activities were supported through provision of data collection tools which included registers and monthly reports to health units, equipping selected districts with computers and external hard drives for data storage/management, as well as logistical facilitation of HMIS focal persons to collect data periodically. NUMAT also supported the districts in the dissemination of key study findings at various forums including conferences, workshops and others. Some of the findings disseminated included the Lot Quality Assurance Survey (LQAS) reports. A total of 14 district technical persons were supported to attend the Uganda National AIDS Conference. NUMAT has also supported districts to conduct quarterly review meetings on data related issues.

In FY 2009 NUMAT will build on its previous activities to continue to strengthen the capacity of its supported districts to collect and utilize timely and quality data for planning purposes and informed decision making. NUMAT hopes to do this by promoting a continuous cycle of data demand, collection, analysis and utilization to improve on management of health conditions through support to a number (7) of initiatives as follows;

(1) Health Management Information System (HMIS): NUMAT will train district HMIS Focal Persons (FP) to manage data collection from the lower level health units and facilitate detailed analysis (on performance indicators & coverage rates), and utilization of data. Record assistants at health sub-districts will be sensitized, equipped with skills and facilitated to extract data from service registers and enter it into summary forms. The HMIS Focal Persons and the record assistants will be supported in data analysis, utilization and storage at the district and lower levels. Districts will be supported annually to monitor progress on critical health indicators specifically: HIV/AIDS, TB and malaria indicators, and to routinely utilize data for their planning purposes and supporting service delivery. NUMAT will continue to work with the Community Services Departments (CSD) in the districts to strengthen the collection of community services data. NUMAT is also committed to accuracy of information for purposes of accountability and, more importantly, for use of quality data to improve programme activities. With that regard, data quality assessment and validation exercises will be conducted to identify data challenges and improve on the quality of data. NUMAT will also support the scale up of the web enabled HMIS in few piloting districts. (2) Dissemination: NUMAT will support the production of focused documents aimed at informing decision makers as well as disseminate information through a wide range of products and avenues such as comprehensive reports, manuals, brochures, journal articles, technical briefs, and workshops. District staff will be supported to participate in relevant national/international conferences (3) Lot Quality Assurance Sampling (LQAS): NUMAT will conduct individual district-based LQAS surveys which will be used by the districts to identify priority areas and assist in developing strategies for addressing the identified gaps and monitor progress towards improving the quality of the health systems. The surveys will also provide accurate measures of coverage or health system quality at a more aggregate level, (4) Health Facility Assessment (HFA): NUMAT will supplement the LQAS information with a Health Facility Assessment to generate data on the status, availability and quality of health services, (5) District health assembly: District health assemblies will be supported to improve planning of district health systems and evaluation of their performances prior to the national health assembly, (6) Performance Monitoring Plans: NUMAT supports the demand for effective monitoring and evaluation and hence will build 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 activities, (7) GIS Mapping: At NUMAT, we know that improved analysis and use of data lead to better health program decision making and, ultimately, to improved health outcomes. NUMAT will thus use GIS as a tool to turn data about 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 will go a long way in guiding districts and other stakeholders in the allocation and targeting of resources.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15495

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15495	4712.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$200,000
8475	4712.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$200,000
4712	4712.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$200,000

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 7292.09	<b>Mechanism:</b> AIDS Indicator Survey Final Activities- MACRO
<b>Prime Partner:</b> Macro International	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 15928.21793.09	<b>Planned Funds:</b> \$2,838,408
<b>Activity System ID:</b> 21793	

**Activity Narrative:** Activity narrative: A nation-wide population-based serological and sexual behavior survey (HSBS) was conducted in 2004-05 to measure the burden of HIV/AIDS disease and the progress in implementation of the PEPFAR program in Uganda. This survey provided vital data on the magnitude of HIV and associated risk factors as well as data on other program indicators. It also provided calibration factors for the routine antenatal based surveillance systems that will continue to be the main source of HIV surveillance data. Furthermore, the survey findings were extensively used to define the focus of the next phase of HIV/AIDS Control in Uganda. WHO/UNAIDS recommend that this type of survey should be conducted every 3-5 years to complement annual routine antenatal HIV surveillance. During the planning for the FY 2008 COP, a decision was made to conduct a follow-on Uganda AIDS Indicator Survey (UAIS) to measure the trend of HIV/AIDS in Uganda and provide end-term information for PEPFAR I. The main objectives of the 2008/2009 Uganda HIV/AIDS Survey (AIS) are to track trends in key HIV/AIDS indicators—including HIV prevalence, to gather information on the proportion of Ugandan adults in need of treatment for HIV, and to measure the key malaria-related indicators including conducting malaria and anemia testing. The survey is a follow-on to the 2004-05 Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS) and in some ways, the 2006 Uganda Demographic and Health Survey (UDHS) as well.

The specific objectives of the 2008 UAMIS are to:

- collect high-quality data on knowledge and attitudes regarding HIV/AIDS and on sexual behavior among women and men aged 15-59;
- collect data on orphans and vulnerable children;
- measure the prevalence of infection with HIV, herpes simplex-2, syphilis, and hepatitis B among adults; and
- measure the CD4 level among adults who test HIV positive.

To save on cost and other resources, the USG and the Government of Uganda (GoU) decided to combine both the Malaria and HIV/AIDS indicator surveys. The survey will be implemented in a sample of 11,500 households from 460 census enumeration areas/clusters throughout the country. The sample will be designed so as to provide results at the national level, for urban and rural areas separately and for each of 10 “regions”, each consisting of 5-10 districts that are geographically contiguous. The sample will be designed to enable comparison of results with both the 9 regions used in the UHSBS, as well as those used in the UDHS. The AIS will cover the age groups of 0-5 years and 15-59 years.

Funds to support the combined survey will come from FY2008 Malaria Operational Plan (MOP) and PEPFAR FY2008 and FY2009 COP. The PEPFAR funds for the AIS component of the survey will go to both USAID/Uganda and CDC/Uganda. CDC/Uganda will support the HIV/STI laboratory component of the survey while the rest of the funds were programmed under the USAID/Uganda funded Implementing Partner- Macro International. During the FY08 COP planning, \$100,000 was programmed as field support to MEASURE DHS/ORC Macro International to support the preparatory phase of the UAMIS. The funds covered the preparation of the concept note, survey design, protocol development, and adaptation of the questionnaires. The remaining FY2008 and the FY2009 PEPFAR funds will go towards the actual implementation of the UAMIS.

Activities for FY 2009: Since the survey implementation has been funded in FY 2008 COP, the FY 2009 funds will go towards supporting 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 2008 UAMIS, the USG will explore the possibility of expanding the involvement to include members of the local universities. The FY 2009 funding is also expected to cover new target groups for specific information dissemination based on the results of the survey. The third activity will involve a specialist course on how to communicate scientific information to policy makers. Details of this will be worked out but will involve training 30 middle and senior managers from MOH, UBOS, UAC, etc, on how to communicate complex scientific information and data to policy-makers.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15928

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15928	15928.08	U.S. Agency for International Development	Macro International	7292	7292.08	AIDS Indicator Survey preparatory-MACRO	\$100,000

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 7293.09

**Mechanism:** Mid-term and End of Program Evaluations/UMEMS

**Prime Partner:** The Mitchell Group

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 15930.21818.09

**Planned Funds:** \$700,000

**Activity System ID:** 21818

**Activity 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 PEPFAR 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: NUMAT, HIPS, SPEAR, Nutrition for PHAs and Deloitte and Touche. The remaining are TBD pending PEPFAR priorities for ongoing programming.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15930

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15930	15930.08	U.S. Agency for International Development	Monitoring and Evaluation Management Systems	7293	7293.08	End of Program Evaluations	\$700,000

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 9482.09

**Mechanism:** Capacity Building/Leadership and Management Program/ACE-Follow-on

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 21889.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 21889



**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team. One of the primary focuses for this strategic information activity is the strengthening of leadership and management skills for professionals charged with the responsibility of steering implementation and monitoring of the HIV/AIDS strategic plan. A secondary, but critical, focus is the support for conceptualization, design, and implementation of functional health information management systems (HMIS) at the Ministry of Health by supporting the Resource Centre and facilitating linkages with HMIS activities at the sub-national level.

Since 2006, this program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 2009.

Building on the success of this program, the USG is proposing a follow-on activity in FY 2009 that will continue to support local institutions which provide the majority of HIV prevention, care and treatment services and information/data in the country. Since some of the local organizations that have received past support (e.g. JCRC) have now been graduated, the scope and focus for FY 2009 will be shaped during the actual design of the activity. However, the USG has identified three broad components.

One of the three broad components will involve deepening the leadership and management capacity initiated in past years. Although the depth and width of this activity will be based on analysis and consultations of the USG and partners, it will be focused on supporting increased leadership and management skills for those charged with strategic and management responsibilities for the implementation and monitoring of the HIV/AIDS Strategic Plan in the context of the "three ones". This component is the main thrust of the FY 2009 activity. The second, and related to first, is the support for an external position recruited to mentor and advise the management within the MOH RC on their efforts to re-design and implement a functional national resource centre including HMIS. A national HMIS is the backbone of monitoring and evaluation activities in the MOH. This position will be filled by a senior local or international professional with capacity to analyze internal (HMIS) and external (wider MOH, other ministries, private sector, civil society, and donor partners) links with the MOH RC, and motivate MOH RC managers to mobilize support for the re-design and implementation of MOH RC including HMIS. The position therefore requires a professional with technical, organizational, leadership and management skills needed to catalyze and fast-track action. The third component is a further extension of the second and will involve providing financial resources to support the MOH RC to carry out the necessary supportive supervision by the Districts to the health units so that they can correctly use HMIS tools, manage, utilize, and transmit data for management (District) and strategic (National) decision-making. At a minimum, six local organizations will be supported and 100 people (one in each District and 20 at national level) trained in strategic information/HMIS.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

<b>Emphasis Areas</b>
<b>Human Capacity Development</b>
Estimated amount of funding that is planned for Human Capacity Development [REDACTED]
<b>Public Health Evaluation</b>
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>
<b>Food and Nutrition: Commodities</b>
<b>Economic Strengthening</b>
<b>Education</b>
<b>Water</b>

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9479.09	<b>Mechanism:</b> Monitoring & Evaluation of the Emergency Plan Program/MEEPP Follow On
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 21876.09	<b>Planned Funds:</b> [REDACTED]
<b>Activity System ID:</b> 21876	

**Activity Narrative:** This is a NEW activity which is a follow-on to the Monitoring and Evaluation of the Emergency Plan Progress (MEEPP) Project. MEEPP was launched in January 2005 and comes to an end in December 2009. The PEPFAR program in Uganda still needs monitoring and evaluation services as envisaged in the MEEPP Project objectives.

The purpose of the MEEPP Project was to design, implement and maintain a comprehensive PEPFAR performance management, monitoring and reporting system. Specifically, the MEEPP Project was to support the USG PEPFAR team and its implementing partners, using performance improvement processes and targeted technical assistance, to report high quality data in a timely and efficient manner in accordance with OGAC's strategic information requirements. The project was also required to establish strong linkages with host country institutions that are involved in the monitoring of HIV/AIDS activities in the context of the national response.

This new activity is being designed with the same objectives as those of the MEEPP project but will be competed so that a new implementing partner can be determined. An evaluation of the original MEEPP program will be conducted and the lessons learned will influence the design of this new activity. The new activity will therefore aim to pursue the same objectives as those of MEEPP but with modifications to reflect what has already been achieved as well as addressing any new areas or approaches. The new activity will therefore, at a minimum, assist the PEPFAR team, which includes CDC, DOD, NIH, Peace Corps, and USAID under the leadership of the US Embassy, to maintain a comprehensive performance management, monitoring and reporting program, including collection, reporting and validation of data from HIV/AIDS activities and partners that are funded under PEPFAR. It will also coordinate with, and complement the M&E activities of PEPFAR's implementing partners, facilitating harmonization and aggregation of data, coordination with the Government of Uganda (GOU), and avoiding duplication of effort, using proven, portfolio management approaches. By providing PEPFAR and its partners with a unified picture of USG-funded HIV/AIDS activities, the new activity will help PEPFAR to maximize the impact of the USG resources in achieving PEPFAR goals and targets. In this new activity the advances made by the MEEPP Project will be built on in order to identify and implement the appropriate capacity building approach which will contribute to strengthening the knowledge and systems for a sound, sustainable national HIV/AIDS M&E system.

Over the period of implementation the MEEPP Project has accumulated knowledge and insights that were useful in the development and improvement of data quality assessment tools that in turn contributed to better target setting and annual results reported to OGAC. MEEPP has established strong working relationships with GOU and other stakeholders as is evident in the joint field data quality assessment missions. Some of the important achievements include development and maintenance of user-friendly web-based program performance database that stores and manages data by PEPFAR indicators, geographical location, prime partner, USG Agency, and reporting periods among other attributes. The MEEPP Project also conducted several data quality assessments that resulted in progressively more precise data on partner performances where data overlaps (double counting etc) have been substantially minimized. Other accomplishments include development of tools and reports that have facilitated clarity of data presentations. In the process of improving the estimation of direct and indirect contributions of USG the MEEPP Project worked with GOU to conduct joint data quality assessments that included the estimation of the national ART coverage from which the USG indirect contribution is derived. Given these accomplishments, it was recommended at the Mission Portfolio Review and by the PEPFAR Country Team that a MEEPP follow-on project be designed in order to continue the useful work as well as venture into new strategic areas.

This new activity is designed to support all other program areas in enhancing program performance management including measurement, monitoring, reporting, and evaluation. It is also intended to build capacity and strengthen the national M&E systems. The main objectives of the new activity include, but are not limited to, the following; 1) Assess reporting readiness of EPT and related Implementing Partners against OGAC reporting requirements, 2) Building on the monitoring methodology and evaluation developments already accomplished, the activity will: i. Validate baselines and targets for each year of activity, ii. Ensure use of common definitions and standards, iii. Collate and review data submitted by IPs in order to analyze EPT trends and compare against targets, iv. Provide aggregated data to EPT in a format usable for formal reporting to OGAC and the GOU, 3) Maintain a system for documenting processes and impact to document how results and impact are achieved, which factors contribute to or hinder achievement of results, and suggest ways to expand use of effective practices and improve PEPFAR performance, 4) Advise the PEPFAR SI working group on defining the evaluation agenda and recommend methods to ensure use of evaluation results for program improvement, identify lessons learned, and disseminate evaluation results effectively, 5) Strengthen the M&E capacity of the PEPFAR Country Team, IPs, and host country counterparts; and contribute to performance improvement and sustainable systems.

The activities of the new project will strike a balance between the immediate SI needs for PEPFAR and the longer-term development needs for the national M&E system. The key activities can be summarized broadly as follows; (i) Support the semi-annual and annual data collation, cleaning, and report submission to the OGAC (ii) Populate and maintain various databases for purposes of facilitating data analysis and use (including reporting) by the USG PEPFAR Team in Uganda, host government and other users, (iii) Working with the SI team and host government to conduct data quality assessment and improvement surveys (DQAIS), (iv) Mentor GOU staff to conceptualize, design, implement, monitor and evaluate their M&E activities, (v) Assist the GOU to develop/improve and institutionalize M&E Systems (information systems, databases, reports etc) in the context of the national Health Strategic Plan and multi-donor contribution to the HIV/AIDS response- the "three ones", and (vi) Coordinate the carrying out of special studies/evaluations (s) of PEPFAR.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3440.09

**Prime Partner:** Uganda Virus Research  
Institute

**Funding Source:** GHCS (State)

**Budget Code:** HVSI

**Activity ID:** 22525.09

**Activity System ID:** 22525

**Mechanism:** Laboratory Quality Assurance-  
Cooperative Agreement

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Program Area:** Strategic Information

**Program Budget Code:** 17

**Planned Funds:** \$100,000

**Activity Narrative:** The Uganda Virus Research Institute (UVRI) is a department within the Ugandan Ministry of Health (MOH), and has been dedicated to conducting research on viral diseases since 1936. In the area of HIV/AIDS, UVRI conducts research on the isolation and characterization of HIV strains, the epidemiology and molecular epidemiology of HIV before and after the introduction of ART, comparing modalities of delivering ART, HIV vaccines and microbicides, and PMTCT. UVRI also assists in the implementation of national sero-behavioural surveys, and provides the MOH with HIV surveillance data from ante-natal clinic (ANC) and STI clinics. UVRI is mandated by MOH to perform Quality Assurance/Quality Control (QA/QC) of all HIV serological testing sites, both public and private. With USG funding assistance, the HIV Reference and Quality Assurance Laboratory at UVRI has established a national laboratory QA program focused specifically on HIV-related testing.

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.

Prevention of ART resistance is most important in countries such as Uganda where first and second line treatment options are limited. 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. 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. These results were recently published (Ndembu et al. AIDS Research & Human Retroviruses 2008; 24 (6):889-895), and presented at various meetings including the national UAC meeting and the International AIDS Society meeting in Sydney, 2008. The HIVDR WG recommended that this activity be repeated in 2008. Plans exist for these threshold surveys to be conducted among teenage pregnant women in Kampala. Funding for this activity is being sought from PharmAccess. With funding from MRC and the Global Fund, UVRI established the National HIV drug resistance reference laboratory and was accredited by WHO; this is one of few laboratories in Africa that are accredited. The UVRI laboratory has provided training in drug resistance testing for other technicians and scientists, including one from Zambia, and has also provided testing for samples from other sub-Saharan African countries. The DR WG is making efforts to secure additional funding from other sources to implement the National plan.

In FY 2009, The USG country team will support the implementation and evaluation of Early Warning Indicators, as part of the National HIVDR prevention activities and as part of the HIV DR working group activities. An assessment of EWI will support ART program practices and country planning to minimize the unnecessary emergence of HIV drug resistance. This evaluation will help determine the degree to which ART programs are functioning to minimize emergence of HIVDR emergence.

This activity will include the following:

- develop a list of EWIs that can be/should be regularly collected at all sites
- determine methods of data abstraction of EWI from different current systems
- identify sites for collecting EWI

**Activity Narrative:** •strengthen the ART information management systems by integrating EWI into routine ART monitoring and reporting  
 •monitor whether ART programs are functioning to optimize prevention of HIV drug resistance  
 •identify and implement mechanisms to provide support supervision to improve EWI and ART delivery

The HIVDR WG will work with USG partners and the MOH to determine which of the listed EWI can be captured from current ART medical records systems or ART cards. WHO recommends that countries collect EWI that are readily available and that are most useful for program assessment. Countries need not collect all indicators. The following are the primary indicators suggested for use in Uganda:

- 1) Prescribing Practices: the proportion of individuals starting ART during a selected quarter who are prescribed a standard regimen, or a regimen considered appropriate according to national guidelines and the HIV DR WG. The recommended target is 100%.
- 2) Percentage of patients Lost to Follow-up: the proportion of ART clients lost to follow up during the first 12 months following initiation of ART, not including those who are dead, transferred out or stopped ART. The recommended target is <20%
- 3) Patient retention on first-line ART: the proportion of clients initiating first-line ART who are still on first-line ART after 12 months. The recommended target is >70%
- 4) ART appointment-keeping: the proportion of clients who attended all scheduled appointments during a year, excluding those who are lost to follow-up, dead, transferred out, or stopped ART. The recommended target is 80%
- 5) Drug supply continuity: the number of quarters in the last year in which there were ARV drug stock-outs for any of the standard ART regimens supplied by the site. The target is zero.

Although WHO recommends collecting information on pill count/adherence, this indicator could not be assessed during the pilot study due to weaknesses in routine ART adherence assessment at most sites. In addition, the suggested use of adherence for each individual drug was rarely collected, and will be left out of future EWI evaluations. The recommended indicator for "On-time Drug Pick up", meaning the proportion of persons who pick up all prescribed drugs within 3 scheduled days, could not be assessed because some clinics provide more drugs to cover for delayed pick-up times. Therefore, this indicator will also be excluded.

The country team, particularly the SI working group, will work with partners, the MOH, and the HIV DR WG to develop systems for routine integration of these EWI into data collection systems, and for partners and other clinical sites to have the capacity to extract and evaluate this information routinely. This will also require coordination not only with partners, but also with the SI TWG, the HIV DR WG and the MOH Resource Center that supports the national HMIS system. We will perform training in the collection, extraction, and programmatic utilization of EWIs. Specific evaluation of EWIs will be expanded to 80 sites in FY2009, covering all regions, in order to strengthen the ART information management systems, to ensure that EWI are integrated into routine ART reporting systems and to monitor whether ART programs are functioning to optimize prevention of HIV drug resistance. Through training and consultations, we will provide support supervision to improve on the indicators for better ART delivery.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

#### Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

#### Human Capacity Development

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 7273.09  
**Prime Partner:** Population Council  
**Funding Source:** GHCS (State)  
**Budget Code:** HVSI  
**Activity ID:** 22302.09

**Mechanism:** Project SEARCH  
**USG Agency:** U.S. Agency for International Development  
**Program Area:** Strategic Information  
**Program Budget Code:** 17  
**Planned Funds:** \$250,000

**Activity System ID:** 22302

**Activity Narrative:** Project Search is a new activity aimed at supporting the Uganda AIDS Commission (UAC) to operationalize an M&E system. Once the M&E system is in place, UAC will be able to collate, analyze and disseminate multisectoral 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 ones" principle in Uganda.

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.

In FY 2009 USG will continue to support UAC to ensure that a multisectoral M&E System and its accompanying information flow system are fully operational. Given that USG is only one of the several development partners assisting the UAC, the FY 2009 support will be based on an agreed set of activities that are catalytic to realizing a functional M&E and Information system. The UAC is currently in the process of mapping out the technical support needs for the roll out of the PMMP. Areas of USG support may include database development and management, capacity building of UAC M&E staff and operationalizing the PMMP. Once the areas of support are mapped out, USG will be able to identify which needs could be best met with PEFPAR support. These resources will be used to support the areas of need identified through a consultative process with UAC, donors and other stakeholders.

It is expected that the majority of activities that may be selected for support will include training of the relevant staff to use the tools anticipated under the PMMP. At least one person from each of the 80 districts and 20 at the national level will be trained. The assistance will also involve other organizations (e.g. Ministries of Gender, Health, Local Government, Education, Agriculture etc) that are either users or suppliers of UAC data/information.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09  
**Prime Partner:** US Centers for Disease Control and Prevention  
**Funding Source:** GHCS (State)  
**Budget Code:** HVSI  
**Activity ID:** 22932.09

**Mechanism:** CDC GHAI  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Strategic Information  
**Program Budget Code:** 17  
**Planned Funds:** \$150,000

**Activity System ID:** 22932

**Activity Narrative:** This funding will be used to pilot new methods for population-based, PEPFAR-funded surveys.

ACASI (audio-computer assisted self-interviewing) is an interview technique that eliminates the interviewer. The respondent reads and/or listens to questions on a computer and enters the answer by use of a keyboard, mouse, or touch screen. There is a growing body of literature suggesting that respondents more frequently confirm socially undesirable behaviors when asked through ACASI than through face-to-face (FTF) interviews. ACASI also has been evaluated or used in Africa, including in rural household based surveys, confirming its feasibility among respondents who are illiterate or may not have used a computer before. Facilitating more accurate answers to sensitive questions or questions on socially undesirable behaviors may help to better analyze HIV-related survey data. ACASI may be a suitable data collection tool for population-based HIV-related surveys but thus far has never been piloted or evaluated in AIDS Indicator Surveys (AIS). This is primarily a proof of concept evaluation with the aim of demonstrating the feasibility of using ACASI for a bio-behavioral household-based survey and its potential advantages. This evaluation will take place in enumeration areas (EAs) separate from the main AIS survey. Data from this evaluation will not be included in the main survey. Consenting adult household members will undergo the same survey procedures as in the main survey including biomarker collection and testing. The sequence of events will be identical to that in the main survey. A few questions will be asked twice: through FTF and through ACASI. The ACASI will include the entire AIS questionnaire. Qualitative interviews will be conducted with a small number of survey respondents in both old and new EAs.

The protocol describing the methods in detail is nested into the main AIS protocol that is currently under review.

We anticipate that the field methods will take place immediately following the planned Uganda AIDS and Malaria Indicator Survey. UAMIS will start in May 2009 and likely end in August or September 2009.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Emphasis Areas**

Gender

- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$25,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09

**Mechanism:** CDC GHAI

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 16782.22933.09

**Planned Funds:** \$40,000

**Activity System ID:** 22933



**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

This surveillance activity aims at most-at-risk populations including men having sex with men (MSM), female sex partners of MSM, female sex workers, male sex partners of female sex workers, university students, and transport workers in Kampala, Uganda. The project goal is to inform Uganda's public health system about groups at high risk for HIV infection and to eventually facilitate and evaluate prevention activities and related services. The project objectives include identification and recognition of selected high risk groups, monitoring trends in prevalence of HIV and other selected sexually transmitted infections (STIs), and identifying and describing risk factors associated with HIV infection. This PEPFAR-funded surveillance system is conducted in collaboration with the Ugandan MOH and the School of Public Health, Makerere University.

The target sample size is approximately 600 per MARP group; the estimated sampling period is 3-6 months per group. All MARP groups will be sampled using the same infrastructure. Respondent-driven sampling will be employed; quantitative data will be collected through computer-assisted self interviews; qualitative data will be collected through individual semi-structured interviews. Specimen collection includes blood and urine, as well as rectal and vaginal swabs. HIV voluntary counseling and testing will be provided, as well as testing and treatment for selected STIs. The activity started its field procedures in May 2008.

Currently, sampling is progressing. We anticipate that sampling of the above mentioned groups will end in FY 2009. Thereafter, this activity will prepare to sample new potential high risk groups. Findings will be disseminated to develop or improve control activities and services.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16782

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16782	16782.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$26,650

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Reducing violence and coercion

**Human Capacity Development**

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1245.09	<b>Mechanism:</b> Makerere University Walter Reed Project (MUWRP)
<b>Prime Partner:</b> Walter Reed	<b>USG Agency:</b> Department of Defense
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17

**Activity System ID:** 20040

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection and reporting, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a vast array of counseling and testing and prevention programs.

During FY2008, the focus of MUWRP's SI program was to strengthen the HMIS capacity of Kayunga District Hospital and its five 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 to all District 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. Funding support salary of 4 SI staff, training, maintenance, six computers, supplies, technical expertise and internet service provision. Finally during 2008, MUWRP staff continued to conduct analysis of data that are collected as a part of routine patient/client visits. Some of the analysis will include 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 were able to present 4 posters on HIV/AIDS activities in Kayunga at the International AIDS Conference in Mexico City in August 2008.

**THIS ACTIVITY IS A CONTINUATION FROM FY2008 WITH THE FOLLOWING UPDATES:**

During FY09 a pilot MUWRP supported SI innovative will build on past successes. The goal of this new activity 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. Success will require material support as well as technical assistance. MUWRP intends to partner with the Hospital Information System Program (HISP) based in South Africa, to accomplish this task. The HISP will send computer engineer consultants to configure their District Health Information Software (DHIS) for Kayunga District purposes. The DHIS software has already been successfully rolled out in rural areas similar to Kayunga District in South Africa and Nigeria. The HISP has agreed to provide the DHIS software free of charge to MUWRP and any other Ugandan Districts. Training on the DHIS was given to a broad spectrum of persons so District and MUWRP staff will not be dependent upon the HISP staff for technical assistance. Efforts so far have focused on completely customizing the DHIS for the Uganda HMIS system, with over 2000 indicators added to the software and all of the Uganda HMIS forms incorporated back to the year 1995. It is our hope that Kayunga will be a model site for this endeavor since no other Districts have yet attained this capacity. MUWRP costs will cover a two-week training by the DHIS engineers which will be offered to technicians from Uganda MOH, USG agencies, as well as technicians from MUWRP and Kayunga District. Progress has already been made in this regard: 1600 Uganda specific health indicators have been tailored to the DHIS software and Kayunga District HMIS staff have updated the database with one year of prior health data and made reports. Also during FY2009, a CDC provided electronic tracking system for HIV/AIDS patients at the Kayunga District Hospital will be rolled out. 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 which has the largest patient load of all the HIV clinics in Kayunga District. ART treatment club members at the District hospital will be trained to administer the tracking program. During the past year, other program areas within the MUWRP comprehensive model experienced great success in task-shifting to treatment club members. Moreover during FY09, MUWRP needs to address the SI needs of the District Hospital laboratory which processes and reports all of the HIV samples for Kayunga District. This new automated laboratory information system, to be piloted at the Kayunga District Hospital, will link lab reports to patients files. Finally in FY2009 MUWRP intends to expand its services into Mukono District and initially support the Kojja Health Center IV. The initial aims of this support will be to promote care, treatment and Counseling and Testing processes for the entire sub-district of Mukono South; including supporting three surrounding health center III's in the same service provision. Program activities that are included in MUWRP's comprehensive approaches, such as care, treatment, laboratory, and CT services, will be budgeted under their respective program areas. However, in order for these programs to operate successfully, MUWRP will leverage SI funding to cover required expansion of staffing, increased materials and data management and training of local implementing partners.

**New/Continuing Activity:** Continuing Activity**Continuing Activity:** 15715

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15715	4516.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$125,000
8529	4516.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$107,000
4516	4516.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$32,375

### Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$21,500

### Public Health Evaluation

### Food and Nutrition: Policy, Tools, and Service Delivery

### Food and Nutrition: Commodities

### Economic Strengthening

### Education

### Water

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 5246.09

**Mechanism:** Tuberculosis/HIV Intergration Activities

**Prime Partner:** AIDS Information Centre

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 10036.20749.09

**Planned Funds:** \$0

**Activity System ID:** 20749

**Activity Narrative:** This PHE activity "Evaluating the Utility of Re-testing HIV Negative VCT Clients" was approved for inclusion in the COP. The PHE ID associated with this activity is "UG.07.0155"

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13257	10036.08	HHS/Centers for Disease Control & Prevention	AIDS Information Centre	6426	5246.08	Tuberculosis/HI V Intergration Activities	\$0
10036	10036.07	HHS/Centers for Disease Control & Prevention	AIDS Information Centre	5246	5246.07		\$0

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$0

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechansim**

**Mechanism ID:** 1298.09

**Mechanism:** HIV/AIDS Project

**Prime Partner:** Mildmay International

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 8640.20804.09

**Planned Funds:** \$293,457

**Activity System ID:** 20804

**Activity Narrative:** This PHE activity 'Targeted Evaluation of Strategies to Decrease HIV-transmission Risk Behavior and Increase Drug Adherence Among HIV-Infected Adults Initiating Antiretroviral Therapy in Uganda' was approved for inclusion in the COP. The COP tracking ID associated with this activity is 'UG.07.0164'.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13292

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13292	8640.08	HHS/Centers for Disease Control & Prevention	Mildmay International	6433	1298.08	HIV/AIDS Project	\$350,000
8640	8640.07	HHS/Centers for Disease Control & Prevention	Mildmay International	4808	1298.07	HIV/AIDS Project	\$300,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$293,457

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3481.09	<b>Mechanism:</b> CDC GHAI
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 13332.20833.09	<b>Planned Funds:</b> \$550,000
<b>Activity System ID:</b> 20833	

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

The CDC Informatics Unit provides technical assistance for the development and implementation of strategic information systems to the PEPFAR/Uganda country partners. The informatics initiatives include support to the Ministry of Health Uganda Government, routine health service data collection at the district and National levels and support to USG partners offering ART care to patients, through the development and deployment of system.

Two main activities were funded in FY 2008 - Appropriate Technologies for Health and Electronic Medical Records.

\*\* Appropriate technologies for Health: A survey within Uganda, Tanzania and Rwanda at both public and private sites as well as CDC offices was conducted by CDC Informatics team and consultants to assess availability of health related information communication technologies in healthcare delivery and a report written. Key findings show that a variety of technologies exist in the countries mentioned, all at various cost levels. These include usage of mobile phones, PDAs, wireless technology, GPRS among others. One key finding was that sometimes the technology is pushed without a clear business case defined (in other words, the technical solution was available before it was known in which field it should be applied, which does not necessarily result in the best solution) The results will further inform a technical pilot on mobile technologies in Government health facilities including the usage of GPS, GPRS, PDAs and mobile phones, which is in the design phase now, to assess the use of these technologies in capturing, transferring and reporting information collected at public health facilities. Currently there is an activity to pilot power backup alternatives in resource limited settings; solar panels and PDA are being used for data collection to enhance the use and quality of data received at the district level. Two Implementing Partners have been identified to assess this technology and execution will begin by early December for a period of one year. Results will inform Ministry of Health, donors and partners as to whether it is feasible to roll out this technology to rural settings.

\*\* Electronic Medical records: Several meetings have been held to work out an implementation plan that will be acceptable to all stake-holders. An ART EMR database will now be installed at six PEPFAR funded partners whereby all indicators have the same definition, thus allowing for easy comparison and analysis of data. Several clinical reports have been suggested and will be developed to assist the USG partners in tracking the progress of their programs. In FY 2008, the focus was on ART indicators. Additionally, besides the clinical reports, program reports for monitoring purposes will be developed, including national reports which feed into the national system, and the PEPFAR specific reporting needs. Currently, this activity focuses on PEPFAR partners only, but it is expected that the dataset being developed can be adopted by the Ministry of Health as it will be based on the WHO HIV Care and Treatment card.

The above activities will continue in FY 2009. Several PEPFAR funded Implementing Partners have limited capacity to evaluate and select appropriate laboratory information systems – it should be noted that laboratories are a key component to the provision of appropriate and quality HIV/AIDS care and treatment for PLWHAs. This activity will assist PEPFAR funded partners in the selection and implementation of clinical laboratory system(s) and assess the feasibility for each to function in a typical clinical laboratory setting, such as found at PEPFAR funded sites or non PEPFAR funded Ministry of Health facilities. It will also pilot and identify appropriate technologies in the electronic transfer of laboratory results between collaborating laboratories, while considering the sensitivity of the data, for the provision of health care. There will also be a continuation of the technology pilot activities started in FY 2008 and an evaluation will be carried out to assess if the technologies can be scaled up within the country to meet the reporting needs.

There will be a continuation of the EMR activities started in FY 2008. For FY 2009, it is projected that more partners will benefit from the common dataset, and technologies will be tested to transfer data on clients who receive services from multiple sites for various reasons (for example, using a smart card). This will reduce double counting during reporting. It will also provide an electronic data transfer mechanism to various stakeholders, such as the Ministry of Health AIDS Control Program and the Resource Centre. This activity will be a continued effort with the PEPFAR Uganda Care and Treatment Working Groups. Additionally, the activity will assess the feasibility of including VCT indicators in the EMR. The feasibility of feeding data from this system directly to the MOH (such as the Resource Centre and the AIDS Control Program) will also be addressed. This activity will bring the various service databases that currently exist at partner sites together in one database, so that comprehensive reports for clinical monitoring and program monitoring (national and PEPFAR) can be developed, reducing the burden of reporting.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13332

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13332	13332.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$550,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$302,500

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09

**Prime Partner:** US Centers for Disease Control and Prevention

**Funding Source:** GHCS (State)

**Budget Code:** HVSI

**Activity ID:** 10084.20835.09

**Activity System ID:** 20835

**Mechanism:** CDC GHAI

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Program Area:** Strategic Information

**Program Budget Code:** 17

**Planned Funds:** \$120,000

**Activity Narrative:** CDC Uganda and the Ministry of Health Uganda National TB & Leprosy Program (NTLP) will support a survey of anti-tuberculosis drug resistance among smear-positive TB patients. This survey will provide national data regarding primary and acquired anti-TB resistance, and multi-drug resistance (MDR) in Uganda. In addition, further data will be obtained on HIV prevalence among smear positive TB patients. The survey will provide an estimate of the extent of mono-drug resistance, MDR, and extreme drug resistance (XDR) among smear positive TB patients as well as those who are HIV co-infected. This activity is a continuation from last year, during which planning, protocol development, and NRD/IRB clearances were initiated.

The World Health Organization (WHO) estimates that approximately 19% of adults with active TB disease in Uganda are HIV-infected. However, a recent study among a select group of patients in Uganda found that 50% of newly registered TB clients were HIV positive. HIV co-infection poses additional challenges in the prevention, diagnosis and treatment of drug-resistant TB. Mortality rates for MDR TB are greater among those who also have HIV--as high as 89% compared to 37% among those without HIV infection. It was recently reported that among 52 co-infected South African patients with XDR TB and on antiretroviral therapy, the median survival was only 16 days.

The WHO and the International Union Against TB and Lung Diseases (IUATLD) recommend monitoring of anti-TB drug resistance either through ongoing surveillance or periodic surveys. In Uganda, however, no nationally representative TB drug resistance data are available. A survey conducted in three regions in 1996-97 found that resistance to rifampicin was 0.8% and the prevalence of MDR TB was 0.5% among all TB isolates collected. In 2005, a survey conducted among hospitalized patients at Mulago, the national referral hospital in Kampala, found the prevalence of MDR TB to be 4.5% among new TB patients, representing a 10-fold increase in drug resistance in less than a decade.

In order to address the lack of country-level data, the survey proposed here will provide a national estimate of primary and acquired anti-TB drug resistance including MDR. As per the National TB/HIV policy, all TB patients included in the survey will undergo HIV counseling and testing. Given the important overlap between TB and HIV epidemics, this survey will also serve to obtain HIV prevalence data among TB patients. Data will allow comparison of the prevalence of drug resistance (including MDR TB and XDR TB) between TB patients with and without HIV infection. It will also help assess the capacity to diagnose and manage MDR TB at the National Tuberculosis Reference Laboratory (NTRL) and within the National TB program.

The surveillance activity will be a cross-sectional survey of patients aged 13 years and above with sputum smear-positive TB in Uganda. The sampling frame has been designed to be representative of all sputum smear positive TB patients within the 9 NTLP zones of the country. A modified weighted 30-cluster sampling technique proportional to the number of new smear positive TB cases diagnosed in health facilities throughout the country will be used (population proportionate cluster sampling). The 30 clusters have been selected from a 2007 list of facilities reporting the requisite number of smear positive cases. The number of new sputum smear positive cases registered by NTLP in 2005 and officially reported by WHO was 20,559, from which the sampling interval ( $20,559/30 = 685$ ) was calculated. The WHO recommends powering drug resistance surveys for significance based on the estimated prevalence of rifampicin resistance. In a recent survey conducted at Mulago Hospital, the prevalence of rifampicin resistance was 1.4%. Therefore, a sample size of 1,500 smear positive TB patients was calculated based on detecting a prevalence of 1.4% with a precision of 1-2%, using a 95% confidence interval; at least 50 smear-positive sputum cases would be needed within each of 30 clusters. Selected facilities (clusters) identifying less than 50 smear positive cases will be grouped into pseudo-cluster facilities so that at least 50 cases are available for sampling. All eligible diagnosed patients within clusters will be consecutively sampled from the time of survey initiation until the required number for each cluster is reached. Enrolment will take place over a maximum of 12 months. All re-treatment cases identified during the intake period at survey sites will also be evaluated, but will be in addition to the sample of 50 newly diagnosed cases per cluster.

Suspected TB patients will undergo sputum smear evaluation at the facility; if positive and eligible for enrolment, they will be administered a consent form by on-site clinical staff. Two new sputum samples from each enrolled patient will be transported to the NTRL for culture examination using the existing National Sputum Referral System, which employs POSTA, the Ugandan postal service. Results of drug resistance testing will be returned to the originating health facility through the same system, to ensure that clinical staff have timely access to results. All isolates found to be MDR TB will be tested for second line drug susceptibility to determine the presence of XDR TB. HIV testing and counseling will be provided to all patients at the site of enrolment according to the national TB HIV policy, and persons identified as HIV infected will be referred for HIV care & treatment. Patients with MDR or XDR TB will be referred to one of two national referral sites for treatment of resistant TB.

Data will be entered centrally at the NTLP and analyzed using specifically designed WHO software. Results will be written up and presented in report form and published, and disseminated to interested stakeholders. These results will help provide information on the extent of drug resistant TB in Uganda, and guide programming, policy and guidelines for detection and management of TB and TB/HIV co-infection.

This activity began in FY2008 during which time the sampling methodology was developed, protocols were written and submitted, and initial logistical preparations made including procurement of some laboratory supplies. The sampling methodology was reviewed by statisticians at CDC-GAP, and revised accordingly. A protocol was then completed and submitted to the CDC GAP-ADS office for technical review and ethical clearance (October, 2008). Comments are pending. The protocol has also been submitted to the Makerere University Faculty of Medicine IRB for review. The time line for completion of the project is 18 months from the start of client enrolment.. This surveillance activity can begin as soon as IRB and ADS comments are received, revisions made, and final approvals obtained.

**New/Continuing Activity:** Continuing Activity



**Continuing Activity: 13334**

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13334	10084.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$120,000
10084	10084.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4819	3481.07		\$268,278

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09 **Mechanism:** CDC GHAI  
**Prime Partner:** US Centers for Disease Control and Prevention **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State) **Program Area:** Strategic Information  
**Budget Code:** HVSI **Program Budget Code:** 17  
**Activity ID:** 16832.20836.09 **Planned Funds:** \$75,000  
**Activity System ID:** 20836  
**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

This activity was originally proposed as a PHE but was subsequently determined to be a SI activity. Note: The protocol title for this activity has been changed to "VCT-based surveillance of HIV-acquisition"

Conventional HIV surveillance focuses on monitoring HIV prevalence. Prevention programs however need information on the determinants of acquiring and transmitting HIV. The surveillance system described here is tailored after the slogan "Know your epidemic – the last 1000 HIV infections". It primarily aims at tracking recently HIV-infected persons to better inform about the current determinants that put people at risk. At selected sites VCT clients' demographic and behavioral characteristics will be evaluated by their HIV status: HIV-negative, recently HIV-infected, long-term HIV infected. The clients' left-over HIV-positive blood will undergo additional off-site testing to identify those likely to have been recently infected. Same-site HIV-negative "controls" serve as a comparison group. At the sites where this activity will be implemented, a more risk profile will be available to counselors for the purpose of counseling. Further, the introduction of computer-assisted self interviews (CASI) may decrease workload for site staff. This activity intends not to monitor HIV acquisition/transmission risk behaviors and characteristics.

Its main objectives are to describe:

- 1) HIV acquisition determinants (among recently infected individuals)
- 2) HIV transmission risk behaviors (among both recently and long-term infected individuals)

These data will facilitate the tailoring of prevention activities targeting HIV-uninfected and 'Prevention With Positives' (PWP) programs. It will also facilitate more targeted counseling for VCT clients at the involved VCT centers.

The protocol for this activity is currently under review at CDC Atlanta. Work is undergoing with the implementing partner to revise the client form and prepare the ACASI interview format; also to integrate the new IT components in the partner's routine system and work flow.

In FY 2009, upon obtaining human subjects approval, we will implement this activity first at the main site in Kampala, and thereafter at other sites.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16832

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16832	16832.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$75,000

## Emphasis Areas

Gender

- \* Increasing gender equity in HIV/AIDS programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development \$5,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

Table 3.3.17: Activities by Funding Mechanism

<b>Mechanism ID:</b> 3481.09	<b>Mechanism:</b> CDC GHAI
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 16546.20837.09	<b>Planned Funds:</b> \$50,000
<b>Activity System ID:</b> 20837	
<b>Activity Narrative:</b> ACTIVITY UNCHANGED FROM FY 2008	

This activity is a continuation from FY 2008 and is largely unchanged. The main changes are that the previously described methods will be limited to PMTCT sites, i.e., the activity will not include STD clinics or VCT centers. This activity focuses on Evaluating the Utility of: (1) Using Routine Program HIV testing Data for Surveillance and (2) the HIV-1 Incidence Assay for Incidence-Based Surveillance. Note: The protocol title is "Program and incidence-based HIV surveillance in Uganda"

The traditional ante-natal clinic (ANC) based surveillance system relies on unlinked anonymous HIV testing (UAT), is relatively small (~10,000 clients/year) and slow in detecting changes in trend. In Uganda, PEPFAR is the largest donor for HIV testing for PMTCT. Such routine testing programs generate large amounts of HIV testing data (PMTCT: 250,000), therefore having the potential of facilitating more precise prevalence estimates for surveillance. Importantly, HIV-positive left-over blood from the PMTCT program can be tested with HIV incidence assays, with the prospect of establishing an incidence-based surveillance system for a more timely detection of trends in Uganda's HIV epidemic. This activity evaluates the utility of routine PMTCT program data and specimens for an expanded prevalence and a new incidence-based surveillance system. Potential biases and limitations to be examined include self-selection bias for testing and the accuracy of laboratory-based incidence testing for surveillance. The new methodologies will be piloted at no more than a total of 5 PMTCT clinics. Routinely collected program data will be transcribed and left-over HIV-positive blood will be collected on filter paper for incidence testing. As PMTCT clients are not consented for further testing and data analysis, testing of these left-over specimens will be performed unlinked, akin to the traditional UAT-based ANC surveillance system. Same site PMTCT and UAT-based prevalence data will be compared, as well as PMTCT-based incidence estimates generated. The sampling populations constitute PMTCT clinic clients. Akin to traditional ANC-based surveillance, PMTCT-based prevalence (and incidence) estimates and trends would be extrapolated to the general adult populations with or without adjustments.

The protocol is fully developed and is currently under review locally and at CDC Atlanta. We anticipate that this activity will commence its "field activities" by in the first quarter of FY 2009. The activity will first be implemented at 5 PMTCT sites, and expanded to 15 sites in FY 2010 and likely 30 sites in FY 2011. We expect that in FY 2011 this activity may be fully handed over programmatically to Ministry of Health.

**New/Continuing Activity:** Continuing Activity

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16546	16546.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$50,000

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$5,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

Estimated amount of funding that is planned for Food and Nutrition: Policy, Tools and Service Delivery \$5,000

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1257.09	<b>Mechanism:</b> CDC Base GAP
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 4703.20845.09	<b>Planned Funds:</b> \$840,816
<b>Activity System ID:</b> 20845	

**Activity Narrative: ACTIVITY UNCHANGED FROM FY 2008**

The CDC Informatics Unit provides technical assistance for the development and implementation of strategic information systems to the country office and prevention, care and treatment implementing partners, including the Ministry of Health. Some of these service providers are funded by PEPFAR, and CDC Informatics Staff provide all of them with direct, hands-on support to design strategic information systems tailored to meet the specific needs of the programs and to build institutional capacity across the organization. The team actively engages partner management and clinic staff at all levels to build consensus and develop applicable standards for effective information system development. Strategic information program interventions range from the design of patient care records, clinic management and logistics system to the integration of monitoring and evaluation of national indicators between the MOH HMIS and the PEPFAR program.

Through coordination with the PEPFAR program and CDC Uganda Program Unit we have developed an in depth understanding of Uganda's infrastructure and our partner's resources, capabilities and desires. CDC Informatics has a number of highly skilled, well educated individuals who understand our mission is to assist our partners in developing their capabilities and abilities. For the most part our partners have become capable of maintaining the initial less complicated data base and data entry systems. They recognize the need for better data quality control, and better reporting tools. We have partners that are using and tracking thousands to a little over a hundred thousand patients.

The Uganda infrastructure is lacking in reliable power and computer connectivity systems. Some areas have no access to internet, telephone or power. Developing systems that allow these areas to be included in surveillance system will require multiple capability systems that are standardized. Multiple parties working independently on the same problems often create incompatible systems which reduce efficiency and causes unnecessary delays. CDC Uganda informatics Unit will continue to provide guidance to our partners and develop software following proven computer software design techniques such as structure programming, industrial data base data management standards will be used and taught. System development planning will be based on the practical needs of the partner, the expected long term resources available to the partner, and the skills and capabilities of the partner.

In following activities initiated in FY 2005, FY 2006, FY 2007 and FY 2008, the Informatics Unit will focus on the following key areas in FY 2009: \*\*investigate and where applicable develop computer related capabilities such as biological patient recognition, computer power sources, and hand held computers which support our public health partners, support the MOH Resource Center development of computer capacity for national data collection and reporting;

\*\*connectivity and computer infrastructure from internet access to specific network topology design and implementation; applications development for the creation of standard information systems and tools for management and clinic facilities; development and design of SI collection instruments; data entry and management; analysis and reporting of SI;

\*\* information and infrastructure security and maintenance.

Training in each of these areas will also be developed and supported either directly by the CDC Informatics team or through utilization of outside resources and partners. The goal of training and technical support provided is aimed at building partners' capacity to implement and maintain their own HMIS with limited on-going technical support from CDC. Technical assistance will also be provided in the interconnectivity of MIS for all partners into the national HMIS and USG systems where required or relevant. Finally, the CDC Informatics Unit will conduct on-going SI needs assessments of partners to ensure informatics resource growth to match needs necessitated by increasing care and prevention activities. The increases in demand reflect the success in implementing initial programs since the partners have used these initial systems and by passed the systems capacity.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13342

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13342	4703.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6446	1257.08	CDC Base GAP	\$899,504
8384	4703.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4820	1257.07	CDC Base GAP	\$899,504
4703	4703.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3347	1257.06	CDC Base GAP	\$872,000

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

Human Capacity Development

Public Health Evaluation

Food and Nutrition: Policy, Tools, and Service Delivery

Food and Nutrition: Commodities

Economic Strengthening

Education

Water

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 679.09

**Mechanism:** Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)

**Prime Partner:** Protecting Families Against AIDS

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 10083.20863.09

**Planned Funds:** \$367,000

**Activity System ID:** 20863

**Activity Narrative:** This PHE activity 'Interactions between HIV and malaria in African Children: Tororo Child Cohort (TCC) Study' was approved for inclusion in the COP. The PHE tracking ID associated with this activity is 'UG.07.0162.'

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13311

## Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13311	10083.08	HHS/Centers for Disease Control & Prevention	Protecting Families Against AIDS	6438	679.08	Promoting Extensive Implementation of Quality Prevention of Mother to Child Transmission (PMTCT)	\$145,000
10083	10083.07	HHS/Centers for Disease Control & Prevention	Protecting Families Against AIDS	4813	679.07		\$145,000

---

**Emphasis Areas****Human Capacity Development****Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$367,000

**Food and Nutrition: Policy, Tools, and Service Delivery****Food and Nutrition: Commodities****Economic Strengthening****Education****Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 10102.21225.09

**Planned Funds:** \$309,150

**Activity System ID:** 21225

**Activity Narrative:** Makerere University School of Public Health (MUSPH) is located within the Mulago National Teaching and Referral Hospital in Kampala. 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 Phase 1. The grant has three major programming components. 1) The comprehensive community based HIV prevention, care and treatment implemented by RHSP. 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. 3) MUSPH also recently received additional funds from CDC to to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with Johns Hopkins University Center for Clinical Global Health Education (CCGHE). MUSPH also receives funding for a Public Health Evaluation (PHE) "Crane Survey" Surveillance of HIV and STI infections and associated risk factors among most-at-risk populations in Kampala, Uganda.

In Uganda, HIV surveillance and prevention activities focus almost entirely on the general population. Little is known about the risk of HIV infection among most-at-risk populations (MARPs), as well as their prevention, care and treatment needs. Similarly, little bio-behavioral surveillance is conducted among MARPs. This public health evaluation (PHE) employs MARP surveillance methods for high-risk groups including men having sex with men, female partners of MSM, female sex workers, non-paying partners and paying clients of sex workers, university students, and transport workers in Kampala, Uganda. The project goal is to inform Uganda's public health system about groups at high risk for HIV infection and to eventually facilitate and evaluate prevention activities and related services. The project objectives include a) identification and recognition of selected high risk groups, b) monitoring trends in prevalence of HIV and other selected sexually transmitted infections (STIs), and c) identifying and describing risk factors associated with HIV infection. This PEPFAR-funded surveillance system will be conducted in collaboration with the Ugandan MOH and the Centers for Disease Control and Prevention. These surveys will be conducted every other year with different MARP groups sampled on alternate years. The target sample size is approximately 600 per MARP group, totaling 3600; the estimated sampling period is 3 months per group beginning in May 2008. Future MARP groups may include street youth, people in concurrent sexual partnerships, women having sex with women, and fishing communities. MARP groups are sampled nearly concurrently using the same infrastructure. Respondent-driven sampling are employed; quantitative data are collected through audio-computer-assisted self interviews; qualitative data are collected through individual semi-structured interviews. Specimen collection includes blood and urine, as well as rectal and vaginal swabs. HIV voluntary counseling and testing are provided, as well as testing and treatment for selected STIs. Findings will be disseminated to develop or improve control activities and services.

During FY 2008, the Crane Survey accomplished all logistical measures for survey setup. The investigators conducted planning meetings with MUSPH, MOH, CDC, and other key stakeholders. All IT and lab systems were developed and implemented, including innovative software WinMARP a results.exe program, designed by CDC-Uganda software design team. Furthermore all questionnaire instruments were placed into ACASI (Audio Computer Assisted Self Interview) format using the QDS (Questionnaire Design Studio) format so that recruits could self-administer the behavioral questionnaires. These softwares ensure anonymity, confidentiality, scheduling, patient flow, and results delivery to all recruits. Over the months prior to initiating the survey, the Crane Survey team pretested and refined all research instruments, methods, and clinic flow.

In January and February 2008, 10 Nurse Counselors, 4 Coupon Managers, 2 Data Managers, 4 Medical Laboratory Technicians, 1 Administrative Assistant, and 3 Janitors were selected after a competitive interview process at the MUSPH to comprise the Crane Survey staff. All hired contracted staff received initial and continued training and capacity building of respondent driven sampling (RDS) methodology to 19 individual members. The initial training was for a 2-week period in February 2008 during which sampling concepts were taught, HIV VCT for MARPs reviewed, network, software and data systems implemented, and training on specimen collection and testing provided to appropriate staff members.

The surveillance system formally began data collection activities on May 19 2008. Since the beginning of the survey, 30 seeds have been trained to initiate peer and partner recruitment for initial waves for five MARP groups. As of August 23 2008, 1,075 recruits have redeemed their coupons in order to be screened, of whom 823 were eligible for survey participation. 212 recruits tested positive for HIV antibodies and were referred to or will be referred to HIV care centers in greater Kampala. 133 recruits have tested positive for STIs and have been offered (or will be offered) appropriate treatment onsite. 20 recruits have been interviewed for in-depth individual qualitative interviews.

As of 23 August 2008, there are 2,777 MARP survey participants remaining to be enrolled and is expected to take a time period through early 2009. The sixth (and final) group for this cycle will be introduced in mid-September 2008. There are 55 qualitative interviews remaining. As the MARP surveillance system has been proposed as an ongoing surveillance activity, the infrastructure now exists to sample other MARP groups not previously included in the first cycle.

In FY 2009, the Crane Survey will conduct formative research for other identified urban Kampala MARP groups based on literature and data in order to include them in the surveillance system. The surveillance system will continue to sample current FY 2008 MARP groups if target sample not yet attained.

Once appropriate MARP groups have been identified by formative research, a minimum of four new groups will be introduced into the surveillance system, with the same expectation that they would be sampled every other year throughout the surveillance system. This would introduce an additional 2,400 recruits.

**Activity Narrative:** The Crane Survey staff will continue to receive ongoing refresher courses in RDS methodology and sampling, HIV counseling and testing for MARP groups, data management, and laboratory testing. All recruits will participate in specimen collection and testing, behavioral data collection using ACASI or CAPI technology, and peer recruitment. Furthermore, FY 2009 Crane Survey activities will require submission for ethics continuations for both the main and formative protocols (from CDC-Atlanta, UVRI, and UNCST). As the surveillance system will have collected complete data sets, standard data cleaning will be required and data analysis may then be conducted. These results will be disseminated via Local Stakeholders meeting, national and international conferences, and peer-reviewed scientific publications. There will be an ongoing collaboration with existing HIV treatment centers in greater Kampala in addition to other MARP-specific programs (e.g. MARPI project at the STD Clinic at Mulago Hospital).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13240

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13240	10102.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV/AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$473,300
10102	10102.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV/AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$386,672

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$142,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**



**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 17111.21226.09

**Planned Funds:** \$0

**Activity System ID:** 21226

**Activity Narrative:** This PHE activity 'Assessing the Relationship between Intimate Partner Violence and HIV Status Disclosure in Rakai District, Uganda' was approved for inclusion in the COP. The PHE tracking ID associated with activity is 'UG.07.0157'.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 17111

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
17111	17111.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$50,000

**Emphasis Areas**

**Human Capacity Development**

**Public Health Evaluation**

Estimated amount of funding that is planned for Public Health Evaluation \$0

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.17: Activities by Funding Mechanism**

**Mechanism ID:** 1259.09

**Mechanism:** Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development

**Prime Partner:** Ministry of Health, Uganda

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Strategic Information

**Budget Code:** HVSI

**Program Budget Code:** 17

**Activity ID:** 4406.21236.09

**Planned Funds:** \$1,140,000

**Activity System ID:** 21236

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MOH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

The MOH SI activity provides accurate data to inform both the strategic planning and monitoring and evaluation (M&E) for HIV prevention, care and treatment, as well as broaden integrated health sector programs. The MOH SI activity also support elements of STI surveillance, behavioral surveillance, and AIDS case surveillance as part of monitoring of the ART program. STI surveillance and STI case reporting is done through the national universal reporting system (HMIS). The PEPFAR support has improved the implementation of second generation HIV surveillance, M&E, and public health evaluation. A strengthened surveillance system is particularly important in light of the current trends of HIV prevalence. The surveillance sites use enhanced methods to continually observe HIV trends, as well as estimate the overall burden of HIV/AIDS in Uganda through mathematical modeling; which supports setting of potential targets and impacts of prevention and care programs.

In FY2008, The MOH HIV surveillance system was expanded from 25 to 30 sentinel surveillance sites in several districts. The 2007 sentinel survey round was successfully implemented and samples collected and shipped for central laboratory testing. A protocol for a behavioral surveillance survey among fishermen was written and submitted to CDC Atlanta for review. Policy briefs from recommendations of the 2004-2005 serobehavioral survey were finalized and disseminated to key stakeholders. Working papers and some manuscripts were completed and published. The M&E system was evaluated with support from GFATM. A technical working group on HIV drug resistance (HIVDR) was appointed and data on HIVDR early warning indicators from 4 sites were presented to stakeholders. The initial discussions and planning for the 2009 AIDS and Malaria indicator survey were held.

The national Health Information Management System (HIMS) is being supported through a two pronged approach: 1) the training of sentinel, district, and sub-district surveillance staff, and 2) through the collection, analysis and dissemination of data, as well as direct support to the Resource Centre.

HIV sero-prevalence surveys have been started amongst selected high risk groups such as sex workers, fishermen, and truckers. These surveys will assist in updating relevant surveillance protocols and obtaining institutional ethical approvals for continued surveillance. Support under this activity directly relates to all other activities supported by the USG through PEPFAR as well as other HIV/AIDS activities supported by other bilateral and multilateral development partners in the country.

During FY 2009, this activity will continue to improve the second generation HIV surveillance program, M&E, and the HMIS. Sero-prevalence data from ancillary sources including: programmatic data, HIV Counseling and Testing (HCT), PMTCT and blood transfusion services and secondary data will be collected. The MOH has the lead role in the Uganda Malaria and AIDS indicator survey and hope to initiate fieldwork this year. The HIV and STI antenatal surveillance will be strengthened including training of sentinel site staff from 30 ANC sentinel sites, collection of biological samples and data, procurement of test kits, laboratory testing and quality assurance, data management and analysis as well as dissemination of the surveillance reports.

The HMIS will be strengthened to support STI and AIDS case reporting through training of sentinel, district, sub-district based, and resource centre staff in collection, analysis and dissemination of data. The activity will regularly collect HIMS data and integrate M&E from health sector HIV programs including: STI, PMTCT, ART, HCT, condom promotion, ABC programs and AIDS treatment data. The HIMS data integration project, will strengthen the country's monitoring and surveillance system. During FY 2009, efforts to implement activities in the national strategy for HIVDR surveillance will be supported. Technical support to districts and other organizations will continue to be provided, in order to improve competence for local M&E teams; with emphasis on output and process monitoring. Program indicators for output, process, outcome, and impact monitoring will be reviewed and updated; particularly taking into account emerging program areas such as ART, cotrimoxazole prophylaxis, and TB/HIV collaborative activities. Utilization of M&E and surveillance data will continue to be strengthened through appropriate training of users and enhanced dissemination of M&E findings. Data collection and management of ART longitudinal data (from client follow-ups), including cohort analysis to provide data on treatment outcomes will be done. MOH will assist with facility level data collection, compilation, analysis and reporting of ART data; as it is reported regularly to districts and sub-district levels. MOH will be able to provide support supervision and technical assistance to service delivery sites. Furthermore, this activity will improve data management for the

**Activity Narrative:** STD/ACP data unit and Resource centre including procurement of relevant hardware and software, supporting internet connectivity and incorporating geo-referencing in surveillance and programme monitoring activities.

The training component will create continuity in quality improvement of integrated HIV prevention care and support programs. Support under this activity directly relates to all other activities supported by the USG through PEPFAR as well as other HIV/AIDS activities.

additional narrative to existing text

The HMIS of the Ministry of Health largely depends on data sent forward by districts. Districts, under the decentralization process are required to collect data from individual health facilities, aggregate it and forward it to the Ministry of Health. They are also expected to analyze the data at district level and make interventions, if necessary.

The activities to be carried out require infrastructure and human resources, such as computers, electronic HMIS systems and training. In general, districts are under funded to perform all required HMIS activities, and some districts are being supported through district-based programs, such as NUMAT. Other districts receive support directed at health clinics within the district, but may not be directly supported to carry out their HMIS activities. Focused support activities are necessary to build a functional HMIS. Sharing of experiences may be undertaken across districts that receive support through district based programs and those under the currently proposed support in a bid to create unified USG approaches to HMIS support.

This activity proposes to provide some support, as described below, to build capacity within districts that do not directly benefit from a district-based program. Furthermore, this activity is expected to further strengthen the Resource Centre to carry out the activities mentioned below.

#### Tasks

The following tasks are proposed as part of the activity:

- § Improve district capacity in the analysis and use of district-based HMIS and program data
- § Supplement district HMIS budgets in districts with Non USG supported programs.
- § Provide training to national and district-based HMIS focal person in the use of HMIS and the available electronic HMIS system supporting software
- § Install an electronic HMIS system in districts with computers without any software, and repair/restore electronic HMIS systems in districts where a system was installed, but are no longer working
- § Facilitate support supervision by national level to districts and districts to service sites to improve point-of-care data collection
- § Provide guidance and leadership to districts served by district-based programs (such as NUMAT) in order to improve HMIS capacity
- § Support and facilitate the revision of tools as part of HSSPIII development process, and the national information strategy (Vision 2012)

#### Indicators

- § Number of data use workshops carried out and number of people in attendance;
- § Number of district supplemented with HMIS funds and amounts provided;
- § Number of districts reporting electronically to the national level after 6 and 12 months;
- § Number of district-based and HQ people trained in HMIS activities;
- § Number of support supervision activities carried out;
- § Further outputs;
- § Quarterly progress reports;
- § Monthly national HMIS summaries shared from the district data

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13300

### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13300	4406.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$740,000
8345	4406.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$739,862
4406	4406.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$672,602

Program Budget Code: 18 - OHSS Health Systems Strengthening

**Total Planned Funding for Program Budget Code: \$7,884,091**

#### Program Area Narrative:

The USG is working collaboratively with the UN systems, 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. Support is also being extended to key line ministries for policy development and program implementation, human resource capacity development, institutional capacity enhancement for indigenous organizations, and supporting democracy and governance programming, especially for decentralized HIV/AIDS response.

##### A. National leadership and coordination

The USG continues to engage with the UAC in spear heading mobilization of resources for HIV/AIDS programs. In 2008, with USG support the UAC started the operationalization of the five-year National Strategic Plan as well as the development of a Performance Monitoring and Management Plan. These are key guiding instruments against which progress can be measured and future strategies developed. In collaboration with UNAIDS and other AIDS development partners, the USG will continue to provide support to strengthen the capacity of the UAC to effectively lead the national response.

USG will continue to support the Government of Uganda to reorganize governance structures and implementation arrangements for the management of the Global Fund resources. Work is in progress to support UAC to ensure that GFATM funds for HIV/AIDS activities for government and non-governmental partners are channeled through the Civil Society Fund (CSF) that will be managed by UAC-Partnership Committee. USG/PEPFAR is contributing financial and technical management support on behalf of the development partners. The resource envelop for the CSF is expected to grow larger due to the three recently approved proposals. Proper management of these resources will position the CSF as a reliable and effective structure for channeling resources to civil society organizations.

##### B. Policy development and implementation

USG provides technical and financial support to MOH to meet its mandate of developing policies, standards and technical guidelines for the provision of quality health services. All PEPFAR working groups are represented on all MOH's technical committees that develop, review and update policies and technical guidelines. Some of the technical policies and guidelines so far developed include: the National Policy documents for ART, HCT, PMTCT, Nutrition in HIV/AIDS and Home-based Care, HIV/TB Collaboration, Cotrimoxazole Prophylaxis for People with HIV/AIDS, Post Exposure Prophylaxis, Infant Feeding guidelines, Communication Strategy for ART and TB/HIV Collaboration, the National ART Scale up Plan, and the National Condom Use and Distribution Guidelines among others. These policies and guiding instruments directly support service delivery and uptake of HCT, ART, HBC, PMTCT, and TB management.

In FY09, USG will continue to support MOH to complete unfinished policies and technical guidelines as well as to develop, update and disseminate these instruments in all regions. Priority will be given to developing new policies and guidelines for: Medical Male circumcision, Isoniazid prophylaxis, Positive Prevention, and HSV2 management. With the availability of new information and rapid development of new technologies, the MOH has plans to review and disseminate the following policies: the revised national HCT policies and related guidelines, ART implementation guidelines, STI treatment guidelines and in-service training manuals, and PMTCT implementation guidelines.

The Ministry of Gender Labor and Social Development has recently developed an HIV/AIDS in the workplace policy that is currently under review by Cabinet. The new follow-on private sector initiative will support the GOU to roll-out and implement the HIV/AIDS workplace policy through the private sector. Building on previous successes, this activity will continue to assist 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.

### C. Human Resources for Health

HRH policy and planning. To ensure an adequate health workforce for integrated HIV/AIDS and health services, the Capacity Project (CP) will continue to support the central and district levels to strengthen systems for effective performance-based health workforce development and management practices for improved performance and retention. The MOH's HRH Strategic Plan 2005-2020 has been strengthened and a Health Sector Master Plan for 2008 -2015 developed. Almost all (78) districts have developed district specific HRH Action Plans in line with national HRH Policy and Strategy. Using results from an MOH study on high staff turnover, comprehensive strategies for improved retention and motivation, and policy and guidelines for workplace safety and health, are being developed. The MOH has introduced a Performance Improvement (PI) program, including a Technical Resource Team to provide assistance at the central and district levels. HRH databases have been established in four Professional Councils and linked to the MOH and two pilot districts to improve recruitment and placement of health workers. In FY09 support will continue to complete the development of Human Resource Information System linking it to MOH Planning department and districts.

Leadership and management. Key training programs for HIV program managers and service providers will be expanded to support the development of quality high- and mid-level national leaders who will be charged with sustaining the national response over the long-term. Makerere University School of Public Health (MUSPH) started an HIV leadership training program in 2002 with USG support. This two-year apprenticeship training program graduated over 45 professionals who are occupying senior management positions in leading HIV/AIDS organization in Uganda and abroad. The HIV leadership fellowship was the first on the African continent and its model is being replicated in a number of African countries with similar human resource challenges. The program was evaluated in 2007 and modified and additional funding was obtained for another five years. In phase two, the program introduced short to medium term fellowships of 4-6 months and technical placements in addition to longer-term fellowships.

Internship Program. The USG team will continue to support the project that identifies and places Ugandan interns and trainees as technical support staff or advisors in civil society organizations, implementing partner organizations, and host country organizations that are implementing HIV prevention and treatment programs. This new activity will identify and provide support to academic public health, medical and/or social science training institutions to increase students' practical experience in HIV/AIDS service delivery and prevention areas. The ultimate goal of this project is to strengthen and diversify the pool of Ugandan skills and expertise needed to address the multifaceted challenges posed by the HIV/AIDS epidemic, and mobilize national resources in the national response to the epidemic.

Skills development. PEPFAR supports a number of capacity building and training programs. HIV/AIDS care and management programs are offered through central and regional centers by the Mildmay Center, Joint Clinical Research Center (JCRC), The Aids Support Organization (TASO) and Infectious Diseases Institute (IDI). Laboratory leadership training programs are offered by Central Public Health Laboratories (CPHL), AMREF and JCRC. The USG funded project for Strengthening Counselor Training in Uganda (SCOT) has supported the national program to standardize curricula for different cadres of counselors and roll out trainings in the districts. In January 2008, five curricula developed through the SCOT partnership were launched by the MOH as national standards for training counselor in the areas of: Provider Initiated Counseling and Testing in health care settings (PICT), Home Based HIV counseling and testing (HB HCT), Basic HIV Counseling and testing (HCT) and HIV Counseling Supervision. In addition, the SCOT provides institutional support to the Uganda Counseling Association (UCA). The USG has also supported Health Professional Councils and Associations in developing standards for accreditation of in-service training and continuing professional development (CPD).

In FY09, the SCOT program will continue to support the national program to develop, review and update materials for training of counselors, work hand with MOH and partners to develop a common certification framework for the different cadres of counselors and most importantly advocate to establishment of the cadre of counselors in the Public service

Task shifting. The USG participates in the national committee on task shifting, which was created following discussions with WHO/Geneva. The committee is comprised of MOH, UNAIDS, WHO/Uganda and USG. Guidelines are expected to be finalized and posted in November. USG/Uganda will follow the guidance outlined and work in partnership with other development partners to identify the most appropriate ways to support the GOU to address recommendations

**D. Capacity enhancement for indigenous organizations**

USG will also continue to provide organizational systems strengthening to national indigenous organizations playing key roles in the national response and decentralized local governments. Given Uganda's decentralized system of financing and governance, and the increasing number of new districts (from 56 in 2001 to 82 in 2008), USG efforts will continue to support improved HIV/AIDS planning, management, implementation and monitoring at district level through key political and technical HIV/AIDS structures. A key outcome will be integration of HIV/AIDS into District Development Plans, budgeting for HIV/AIDS services beyond basic commodities and improved coordination of resources and service delivery at the district and sub-county level.

In addition, the ongoing peace process in Northern Uganda has resulted in approximately 95% of people in the Lango region returning to their homes and 45% of people in the Acholi region moving to transit camps or their homes. A key focus in the North will be to improve service equity for vulnerable populations including internally displaced individuals, women and children. This will continue to require significant systems strengthening of key political and technical HIV/AIDS systems and structures to ensure well-planned, implemented and monitored HIV/AIDS activities after an 18-year civil war that decimated livelihood, education and health structures.

**E. Democracy and governance**

For democracy and governance programming, the USG will support the work of accountability committees and issues-based caucuses in Parliament focusing on the conflict in the North, women and children impacted by conflict, corruption, health and HIV/AIDS. These efforts are intended on increasing accountability and transparency between national level leaders and their constituents as well as creating increased demand at the local level for services and accountability. PEPFAR resources will leverage USAID's democracy and governance activities.

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1259.09	<b>Mechanism:</b> Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development
<b>Prime Partner:</b> Ministry of Health, Uganda	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 4502.21237.09	<b>Planned Funds:</b> \$795,000
<b>Activity System ID:</b> 21237	

**Activity Narrative:** The Uganda Ministry of Health (MOH) AIDS Control Programme (ACP) conducts activities to achieve the objectives of the Second National Health-Sector Strategic Plan, (HSSP II) 2006-2010, and the National HIV/AIDS Strategic Plan (NSP) 2007-2012, which are aimed at expanding access to quality HIV prevention, care, and treatment to HIV infected persons and their families. This cooperative agreement specifically supports the MoH to undertake the following five initiatives: 1) HIV Prevention, Palliative Care, Treatment and Support initiatives 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; 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 HIV counseling and testing through provider-initiated and home-based testing approaches; 2) TB/HIV integration initiative strengthens the prevention and clinical management of both illnesses; while increasing access to confidential HIV testing for TB patients, and provides TB diagnosis and treatment for HIV-infected individuals; 3) Policy and Systems Strengthening initiatives are used to identify gaps and assist in developing, revising and updating the Ugandan national policies and technical guidelines for HIV/AIDS related health services; creating improved management of TB/HIV co-infection and other Opportunistic infections; 4) Laboratory Infrastructure initiative supports the national central public health laboratory (CPHL) to develop policies, standard operating procedures, quality assurance and quality control process. The CPHL is able to conduct training and provide supervision to peripheral, district and, regional laboratories; improving access to early infant HIV diagnosis (EID). Similarly, this initiative supports strengthening capacity of health center IVs and IIIs laboratories to diagnose HIV related HIV, TB infection. 5) Strategic Information initiative supports the HIV/TB/STI surveillance activities, monitoring and evaluation of national and decentralised HIV/TB/STI programs and population-based studies, and support to the resource centre.

Under previous support under this activity, The MOH's has been able to meet its mandate of developing policies, standards and technical guidelines for the provision of quality health services. This support has enabled the review, revision, development, and dissemination of updated HIV/AIDS-related technical policies to guide national and district health services and frontline service providers in providing comprehensive and effective prevention, care and treatment services. Some technical policies and guidelines developed with support under this activity include; National Strategic Framework for HIV/AIDS activities in Uganda, the National Strategic Framework for the Expansion of HIV/AIDS Care and Support in Uganda, National Policy documents for ART, HCT, PMTCT, Nutrition in HIV/AIDS and HBC, HIV/TB Collaboration Policy, National Policy Guidelines for Cotrimoxazole Prophylaxis for People with HIV/AIDS, Post Exposure Prophylaxis (PEP) Policy, Training guidelines for Counseling, HCT, PMTCT, ART, Home Based Care/Palliative Care, and Infant Feeding, Communication Strategy for ART and TB/HIV Collaboration, the National ART Scale up Plan and the National Condom use and Distribution Guidelines. Other agencies that support policy development this activity include DFID, UNICEF, GTATM and PSI. In FY 2008 MOH reviewed the Communication strategy for ABC + promotion, printed and distributed the PEP policy and implementation guidelines; initiated policy discussion on Male circumcision, initiated development of child counseling guidelines. MOH revised the ART treatment guidelines and started adaptation of protocols for monitoring HIV drug resistance.

In FY 2009 this activity will develop, review, and update technical policies and guidelines, ensuring that all relevant policies and guidelines are evidence based, relevant, appropriate and responsive to meet the demands for appropriate services to address the current epidemic in Uganda and to ensure the achievement of the program goals. During policy development, the MOH will conduct wide consultation with national and international experts and local stakeholders, service providers, nongovernmental organizations, community based organizations, other sectors whose activities impact on the program and most importantly with the intended users of the services, persons infected with HIV and their families. The MOH in FY 2009 will review and disseminate the following policies: the revised national HCT policies and related guidelines, regional dissemination of ART implementation guidelines, develop STD management implementation guidelines, update STI treatment guidelines and in-service training manuals, review and update the PMTCT implementation guidelines., adopt the Family Support Groups' guidelines for PMTCT, dissemination of national HBC policy guidelines, develop policy framework on nutrition in HIV/AIDS, disseminate policy guidelines for laboratory services. In addition, the activity will support the development of new policies for the implementation of male circumcision, isoniazid prophylaxis, prevention with positives and HSV-2 management. The MOH's human resources department will be supported to implement the new Human Resource policy to create the position of HIV counselors in public health facilities and address task-shifting concerns. Finally, the MOH will ensure the completion of unfinished policies and guidelines and will undertake activities to evaluate existing policies with a view to identifying gaps.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13301



**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13301	4502.08	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	6434	1259.08	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$800,000
8348	4502.07	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	4809	1259.07	Support for National HIV/AIDS/STD/TB Prevention, Care, Treatment, Laboratory Services, Strategic Information and Policy Development	\$250,000
4502	4502.06	HHS/Centers for Disease Control & Prevention	Ministry of Health, Uganda	3342	1259.06		\$150,000

## Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs
- \* Reducing violence and coercion

Health-related Wraparound Programs

- \* TB

Military Populations

Refugees/Internally Displaced Persons

Workplace Programs

## Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$100,000

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

## Education

## Water

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 5738.09

**Mechanism:** 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:** Makerere University School of Public Health

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 4017.21227.09

**Planned Funds:** \$1,557,839

**Activity System ID:** 21227

**Activity 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 Phase 1. The grant has three major programming components.

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 neighbouring districts. RHSP also has a program for prevention of Gender Based Violence (GBV) and Medical Male Circumcision (MMC). Details of the activities under RHSP are described in other separate 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) MUSPH also recently received additional funds from CDC to establish an internet based distance learning program to support the training of PEPFAR partners in collaboration with 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, that 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.

Progress of the SPH-CDC Fellowship Program: The SPH-CDC Fellowship program currently has four major training activities: 1) the two-year (long-term) fellowship which has been implemented for the last six-seven years, 2) short courses, 3) the recently launched six month (medium-term) fellowship, and 4) the technical placements which will begin in the third quarter of FY 2008. The medium-term fellowships target mid-level managers and coordinators of programs who may not be able to spend 2 years undertaking the long-term Fellowship. Medium-term Fellowships will be offered for a 6-months period, during which participants undergo a one-month training and implement a project related to the training received. A number of achievements have been registered. In the previous grant, 45 long-term fellows were trained and the majority are currently in senior management positions within the country, with four working in other countries within Africa and one in Nepal. Over 1,000 individuals received short courses in management. Since the start of the new grant in December 2007 several activities have been conducted including selection, enrolment, and training of long-term Fellows, the mentorship workshop held May 30, 2008, offsite training courses and placement of long-term Fellows in different host institutions. A total of eleven (11) Fellows were recruited for the long-term Fellowship for the period April 2008 – March 2010. Fellows reported for their orientation and training on April 8, 2008 and undertook short courses in monitoring and evaluation, behavior change communication for HIV/AIDS, healthy plan-it, and design and implementation of HIV/AIDS programs up to May 16, 2008. All Fellows reported to their host institutions on May 19, 2008 and will stay with these institutions until November 3, 2008 when they will report back for additional short courses. A total of eleven host institutions were selected for the long-term Fellowship during this period. Each Fellow has been assigned a host and academic mentor for purposes of professional and academic growth. Four offsite training courses were run for four institutions during this period (KADDE-NET, CRS, Reproductive Health Uganda, and Pallisa Youth Development Association). The four courses attracted a total of 92 participants. The courses conducted included Design and Implementation of HIV/AIDS Programs, Advocacy and Resource Mobilization, and Scientific Writing. Curriculum development for medium-term fellowships is ongoing; a new curriculum for the continuous quality improvement (CQI) course was developed and the course started running on August 4, 2008, with 24 fellows drawn from 12 institutions (two fellows from each institution). The fellows from each institution are given funding and technical support to implement a project to enhance learning and also improve on the systems within their organization. We are in the process of developing other curricula for other courses including monitoring and evaluation (M&E), strategic leadership and management, finance for non-financial managers, scientific writing, among others. In FY 2008 671 individuals will be supported; 600 individuals will receive training through short courses, 48 through medium-term fellowships and 12 through technical placements, in addition to the 11 long-term Fellows.

Progress of the CCGHE initiative: This is a new program, started in FY 2008. Capacity building for PEPFAR is the primary goal of this distance learning initiative. An initial needs assessment has been conducted, informed by discussions with key PEPFAR partners and sponsors in Uganda.

FY 2009 plans for CCGHE initiative: In the next year (FY 2009), the initial phase of this initiative plans to assist the IT departments of 19 PEPFAR partner and sponsor institutions in Kampala, Entebbe and Rakai in for connectivity to the new high band internet network. Based on the initial needs assessment, the following

**Activity Narrative:** specific PEPFAR capacity building activities will be prioritized for the next year:

- Establish Web-based (audio and video) conferencing between PEPFAR partners
- Establish Telemedicine links between PEPFAR partners
- Initiate web-casting and digital archiving of key PEPFAR educational programs in Uganda
- Establish a Learning Management System for creating on-line training courses for PEPFAR in Uganda
- Establish a digital library for production and sharing of key PEPFAR educational resources
- Initiate PEPFAR Uganda HIV Clinical Grand Rounds, which would be supported by video conferencing between Kampala and Entebbe (and possibly Rakai) with web streaming and DVDs provided to other PEPFAR partners in Uganda.
- Develop a telemedicine Consult Service with video conferencing between Kampala and Entebbe (and possibly Rakai) with audio and/or text portal-based chat links to other PEPFAR institutions.
- Creation and distribute on-line and DVD video training program for male circumcision.
- Create a digital interactive laboratory training course in rapid HIV testing for PEPFAR partners.
- Create a distance learning course for Pediatric HIV Care.
- Creation of Distance Learning Course for MEPP Data Management.

FY 2009 plans for SPH-CDC Fellowship: In FY 2009, MUSPH fellowship program will support a total of 600 individuals. We will support 22 long-term fellows (11 fellows continuing and 11 new fellows admitted in FY 2009). 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 518 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. In addition to the M&E and CQI courses that have been developed in FY 2008, more courses will be evaluated through a formal needs assessment involving key stakeholders. 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; two weeks at the beginning of the course, one week in the middle of the course and another week at the end of the course. Technical placements involve attachment of an individual working with an HIV/AIDS organization at another institution to learn and enable transfer of best practices. Short courses will be provided to institutions, tailored to their needs. Through the Fellows apprenticeship attachments 46 organizations involved in HIV/AIDS service provision, information dissemination as well as policy development and implementation will be supported (22 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. Varied emphasis areas, beneficiaries and stakeholders associated with organizations that will be hosting the fellows and receiving short courses will therefore be reached indirectly. The indirect targets may include people affected by HIV/AIDS as well as special populations such military and refugees.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13241

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13241	4017.08	HHS/Centers for Disease Control & Prevention	Makerere University School of Public Health	6421	5738.08	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$1,566,587
8322	4017.07	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	5738	5738.07	Developing National Capacity for Management of HIV /AIDS Programs and Support for the Delivery of HIV Prevention, Care and Treatment Services in Rakai District	\$850,000
4017	4017.06	HHS/Centers for Disease Control & Prevention	Makerere University Institute of Public Health	3177	1084.06		\$700,000

**Emphasis Areas**

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$935,674

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 693.09

**Mechanism:** Strengthening HIV Counselor Training

**Prime Partner:** The AIDS Support Organization

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 4426.20884.09

**Planned Funds:** \$695,000

**Activity System ID:** 20884

**Activity Narrative:** The Strengthening HIV Counselor Training Project (SCOT) is a collaboration among organizations with a stake in HIV counselor training in Uganda. It aims at improving the quality of HIV counselor training through standardizing curricula, building the capacity of institutions to utilize standardized curricula, supporting the development of accreditation and certification criteria for HIV counselor training institutions, supporting advocacy for the counseling profession and developing a standardized monitoring and evaluation system for HIV counselor training. SCOT has continued to work very closely with the Ministry of Health (MOH), Uganda AIDS Commission (UAC), Uganda Counseling Association (UCA), other line ministries, Forum for People Living with HIV/AIDS (NAFOPHANU), HIV counselor training institutions and development partners to improve the quality of HIV counselor training in the country.

In FY 2008, SCOT together with Engender health, ACQUIRE project supported MOH, AIDS service organizations (ASO's) and People Living with and or Affected by HIV/AIDS (PHA) networks to scale up HIV prevention in the country through implementing the Positive Prevention (PP) program. 37 trainers were oriented in the use of the PP Peer counseling & Education curriculum. These have been able to train 189 PHA from 8 Support groups to enhance HIV prevention activities within the communities. 216 service providers including counselors, nurses, and clinical officers have been trained to incorporate positive prevention counseling into existing prevention, care and treatment programmes. The HIV discordant couples curriculum has been developed, pre-tested and undergoing final reviews; thereafter, 20 trainers will be trained to train 200 service providers. To ensure quality of counseling training and service delivery, SCOT in collaboration with Ministry of Health (MOH) is developing a joint accreditation system and a common certification framework for HIV counseling courses (HBHCT, RCT, ART, HIV counselor supervision, HCT, and PP curricula). This shall strengthen the capacity of accredited Training institutions to roll out training courses in accordance to national standards in HBHCT, RCT, ART, HIV Counselor supervision, Positive Prevention and HCT trainings and other SCOT accredited courses in the country. The SCOT M&E system has been enhanced to provide information necessary for programming and reporting purposes. This has been shared with SCOT partners to appreciate and ensure proper and accurate documentation of training activities. A mid-term joint program review for the SCOT project has been completed to help to re-align the project activities. An information booklet on Ethics and Code of Conduct for counseling practice in Uganda is being reviewed in collaboration with UCA and shall be printed and disseminated to all counselors including HIV counseling providers. In addition, SCOT supported UCA to convene an annual counselors' conference that was attended by over 250 delegates.

In FY 2009, SCOT shall scale up HIV prevention in communities through supporting 08 ASOs and 08 PHA networks to implement Positive Prevention. 200 PHA peer counselors and 200 service providers shall be trained. In order to ensure quality HIV counseling service delivery, SCOT together with MOH shall strengthen the support supervision and follow up component by conducting visits to ASOs and PHA networks trained using SCOT developed curricula. SCOT shall partner with MOH and other key partners to ensure utilization of the developed curricula through certifying HIV Counselor training institutions as per the common certification framework developed. SCOT will continue to contribute to the professional growth of counseling in Uganda, by supporting institutional growth of Uganda Counseling Association (UCA) and work with other partners to advocate for the establishment of the counseling cadre in the Public service. This shall entail supporting UCA to develop counseling levels and certification criteria for the already trained HIV counselors and thereby facilitate their continuing education. SCOT shall also support HIV counselor training Institutions to monitor and evaluate their training and consequently upgrade the SCOT M&E system into a National M&E system for HIV counselor training in Uganda. SCOT shall also strengthen partnerships in HIV Counseling training and service delivery through establishing a National training reference group/think-tank and rejuvenating efforts to establish a coordinating mechanism for HIV counselors in Uganda. These shall enhance the quality of training materials developed and services provided. SCOT shall work with MOH and Ministry of Education and Sports (MOES) to develop an HIV counseling module that shall be incorporated into the different curricula for Pre-service training of paramedical workers.

In FY 2010, SCOT shall focus on winding up project activities and building mechanisms to ensure sustainability of SCOT programs in the country. Hence key activities shall include building capacity for certified HIV Training Institutions to evaluate and update their own training curricula through skills building workshops; writing end of project reports, and planning for the transition to the second phase of the SCOT project. However, 100 PHA shall be trained in PP Peer counseling and community education for 04 Peer support groups.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13319

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13319	4426.08	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	6441	693.08	Strengthening HIV Counselor Training	\$700,000
8365	4426.07	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	4814	693.07	TASO CDC	\$600,000
4426	4426.06	HHS/Centers for Disease Control & Prevention	The AIDS Support Organization	3188	693.06	TASO CDC	\$537,501

**Emphasis Areas**

Gender

\* Increasing gender equity in HIV/AIDS programs

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$391,777

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9482.09	<b>Mechanism:</b> Capacity Building/Leadership and Management Program/ACE-Follow-on
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 21884.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 21884	

**Activity Narrative:** In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program providing technical assistance to improve the internal management structures of targeted Ugandan institutions providing HIV services throughout the country. The identified organizations already had direct service delivery agreements with the USG, and the technical assistance provided through this mechanism supported this increased PEPFAR funding by engaging highly specialized local and international consultants to build management and administrative systems to improve the quality and breadth of HIV prevention, care and treatment program outcomes. The program also provided key facilitation and coordination services for the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) Country Team.

This program has worked extensively with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), the Ministry of Health Resource Centre (MOH RC) and the Uganda Women's Effort to Support Orphans (UWESO). Four organizations, JCRC, HAU, IRCU and UWESO play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda, while UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. Since its inception, this program has assisted these institutions in five broad thematic areas: organizational development, monitoring and evaluation, health management information systems, finance and communications. These institutions have already achieved great success in improving the management of their programs. The targeted guidance and technical assistance has ensured that client organizations can now accurately track spending; manage procurements, grants and inventory more efficiently; and produce timely reports for senior management and donors. They can collect, aggregate and analyze critical data, at multiple levels, for improved program implementation. They 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. And they have adopted better governance practices through mentoring and training of board members, directors and senior management staff. This program is scheduled to end in September 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. Many of the direct agreements with these local institutions are scheduled to end in 2009 and new follow-on activities are currently being designed. It is anticipated that a similar capacity building mechanism will need to be in place to support these new follow-on activities and the implementing institutions. This program will continue to ensure that all activities maximize systems strengthening, capacity building and skills transfer so as to develop the sustained ability of these indigenous institutions to expand access to high quality HIV services. It will also be expected to incorporate issues of gender and stigma/discrimination into all its activities 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 client organizations will be identified once all the new activities are in place.

The follow-on activity will also include a new human resource component that will focus on improving the availability of appropriately trained managers and service providers. 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. Building a sustainable technical workforce for planning, management, and implementation of Health and HIV/AIDS services calls for a two-pronged program that will address the skills gap of the undergraduates and another that will address the leadership and management skills of the managers of health and HIV/AIDS services at national, district, facility and community level, both in the private and public sectors.

The goals of this new Internship, Leadership and Management Program component will be to 1) 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); USG chief's of Party (priority on Ugandans); National NGOs, and other civil society organizations; etc. This program will not address the quality of managers and service providers in providing clinical services, nor the quantity/numbers of service providers as this is being addressed by the on-going Capacity Project. The anticipated outcomes of this program include: 1) Improved technical competences of local Ugandan professionals, 2) Improved leadership and management of Health and HIV/AIDS services and 3) Organizational development for training institutions. This program will also receive wrap-around funding from the President's Malaria Initiative.

**New/Continuing Activity:** New Activity

**Continuing Activity:**



**Emphasis Areas**

Health-related Wraparound Programs

\* Malaria (PMI)

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development [REDACTED]

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 7274.09

**Mechanism:** SPRING (Stability, Peace and Reconciliation In Northern Uganda)

**Prime Partner:** Emerging Markets

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 15855.21804.09

**Planned Funds:** \$95,000

**Activity System ID:** 21804

**Activity Narrative:** The U.S. Government (USG) and Uganda government are working together to ensure peace and security, good governance, access to social services, economic growth, and humanitarian assistance in northern Uganda. The United States Agency for International Development (USAID) Mission in Uganda intends to support an integrated program to promote peace and stability in northern Uganda. The program is entitled Stability, Peace and Reconciliation In Northern Uganda (SPRING). In light of recent developments in northern Uganda, including the ongoing peace talks between the Government of Uganda (GoU) and the Lord's Resistance Army (LRA), improved security and the return home of large numbers of internally displaced populations, the new program will contribute to the transition from relief to recovery and development. SPRING will support a core set of activities in three component areas: (1) Peace-building and reconciliation, (2) Economic security and social inclusion, and (3) Access to justice. Evidence from other post-conflict situations illustrates the relationship between HIV/AIDS (and women), property rights and access to land, namely: 1) access to land at the time of return and resettlement; 2) ability to use land to earn income for their families; and 3) ability to inherit land or pass it on as inheritance to their children. When women or other vulnerable groups have no access to land and other resources, there is an increase likelihood of HIV infection as they may be reliant on males for survival and are therefore more vulnerable to high-risk activity such as transactional sex, and sexual violence. To promote equity and economic growth for vulnerable persons, and to reduce the number of new HIV infections that will occur as people leave the camps, prevention, education and advocacy support to HIV/AIDS affected families and individuals will be an integral part of SPRING. SPRING will support activities that promote non-violent decision-making and constructive social and economic participation. This project will link with and complement the SPRING OVC and AB activities. Illustrative activities under this component will include: a) Advocacy to increase access to economic opportunities (including access to land) that enable vulnerable people including HIV/AIDS affected women to maintain a stable and secure standard of living; b) Engagement of the community to decrease social exclusion of vulnerable populations, including HIV/AIDS affected women and infected families and individuals, particularly women; c) Activities with civil society organizations (including NGOs, women's groups and business associations) to promote local economic development for selected vulnerable populations including HIV/AIDS affected and infection women and their families; and d) Advocacy to increase access by vulnerable populations including HIV affected women and their families to legal aid, and to increase awareness of human rights and land/property issues.

The project is on track having started in January 2008. Implementation of activities will begin shortly and therefore little progress has been made.

It is expected that with FY2009 funds, SPRING can support activities that promote non-violent decision-making and constructive social and economic participation. SPRING will work with young people most at-risk for marginalization, HIV/AIDS or recruitment into destructive activities and through proactive outreach, will engage people constructively. This project will link with and complement the SPRING OVC and Policy activities. SPRING will include HIV/AIDS components (prevention, education, OVC, and advocacy support for HIV/AIDS-affected families and individuals) as part of its overall strategy to promote equity and economic growth for HIV vulnerable women and youth.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15855

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15855	15855.08	U.S. Agency for International Development	Emerging Markets	7274	7274.08	SPRING (Stability, Peace and Reconciliation In Northern Uganda)	\$100,000

## Emphasis Areas

Gender

\* Increasing gender equity in HIV/AIDS programs

\* Reducing violence and coercion

Refugees/Internally Displaced Persons

## Human Capacity Development

## Public Health Evaluation

## Food and Nutrition: Policy, Tools, and Service Delivery

## Food and Nutrition: Commodities

## Economic Strengthening

Estimated amount of funding that is planned for Economic Strengthening \$50,000

## Education

## Water

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 5030.09

**Prime Partner:** State University of New York

**Funding Source:** GHCS (State)

**Budget Code:** OHSS

**Activity ID:** 9092.21776.09

**Activity System ID:** 21776

**Mechanism:** Strengthening Democratic Linkages in Uganda (Linkages)

**USG Agency:** U.S. Agency for International Development

**Program Area:** Health Systems Strengthening

**Program Budget Code:** 18

**Planned Funds:** \$525,000

**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008

The LINKAGES activity aims to improve transparency and accountability in Uganda by increasing civil society participation and improving democratic representation in key Government institutions. Its activities strive to strengthen linkages between key Ugandan government actors and civil society by improving advocacy for more effective local and national government response to grassroots needs. Its activities will focus on select parliamentary committees and issue-based caucuses, ten district and 50 sub-county governments, and national and local civil society. LINKAGES includes an emphasis on oversight, policy advocacy and reform regarding HIV/AIDS and family planning.

In FY 2008, the Ugandan Parliament, with support from LINKAGES and other agencies such as Uganda Aids Commission and the International Aids Vaccine Initiative (IAVI), organized a commemoration activity to honor persons who had contributed to the response to HIV/AIDS in Uganda over the last 25 years. The activity commenced with a special Parliamentary session where individuals and organizations were honored for their contribution in Uganda. This took place in the parliamentary chambers on March 13, 2008. To further encourage linkages between the Parliament of Uganda and communities, as well as dialogue between policy makers and communities so as to broaden and deepen political and popular support for HIV/AIDS policies and programs, phase two of the commemoration activities was held at Kasensero, Rakai district on March 14, 2008. Kasensero was chosen as the venue for these events because it was the site at which the first HIV/AIDS patient was seen in Uganda. In addition to the abovementioned attendees, His Excellency, Yoweri Kaguta Museveni, the President of Uganda, His Wife, Hon Janet Museveni, 75 Members of Parliament and approximately 2000 persons from Rakai and surrounding districts participated. Activities included: an exhibition where organizations demonstrate the services they offer to the public; a ground breaking ceremony for construction of the HIV/AIDS Care Centre at Kasensero; the award of Parliamentary recognition to 19 persons and institutions. Among the awardees was the United States Government, which was specially recognized by the Parliament of Uganda for being the largest external supporter of HIV/AIDS intervention in Uganda; and voluntary Counseling and testing was provided to 118 individuals.

In FY 2009, continued support will be provided to the HIV/AIDS Committee of Parliament, including oversight visits to the field and support to the development and passage of the HIV/AIDS Bill. Support will also be provided to civil society groups contributing to the legislative development process. Field visits will be national in nature, to include the existing ten LINKAGES districts where possible. Special attention will be given to Northern Uganda recovery and development.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14176

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14176	9092.08	U.S. Agency for International Development	State University of New York	6724	5030.08	Strengthening Democratic Linkages in Uganda (Linkages)	\$530,000
9092	9092.07	U.S. Agency for International Development	State University of New York	5030	5030.07	Parliament and Local Government Initiative	\$530,000

---

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$525,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 7156.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** OHSS

**Activity ID:** 4711.21732.09

**Activity System ID:** 21732

**Mechanism:** NUMAT

**USG Agency:** U.S. Agency for International Development

**Program Area:** Health Systems Strengthening

**Program Budget Code:** 18

**Planned Funds:** \$195,000

**Activity Narrative:** Introduction and overview of the organization and project:

This activity relates to Prevention /Abstinence and Being Faithful, Prevention Other, PMTCT, Palliative care: Basic health care, Counseling and testing, ART, Strategic Information and Lab infrastructure improvement. The NUMAT project, which covers the sub regions of Acholi and Lango, was awarded in August 06 with FY 2006 resources. The project covers 9 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 both sub regions now enjoying relative peace, NUMAT has continued to place 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 population is returning.

**Progress to date and outline of activities and achievements:**

In FY2008 NUMAT undertook capacity assessment of HIV/AIDS coordination structures in the 9 districts in the region with a view of identifying the status of functionality and consequently areas of support. Uganda AIDS Commission and other members of the Decentralized Response and Self –Coordinating Entity provided technical support and were also invited to participate. The findings revealed that generally coordination of HIV/AIDS was weak due largely to the insurgency in Acholi-region but also due to the failure of some districts to constitute coordination structures; lack of funding; limited coordination capacity; non-ratification of HIV/AIDS coordination guidelines; Lack of HIV/AIDS strategic plans and poor civil society coordination. As a result of this, the assessment exercise was preceded by trainers of trainer's (TOT) workshop on HIV/AIDS coordination in all the 9 districts for the purpose building internal capacities of districts to coordinate HIV/AIDS. Participants for this workshop included; District planners (9), HIV/AIDS focal persons (9), District Education officers (9), PHA representatives (2), CSO representatives (2), and AMICAAL coordinators (5). Follow-up activities that were planned and done by the trainees included; the development of specific HIV/AIDS coordination work-plans for the 9 districts and some urban centers. NUMAT specifically funded the ; Re-activation of coordination structures at the district and sub-county level; meetings and field monitoring activities of coordination structures (District HIV/AIDS Committees (DAC); District HIV/AIDS Task forces (DAT) and Sub-County HIV/AIDS Committees (SAC) /Sub-County HIV/AIDS Task force (SAT). Other forms of financial and technical support provided by the program to address HIV/AIDS gaps identified during the assessment included the development of 5 year HIV/AIDS strategic plans for Gulu, Amuru and Kitgum districts that will be integrated in the District Develop Plans of the respective districts as well as the strengthening of Civil Society Organizations involved in HIV/AIDS work in the region. Notably the program was able to support PHA networks of Gulu, Kitgum and Lira to undergo organizational self assessment and develop their 5 year strategic plans. The PHA forums that were supported are now currently using the plans to re-organize their internal systems and structures and are now more focused in implementing activities for the benefit of their members. NUMAT has also provided equipment and supplies to PHA networks as partial support to actualizing their strategic plans. Other capacity building initiatives by the Program to the PHA networks included the facilitation of the networks to participate in national events such as woman's day, national HIV/AIDS conference and PEPFAR implementer's workshop.

As part of strengthening the health systems in the region, the program facilitated districts to form and train Health Unit Management Committees in the districts of Pader, Kitgum, Apac, Dokolo, Oyam, Amuru, Amolatar and Lira. Other forms of included District health Team meetings, support supervision and planning by DHT for Malaria, HIV/AIDS and TB activities.

Human resource for health continues to be a critical factor in health service delivery in the region. The program carried out a rapid assessment on the status of human resources for health in all the 9 districts with a view of identifying the staffing gaps and critically needed cadres of health workers. The assessment revealed overall low staffing levels in the region: with following specific staffing gaps: Gulu (75%); Kitgum (60%); Pader (37%); Amuru (66%); Amolatar (20%); Oyam (20%); Lira, Apac, Dokolo (10% each). The most critically needed cadres of health workers are medical officers, Enrolled Nurses, Enrolled Mid-wives, Enrolled Psychiatric Nurses, Senior Medical officers, Orthopedics, Public health nurses, Laboratory personnel, dentists and information assistants. Other factors that habit human resources for health in the region that were identified in during the assessment and also in another assessment carried out by Ministry of Health and Capacity Project (2008) included the lack of accommodation for health workers; difficulties in accessing the government payroll; lack of basic equipment and supplies ; inadequate skills of health workers; Incomplete composition and facilitation of District Service Commission (DSC); Failure of districts to induct newly recruited staffs and poor records management among others.

In addressing the human resource gaps, NUMAT supported the recruitment process (advertisement, short-listing and interviewing) of health workers in Gulu (215 positions) and Oyam (20 positions); trained Lira District Health Management Team (22 persons) on performance improvement through support supervision with a focus on PMTCT in partnership with Capacity project; Identified sites for Distance Education Programme in Lango sub-region for skills enhancement of in-service health workers; trained a number of health workers in various skills related to HIV/AIDS across the region and stated the process of reviewing distance education training materials with the review of medical laboratory practice manual; As a stop-gap measure to address the acute shortage of health workers in the region, the program partnered with Makerere University under the Community Based Education Services (COBES) program in which 40 medical students with a professional mix of pharmacy, nursing, general medicine, and radiology were deployed in 7 health units in the region. The students were able to temporarily fill the human resource gaps in these units through involvement in a range of health activities (immunization of infants & pregnant women mothers, strengthening of HMIS gap through recording of accurate data, HCT activities, dispensing of ART drugs and clerking patients etc.

**Activities for FY2009:**

ALL ACTIVITIES ARE UNCHANGED FROM FY 2008

1. Support HIV/AIDS coordination structures in districts (DACs, DATs, SACs and SATs). The program will continue to support the re-activation of HIV/AIDS coordination structures especially in Acholi region were

**Activity Narrative:** populations are gradually returning to their original homes. Special focus will be put to on the sub county coordination structures in those sub counties where populations are returning. NUMAT will continue to work with PHA networks and other AIDS civil society organisations to strengthen coordination among CSOs and participation in the HIV/AIDS response at the district and lower levels. Coordination structures will continue to be provided with logistical support to meet and monitor HIV/AIDS related activities .

2. Support towards Health Sub-district coordination: NUMAT will continue to facilitate districts to establish,, train and support health unit management committees so as to improve community involvement and participation in the management of health facilities .
3. Develop District HIV/AIDS strategic plans for Amolatar, Lira and Apac : Mainstreaming of HIV/AIDS in district development plans is a key requirement for local governments and HIV/AIDS strategic plans are strong tools for mobilising different stakeholders in achieving District HIV/AIDS objectives. NUMAT will therefore support the 3 districts of Amolatar, Lira nad Apac to strengthen HIV/AIDS coordination, develop HIV/AIDS strategic plans and integrate HIV/AIDS in district development plans.
4. Support technical and policy review meetings/workshops on specific areas in HIV/AIDS: NUMAT will continue to up-date key stakeholders in the region on key government policies related to its core business of malaria, HIV/AIDS and TB. These forums will also be used to share and learn about models being piloted /used by NUMAT and other key stakeholders in the region and nationally.
5. Organisational and institutional support of partnering civil society organisations and PHA forums; To strengthen the Civil society voice in the management and coordination of the HIV/AIDS response and to increase the implementation capacity of CSOs to implement HIV/AIDS activities, NUMAT will provide institutional support to selected partner CSOs including PHA networks. The support will go towards strengthening of the CSOs' systems , structures and human capacity
6. Support districts to recruit and deploy health workers. NUMAT will provide financial, logistical and technical support to districts to advertise vacant positions, interview, recruit, orient and deploy health workers to address the identified human resource gaps in the districts
7. Support districts to carry out induction training of newly recruited staff. Staff induction is critical in the retention of staff since it's through this process that they get empowered with information regarding Government of Uganda civil service standing orders and what is expected of them as health workers. NUMAT will therefore continue to work with the Ministry of health, Public service and the districts to ensure this is done for all the 9 districts.
8. Conduct pre-service and in-service training of health workers; NUMAT will continue to support training of health workers in relevant skills
9. Strengthen continuing professional development (CPD) of health workers through distance education programmes (DEP): In close partnership with Ministry of Health Human Resource Division and Capacity project, NUMAT will operationalize the Distance Education Programme Centres by training tutors, centre coordinators and providing the required resources (reading materials, course curriculums, computers etc.)
10. Continue to partner with human resources for health stakeholders and health training institutions and communities; NUMAT will partner with health training institutions in the region and at the national level in order to address human resource gaps. The Community Based Education Services approach of Makerere medical school will be supported and replicated elsewhere with other health institutions since it has proved effective in supporting health units cope with workload while at the same time addressing the training needs of students.

#### NEW ACTIVITIES FOR FY 2009

1. Support districts to undertake performance improvement support supervision of health workers; the performance improvement approach that was piloted for PMTCT will be replicated in other areas in HIV/AIDS, Malaria, and TB. The approach has proved to be simple to adopt and effective in addressing quality of service issues.
2. Support districts to establish and maintain human resources for health information systems; NUMAT will work with Ministry of health, Capacity project and districts to set up human resource data base that will be used to maintain staff records on training, deployment etc.
3. Work with districts in the region to undertake training needs assessment of health workers and develop district training plans; In order to support districts to rationalise training and to avoid duplication, NUMAT will support districts to undertake training needs assessment of health workers and to use this in developing training plans.
4. Work with others in identifying appropriate strategies for attracting, retaining and motivating health workers; NUMAT will work with others in the region and nationally to advocate for appropriate mechanisms of attracting and retaining health workers in the region.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15494

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15494	4711.08	U.S. Agency for International Development	John Snow, Inc.	7156	7156.08	NUMAT	\$400,000
8474	4711.07	U.S. Agency for International Development	John Snow, Inc.	4839	696.07	UPHOLD; UPHOLD/PIASC Y Primary; TASO; AIC; Conflict	\$350,000
4711	4711.06	U.S. Agency for International Development	John Snow, Inc.	3167	3167.06	NUMAT/Conflict Districts	\$200,000

**Emphasis Areas**

Refugees/Internally Displaced Persons

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development \$110,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3312.09	<b>Mechanism:</b> The Capacity Project
<b>Prime Partner:</b> IntraHealth International, Inc	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 4376.21720.09	<b>Planned Funds:</b> \$1,251,252
<b>Activity System ID:</b> 21720	



**Activity Narrative:** Activity Narrative: Uganda like many developing countries is experiencing a crisis in human resources. The human resources are inadequate both in number and skill mix to effectively respond to the health needs in Uganda. The HIV/AIDS epidemic presents additional demand on the human resources because of special skills required for HIV/AIDS prevention and treatment, and health workers themselves are being affected by the disease. The Government of Uganda institutional capacity for Human Resource and Health (HRH) policy and planning is weak. There is no reliable source of HRH information for planning and management. This makes planning and monitoring of the human resource situation difficult. There is no capacity to develop, regularly monitor and review HRH policy and plans either at national or district level. HRH development, deployment and utilization are therefore not guided. This results into mismatch between service requirements and training, both in numbers and skills, and inequity in the distribution of the available human resources.

The working condition of health staff is difficult, characterized by poor infrastructure, lack of staff accommodation, inadequate equipment and supplies, work overload and inadequate remuneration. The poor working condition is aggravated by weak HRH management. Performance management, regulatory and disciplinary mechanisms are ineffective. Poor working conditions do not attract staff nor motivate them to stay. As a result the staff turnover is high, particularly in remote rural districts generally regarded as difficult-to-reach and difficult to stay in. As a result of poor working conditions the morale of health workers is low, which in part results in poor attitude towards clients, absenteeism and low productivity. The public image of health staff has been eroded, the quality of care provided is perceived as poor and the utilization of health services is not optimal. There are inadequate resources to sustainably support initiatives to address these human resources issues and the crisis persists in a vicious circle. Despite increased investment in the HRH sub-sector and health sector in general, the performance of health workers and the quality of HIV/AIDS and health services are still substandard. Consequently, the utilization of HIV/AIDS services is low, contributing to low achievement of the indicator targets. The USAID-funded IntraHealth/Capacity Project (CP) goal is to improve human resources for health in order to contribute to improved access for HIV/AIDS and other health services. The objectives of the Capacity Project are to enhance capacity for HRH policy and planning at the central and district levels to ensure adequate health workforce for integrated HIV/AIDS and health services; strengthen systems for effective performance-based health workforce development; and identify and promote health workforce management practices for improved performance and retention.

Progress to-date and achievements: The CP has made significant progress in HRH policy and Planning and HRH development and management. The CP supported the Ministry of Health (MoH) to establish the HRH databases at the four Professional Councils of Medical Doctors and Dental Surgeons, Nurses and Midwives, Pharmacists: and Allied Professionals, and linked the database to the MoH and the two pilot districts of Apac and Oyam. The CP supported the MoH to review the HRH Strategic Plan 2005-2020 and further develop the plan into the comprehensive HRH plan. The CP collaborated with the MoH to develop a Health Sector Master Plan for 2008 -2015 that prioritized HRH, infrastructure, and medicines and supplies to attract increased funding for health sector. Nine districts of northern Uganda were facilitated to do detailed analysis of staffing gaps and prepare district specific strategies to address the staffing gaps; while 78 districts developed district specific HRH Action Plans in line with national HRH Policy and Strategy. A total of 133 members of the Uganda National Association of Nurses and Midwives (UNANM) were trained as regional trainers in communication skills; while Health Professional Councils and Associations were supported to develop standards for accreditation of in-service training and continuing professional development (CPD). The CP supported the MoH to introduce a Performance Improvement (PI) program, including training of the Technical Resource Team at the central and district levels, development of reproductive health and PMTCT standards, and performance indicators and tools for PI. Central level resource team was trained for strengthening performance management based on ROM and open performance appraisal system in collaboration with the Ministry of Public Service. The MOH was supported to study the factors that contribute to high staff turnover in public and private-not-for-profit (PNFP) sectors. Comprehensive strategies for improved retention and motivation, and policy and guidelines for workplace safety and health are being developed. Bottlenecks in HRH management and solutions for tackling them were identified. Strategies are being developed to strengthen leadership and management at district, sub-district and health facility levels.

Activities for FY 2009: With FY 2009 funding, the Capacity Project, in partnership with the line ministries of Health, Public Service, Education and Sports, and Local Government will:

1. Enhance the capacity for HRH policy and planning at the central and district levels to mitigate the HRH impact of HIV/AIDS by:
  - a. Completing the HRIS development and integration by linking the district and PNFP data base to the MoH Human Resource Management (HRM) data base; link the pre-service training database at the Ministry of Education and Sports to the MoH training database; and develop an interface of all HRIS information to the Resource Centre at the MoH. The CP will establish an HRIS planning module at Human Resource Development (HRD) and Planning Department of the MOH; support regular production and dissemination of biannual HRH report for decision making; and implement strategies to improve communication between the central MOH and districts for HRH management.
  - b. Strengthen the coordination of HRH by providing technical and logistical support to the coordinating structures, including the Human Resource Working Group (HRWG), the Health Workforce Advisory Board (HWAB), and other SWAp process. The CP will strengthen the HRD of the MOH by providing technical assistance for development of the strategy for task shifting; facilitate the HRD and HRM divisions of MOH to develop plans for follow up implementation of HRH related recommendations of the Mid-Term Review of the Health Sector Strategic Plan II (2005/06-2009/2010); continue to support the roll out and reviews of HRH Strategic Plan; and facilitate follow up support of district HRH planning.
2. Strengthen systems for effective performance-based health workforce development by:  
Harmonizing pre-service and in-service training of the health workforce; developing and promoting approaches for effective performance improvement (on-job training, task shifting, mentoring, supportive supervision, action learning); developing strategies to motivate continuing professional development including accreditation, certification, licensure; strengthening the role of the health workforce professionals'

**Activity Narrative:** councils and associations in in-service training and continuing professional development; and providing technical assistance to the Human Resource Department of the MOH and Health Manpower Development Center to rationalize training and develop a training plan for pre-and in-service training.

3. Identify and promote health workforce management practices for improved performance and retention by: strengthening systems for health workforce performance management; enhancing MOH and district capacity for health workforce management; building capacity for results oriented management (ROM); developing strategies and systems for improved recruitment and deployment; developing tools and initiatives for improved job satisfaction and retention; strengthening systems for Performance Improvement (PI) and support supervision; enhancing systems for community co-management of health services; and strengthening systems for workplace safety, and protection and care of the health workforce.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14215

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14215	4376.08	U.S. Agency for International Development	IntraHealth International, Inc	6741	3312.08	The Capacity Project	\$1,260,000
8429	4376.07	U.S. Agency for International Development	IntraHealth International, Inc	4837	3312.07	The Capacity Project	\$1,260,000
4376	4376.06	U.S. Agency for International Development	IntraHealth International, Inc	3312	3312.06	The Capacity Project	\$500,000

#### Emphasis Areas

Gender

- \* Addressing male norms and behaviors
- \* Increasing gender equity in HIV/AIDS programs

Health-related Wraparound Programs

- \* Family Planning
- \* Safe Motherhood

Refugees/Internally Displaced Persons

#### Human Capacity Development

Estimated amount of funding that is planned for Human Capacity Development      \$1,250,000

#### Public Health Evaluation

#### Food and Nutrition: Policy, Tools, and Service Delivery

#### Food and Nutrition: Commodities

#### Economic Strengthening

#### Education

#### Water

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 5028.09

**Mechanism:** HIPS (Health Initiatives in the Private Sector)

**Prime Partner:** Emerging Markets

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 9082.21758.09

**Planned Funds:** \$195,000

**Activity System ID:** 21758

**Activity Narrative:** The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2010) is a follow on program that builds on USG private sector initiative - Business PART (Preventing HIV/AIDS and Accelerating Access to Anti-retroviral Treatment) which ended in May 2007. The HIPS project has continued to serve as the USG prime mechanism for leveraging the private sector to increase access to and use of AIDS treatment, prevention and care services through mid and large size employers. HIPS works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community. Specifically, the Project facilitates partnerships and provides technical assistance to design and implement comprehensive workplace health programs that maximize the accessibility of HCT, HIV/AIDS, TB & Malaria prevention and treatment services and improve use and knowledge of Reproductive Health and Family Planning services and products. HIPS implements support for OVC through the private sector and strengthens private sector organizations to support health initiatives.

The HIPS project puts high attention on the sustainability of health initiatives in Uganda by strengthening private sector organizations to manage and sustain private sector health initiatives. To affect this, memoranda of understanding have been signed with leading private sector organizations: Uganda Manufacturers Association (UMA) and Federation of Uganda Employers (FUE), to engage in capacity building to eventually assume the technical support role of health services to companies. HIPS has engaged in training UMA and FUE staff in various aspects of workplace health initiatives in the private sector including: development of HIV/AIDS and OVC workplace policies, Counseling and Testing, proposal/report writing, development of health information material in the areas of HIV/AIDS, TB, Malaria and reproductive health and to conduct peer education training and health fairs. To date, FUE and UMA have assisted over 20 companies to design and launch HIV/AIDS workplace policies. UMA and FUE have successfully trained over 140 peer educators, conducted two health fairs attracting more than 1500 participants, with more than 200 people receiving HCT. HIPS is also working with over 50 companies and private clinics networks and has met its target in signing five Global Development Alliances (GDAs) to leverage resources on a 2:1 basis. HIPS has also established working links with the Ministry of Health (MOH), Ministry of Gender, Labor and Social Development (MGLSD), Global Fund, the National TB and Leprosy Program (NTLP) and Uganda Health Marketing Group (UHMG) to facilitate accreditation of clinics in ART and TB, promote HIV and OVC national policies and access to free and low cost commodities.

The Health Systems Strengthening activities for FY 2009 include but are not limited to the following:

1. Expand FUE and UMA's capacity to provide technical support to companies in workplace interventions on HIV/AIDS, TB, malaria and FP/RH.
2. Promote and Support companies to develop and implement HIV/AIDS and health policies and programs using best practices.
3. Demonstrate the business case for health investments and encourage companies to provide HIV/AIDS and TB treatment to employees and neighboring communities. HIPS will also encourage the extension of services to the supply chain to include company out growers and neighboring communities.
4. HIPS will continue to strengthen relationships with key partners such as MOH, AIDS Control Program, MGLSD, Uganda AIDS Commission, National TB and Leprosy Program, Global Fund.
5. Facilitate private sector support of the National Social Health Insurance Scheme (NSHIS)
6. HIPS will continue to work with health insurance companies to facilitate greater and more affordable coverage of HIV treatment.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14175

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14175	9082.08	U.S. Agency for International Development	Emerging Markets	6723	5028.08	HIPS (Health Initiatives in the Private Sector)	\$200,000
9082	9082.07	U.S. Agency for International Development	Emerging Markets	5028	5028.07	Private Sector Initiative	\$200,000

**Emphasis Areas**

Health-related Wraparound Programs

\* Family Planning

\* TB

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$80,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 9221.09

**Prime Partner:** John Snow, Inc.

**Funding Source:** GHCS (State)

**Budget Code:** OHSS

**Activity ID:** 21145.21582.09

**Activity System ID:** 21582

**Mechanism:** STAR-EC

**USG Agency:** U.S. Agency for International Development

**Program Area:** Health Systems Strengthening

**Program Budget Code:** 18

**Planned Funds:** \$65,000

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – East Central will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

Since supportive policy environment is very important for the implementation of activities, the district based HIV/AIDS/TB program – East Central 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. The project will cover activities in 6 districts. For example, the district based program will support the continued roll out of the revised policies of PMTCT, RCT, ART, TB and any other policies as they get approved. This program will build on past efforts by the AIM, UPHOLD and Uganda AIDS Control Program (UACP) to strengthen district planning (fresh support for new districts) 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 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 isoniazid 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).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 21145

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
21145	21145.08	U.S. Agency for International Development	To Be Determined	9221	9221.08	TBD/District East Central	

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 6181.09

**Mechanism:** Financial Management Agent/  
Civil Society Fund (FMA/CSF)

**Prime Partner:** Deloitte Touche Tohmatsu

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 15859.21748.09

**Planned Funds:** \$495,000

**Activity System ID:** 21748

**Activity Narrative:** The Civil Society Fund (CSF) is a newly established harmonizing fund to provide grants to civil society supported through a partnership with DFID, DANIDA, Irish AID, Uganda civil society organizations and various line ministries within the Ugandan Government. The program began in early 2007 and is just completing its first year of operation. The CSF is considered a partnership between government, donors and civil society, is housed at the Ugandan AIDS Commission and managed by a Steering Committee that includes representatives from all members. Under the direction of the Uganda AIDS Commission, the Steering Committee manages the multiple donor resources supporting the civil society response to HIV/AIDS, OVC, TB and Malaria. The Civil Society Fund (CSF) receives funding support from USAID, DfID, DANIDA and Irish AID for HIV/AIDS and OVC grants. Plans are at advanced stages to have the Uganda Global Fund provide funding for civil society in these areas, in addition to TB and Malaria. Grants to CSF recipients are managed through Deloitte and Touche, a USAID contractor that serves as the official CSF Financial Management Agent. They provide financial management technical assistance to all the CSF grantees. The Technical Management Agent function is currently being handled by Care International through the CORE Initiative, and a new implementing partner is expected to be in place mid-FY 2009 to take over this role when the CORE Initiative ends in September 2009. USAID is also in the process of contracting the Monitoring and Evaluation Agent which is expected to be in place by October 2009. These three arms of the CSF provide the necessary technical assistance to the CSF grantees in order to monitor their progress and improve their internal/external operations to ensure that grant monies are achieving impact throughout the country. The overall objective is to strengthen the Ugandan civil society to better respond to the needs of those affected and infected by HIV/AIDS.

Through open and competitive solicitations, grants have been provided to local districts and civil society organizations to support the Uganda National Strategic Plan for Prevention and the National Orphans Policy and National Strategic Plan of Implementation. To date, a total of 40 grants have been awarded to NGOs implementing prevention service delivery activities; with another 90 expected in be awarded at the end of FY 2008 in both the areas of prevention and OVC service delivery. Grants will continue to be awarded throughout FY09. At this time, USAID covers all the administrative costs of the program and contracts the financial, technical and M&E agents supporting the fund and its grantees on behalf of the contributing partners; this is in addition to grant funding provided for prevention and OVC activities. In doing so, USAID is able to provide in-kind cost sharing to the CSF for the management costs of the Fund and is well positioned to do so. From a donor perspective, one of the reasons the CSF was established was because many other donor agencies do not have the capacity to manage grants and contracts. This mechanism was a unique way to streamline their support to civil society, and at the same time alleviate their management burden to create a true partnership within the donor community.

Policy development and strategic planning remain a challenge within civil society and resources will continue to be used to provide capacity building support to CSOs competitively selected to receive grants. These resources will be also used to support the total direct cost plus fee of the Financial Management Agent's contract, while the Global Fund will cover any additional management costs associated with administering their resources through the CSF should this decision be made. Negotiations between the CSF, Global Fund and the Uganda AIDS Commission continue but it is anticipated that funding for civil society will eventually be administered through the CSF mechanism. The Financial Management Agent is responsible for funds management, grants management and financial capacity building of CSF grantees. They work in close partnership with the Technical Management Agent and the M&E Agent, in addition to providing technical support to the Steering Committee.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15859

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15859	15859.08	U.S. Agency for International Development	Deloitte Touche Tohmatsu	6733	6181.08	Financial Management Agent/ Civil Society Fund (FMA/CSF)	\$500,000

<b>Emphasis Areas</b>
<b>Human Capacity Development</b>
Estimated amount of funding that is planned for Human Capacity Development      \$200,000
<b>Public Health Evaluation</b>
<b>Food and Nutrition: Policy, Tools, and Service Delivery</b>
<b>Food and Nutrition: Commodities</b>
<b>Economic Strengthening</b>
<b>Education</b>
<b>Water</b>

**Table 3.3.18: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 12192.09	<b>Mechanism:</b> TBD - SHARE
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 29695.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 29695	
<b>Activity Narrative:</b> FY08 Collaborative Ugandan PHE- UG.08.0205: Multi-country HRH Impact of Task Shifting Type II for ART Delivery on Patient and Process Outcomes in Emergency Plan Countries	
<p>The multi-country PHE "Impact of task shifting type II for ART delivery on patient and process outcomes in Emergency Plan Countries" will be conducted in Uganda, Nigeria, and Tanzania. The primary objective of this evaluation is to determine if primary patient care and treatment outcomes are equivalent over 24 months of follow-up across three provider delivery models: clinician-initiated ART/refills; clinician-initiated ART with nurse follow-up/refills; and nurse-initiated ART with follow-up/refills. If equivalence is demonstrated, it will provide a strong impetus for legislative and operational action to accelerate task shifting across Emergency Plan countries, allowing much greater access to life saving ART.</p>	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.18: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 12190.09	<b>Mechanism:</b> TBD - SWEPT
<b>Prime Partner:</b> To Be Determined	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 29696.09	<b>Planned Funds:</b> ██████████
<b>Activity System ID:</b> 29696	

**Activity Narrative:** New Ugandan PHE- UG.09.0221: Multi-country Study Health Systems Strengthening System-Wide Effects of PEPFAR-Supported HIV Service Provision

This is a multi-country public health evaluation which will look into the impact of PEPFAR HIV/AIDS funding on overall health system and delivery and utilization of other essential health services. Participating countries include: Uganda, Mozambique, Haiti and Nigeria

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 3370.09

**Mechanism:** AIDS Capacity Enhancement Program (ACE)

**Prime Partner:** Chemonics International

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 4532.26768.09

**Planned Funds:** \$0

**Activity System ID:** 26768



**Activity Narrative:** ACTIVITY UNCHANGED FROM FY 2008 AND ENDING IN SEPTEMBER 2009. NO FY 2009 FUNDS WILL GO TO ACTIVITY.

In December 2005, USAID/Uganda initiated a contract with Chemonics International Inc to implement a program to provide organizational development technical assistance and engage highly specialized local consultants to build the capacity of targeted Ugandan institutions for improved HIV prevention, care and treatment program outcomes. This program also aimed at strengthening administrative and managerial systems to fortify in a sustainable manner the targeted institution's ability to respond effectively to emerging opportunities resulting from the vast increases in HIV/AIDS funding. The program, named AIDS Capacity Enhancement (ACE) currently works with the Joint Clinical Research Centre (JCRC), Hospice Africa Uganda (HAU), the Inter-Religious Council of Uganda (IRCU), the Uganda AIDS Commission (UAC), and the Ministry of Health Resource Centre (MOH RC). Three organizations, JCRC, HAU, and IRCU play pivotal roles in expanding access to HIV/AIDS prevention, care and treatment in Uganda. UAC and MOH RC serve to coordinate the national HIV/AIDS response in terms of strategy, policy, monitoring, evaluation as well as reporting outcomes and results. The Chemonics/ACE program will consolidate the achievements made to date and will support the target organizations through the entire first phase of PEPFAR. ACE has made substantial progress in building the capacity of the targeted organizations.

Over the last two years, ACE assisted UAC in the evaluation of the previous National Strategic Framework for HIV/AIDS and the development of Uganda's HIV/AIDS National Strategic Plan 2007/2008- 2011/2012 (NSP), which is currently almost complete. ACE also supported UAC to develop the new long term institutional arrangements which will govern the Global Fund process in Uganda, particularly HIV/AIDS funds. In FY 2007, ACE will support UAC to improve coordination of the HIV/AIDS response through the operationalization of both the NSP and the accompanying Performance Measurement and Management Plan (PMMP). In addition, ACE will continue to support UAC in the development of the national HIV/AIDS comprehensive communications strategy that will provide guidance to partners implementing HIV/AIDS activities under the NSP.

In FY 2008, ACE will be required to further support UAC to reposition itself as a coordinating body. UAC will have increased responsibilities in serving as the country coordinating mechanism for the Global Fund. It will require support to ensure there are effective and transparent systems in place for the management of the entire global fund process, from proposal to implementation to evaluation. In addition, support is also needed to strengthen the Partnership Committee (PC) to be able to provide strategic and policy level oversight to the newly initiated multi-donor Civil Society Fund, managed by Deloitte and Touche. The steering committee for the CSF sits under the PC of the Uganda AIDS Commission.

ACE will work with UAC in improving their coordination of HIV/AIDS partners in Uganda, including development of a documentation center where UAC will collect and maintain reports, documents, and information from major civil society and government partners in Uganda working on HIV/AIDS. ACE will work with UAC to develop the terms of reference for how the center will work and link it with the MOH Resource Centre, particularly with its digital library of health information.

To-date, ACE has provided significant support to IRCU, resulting into strengthened sub granting processes, financial systems, monitoring and evaluation systems, as well as improved management and leadership. ACE has supported IRCU to raise their competence and confidence in sub-granting to their implementing partners. IRCU was assisted to gain competence in competing, negotiating and awarding grants. Currently, IRCU has provided 86 sub-grants to indigenous faith-based organizations undertaking interventions in ART, palliative care, OVC, and HIV prevention. ACE has helped IRCU to improve its financial management systems. Specifically, ACE supported IRCU to recruit staff in the finance department and installed and trained staff on the Navision financial system which will help IRCU develop a more robust and transparent financial system that enables them to track and report use of funds with greater detail and accuracy. ACE support to IRCU will continue through FY 2007, with the key focus on strengthening human resources management and governance systems.

As IRCU further expands its sub-granting portfolio and partners, challenges exist in providing effective oversight of the programs. Continued support will be required to enable IRCU evolve as a stronger organization better able to manage the large HIV/AIDS program, develop a stronger and more transparent grants program, and improve capacity to support the grantees. Therefore, in FY 2008, ACE will work with IRCU to continue to improve its coordination abilities, particularly among the Religious Coordination Bodies (RCBs) so that the IRCU Secretariat and the RCBs become even more effective leaders in the faith-based response to HIV/AIDS. These coordinating bodies will then work with the grantees to strengthen their approaches in prevention, OVC, palliative care, and ART, and will document their lessons learned and best practices for dissemination both within their network of religious organizations and to the wider HIV/AIDS community. In addition, IRCU will need assistance to plan for greater organizational sustainability by helping it diversify its funding sources and create a longer term plan for funding HIV/AIDS activities. IRCU will need support to enhance its ability to provide quality assurance to the grantees, particularly in ART and palliative care. This may be through training certain key staff to provide this service, developing tools that the Secretariat can use in monitoring and evaluating progress at the facilities or partnering them with other the PEPFAR supported quality assurance institutions such as Infectious Disease Institute or the Quality Assurance Project.

ACE is undertaking an assessment of the needs of the grantees in areas such as finance, M&E, planning, reporting, management/leadership, and sustainability. Using assessment results, ACE will design trainings and technical assistance tailored to the needs of these grantees. The facility-based grantees have stronger institutions and require assistance in managing ART and palliative care. The community-based grantees need more general support to their management systems so they are better able to manage the HIV/AIDS grant funds.

Over the last two years, ACE strengthened HAU's capacity to deliver palliative care services by working with them to improve their organizational structure, governance practices at the Board level, and human

**Activity Narrative:** resources policies. In FY 2007, ACE is supporting HAU in upgrading its accounting and financial systems and working with HAU to develop a communications and advocacy strategy that will give HAU the tools to more effectively communicate about the importance of palliative care for HIV/AIDS patients in Uganda.

HAU is strategically placed to increase access to key components of palliative care, particularly management of pain and symptoms as well as end of life care. To achieve economies of scale, HAU seeks to build the capacity of indigenous HIV/AIDS care organizations to integrate these key components within their existing programs. To achieve this, the HAU will need support in FY 2008 to develop a business strategy for its education program, which will help to plan better and increase the size, awareness, visibility and impact of the education program. HAU will also need continued support in developing its plans for expanding its directly managed services to more sites and increasing the availability of palliative care in Uganda.

At JCRC, ACE has provided support in expanding the Navision financial system, improving ICT infrastructure, developing a strategic plan for the organization and an annual work plan for the TREAT program. In FY 2007, ACE will continue supporting the finance department in writing new financial management guidelines, the M&E department in development a new M&E framework, plan and database, and the leadership of the organization as they upgrade their organization structure, job descriptions, and decision-making protocols.

Beyond FY 2007, JCRC will need further support to plan a longer term sustainability strategy and to think about how it can diversify its funding sources and develop long-term business plans. To achieve this, ACE will work with JCRC in strengthening their regional centers of excellence (RCEs) so that they are effective fully functional institutions in and of themselves. This will involve strengthening the human resources and staffing at the RCEs as well as helping them improve their financial systems, IT infrastructure, data management and reporting.

As more HIV/AIDS resources become available, and new partners come on board, the capacity building needs also grow. Therefore, in FY 2008, besides consolidating the achievements of ACE within the partner institutions, ACE will be expected to expand to include new client organizations as identified in consultation with USAID. As the civil society basket fund becomes the primary mechanism for funding a number of local organizations, ACE will be a resource of capacity building to recipients of funds, working with identified organizations in a participatory way to identify their strengths and weaknesses and then designing capacity building interventions tailored to their needs. This will be crucial for leveraging the investment the USG is making in the basket fund and will strengthen a wider array of organizations, enhancing their capacity to manage HIV/AIDS programs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15631

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15631	4532.08	U.S. Agency for International Development	Chemonics International	7210	3370.08	AIDS Capacity Enhancement Program (ACE)	\$600,000
8461	4532.07	U.S. Agency for International Development	Chemonics International	4850	3370.07	AIDS Capacity Enhancement Program, ACE	\$500,000
4532	4532.06	U.S. Agency for International Development	Chemonics International	3370	3370.06	Capacity Building of Indigenous Institutions	\$325,000

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 7204.09

**Mechanism:** Eastern Region - HIV/AIDS & TB Program

**Prime Partner:** Management Sciences for Health

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 24062.09

**Planned Funds:** \$65,000

**Activity System ID:** 24062

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – Eastern will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

Since supportive policy environment is very important for the implementation of activities, the district based HIV/AIDS/TB program – Eastern 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. The project will cover activities in 6 districts. For example, the district based program will support the continued roll out of the revised policies of PMTCT, RCT, ART, TB and any other policies as they get approved. This program will build on past efforts by the AIM, UPHOLD and Uganda AIDS Control Program (UACP) to strengthen district planning (fresh support for new districts) 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 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 cotrimoxazole prophylaxis among people living with HIV/AIDS (PLHAs) as well as the provision of isoniazid 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).

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 7253.09

**Mechanism:** TBD - Districts South-Southwest

**Prime Partner:** To Be Determined

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 15896.24030.09

**Planned Funds:** ██████████

**Activity System ID:** 24030

**Activity Narrative:** This activity relates to PMTCT, sexual prevention, care and treatment (adult care and treatment, pediatric care and treatment, TB/HIV, HIV/AIDS treatment/ARV drugs and laboratory infrastructure), counseling and testing, and Strategic information.

This activity is a combination of the Uganda Program for Human and Holistic Development (UPHOLD) follow-on and TBD District Support for Rural Access to ART in Eastern and Western Uganda. Both activities have been approved in COP 08. The USAID funded district-based HIV/AIDS/TB program – West/South West will be a follow-on project to the Uganda Program for Human and Holistic Development (UPHOLD) program ending in September 2008. The district-based program will support the national efforts to improve the quality, utilization and sustainability of services delivered in the areas of HIV/AIDS and TB in an integrated manner at both facility and community levels. In partnership with the Government of Uganda and other stakeholders, the district-based HIV/AIDS/TB program will strengthen the national response to the HIV/AIDS epidemic. Within the National Strategic Framework, the district-based HIV/AIDS/TB program 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.

Since supportive policy environment is very important for the implementation of activities, the district based HIV/AIDS/TB program – West/South West 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. The project will cover activities in 9 districts. For example, the district based program will support the continued roll out of the revised policies of PMTCT, RCT, ART, TB and any other policies as they get approved. This program will build on past efforts by the AIM, UPHOLD and Uganda AIDS Control Program (UACP) to strengthen district planning (fresh support for new districts) 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 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 cotrimoxazole prophylaxis among people living with HIV/AIDS (PLHAs) as well as the provision of isoniazid 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).

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15896

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15896	15896.08	U.S. Agency for International Development	To Be Determined	10368	10368.08	Districts South-Southwest	████████

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 8655.09

**Mechanism:** Technical Assistance for data use/M&E systems strengthening for Implementing Partners

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Health Systems Strengthening

**Budget Code:** OHSS

**Program Budget Code:** 18

**Activity ID:** 4421.26516.09

**Planned Funds:** ██████████

**Activity System ID:** 26516

**Activity Narrative:** In FY 2009 the university technical assistance (UTA) mechanism will be competed to continue provision of high quality expert technical support for PEPFAR programs in Uganda. The focus of this assistance will be in three key program areas.

Treatment services technical assistance will be concentrated on enhancing comprehensive care and treatment interventions to strengthened partners' clinical programs. In FY08 the primary focus will be to review patient management and record keeping systems at treatment sites and identify areas and implement improvements in the clinic operations to substantially improve patient outcomes.

The strategic information component of UTA will be to assist the PEPFAR program in using the substantial amounts of program area data collected over the past five years in combination with country surveillance data to provide a better understanding of PEPFAR outcomes and contributions to the national portfolio. Examining the data from multiple sources will provide the country team will a more comprehensive analysis to assist with future programming directions.

For systems strengthening/policy development the UTA technical expertise will be transferred to local partners through a series of in-country workshops for advanced data analysis and triangulation and training on how to interrupt the results for policy guidance and program direction; and, training on how to prepare technical presentations and manuscripts.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13327

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13327	4421.08	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	8655	8655.08	UCSF	\$200,000
8369	4421.07	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	4818	1273.07	University of California San Francisco - UTAP	\$160,000
4421	4421.06	HHS/Centers for Disease Control & Prevention	University of California at San Francisco	3345	1273.06	University of California San Francisco - UTAP	\$140,000

Program Budget Code: 19 - HVMS Management and Staffing

**Total Planned Funding for Program Budget Code: \$18,992,034**

**Program Area Narrative:**

The US Ambassador, as the head of the US Mission in Kampala, has been charged with managing the overall PEPFAR country program. Working through the Executive Committee and the PEPFAR Coordinator, the Ambassador provides leadership for USG interagency coordination, and gives policy, strategic, and budgetary guidance for achieving the overall PEPFAR goals.

Five PEPFAR implementing agencies are represented in Uganda, the Department of State, Department of Defense (DOD), Department of Health and Human Services (HHS), Peace Corps, and U.S. Agency for International Development (USAID). HHS works through its Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). DOD works through its Office of Security Cooperation in the Embassy and the Walter Reed Army Medical Center.

The PEPFAR Executive Committee is responsible for making policy and strategy decisions. It is made up of the Ambassador, the Deputy Chief of Mission, the CDC Country Director, the DOD Security Cooperation Chief, the Peace Corps Country Director, the USAID Country Director, and the PEPFAR Country Coordinator who is an ex-officio member. At the program level, the Executive Committee is responsible for the final review and approval of the annual Country Operational Plan (COP) activities and resource allocation decisions, and semi-annual and annual reports prior to submission. The Executive Committee will address and make decisions on operational matters that cannot be resolved by the PEPFAR Interagency Country Team or the PEPFAR Coordinator, with the Ambassador holding authority to make final decisions.

The Government of Uganda established a PEPFAR Advisory Committee that includes representatives from Government and the private sector. It is chaired by a former Prime Minister of Uganda; the Uganda AIDS Commission acts as the secretariat. The purpose of the Committee is to advise the USG to ensure that the PEPFAR Program is complementary to other HIV/AIDS

---

programs, operates under the National Strategic Plan for HIV/AIDS, and is supportive of Uganda policies.

The PEPFAR Coordinator's Office consists of the Coordinator, Deputy Coordinator, Communications Officer, Strategic Information Liaison, and a Program Assistant. The PEPFAR Coordinator is empowered by the Ambassador to carry out day-to-day leadership and management of the USG PEPFAR program, and is therefore responsible for ensuring that the interventions and approaches of the various USG agencies are harmonized to provide maximize synergy and that they support the Ugandan national HIV/AIDS Strategic Plan.

The PEPFAR program in Uganda is implemented by the Department of State, DOD's Office of Security Cooperation and the Walter Reed Army Medical Center, HHS's Centers for Disease Control and Prevention, Peace Corps, and U.S. Agency for International Development. HHS's National Institutes of Health does not receive PEPFAR funding in Uganda but coordinates its activities with the PEPFAR team.

PEPFAR Technical Workgroups (PWGs) conduct joint partner and program area reviews, outline strategies and interventions specific to their respective program area, help determine the appropriate implementing partner mix for programs and services, ensure linkages and synergies between program areas, and make recommendations to the Country Team when developing the Country Operational Plan and Annual and Semi-annual Reports. There are currently eight PWGs in prevention, care, OVC, counseling and testing, treatment, laboratory, strategic information, and policy and systems strengthening. Agencies assign appropriate staff members with the requisite knowledge, expertise or experience in the specific technical area to each of the workgroups. Work group members, particularly the Co-chairs, are accountable to the PEPFAR Coordinator, not their agency supervisor.

The PEPFAR Interagency Country Team (PICT) has the responsibility to guide the U.S. Mission's development and implementation of a comprehensive HIV/AIDS prevention, care and treatment program that supports the national GOU program. The PICT leads strategic planning and ensures that sound programmatic and resource allocation decisions are made to implement PEPFAR plans and contribute to the GOU priorities. Team members will support collaboration with other development partners by participating in meetings, planning sessions, and national fora to share information on PEPFAR Uganda activities. The PICT is made up of the PEPFAR Coordinator (chair); two representatives from each USG Agency, who represent their respective agency; and the co-chairs of the PEPFAR Workgroups, who will represent the consensus opinion of their respective workgroup. If PWGs cannot reach a consensus decision or a working compromise on an issue, the issue will be brought forward to the PICT for resolution. PICT decisions will be made through consensus or an agreed upon alternative by the group.

PEPFAR Uganda first implemented Staffing for Results in 2006, assisted by a visit from OGAC Deputy Principals. At that time the team established inter-agency Technical Working Groups and outlined the terms of reference for the governance structures that would facilitate country operations. This interagency approach was fully endorsed and supported by the new Ambassador. With the support of an organizational development facilitator and Core Team visits, PEPFAR Uganda has made great strides in joint planning, budgeting, and program review, using an interagency approach with the key principles being consensus, collaboration, and at times compromise. The team acknowledges that this is an evolving process. The facilitator made two visits in 2008 to build PWG strengths, assist the PICT with staffing decisions, and start the COP development process. These joint team meetings, in coordination with agency management, determined the staffing mix and size proposed for FY09.

The PEPFAR Uganda team's SFR vision is aligned with the FY09 COP guidance. We envision having in place a fully staffed and functional interagency team that effectively plans, implements, and evaluates its programs together with appropriate technical leadership and management oversight. While we work through the SFR process to make this vision a reality, we are striving to create an enabling environment where team members are empowered and their contributions are valued, where the diversity of the various USG agencies is appreciated, and where teamwork, trust, transparency, and collaboration are core values.

A key accomplishment to date is the delegation of planning, decision making and monitoring to the interagency PEPFAR Workgroups. During PEPFAR Uganda Team's continuous assessment of the processes and lessons learned, the Team will also look at how best to address some of the challenges that include the need to bolster intra- and inter- agency communication as responsibilities devolve to working groups, and ensure the PWGs have the requisite skills in leadership, management, budgeting, and conflict resolution. We plan to continue with the current management structure and make minor modifications based on evolving administrative and programmatic needs. For example, with the realignment of OGAC program areas and with pediatric care "outgrowing" PMTCT we may need to realign the PWGs. With an enlarged PEPFAR Coordinator's office, functions such as communications may move to that office. The basic management structure, built on inter-agency collaboration, will continue.

We will work with the Staffing for Results framework and plan throughout the year. As noted below and in agency activity narratives, we are requesting more staff for FY09 and may do so in the future. As we discussed staffing issues in team meetings, we realized that during the first phase of PEPFAR, funding grew much more rapidly than staffing. We will use the staffing analysis tools throughout the year (and not just as we develop the COP) to determine which technical areas are understaffed (or possibly overstaffed), given funding and workload. As we reach a steady-state environment, with stable funding and fewer new contracts and grants to award, we will work with non-program offices to match their staffing to our workload.

The PEPFAR Uganda team is requesting 24 new positions in FY09. These are: 1 Applications Development Coordinator; 3 Behavioral Scientists; 2 Care and Treatment Specialists; 1 Deputy Chief (Behavioral); 2 Drivers ; 1 Epidemiology Services Coordinator; 2 Health Systems Support Specialists; 1 Prevention Specialist; 1 Program Management Specialist, Civil Society; 1 Program Management Specialist, Decentralization ; 1 Program Management Specialist, Decentralization; 1 Program Management Specialist, DLI Program; 1 Program Management Specialist, Health Systems; 1 Program Management Specialist, Nutrition; 1 Program Management Specialist, OVC; 1 Program Management Specialist, Planning Program Manager; 1 Property Clerk; 1 Quality Assurance Technician; and 1 Secretary. These positions will provide the technical and administrative assistance needed to implement PEPFAR activities in Uganda, including strengthening indigenous partners' capacity and thus sustainability. As

noted above, these positions were discussed and decided upon by the PEPFAR team, and agency management, operating within the staffing for results framework.

Twenty-eight previously approved positions were vacant on September 30, 2008. These were: 1 Administrative Clerk; 1 Behavioral Advisor; 1 Chief, Informatics; 1 Communication Specialist; 1 Computer Management Assistant; 2 Data Clerks; Deputy Team Leader (HIV/AIDS); 2 Drivers; 1 Epidemiologist (DHAP); 2 HIV/AIDS Specialists (Fellows); 1 IT Advisor; 1 Lab Systems Specialist; 1 Medical Epidemiologist; 2 Medical Officers; 1 PEPFAR Administrative Assistant; 1 PEPFAR DOD Program Assistant; 1 Program Management Assistant; 1 Program Management Specialist, Care and Treatment; 1 Program Management Specialist, Conflict Gulu Office; 1 Program Management Specialist, Pediatrician; 1 Public Health Advisor; 1 Roving Secretary; 1 SAS consultant; and 1 Senior Data Analyst. These were vacant due to resignations, delays in arrival of new staff, or due to a sometimes-lengthy hiring process. Some positions (e.g., the Team Leader (HIV/AIDS)) have been filled since the cut-off date. All positions were considered during staffing for results discussions and were deemed still necessary.

**Table 3.3.19: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3481.09	<b>Mechanism:</b> CDC GHAI
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Management and Staffing
<b>Budget Code:</b> HVMS	<b>Program Budget Code:</b> 19
<b>Activity ID:</b> 26359.09	<b>Planned Funds:</b> \$399,535
<b>Activity System ID:</b> 26359	
<b>Activity Narrative:</b> This activity is not new - according to the FY 2009 COP Guidance Clarifications [October 24, 2008], third party company contractors such as CTS Global (COMFORCE) should be teased out. The 261 staff total includes 8 non-personal services contractors, who have been hired through a contract with COMFORCE. CDC Atlanta issued a cost-reimbursement agreement to COMFORCE in March 2006 to provide field offices with a mechanism to hire individuals to provide much needed technical expertise in-country.	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.19: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11120.09	<b>Mechanism:</b> USAID IRM
<b>Prime Partner:</b> US Agency for International Development	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Management and Staffing
<b>Budget Code:</b> HVMS	<b>Program Budget Code:</b> 19
<b>Activity ID:</b> 26750.09	<b>Planned Funds:</b> \$258,610
<b>Activity System ID:</b> 26750	
<b>Activity Narrative:</b> The IRM tax pays for cost recovery for USAID program funded staff using IT resources such as computers, Internet, etc.	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.19: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 11118.09	<b>Mechanism:</b> USAID ICASS
<b>Prime Partner:</b> US Department of State	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 26746.09

**Planned Funds:** \$780,000

**Activity System ID:** 26746

**Activity Narrative:** In FY 2009 this funding will support the US Embassy assistance to USAID for the cost of services for health, security, community liaison, procurement, shipment, vehicle operations, NXP management, leasing, pouch, mail and switchboard.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 690.09

**Mechanism:** N/A

**Prime Partner:** US Department of Defense

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 3971.21603.09

**Planned Funds:** \$117,866

**Activity System ID:** 21603



**Activity Narrative:** 1. Activity Narrative – The UPDF is Uganda’s national Army. As a mobile population of primarily young men, they are considered a high-risk population. As commander in chief of the armed forces, the President mandated the UPDF’s AIDS Control Program to oversee and manage prevention, care and treatment programs throughout the forces. Although the exact HIV prevalence rates from the military are unknown, 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 trend is the utilization of military clinics and hospitals by civilians not affiliated to the military, with up to 50% of patient visits for HIV care and treatment being non-military. Thus the demand to provide quality ARV services is continually growing. With PEPFAR support, 8 sites now provide ART and HIV care services. ARV services have been strengthened through training of health care providers, via the Infectious Diseases Institute (IDI) based in Kampala, and a partnership with San Diego DHAPP. A critical resource in the provision of HIV care and treatment services is the human resource (healthcare providers). The military community is among the hard-to-reach communities and as such, requires special consideration when planning for their health professionals. While there is understaffing particularly with health professionals, not many providers are comfortable working in military establishments. These inadequacies are being systematically addressed via the support from the USG, initially in the Kampala based Bombo military hospital, and Mbuya military Hospital. A course has been developed for nurses and clinical officers through the Infectious Diseases Institute, Kampala and for the past 2 years this training has been used to ramp up care in HIV clinical management, to include addressing military specific issues. A delicate balance must therefore be established between training the existing staffs and bringing on board new ones. Most importantly, innovative ways of task-shifting to already existing military volunteers must be explored.

2. Progress to-date.

There are currently 4,000 active duty UPDF personnel, family members and civilians followed for ART and HIV clinical management. Current plans are to support expansion of ARV services in training of UPDF personnel and modify and extend the adherence protocol to the other 6 treatment sites. This program will also be evaluated, and clinic procedures modified to include adherence practices as standard protocol. Additional training of physicians (6) and nurses and clinical officers (25), through the IDI in Kampala and the DHAPP program (2) will also be conducted. The IDI in collaboration with the UPDF have developed a 4 week (and 2 week respectively) course aimed to ramp up skills in ARV use, recognition and management of OIs and PMTC.

This year, an HIV/AIDS technical advisor was hired to directly provide technical support to UPDF at strategic planning level and program monitoring and evaluation. The program will soon recruit an administrative assistant to help track administrative issues at the embassy and in the field.

3. Planned activities for FY 2009. ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS: The recruited staff will continue to support UPDF in planning and implementing the plans. Partnerships will be strengthened with organizations like RTI to leverage the capacity gap. In addition in all the 8 ART sites, volunteer expert clients will be supported to work with the medical teams to strengthen linkage from testing to enrollment into care, follow-up patients with missed appointments and support adherence to medications. Support will be in form of training and activity based facilitation while in the field following-up clients. Regular meetings will be held for volunteers to air challenges in executing their work and get their input in plans to improve care in that aspect. The laboratory staffs will be facilitated to transport blood samples to regional laboratories for Early Infant Diagnosis.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16074

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16074	3971.08	Department of Defense	US Department of Defense	7336	690.08		\$228,000
8389	3971.07	Department of Defense	US Department of Defense	4821	690.07		\$100,000
3971	3971.06	Department of Defense	US Department of Defense	3156	690.06		\$100,000

**Table 3.3.19: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 1222.09	<b>Mechanism:</b> Peace Corps
<b>Prime Partner:</b> US Peace Corps	<b>USG Agency:</b> Peace Corps
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Management and Staffing
<b>Budget Code:</b> HVMS	<b>Program Budget Code:</b> 19
<b>Activity ID:</b> 4747.21613.09	<b>Planned Funds:</b> \$350,000
<b>Activity System ID:</b> 21613	

**Activity Narrative:** The Peace Corps Uganda PEPFAR program supports the USG EP for Uganda. Through supporting the EP, Peace Corps Uganda contributes to the Ugandan National Strategic Plan (NSP) for HIV/AIDS, and in turn, to the goals and objectives of the partner organizations hosting our Volunteers. The program is designed so that Volunteers are closely engaged with communities at a grassroots level in a manner that allow them to develop the close personal relationships necessary and deep cultural understanding necessary for effective innovation in underserved areas. The PEPFAR program allows Peace Corps Uganda to strengthen community and Volunteer HIV/AIDS expertise, and to support community organizations in a variety of HIV/AIDS functions. Volunteers and partner organizations work together to identify areas of need and develop appropriate evidence-based strategies that support sustainable interventions.

Management, program direction and supervision, and financial oversight of EP activities is provided by the Peace Corps Country Director, Associate Peace Corps Director for Administration, and Associate Peace Corps Director overseeing the CHED project (3 USDH) and additional support is provided by the entire Peace Corps Uganda staff. This level of effort supported through direct Peace Corps appropriated funds and is required to engage the full cohort of over 125 Peace Corps Volunteers who carry out EP activities. The PEPFAR program manager, EP Coordinator, EP Administrative Assistant, and EP Technical Advisor, Peace Corps Medical Officer, Driver, and Financial Assistant provide support to the PEPFAR program especially in monitoring and reporting, training, resource development, and Volunteer support.

With the current and proposed program expansion in FY 2009, Peace Corps Uganda is recruiting a previously approved additional driver. The Program Manager, EP Coordinator, EP Administrative Assistant, EP Financial Assistant, Medical Officer, and EP Technical Advisor will continue to provide support to the PEPFAR program especially in monitoring and reporting, training, and volunteer support for PCRVs, 47 current serving PEPFAR-funded, two-year Volunteers as well as the nearly 100 appropriated-funded Volunteers who contribute to PEPFAR goals. All EP staff members will support the USG PEPFAR country team and serve on various PEPFAR technical workgroups. If the FY09 Implementation plan is fully funded, Post will receive an additional 45 PEPFAR-funded, two-year Volunteers, 5 third year extensions and 20 Peace Corps Response. The proposed funding level nearly doubles the number of PEPFAR-funded Volunteers serving in Uganda.

Post will organize at least three staff exchange visits possibly to Kenya, Zambia, and Tanzania to review programs dealing with special needs education, economic activities, and permaculture. The PEPFAR Program Manager will coordinate such activities.

Peace Corps Uganda is requesting the addition of two new staff positions to support the increased level of activities involving the proposed expansion into Northern Uganda, and monitoring and reporting requirements. These include a program assistant and a driver. Post will require additional office furniture for additional staff. In addition to staff recruitment, post is proposing to procure a vehicle that will provide transport for staff to monitor and support Volunteer activities as Post expands its activities into Northern Uganda. The computer and audio visual equipment is required to support PST and IST activities, and to document Volunteer projects and best practices.

During FY 2009, management, program direction and supervision, and financial oversight of EP activities will continue to be provided by the Peace Corps Country Director, Associate Peace Corps Director overseeing the CHED project, and Associate Peace Corps Director for Administration (3 USDH). Additional support will be by the entire Peace Corps Uganda staff. This level of effort supported by Peace Corps appropriated funds and is required to engage the full cohort of well over 140 Peace Corps Volunteers who carry out EP activities.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15235

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15235	4747.08	Peace Corps	US Peace Corps	7091	1222.08	Peace Corps	\$310,800
8400	4747.07	Peace Corps	US Peace Corps	4823	1222.07	Peace Corps	\$227,600
4747	4747.06	Peace Corps	US Peace Corps	3162	1222.06	Peace Corps	\$127,600

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 1311.09

**Mechanism:** State Department

**Prime Partner:** US Department of State

**USG Agency:** Department of State / African Affairs

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 4752.21608.09

**Planned Funds:** \$358,700

**Activity System ID:** 21608

**Activity Narrative:** Coordination of the PEPFAR Uganda Program: The US Ambassador, as the head of the US Mission in Kampala, manages the overall PEPFAR country program. Working through the Executive Committee and PEPFAR Coordinator, the Ambassador provides leadership for USG interagency coordination, and gives policy, strategic, and budgetary guidance for achieving the overall PEPFAR goals. The PEPFAR Coordinator is empowered by the Ambassador to carry out day-to-day leadership and management of the USG PEPFAR program, and is therefore responsible for ensuring that the interventions and approaches of the various USG agencies are harmonized to provide maximize synergy and that they support the Ugandan national HIV/AIDS Strategic Plan.

PEPFAR Coordinator's Office: Given the considerable growth of the Uganda PEPFAR program, the interagency Staffing for Results team and the PEPFAR Executive Committee agreed that the PEPFAR Coordinator's Office should consist of:

- a) the PEPFAR Coordinator;
- b) a Deputy PEPFAR Coordinator to support the Coordinator in the day-to-day programmatic operations and liaison with OGAC;
- c) a Communications Officer to work closely with the Embassy Public Affairs Section and other USG agencies to develop and implement a comprehensive PEPFAR communication strategy;
- d) a Strategic Information Liaison, to work closely with the SI Advisors from CDC and USAID to coordinate all SI activities; and
- e) a Program Assistant, to coordinate activities with USG agencies, GOU ministries and organizations, development partners, and implementing partners, and manage the office.

These positions were all filled in FY08. Thanks to actions taken by Embassy and USAID management, the PEPFAR Coordinator's Office has been located in the Chancery Building.

Small Grants Program: State manages a PEPFAR small grants program that includes funding for orphans and vulnerable children and for palliative care. This program complements the Ambassador's Self Help and Democracy Grants Funds. All the small grants programs are under the purview of the Political Officer. After a detailed workload assessment, the Mission decided to hire one staff member to manage the PEPFAR OVC small grants program and another part-time EFM to manage the PEPFAR palliative care small grants program. To facilitate coordination, the Political Officer will liaise closely with the PEPFAR Coordinator and systems will be put in place to ensure coordination between the small grants program and the Coordinator's Office. In addition, the Coordinator's Office will provide systematic technical support, particularly in monitoring and evaluation, to the small grants program.

Refugee Program: PEPFAR also funds HIV/AIDS prevention and care programs for refugee populations, managed by the Bureau for Population, Refugees, and Population (PRM). The primary liaison is PRM's Refugee Coordinator who sits in the Chancery. The PEPFAR Coordinator's Office will provide technical support to the Refugee Coordinator and the implementers of the refugee HIV/AIDS programs, particularly in monitoring and evaluation.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16407

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16407	4752.08	Department of State / African Affairs	US Department of State	7426	1311.08	State Department	\$320,000
8392	4752.07	Department of State / African Affairs	US Department of State	4822	1311.07	State Department	\$130,000
4752	4752.06	Department of State / African Affairs	US Department of State	3455	1311.06	State Department	\$20,000

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 1373.09

**Mechanism:** USAID Management and Staffing

**Prime Partner:** US Agency for International Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 4745.21782.09

**Planned Funds:** \$7,058,000

**Activity System ID:** 21782

**Activity Narrative:** USAID/Uganda's Health, HIV/AIDS and Education funds are programmed to achieve USAID/Uganda's Strategic Objective 8 (SO8), Investing in People. USAID is the largest bilateral donor for HIV/AIDS, health and primary education in Uganda with an FY 2008 budget of \$180 million. USAID is responsible for management of a large portion of the U.S. Government's HIV/AIDS program funded under the President's Emergency Plan for AIDS Relief. In FY 2008, USAID programmed \$129 million under the Emergency Plan. Also in FY2008, additional staff, including 3 FSN Advisors (PMTCT and Malaria), 2 TCNs (Treatment and M&E Advisors), and 1 PSC (Logistics) joined the team making SO8 a 28-person team.

The USAID team brings to the Emergency Plan program refined skills in strategic leadership for HIV and development programs; leadership in HIV/AIDS and health policy development; strategic and technical leadership in national health systems strengthening, particularly in the areas of supply chain management, human resources for health, management information systems, decentralized service delivery, governance and infrastructure development; technical leadership in clinical and non-clinical service provision for HIV/AIDS prevention, care, OVC and treatment in developing countries; and technical expertise in behavior change communication, monitoring and evaluation, and leveraging private sector development. USAID also brings a wide spectrum of support through USAID's broader development portfolio including democracy and governance, peace and reconciliation, economic growth, agriculture development, humanitarian assistance and food aid.

Currently, USAID staff working 100% on PEPFAR includes two (2) USDH HIV/AIDS advisors, (2) Fellows, six (6) professional Foreign Service Nationals, (3) FSN contract staff (1) administrative position and one (1) TCN. USAID also supports recruitment and funding of three (3) positions within the PEPFAR Coordinator's office, including the PEPFAR Coordinator, Deputy Coordinator and Public Affairs Officer, who work closely with all USG agencies to maximize complementarities throughout the PEPFAR/Uganda program planning, implementation and monitoring and evaluation continuum. CDC supports one (1) SI position and the State Department supports (1) administrative position. These positions are directly supervised by the Deputy Chief of Mission. Other critical USAID staff providing technical leadership and management to the program but not devoted full time to PEPFAR include six USDH and USDH-FSL, two U.S. PSC, eight FSN project and financial specialists and administrative staff. These core staff are responsible for managing over 53 different prime activities with 48 of these receiving PEPFAR funding to expand and strengthen programs in abstinence, faithfulness, condom use, PMTCT, injection safety, counseling and testing, palliative care, TB/HIV integration, ART, orphans and vulnerable children, national logistics and laboratory systems, human resource capacity building, comprehensive HIV/AIDS district programs, HIV/AIDS programs in areas of conflict and private sector service delivery, donor coordination and strategic information. USAID/Uganda also manages 18 Track 1.0 and NPI partners. USAID is complemented by professional staff from other teams at the USAID Mission to specifically support integration of HIV/AIDS within democracy and governance, peace and reconciliation, economic growth, agricultural development, and food aid. USAID's contracting, financial, executive and program office support the overall management and implementation of PEPFAR supported activities.

USAID's FY 2009 complement of staff represents the technical and managerial skills and competencies required to effectively implement USAID PEPFAR programming. The funding required for USAID/PEPFAR management in FY 2009 has increased by 34% over FY 2008 to ensure that the technical and managerial requirements of supporting USAID's PEPFAR program in Uganda are met. These increased costs include technical/program staff, administrative and structural support, and the overall costs of doing business in an integrated State/USAID ICASS system. Since 2004, USAID's budget has increased from \$50 million to \$140 million (including Track 1.0 and NPI), representing a large, complex and evolving portfolio. Through the past four years, USAID's recruitment of staff has not kept pace with rising demands of project management, collaborating in an interagency environment, and a growing national response. To date, USAID has increased its full-time technical staff from four (4) to nine (9) and increased the number of technical staff providing limited support (10-60%) from seven (7) to nine (9). For FY 2009, USAID has received Mission level approval to add eight (8) new technical positions fully or partially funded by PEPFAR. Three of these positions will support the health and HIV/AIDS portfolios in the areas of nutrition, health systems, and child survival. Five (5) positions will directly support HIV activities in the areas of OVC, decentralized service delivery, civil society and strategic information. USAID will continue to leverage non-PEPFAR moneys to support staff positions that span the HIV/AIDS, Malaria, Education and Conflict programs.

Indirect costs at 23.7% of salaries and benefits amounts to \$1,286,425.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 14243

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
14243	4745.08	U.S. Agency for International Development	US Agency for International Development	6753	1373.08	USAID Management	\$5,308,384
8477	4745.07	U.S. Agency for International Development	US Agency for International Development	4854	1373.07	USAID Management	\$4,809,097
4745	4745.06	U.S. Agency for International Development	US Agency for International Development	3450	1373.06	USAID Management	\$3,389,000

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 7349.09 **Mechanism:** HHS/CDC CSCS  
**Prime Partner:** US Department of State **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GHCS (State) **Program Area:** Management and Staffing  
**Budget Code:** HVMS **Program Budget Code:** 19  
**Activity ID:** 10178.20850.09 **Planned Funds:** \$470,000  
**Activity System ID:** 20850  
**Activity Narrative:** In FY 2009 this funding will support the calculated capital security cost-sharing (CSCS) 'head tax' charged by the State Department for HHS/CDC staff. The charge took effect in FY 2005 and it applies to all U.S. departments and agencies for each authorized overseas position.  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 13336

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13336	10178.08	HHS/Centers for Disease Control & Prevention	US Department of State	7349	7349.08	HHS/CDC CSCS	\$320,000
10178	10178.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4819	3481.07		\$197,847

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 1257.09 **Mechanism:** CDC Base GAP  
**Prime Partner:** US Centers for Disease Control and Prevention **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Management and Staffing  
**Budget Code:** HVMS **Program Budget Code:** 19  
**Activity ID:** 4430.20846.09 **Planned Funds:** \$6,852,578  
**Activity System ID:** 20846

**Activity Narrative:** The HHS/CDC Uganda Management and Staffing (M&S) budget for FY 2009 supports the USG goal for appropriate staffing and level of effort in order to provide technical assistance, programmatic oversight, and performance monitoring for HHS/CDC funded implementing partner activities. Over 70 percent of these CDC operations and staffing costs are covered through GAP base-funding, with the balance covered by GHCS. The GHCS funds support direct technical assistance to indigenous local implementing partners to strengthen national surveillance and policy initiatives, develop laboratory services, improve care and treatment programs, expand counseling and testing approaches, enhance PMTCT activities, improve TB/HIV integration, and implement public health evaluations.

The HHS/CDC Uganda staffing plan includes the following approved U.S. Direct Hire (USDH) staff positions: Country Director; Deputy Director; two Public Health Advisors, one administrative and one technical; three Senior Scientists that serve as unit chiefs for Laboratory Services, Behavioral and Social Science, and Informatics; and four Medical Officer/Epidemiologists, one of whom serves as the President's Malaria Initiative advisor. Three approved personal services contractors (PSCs) include a Laboratory Services Coordinator, Behavioral Scientist, and Medical Officer/Epidemiologist for PMTCT.

For 2009, two new PSCs are requested to provide technical assistance to the Epidemiology and Informatics Units, respectively. In addition two (1) non-PSC will support care and treatment activities in the Program Unit, and thirteen (13) LES positions are planned. These sixteen positions are necessary for HHS/CDC to continue to provide high quality technical assistance that strengthens indigenous partners' capacity thus ensuring the sustainability of PEPFAR activities. As shown in the organizational charts provided, the HHS/CDC Uganda office is comprised of seven units: Office of the Director, Operations, Program, Laboratory, Epidemiology, Informatics, and Behavioral.

The Program Unit oversees HHS PEPFAR-supported partners and provides technical assistance for program implementation to ensure partner initiatives are based on current evidence-based science. Direct country project officer management is in place for seven of ten active PEPFAR treatment partners: Makerere University Faculty of Medicine, The AIDS Support Organization, Mildmay Center, Reach-Out Mbuya, Rakai Health Sciences Program, Uganda Baylor College Foundation, and Catholic Relief Services-AIDS Relief. These partners work in over 80 public and non-governmental organization (NGO) facilities, treat over 65,000 clients [including 7200 pediatric patients] and provide care to 157,000 HIV-infected persons [of which 18,000 are pediatric patients] and their families. Currently, CDC has twenty-eight local and central cooperative agreements supporting a broad range of predominantly indigenous partners. Partner activities include implementation of HIV prevention interventions, laboratory services, blood safety activities, TB/HIV integration, care and treatment for adult and pediatric patients, and, for orphans and vulnerable children (OVC), PMTCT program expansion, strategic information initiatives and health systems strengthening interventions. HHS/CDC also provides direct funding and technical support to the Ministry of Health (MOH) and the National Medical Stores (NMS). In FY 2009, funding opportunity announcements will likely add two to three new implementing partners.

Working with the national Laboratory Technical Committee and PEPFAR Laboratory Technical Working Group the CDC laboratory staff will continue to support the strengthening of the national laboratory system by providing technical advice and financial inputs to develop and implement a national laboratory services policy and development of the Department of Laboratory Services within MOH. Laboratories at Regional and District Health Facilities will continue to be renovated and equipped to provide full HIV testing and monitoring services. The new Central Public Health Laboratory (CPHL), where CDC will assign technical staff to provide leadership and mentoring and will establish a laboratory information management system to coordinate activities within the laboratory sector and with the MOH Resource Centre. The CDC Laboratory Unit will continue to coordinate technical and management training through the OGAC-Becton Dickinson Public Private Partnership in collaboration with CDC Atlanta. Quality assurance schemes for HIV serology managed by the Uganda Virus Research Institute (UVRI) and for CD4+ counting through CPHL will also be supported by direct technical assistance from CDC laboratory staff. Finally, CDC laboratory staff will provide support supervision assistance to both the District Laboratory Focal Persons and Regional Laboratory Coordinators by working in close collaboration with the District Health Officer. Other Laboratory Unit activities include: assisting National Medical Stores to forecast, procure, store, distribute and monitor laboratory reagents through the national Laboratory Credit Line; support for national HIV drug resistance activities; and, collaboration with MOH in the design and implementation of national HIV/AIDS surveys. The CDC Laboratory will also provide substantial financial and technical support to the National TB Reference Laboratory to rehabilitate training facilities; roll-out a national training program in AFB smear microscopy; establish a national TB specimen referral system; provide containment laboratories for the safe handling of MDR and XDR TB strains, and conduct a national TBDR survey.

The Epidemiology Unit leads and supports the implementation of twelve public health evaluations (PHEs) and HIV surveillance activities. Currently, the team has seven continuing PHEs:

1. Strategies to decrease HIV-transmission risk behavior and increase drug adherence among HIV-infected adults initiating antiretroviral therapy in Uganda;
2. Evaluating the utility of re-testing HIV-negative voluntary counseling and testing clients;
3. Evaluating home-based confidential counseling and testing in Kumi District;
4. Interactions between HIV and malaria in African children;
5. Evaluating anti-tuberculosis drug resistance among smear-positive TB patients;
6. Collaborative cohort of USG-supported anti-retroviral treatment programs in Uganda to assess costs and clinical outcomes associated with different programmatic approaches;
7. Evaluating the utility of (1) using routine program HIV testing data for surveillance, and (2) the HIV-1 incidence assay for incidence-based surveillance.

The Epidemiology Unit staff coordinates the Tororo field station Home-Base AIDS Care (HBAC) project. HBAC is an approved PHE designed to answer key operational questions that will provide valuable information to the MOH and the international community on how to best scale-up ART in rural settings; develop appropriate policies for selection of second line ART drug regimens; evaluate the need for continued cotrimoxazole in ART patients; and, examine the risks and benefits associated with early versus late ART drug switching. HBAC has one of the largest cohort on ART that is being followed up in sub-Saharan Africa. This field station infrastructure will be used to launch additional multi-country PHEs and

**Activity Narrative:** provide a training venue for other PEPFAR country staff with a less developed infrastructure. Other PHE activities conducted by partners and supported by Epidemiology Unit staff include: Comparison of Facility and Home-based Antiretroviral Therapy Delivery Systems; Assessing the relationship between intimate partner violence and HIV status disclosure in Rakai District; and Evaluating two types of male circumcision procedures. CDC Uganda will participate in four new PHEs of global significance proposed for FY 2008.

This team also provides the MOH AIDS Control Program direct technical assistance to conduct antenatal clinic surveillance, and to develop and conduct the combined Malaria and AIDS Indicator Survey. Scientists in the unit are key members of the national technical Surveillance workgroup, the PEPFAR strategic information workgroup, and the OGAC PHE task force. They also advise the MOH and related government agencies on national evaluations and studies.

The Informatics Unit provides Ugandan public health partners with computer system expertise, performs CDC laboratory data management, and provides in-country scientific staff with data management and statistical support. This team also provides technical assistance to the MOH Resource Center in the design and implementation of the national Health Management Information System and provides direct technical assistance to over twenty local implementing partners on data collection applications for clinical and laboratory services, data management and analysis, and the building, maintenance, and management of electronic communication, connectivity and data networking systems. The Informatics Unit provides extensive on-site training opportunities for all HIV partners to strengthen their institutional capacities, and holds on-campus training sessions on Epi-info, SQL, and network management. Trainings are also available for staff, MOH and partners on management of national survey data. Need to add the on-going FY 2008 activities for piloting technologies for health data collection and electronic medical records systems.

The Behavioral Unit provides scientific leadership and technical assistance to numerous indigenous partners, including the MOH, NGOs, universities, other PEPFAR country units, USG agencies, and various international health institutions. The goals of the Unit are to inform the development and implementation of innovative and effective programs addressing HIV prevention, care, and treatment by using multidisciplinary methods based on psychology, anthropology, economics, and epidemiology. The Unit has previously focused on reducing HIV risk behavior and transmission, PMTCT implementation and program harmonization, reducing social harm and stigma associated with HIV testing and home-based care, ART adherence, identifying reproductive norms and reducing unwanted pregnancies among HIV-infected women, increasing social support for care and HIV status disclosure, developing discordant couple counseling protocols, and informing interventions for OVC and HIV-infected children. Future activities will address HIV epidemiology, prevention, care, and treatment within the uniformed services of Uganda with a specific emphasis on Uganda Prison Services, identifying factors related to ART adherence among HIV-infected children, developing task shifting approaches for male circumcision and ART initiation and care, conducting evaluations addressing HIV risk behavior disinhibition within biomedical prevention trials of pre-exposure prophylaxis and HIV vaccines as well as male circumcision roll-out programs.

To fully implement the activities described above, the HHS/CDC office has planned for a full compliment of 261 staff positions, including the fifteen planned positions. These staffing needs are required to support the expanded activities for PMTCT, laboratory services, and strategic information to ensure adequate technical assistance to partners; increased surveillance activities; and additional data management and analysis for the PHEs. M&S staff-specific costs include travel, training, and communication services. The M&S operational costs are inclusive of office and warehouse space, and associated utility and security costs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13343

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13343	4430.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6446	1257.08	CDC Base GAP	\$5,958,764
8377	4430.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4820	1257.07	CDC Base GAP	\$4,482,516
4430	4430.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3347	1257.06	CDC Base GAP	\$3,416,366

**Table 3.3.19: Activities by Funding Mechansim**

**Mechanism ID:** 7348.09

**Mechanism:** HHS/CDC ICASS

**Prime Partner:** US Department of State

**USG Agency:** HHS/Centers for Disease Control & Prevention



**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 10176.20848.09

**Planned Funds:** \$1,300,000

**Activity System ID:** 20848

**Activity Narrative:** In FY 2009 this funding will support the US Embassy assistance to HHS/CDC for financial management services, human resource services, health Unit, general services including procurement services and warehousing facilities as well as residential-security provided to the approved U. S direct hire positions and personal services contractor positions.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 13335

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
13335	10176.08	HHS/Centers for Disease Control & Prevention	US Department of State	7348	7348.08	HHS/CDC ICASS	\$1,199,608
10176	10176.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	4819	3481.07		\$950,000

**Table 3.3.19: Activities by Funding Mechansim**

**Mechanism ID:** 3481.09

**Mechanism:** CDC GHAI

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 16093.20839.09

**Planned Funds:** \$116,658

**Activity System ID:** 20839

**Activity Narrative:** The HHS/CDC Uganda Management and Staffing (M&S) budget for FY 2009 supports the USG goal for appropriate staffing and level of effort in order to provide technical assistance, programmatic oversight, and performance monitoring for HHS/CDC funded implementing partner activities. Over 70 percent of these CDC operations and staffing costs are covered through GAP base-funding, with the balance covered by GHCS. The GHCS funds support direct technical assistance to indigenous local implementing partners to strengthen national surveillance and policy initiatives, develop laboratory services, improve care and treatment programs, expand counseling and testing approaches, enhance PMTCT activities, improve TB/HIV integration, and implement public health evaluations.

The HHS/CDC Uganda staffing plan includes the following approved U.S. Direct Hire (USDH) staff positions: Country Director; Deputy Director; two Public Health Advisors, one administrative and one technical; three Senior Scientists that serve as unit chiefs for Laboratory Services, Behavioral and Social Science, and Informatics; and four Medical Officer/Epidemiologists, one of whom serves as the President's Malaria Initiative advisor. Three approved personal services contractors (PSCs) include a Laboratory Services Coordinator, Behavioral Scientist, and Medical Officer/Epidemiologist for PMTCT.

For FY 2009, two new PSCs are requested to provide technical assistance to the Epidemiology and Informatics Units, respectively. In addition two (1) non-PSC will support care and treatment activities in the Program Unit, and thirteen (13) LES positions are planned. These sixteen positions are necessary for HHS/CDC to continue to provide high quality technical assistance that strengthens indigenous partners' capacity thus ensuring the sustainability of PEPFAR activities. As shown in the organizational charts provided, the HHS/CDC Uganda office is comprised of seven units: Office of the Director, Operations, Program, Laboratory, Epidemiology, Informatics, and Behavioral.

The Program Unit oversees HHS PEPFAR-supported partners and provides technical assistance for program implementation to ensure partner initiatives are based on current evidence-based science. Direct country project officer management is in place for seven of ten active PEPFAR treatment partners: Makerere University Faculty of Medicine, The AIDS Support Organization, Mildmay Center, Reach-Out Mbuya, Rakai Health Sciences Program, Uganda Baylor College Foundation, and Catholic Relief Services-AIDS Relief. These partners work in over 80 public and non-governmental organization (NGO) facilities, treat over 65,000 clients [including 7200 pediatric patients] and provide care to 157,000 HIV-infected persons [of which 18,000 are pediatric patients] and their families. Currently, CDC has twenty-eight local and central cooperative agreements supporting a broad range of predominantly indigenous partners. Partner activities include implementation of HIV prevention interventions, laboratory services, blood safety activities, TB/HIV integration, care and treatment for adult and pediatric patients, and, for orphans and vulnerable children (OVC), PMTCT program expansion, strategic information initiatives and health systems strengthening interventions. HHS/CDC also provides direct funding and technical support to the Ministry of Health (MOH) and the National Medical Stores (NMS). In FY 2009, funding opportunity announcements will likely add two to three new implementing partners.

Working with the national Laboratory Technical Committee and PEPFAR Laboratory Technical Working Group the CDC laboratory staff will continue to support the strengthening of the national laboratory system by providing technical advice and financial inputs to develop and implement a national laboratory services policy and development of the Department of Laboratory Services within MOH. Laboratories at Regional and District Health Facilities will continue to be renovated and equipped to provide full HIV testing and monitoring services. The new Central Public Health Laboratory (CPHL), where CDC will assign technical staff to provide leadership and mentoring and will establish a laboratory information management system to coordinate activities within the laboratory sector and with the MOH Resource Centre. The CDC Laboratory Unit will continue to coordinate technical and management training through the OGAC-Becton Dickinson Public Private Partnership in collaboration with CDC Atlanta. Quality assurance schemes for HIV serology managed by the Uganda Virus Research Institute (UVRI) and for CD4+ counting through CPHL will also be supported by direct technical assistance from CDC laboratory staff. Finally, CDC laboratory staff will provide support supervision assistance to both the District Laboratory Focal Persons and Regional Laboratory Coordinators by working in close collaboration with the District Health Officer.

Other Laboratory Unit activities include: assisting National Medical Stores to forecast, procure, store, distribute and monitor laboratory reagents through the national Laboratory Credit Line; support for national HIV drug resistance activities; and, collaboration with MOH in the design and implementation of national HIV/AIDS surveys. The CDC Laboratory will also provide substantial financial and technical support to the National TB Reference Laboratory to rehabilitate training facilities; roll-out a national training program in AFB smear microscopy; establish a national TB specimen referral system; provide containment laboratories for the safe handling of MDR and XDR TB strains, and conduct a national TBDR survey.

The Epidemiology Unit leads and supports the implementation of twelve public health evaluations (PHEs) and HIV surveillance activities. Currently, the team has seven continuing PHEs:

1. Strategies to decrease HIV-transmission risk behavior and increase drug adherence among HIV-infected adults initiating antiretroviral therapy in Uganda;
2. Evaluating the utility of re-testing HIV-negative voluntary counseling and testing clients;
3. Evaluating home-based confidential counseling and testing in Kumi District;
4. Interactions between HIV and malaria in African children;
5. Evaluating anti-tuberculosis drug resistance among smear-positive TB patients;
6. Collaborative cohort of USG-supported anti-retroviral treatment programs in Uganda to assess costs and clinical outcomes associated with different programmatic approaches;
7. Evaluating the utility of (1) using routine program HIV testing data for surveillance, and (2) the HIV-1 incidence assay for incidence-based surveillance.

The Epidemiology Unit staff coordinates the Tororo field station Home-Base AIDS Care (HBAC) project. HBAC is an approved PHE designed to answer key operational questions that will provide valuable information to the MOH and the international community on how to best scale-up ART in rural settings; develop appropriate policies for selection of second line ART drug regimens; evaluate the need for continued cotrimoxazole in ART patients; and, examine the risks and benefits associated with early versus late ART drug switching. HBAC has one of the largest cohort on ART that is being followed up in sub-Saharan Africa. This field station infrastructure will be used to launch additional multi-country PHEs and

**Activity Narrative:** provide a training venue for other PEPFAR country staff with a less developed infrastructure. Other PHE activities conducted by partners and supported by Epidemiology Unit staff include: Comparison of Facility and Home-based Antiretroviral Therapy Delivery Systems; Assessing the relationship between intimate partner violence and HIV status disclosure in Rakai District; and Evaluating two types of male circumcision procedures. CDC Uganda will participate in four new PHEs of global significance proposed for FY 2008.

This team also provides the MOH AIDS Control Program direct technical assistance to conduct antenatal clinic surveillance, and to develop and conduct the combined Malaria and AIDS Indicator Survey. Scientists in the unit are key members of the national technical Surveillance workgroup, the PEPFAR strategic information workgroup, and the OGAC PHE task force. They also advise the MOH and related government agencies on national evaluations and studies.

The Informatics Unit provides Ugandan public health partners with computer system expertise, performs CDC laboratory data management, and provides in-country scientific staff with data management and statistical support. This team also provides technical assistance to the MOH Resource Center in the design and implementation of the national Health Management Information System and provides direct technical assistance to over twenty local implementing partners on data collection applications for clinical and laboratory services, data management and analysis, and the building, maintenance, and management of electronic communication, connectivity and data networking systems. The Informatics Unit provides extensive on-site training opportunities for all HIV partners to strengthen their institutional capacities, and holds on-campus training sessions on Epi-info, SQL, and network management. Trainings are also available for staff, MOH and partners on management of national survey data. Need to add the on-going FY08 activities for piloting technologies for health data collection and electronic medical records systems.

The Behavioral Unit provides scientific leadership and technical assistance to numerous indigenous partners, including the MOH, NGOs, universities, other PEPFAR country units, USG agencies, and various international health institutions. The goals of the Unit are to inform the development and implementation of innovative and effective programs addressing HIV prevention, care, and treatment by using multidisciplinary methods based on psychology, anthropology, economics, and epidemiology. The Unit has previously focused on reducing HIV risk behavior and transmission, PMTCT implementation and program harmonization, reducing social harm and stigma associated with HIV testing and home-based care, ART adherence, identifying reproductive norms and reducing unwanted pregnancies among HIV-infected women, increasing social support for care and HIV status disclosure, developing discordant couple counseling protocols, and informing interventions for OVC and HIV-infected children. Future activities will address HIV epidemiology, prevention, care, and treatment within the uniformed services of Uganda with a specific emphasis on Uganda Prison Services, identifying factors related to ART adherence among HIV-infected children, developing task shifting approaches for male circumcision and ART initiation and care, conducting evaluations addressing HIV risk behavior disinhibition within biomedical prevention trials of pre-exposure prophylaxis and HIV vaccines as well as male circumcision roll-out programs.

To fully implement the activities described above, the HHS/CDC office has planned for a full compliment of 261 staff positions, including the fifteen planned positions. These staffing needs are required to support the expanded activities for PMTCT, laboratory services, and strategic information to ensure adequate technical assistance to partners; increased surveillance activities; and additional data management and analysis for the PHEs. M&S staff-specific costs include travel, training, and communication services. The M&S operational costs are inclusive of office and warehouse space, and associated utility and security costs.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16093

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16093	16093.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$349,852

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 3481.09

**Mechanism:** CDC GHAI

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 16094.20840.09

**Planned Funds:** \$639,207

**Activity System ID:** 20840

**Activity Narrative:** The \$639,207 M&S cost is for procurement of information technology support office (ITSO) services from Atlanta. The ITSO charges are broken down into four cost areas: headquarter support cost, regional support, connectivity to Internet and CDC headquarters, and hardware refresh and software license refresh costs. These costs include support for the base-level connectivity for the primary CDC office, maintaining the IT equipment in the offices, the regional technology support services executive, and strengthening the ITSO global activities team in Atlanta to better support the field as well as transitional costs from traditional Desktop PCs to Complete Docking stations.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 16094

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
16094	16094.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	6445	3481.08	CDC GHAI	\$552,208

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 1245.09

**Mechanism:** Makerere University Walter Reed Project (MUWRP)

**Prime Partner:** Walter Reed

**USG Agency:** Department of Defense

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 5356.20041.09

**Planned Funds:** \$260,000

**Activity System ID:** 20041

**Activity Narrative:** The Makerere University Walter Reed Program (MUWRP) 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 HIV care, treatment, and prevention. Among the goals of MUWRP is to build the infrastructure and capacity of local public and private partners in central Uganda to ensure quality HIV services for communities participating in HIV cohort studies and vaccine research. Since 2005 MUWRP has increased its PEPFAR support to the Kayunga District by supporting a comprehensive HIV program including: expanding the number of HIV clinical sites, improving laboratory services, infrastructure, data collection and reporting, supplies, human capacity development, innovative task shifting, youth focused programs, short-term technical staffing, OVC services, and a vast array of counseling and testing and prevention programs.

This activity is a continuation from FY2008.

This activity links to MUWRP activities under Treatment, Care, CT, OVC, Lab, S.I., and prevention programs in the Kayunga District of Uganda. In FY05, the program hired one fulltime staff dedicated to PEPFAR activities in the Kayunga District. The focus for FY09 will be to maintain this position.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 15716

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
15716	5356.08	Department of Defense	Walter Reed	7234	1245.08	Makerere University Walter Reed Project (MUWRP)	\$243,000
8530	5356.07	Department of Defense	Walter Reed	4873	1245.07	Makerere University Walter Reed Project (MUWRP)	\$188,000
5356	5356.06	Department of Defense	Walter Reed	3365	1245.06	Makerere University Walter Reed Project (MUWRP)	\$104,705

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 11952.09

**Mechanism:** ICASS

**Prime Partner:** US Department of State

**USG Agency:** Department of State / Office of the U.S. Global AIDS Coordinator

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 29258.09

**Planned Funds:** \$30,880

**Activity System ID:** 29258

**Activity Narrative:** This amount \$26,580 was taken from activity 4752.21608.09 and was added to this new mechanism on 2/9/09. The changes followed clarification from the country team regarding ICASS costs.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 5: Planned Data Collection**

<b>Is an AIDS indicator Survey(AIS) planned for fiscal year 2009?</b>	<b>X</b>	<b>Yes</b>	<b>No</b>
If yes, Will HIV testing be included?	X	Yes	No
When will preliminary data be available?			12/30/2009
<b>Is an Demographic and Health Survey(DHS) planned for fiscal year 2009?</b>		<b>Yes</b>	<b>X</b>
If yes, Will HIV testing be included?		Yes	No
When will preliminary data be available?			
<b>Is a Health Facility Survey planned for fiscal year 2009?</b>		<b>Yes</b>	<b>X</b>
When will preliminary data be available?			
<b>Is an Anc Surveillance Study planned for fiscal year 2009?</b>	<b>X</b>	<b>Yes</b>	<b>No</b>
If yes, approximately how many service delivery sites will it cover?		Yes	No
When will preliminary data be available?			12/31/2009
<b>Is an analysis or updating of information about the health care workforce or the workforce requirements corresponding to EP goals for your country planned for fiscal year 2009?</b>	<b>X</b>	<b>Yes</b>	<b>No</b>

**Other Significant Data Collection Activities**

**Name:** Most at Risk Populations (MARPs)

**Brief Description of the data collection activity:**

This is a surveillance activity among most at risk populations such as Commercial Sex Workers, Men who have Sex with Men [MSM], Sexual Partners of MSM.

**Preliminary Data Available:**

5/1/2009

## Supporting Documents

File Name	Content Type	Date Uploaded	Description	Supporting Doc. Type	Uploaded By
Ug COP09 Spt Docs A. Ambassadors Ltr.pdf	application/pdf	11/10/2008		Ambassador Letter	MAStrong
Ug COP09 Tbl1 - Executive Summary.doc	application/msword	11/13/2008		Executive Summary	MAStrong
Ug COP09 Spt Docs B. Uganda AIDS Comm Ltr.doc	application/msword	11/13/2008	Letter from Uganda AIDS Commission noting alignment of COP09 with National HIV/AIDS Strategic Plan	Other	MAStrong
Ug COP09 Spt Docs 4 - HC Worker Salary.xls	application/vnd.ms-excel	11/13/2008		Health Care Worker Salary Report	MAStrong
Ug COP09 Spt Docs 11 - Budget Justification.doc	application/msword	11/14/2008		Other	MAStrong
Ug COP09 Spt Docs 9 - PPP.xls	application/vnd.ms-excel	11/13/2008		PPP Supplement	MAStrong
Ug COP09 Spt Docs 5 - Pgm Area - Gender.doc	application/msword	11/13/2008		Gender Program Area Narrative*	MAStrong
Ug COP09 Spt Docs 3 - Pgm Area HCD.doc	application/msword	11/13/2008		HRH Program Area Narrative*	MAStrong
Ug COP09 Spt Docs 6 - Global Fund.doc	application/msword	11/13/2008		Global Fund Supplemental	MAStrong
Ug COP09 Spt Docs 1 - Budgetary Requirements (updated for VCT).xls	application/vnd.ms-excel	11/14/2008		Budgetary Requirements Worksheet*	MAStrong
DOD organogram.doc	application/msword	11/14/2008		Other	MAStrong
Peace Corps organogram.xls	application/vnd.ms-excel	11/14/2008		Other	MAStrong
State organogram.doc	application/msword	11/14/2008		Other	MAStrong
USAID organogram.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0156_Progress report_Kumi HBCT.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0158_Progress report_Jinja trial_version2.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0159_Progress report_HBAC (Oct 08).doc	application/msword	11/14/2008		Other	MAStrong
Walter Reed Organogram.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0157_Progress report_domestic violence_rakai.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0162_Progress report_TCC.doc	application/msword	11/14/2008		Other	MAStrong
UG-07-0164_Progress report_TEDAS (Oct 08).doc	application/msword	11/14/2008		Other	MAStrong
Ug COP09 Spt Docs 2 - Summary Tgts.xls	application/vnd.ms-excel	11/14/2008		Summary Targets and Explanation of Target Calculations	MAStrong
Ug COP09 Spt Docs - Procurement Plan.xls	application/vnd.ms-excel	11/14/2008		Other	MAStrong
UG-08-0171_Progress_report_Change Agents_version 2.doc	application/msword	11/14/2008		Other	MAStrong
CDC organogram.doc	application/msword	11/14/2008		Other	MAStrong
PEPFAR Coordinator Office organogram.doc	application/msword	11/14/2008		Other	MAStrong
UG-08-0166_Progress report_Rakai MC.doc	application/msword	11/14/2008		Other	MAStrong
Ug COP09 Spt Docs 10 - Budget Justification M&S.doc	application/msword	11/22/2008	Management and Staffing justification (7.3%)	Budgetary Requirement Justifications	MAStrong
Ug COP09 Spt Docs 7 - MS Budget Tbl all.xls	application/vnd.ms-excel	11/19/2008	M&S Budget Table	Management and Staffing Budget Table	AConforto

