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THE HIPS PROJECT FOURTH QUARTER AND YEAR 4 ANNUAL REPORT FY 2011

OCTOBER 2010 – SEPTEMBER 2011



Bidhampola Group members who are caretakers of OVC having a VSLA group meeting. To date, the VSLA group has UGX 1,0255,000 in savings; is engaged in goat rearing and agricultural production; and have co-funded 3 children to join boarding schools for education (KORD provides UGX 150,000 and the members contribute UGX 100,000 to this fund).

October 2011

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ACRONYMS

AAM	Africa Affordable Medicines
AMFIU	Association of Micro-Finance institutions in Uganda
AIC	AIDS Information Center
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATIC	AIDS Treatment Information Centre
BCC	behavior change communication
CBO	Community Based Organization
CBV	Community Based Caregiver
CD4	Cluster of Differentiation 4
COP	Chief of Party
CPHL	Central Public Health Laboratory
CSF	Civil Society Fund
CUG	Closed User Group
DCA	Development Credit Authority
DCOP	Deputy Chief of Party
DHO	District Health Office
DOTS	Directly Observed Treatment
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FUE	Federation of Uganda Employers
GDA	Global Development Alliance
GLAS	Good Life at School
GOU	Government of Uganda
HCT	Home-based counseling and testing
HIPS	Health Initiatives for the Private Sector
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HR	Human Resources
IAA	International Air Ambulance
IDI	Infectious Disease Institute
IEC	Information, Education and Communication



IGA	Income generating activities
ILO	International Labor Organization
IPT	Intermittent Preventive Treatment
ITN	Insecticide-Treated Net
JHUCCP	Johns Hopkins Bloomberg School of Public Health Center for Communication Programs
KCCL	Kasese Cobalt Company
LTPM	Long term permanent methods (FP)
M&E	Monitoring and Evaluation
MLISADA	Music Life Skills and Destitute Alleviation
MGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organizations
NMS	National Medical Store
NTLP	National TB and Leprosy Program
OGAC	Office of the Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	People Living with HIV/AIDS
PHP	Private Health Practitioners
PICT	Provider Initiated Counseling and Testing
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PPM-DOTS	Public-Private Mix – Directly Observed Therapy
PPPH	Public Private Partnerships for Health
PPP	Public Private Partnership
PSFU	Private Sector Foundation - Uganda
RDTs	Rapid Diagnostic Tests
RH/FP	Reproductive Health / Family Planning
RVZ	Royal van Zanten
SCMS	Supply Management Systems
SMC	Safe Medical Circumcision
SME	Small and Medium Enterprise



STF	Straight Talk Foundation
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
UHF	Uganda Health Care Federation
UHMG	Uganda Health Marketing Group
UMA	Uganda Manufacturers Association
USAID	United States Agency for International Development
UTL	Uganda Telecom Limited
UWEAL	Uganda Women Enterprises' Association
VCT	Voluntary Counseling and Testing
VHT	Village Health Team
VSLA	Village savings and loans association



EXECUTIVE SUMMARY

The USAID-funded HIPS (Health Initiatives for the Private Sector) Project (2007 – 2013) 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 members. Specifically, the project facilitates partnerships and provides technical assistance to design and implement comprehensive workplace health programs that maximize the accessibility of HIV/AIDS, tuberculosis (TB) & malaria prevention and treatment services and improve use and knowledge of reproductive health and family planning (RH/FP) services and products. To foster sustainability, the project is building the capacity of private sector employer organizations such as the Federation of Uganda Employers (FUE) and the Uganda Manufacturers Association (UMA) to assume the support and partnership role that HIPS is currently serving with Ugandan companies. Cardno leads this project with partners Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs (JHUCCP), the Mildmay Centre and O'Brien and Associates International.

The project has four main tasks:

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

This report serves as the Year 4, Quarter 4 Report and the FY 2011 Annual Report.

In Year 4 the HIPS Project continued to significantly expand its scale and scope in all program areas. HIPS is now supporting clinics and programs in 57 districts, 19 of them in northern Uganda. HIPS has supported a total of 102 partner clinics to gain accreditation in antiretroviral therapy (ART) and 45 clinics to gain accreditation in TB treatment. Quality of care and service integration has been a main focus, and through HIPS support 100% of partner sites have received at least two integrated support supervision visits from members of the project, UMA, FUE, local districts and Ministry of Health (MOH). The integration of services has continued to help increase the number of people reached while remaining strictly on-budget. In Year 4, HIPS scaled up and exceeded the majority of its targets, especially in the areas of palliative care, ART, voluntary counseling and testing (VCT), and FP.

The project faced a challenge in Year 4 when the National Medical Stores (NMS) declined to provide antiretrovirals (ARVs) to accredited private sector clinics, including those that are HIPS supported, due to difficulty in tracking the drugs. While the situation is now fairly stable due to PEPFAR and Global Fund support, the issue had an affect on some HIPS activities, such as the roll out of the HIV/AIDS insurance product developed by HIPS and International Air Ambulance (IAA) in Year 3. However, HIPS was still able to launch a number of new initiatives, such as the linkage of its partner clinics to the Africa Affordable Medicines (AAM) network, which will enable access to high quality drugs and medical supplies from AAM's chain of pharmacies at comparatively lower costs.

HIPS also conducted a number of innovative and important studies and other operational research in the areas of ART cost effectiveness, use of rapid diagnostic tests (RDTs) in malaria, health care franchising, TB treatment, and effectiveness of behavior change communication (BCC) models. HIPS intends to build on this evidence base in Year 5 through further study and research.



Year 4 saw HIPS participation in and leadership of a number of conferences and meetings, both in Uganda and in the United States. In Quarter 3, HIPS held an interactive event to bring current partners together with prospective partners and project stakeholders. The symposium showcased HIPS partner achievements, attracting further potential partners for Year 5 by illustrating benefits of project participation, as well as more widely displaying project successes to the full range of HIPS stakeholders. The event also served as a platform to focus on and discuss the sustainability of HIPS activities after project close-out.

In addition, with project support, FUE and UMA have made great strides towards taking over the full complement of HIPS partnerships, evidenced by a significant increase in income generated from HIPS partners – an increase of 67% from Quarter 3 to Quarter 4 alone. Of the 88 total partnerships eligible for migration to FUE or UMA management, 74% have been migrated and are now overseen by the associations. FUE and UMA had other marked successes this year, such as leading the technical support of 19 health fairs during this year, and supporting 90% of all peer education trainings conducted.

Year 4 ends with a transition in the leadership of HIPS from Ms. Barbara Addy to Dr. Dithan Kiragga. Ms. Addy will continue to serve the project through a new role as Director of Partnerships, which will allow her to focus her partnerships expertise on sustainable outcomes going into the last 18 months of the project. Dr. Kiragga's promotion to Chief of Party will see him continuing to contribute his technical expertise to the project, but also taking leadership of the HIPS team towards achieving its targets before project close-out.

Principal Achievements and Success Stories

1. In Year 4, the total number of active GDA partnerships is 42 and the overall number of HIPS partners is 95. The company contribution in Year 4 is USD 1,746,787 with a HIPS contribution of USD 841,373, a 2:1 leverage. Together with its local partners FUE and UMA, HIPS approached a total of 29 new companies and built partnerships with 12 of them; seven of which were GDA partnerships. Three existing partners also upgraded to GDAs.
2. Quality of care and service integration has been a key focus for the project in the 4th year. The project has used a combination of methods ranging from placement programs, classroom training, on-the-job mentorship and regular support supervision to improve provider skills and promote service integration.

All (100%) reporting and active partner sites have received two integrated support supervision visits from members of the project, UMA, FUE, local districts and MOH in the year.

In addition, the project organized technical support visits on pediatric care, health management information system (HMIS), safe male circumcision (SMC), laboratory inventory and logistics, long term permanent methods (LTPM) and safe motherhood to partner clinics.

During this year, the project trained and placed 265 clinicians at Mildmay Uganda to receive practical skills in HIV/AIDS and palliative care. Another 101 clinicians were trained in TB/HIV programs.

3. In Year 4, HIPS scaled up and exceeded the majority of its targets – most notable were that 69,770 people received VCT (target of 45,000) and 29,721 unique individuals received palliative care services (target of 25,000). HIPS had 235% achievement toward the number of new acceptors for FP (achieved 9,401 of 4,000 target), and 265% for couple years of protection (CYP) mainly to due scale up of outreach. HIPS had 766% achievement in the number of clients newly initiating ART (achieved 1,531 of 200 target), and 100% achievement toward the number of current clients receiving ART, as well as those who have ever received ART.
4. The project has increased the role and contribution of the private sector to the national TB response. During the 4th year, HIPS facilitated the National Tuberculosis and Leprosy Program (NTLP) to carry



out inspection of 15 private sector health facilities, of which seven received accreditation for TB treatment, bringing the total number of accredited sites to 45 over the 4 years of the project to date.

5. During the 4th year the SMC program was scaled up with the introduction of camps and outreach sessions. During the 4th quarter, six partner sites at Kakira, KCCL, Macleod Russell, Kinyara, Family Health Resource Centre and Tullow Oil conducted 12 camps. A total of 2,414 SMC procedures were conducted during the year.
6. During the year, the project conducted a number of studies and research to assess impact of interventions.
 - The HIPS project in partnership with the MOH and Boston University completed a study that examined the cost effectiveness of ART programs in both private (three sites) and public (three sites) health facilities in Uganda. The study was a cost-outcome analysis using unlinked, retrospective medical record data to ascertain total resources used in the first year on treatment, and patient outcomes at the end of the first 12 months. In general patient outcomes at these six sites are quite good, with total retention rates of 87 to 98% after the first year on treatment. There is no clear trend or difference in outcomes between the public and private sector sites. (See Annex 1)
 - HIPS facilitated a study to document the cost, savings and benefits that arise from the use of RDTs in the treatment of malaria at 10 selected partner private sector companies. Results indicated that of all the patients that presented with fever, the majority (60%) in hypo-endemic areas had malaria against only 20% in the hyper-endemic areas. It was also observed that on average the savings on anti-malarial drugs from diagnosing all fever patients using RDTs before treatment would be equal to the corresponding cost of the RDTs, therefore making a business case for the use of RDTs in malaria treatment. (See Annex 2)
 - HIPS concluded an operational research project to identify promising health care franchising models and approaches. The research identified existing Ugandan franchise networks; examined their services, levels of financial sustainability and quality standards; and documented successes and challenges.
 - HIPS carried out an evaluation of treatment outcomes of new pulmonary smear-positive patients initiated on TB treatment between July 2009 and June 2010 from 12 partner accredited units. The aim of the study was to assess the quality of TB treatment services among the partner accredited private sector sites. The results showed a TB treatment success rate of 86% which is above the national target of 85%. The Defaulter/Loss to follow up rate was 9%, which was less than 10% as expected per the Uganda NTLP TB DOTS Guidelines of 2002. (See Annex 3)
 - HIPS conducted a Behavioral Change Communication (BCC) operations study among 10 partner companies to establish the extent to which the supported communication models influence utilization of health services and adoption of healthy practices. The study revealed strong correlation between peer education and client motivation/service utilization.
7. HIPS has been very successful in linking partners to potential sources of funding to their workplace and community programs. Notable achievements were:
 - UMA has just completed the first year of implementation of the \$143,000 grant from USAID STRIDES Project to implement a number of RH/FP activities at company sites, leveraging HIPS partners' at TAMTECO, SCOUL, Mpanga Tea Growers and Mabale Tea Growers Company.
 - During the 4th year, both FUE and UMA won a grant of \$70,000 from the USAID-funded RESPOND Project. This grant will build on FUE and UMA's existing programs to support outbreak response capacity in the private sector.



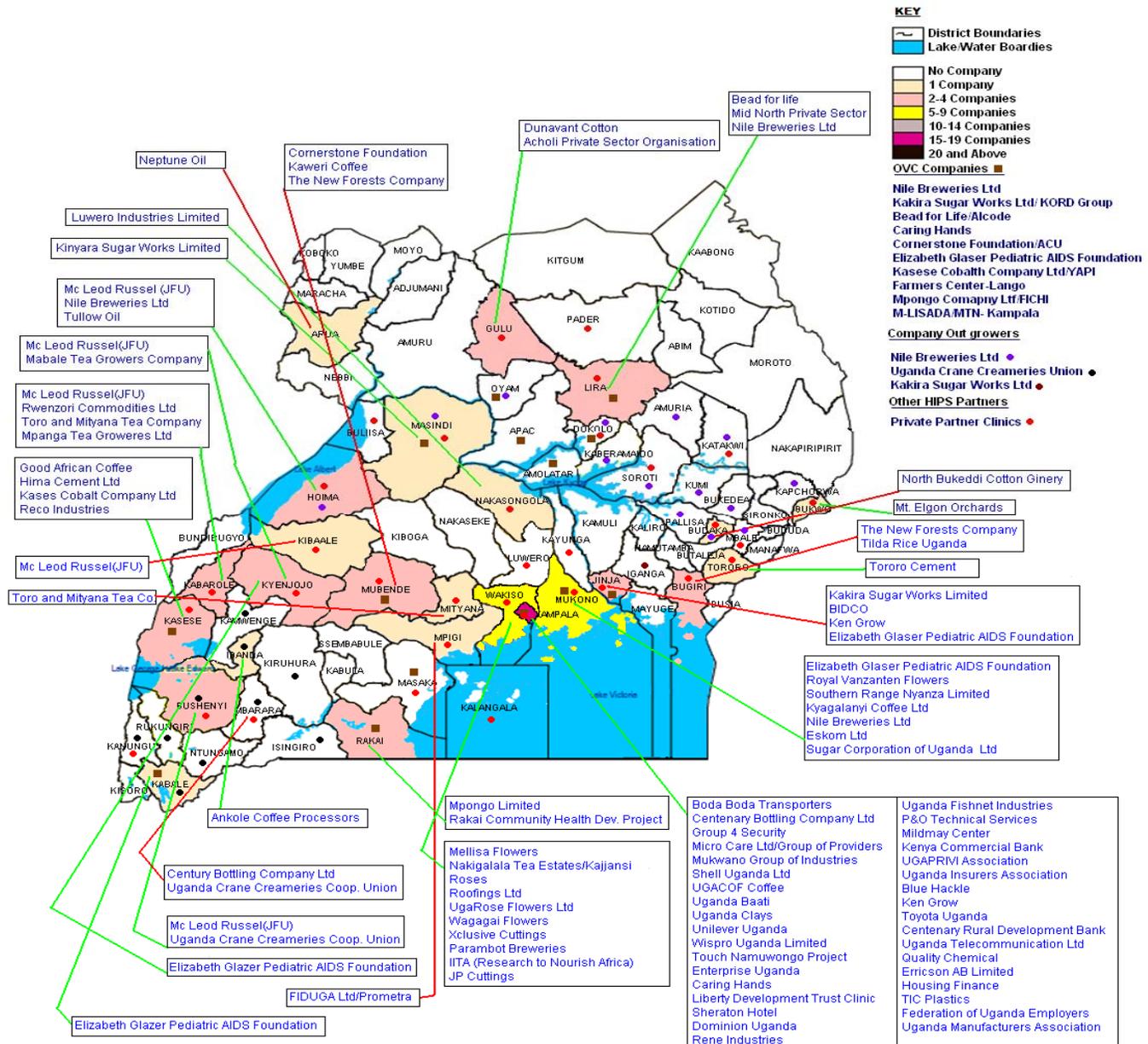
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- Through the Incentive Fund, the Office of the Global AIDS Coordinator (OGAC) and USAID granted \$390,000 to support the delivery and scale up of prevention, care and treatment services for vulnerable and geographically isolated groups in the supply chain of Nile Breweries Limited.

In addition, FUE and UMA saw a significant increase in the income generated from workplace health programs compared to Year 3. Both associations earned a total of \$27,477 from workplace health programs implemented for different companies, compared to \$18,633 earned last year. This represents an increment increase of 47.5% from the income both associations earned last year.

8. To facilitate critical health information flow between the clinics and community members, the project has partnered with mobile telephone companies to provide mobile phones which are then activated on a Closed User Group (CUG) platform, which enables free phone calls amongst the users. These mobile phones are then given to the peer educators, the private clinics in the community and the AIDS Treatment Information Center (ATIC) - the national referral center which medical personnel call when they are faced with HIV/AIDS treatment and care challenges. In addition, the project has scaled up our piloted m-Health programs with both Airtel and Text to Change.



Figure 1. HIPS Now Works in 57 Districts in Uganda



PROJECT ADMINISTRATION

The HIPS Project is fully operational with 22 full time staff. During the 4th quarter and following approval from USAID, Dr. Dithan Kiragga was promoted to Chief of Party for the project, starting October 1, 2011. Barbara Addy will remain on the project as Director of Partnerships. In this role, she will manage the Partnership and Capacity Building teams, working with HIPS partners to implement sustainability strategies for a smooth transition from the HIPS Project. Other notable promotions included: Dr. Fred Ntege, who is now the Team Leader for Health Services; Carol Musimami, who is now the Technical Advisor for SMC; and Mariat Namakula, who was promoted to Office Manager.



TECHNICAL PROGRESS

This section summarizes the technical progress of project activities for Year 4, Quarter 4, and also provides an annual summary. It has been organized under the four primary tasks of the project. Under each task is a brief description of activities that were accomplished for the last quarter of the project and annually, as outlined in the work plan, including progress toward programmatic targets. Each task also includes a description of challenges, recommendations and planned activities for the next quarter.

Coordination

The project is now working with 101 companies and 112 clinics (50% company clinics and 50% private clinics). In Year 4, the project has placed particular emphasis on migration of all companies to either FUE or UMA while ensuring full functionality of all the partner clinics. The project has now successfully migrated 74% of eligible partner companies to either of the two private sector employer organizations. The project has conducted regular support supervision, placement and training programs for clinicians, and has linked partners to national institutions for sustainability. FUE and UMA have taken the lead in the delivery of HIV prevention programs at partner sites while the District and MOH teams have been instrumental in the provision of on-the-job mentorship and supervision programs.

Highlights of **Year 4** coordination initiatives include:

- **Ministry of Health (ACP/NTLP/JMS/NMS).** In Year 4, the project held coordination meetings with the MOH and other stakeholders to ensure that accredited clinics continue to receive free ARVs and other support from the government. During the year, the NMS declined to provide ARVs to accredited private clinics citing inability to track free government labeled drugs in the private sector. The situation is now fairly stable and accredited clinics are getting ARVs from the Joint Medical Stores (JMS) through the PEPFAR and Global Fund support.
- **The Uganda Health Care Federation.** In Year 4, HIPS supported the establishment and launch of the first umbrella private sector organization. The Uganda Health Care Federation (UHF) represents all private medical practitioners and facilitates their participation in policy and budget allocation at national level. Additionally, this umbrella organization will engage in setting quality standards and develop a system for self regulation and accreditation. This group will also allow for important representation within the public private partnership (PPP) working group as Public Private Partnerships for Health (PPPH) Policy guidelines are established and rolled out.
- **PPPH Policy and Collaboration with National Stakeholders.** In Year 4, HIPS, in collaboration with the Italian Cooperation, assisted the MOH to disseminate the National Policy on PPPH. Regional dissemination workshops have been carried out.

During the 4th quarter, HIPS worked closely with the MOH and the Italian Cooperation to assist five pilot districts (Mpigi, Mityana, Kyenjojo, Kasese and Nakasongola) to develop joint Public-Private PPPH plans. Also during the planning meetings, representatives of Private Not-for Profit (PNFP) and Private Health Practitioners (PHP) sub-sectors were able to select their own representatives to form PPPH coordination committees.

- **Coordination on Home-based Counseling and Testing (HCT).** In Year 4, the project, in partnership with MOH and technical specialists, conducted a Provider Initiated Counseling and Training (PICT) Program for 48 health workers. An additional 35 health workers were trained in couples counseling and testing with support from JHCUCCP and MOH. To date 69,770 individuals have undergone VCT (target 45,000).
- **Logistics Coordination.** To improve partner recording and reporting, the project in partnership with MOH and staff from the Central Public Health Laboratory (CPHL) conducted on-the-job training for



64 records staff and 45 laboratory technicians in ART logistics and HCT inventory respectively. Emphasis during the training was on data quality, drug and VCT logistics, district and national reporting.

- **Integration of services.** Through training, logistical support, support supervision, job aides and referral the project has increased the range and quality of services provided at partner sites. 90% of all HIPS partner clinics have integrated at least two additional services, including TB, malaria and FP/RH. In Year 4, the project, in partnership with the NTLP, accredited 7 new sites for TB treatment. 17 new sites were supported to provide SMC services. Also in Year 4, 37 sites were supported with training and logistics to provide LTPM services.
- **Good Life at School Program.** HIPS is implementing an HIV prevention program commonly known as the Good Life at School (GLAS) amongst 29 schools supported by companies. The program utilizes a cascade approach to peer education to reach out to young people aged 12-19 with information and life skills for the adoption of abstinence as an HIV prevention practice. To ensure sustainability of the program, HIPS in Year 4 supported coordination meetings aimed at enhancing technical exchange and harnessing available resources amongst all the stakeholders in Kasese district.
- **In Year 4,** the project supported and participated in several local and international meetings and conferences. Notable among these are:

From the 13-17 June 2011, the project participated in the Global Health Conference in Washington DC. HIPS presented three papers on HIPS activities namely: the UTL mobile technology partnership, Safe Male Circumcision in the private sector and the HCT program in Katakwi district.

HIPS held a symposium that brought together HIPS current partners, potential partners and stakeholders. The interactive event, the first of its kind since the inception of the project in 2007 provided a platform for the project to share its achievements and successes for the last three and a half years as well as plan for the remaining 18 months of the project.

HIPS joined FUE and the Uganda AIDS Commission to organize the first CEO testing event in the country. This event, conducted simultaneously in all the five East African Community member states, was aimed at scaling up leadership for workplace health programs. A total of 119 people attended, of which 37 were CEOs from the Ugandan private sector companies, and 82 were managers at different ranks in the private sector. Other officials from the nongovernmental sector were also present.

Task 1: Expand and Strengthen Access to and Utilization of Health and HIV/AIDS Services in the Private Sector

The HIPS Project partners with companies and private clinics to increase access to and utilization of health services for Ugandan company employees, their dependents and community members. As each company is different and one size does not fit all, the HIPS Team offers companies a menu of services and then collaborates with them on a one-on-one basis to design an appropriate services package and cost sharing arrangement.

1.1. HIV/AIDS PREVENTION

During Year 4, HIPS efforts continued to focus on strengthening capacity of FUE/UMA to provide technical support to partner companies for implementation of quality HIV prevention and other health communication interventions. Technical support included: the dissemination of BCC quality assurance guidelines; orientations on the small group based peer education approach; revised data collection tools; and participation in integrated support visits to partner sites.

Year 4 strongly positioned FUE/UMA as lead providers of health communication services among partner companies. 90% of all the peer education trainings were supported by FUE and UMA. They supported all



the community health fairs, Training of Trainers sessions, and equally participated in technical support visits to partner sites where 61,407 people were reached with HIV prevention communication and skills. The project supported life skills activities in 29 secondary schools for adoption of abstinence as an HIV prevention practice. Other communication models implemented included: men-only seminars, pre-recorded radio discussions; and games/exercises related to sexual networks. HIPS continued to partner with STF, HCP and YEAH to adapt and reproduce relevant communication materials.

A BCC best practices study was conducted to determine the extent to which utilized communication models influence service utilization and adoption of healthy practices among employees and surrounding community members. Study findings revealed a strong co-relation between peer education and health facility client load.

In Year 4, HIPS support reached a total of 61,407 people with HIV prevention messages which included SMC. Messages also addressed prevention practices that include abstinence, being faithful, condom use, and reduction of multiple concurrent sexual partnerships among others.

During the 4th quarter, through the health fairs, peer educators, men-only seminars, community radio discussions and company clinics with community outreach and community videos, HIPS reached over 6,749 persons with HIV prevention messages. Also during quarter 4, 21 health workers from partner companies were trained in the delivery of SMC services. 1,218 procedures were conducted through the static clinics and SMC outreach camps.

Success story: The School HIV Program

During Year 4, emphasis was placed on supporting peer education activities as well soliciting for district stakeholder buy-in to the program. The school HIV prevention program framework for implementation was highly commended by the Ministry of Education and Sports to the extent that they recommended district implementers to replicate the program, the training materials used and the data collection/reporting tools. The Civil Society Fund (CSF) recommended to their implementing partners to use the HIPS-developed training materials and data collection tools for in-school youth programs. Touch Namuwongo, one of HIPS partners, received funding from CSF to replicate the school program at 7 schools in Wakiso district. HIPS provided the technical support during the implementation.



An integrated support visit at one of the schools with district officials, FUE and KCCL staff.

1.1.1. Continue to use the Good Life Module and associated IEC plans and materials

In Year 4, HIPS continued to support the Good Life model to promote partner health services among employees, their families and surrounding communities. FUE/UMA spearheaded marketing of activities among partners and coordinated the year's activity schedule. Additional BCC data collection and monitoring tools were revised and disseminated to reflect the focus on behavior change and stimulation of demand for services. An inventory of all the Information, Education and Communication (IEC)/BCC materials HIPS had adapted and produced was created as a future source of information to the partners. Contact lists of the agencies that had produced relevant communication materials were disseminated to partners for future linkage and access to health communication services.

1.1.2. Training and refresher training for peer educators

In Year 4, HIPS, together with FUE/UMA, supported 4 Training of Trainers (TOT) workshops that benefited 75 people from 17 partner companies. In addition to training, these trainers also conducted peer



educators' review meetings, assisted in mobilization for community health fairs and men-only seminars, data collection, compiling of company reports and supervision of small group based activities. 2,387 peer educators were trained during Year 4. Of these, 1,347 were refreshers while 1,040 were new. Although HIPS had anticipated fewer numbers of new peer educators to be trained, demand increased among some of the partner companies, mainly due to expansion in geographical coverage of their activities. Such companies include Tullow Oil, KCCL and Nile Breweries. There was also a need to conduct refresher trainings of the existing peer educators in order to adequately embrace the small group based approach. As a result, the peer education training targets were surpassed by 59%.

Partner companies were supported through support supervision and management visits to identify and develop internal mechanisms for motivating peer educators to sustain voluntarism. Identified innovations include: award of performance points to committed peer educators during staff appraisals; recognition in company magazines and annual events; consideration for contract renewal; and award of certificates among others. A few companies have embraced the incentive scheme while others are still conducting negotiations with management teams to institutionalize the system.

During the 4th quarter, 755 peer educators were trained. Of these, 335 were new while 420 were refresher trainings. All the new trainings were supported by FUE/UMA while HIPS supported only 10% of the refresher trainings.

Table 1: Number of Individuals Trained (Peer Educators)

Indicator	Male	Female	Quarterly Total	Cumulative total	Annual Target
Peer educators trained this quarter	501	254	755	2,387	1,500
Annual total of peer educators trained	1,523	864	755	2,387	1,500

In Year 4, FUE/UMA coordinated the development and implementation of the activity plans with partner companies. This greatly helped to strengthen working relationships with the newly migrated companies.

1.1.3. Implement strategy to reach informal sector, including out growers /migrant worker, truck drivers, fisherman and other MARPs to disseminate HIV prevention messages

In Year 4, HIPS support was expanded to five additional partner companies to implement pre-recorded community radio discussions among the out growers and employees. Such companies and estates include Mpanga Tea, Mabale Tea Growers, Kakira Sugar Works, Reco industries and Tullow oil. The small group approach makes it convenient to integrate the discussions into employee work place activities because employees are able to discuss issues while carrying out duties, such as plucking their tea. 3,340 people were reached with SMC messages.

During the 4th quarter, 14 partner companies were supported to implement pre-recorded community radio discussions using the small group approach. Condom use, reduction of multiple sexual partners, and HCT, among other issues, were included in the discussions, totaling 422 people reached during the quarter.

1.1.4. Support companies to utilize low cost, sustainable models to conduct health fairs at selected companies

In Year 4, FUE/UMA spearheaded technical support for the implementation of 19 low cost health fairs and community videos. Services that include HCT (including couples HIV testing), FP and malaria prevention (mosquito nets) were provided during health fairs. Referrals for other HIV prevention services that include SMC and sexually transmitted infection (STI) diagnosis and treatment were conducted during the community events. HIPS, together with FUE/UMA, supported 13 partners to implement men-only seminars for promotion of SMC, couples HIV Testing and treatment of STIs. 6,354 people were reached



through this model. Use of locally available human resources (peer educators and local drama groups) helped to keep the cost of health fairs low, increasing the popularity of the model among partner companies.

During the 4th quarter, seven health fairs were conducted reaching 2,183 people with HIV prevention and other health messages. Health fairs were rated as the most popular communication approach among community members followed by small group discussions during the BBC operations study that was conducted. Integration of entertainment education activities like music, drama, games/exercises related to sexual networks and trigger videos increased popularity of the model and thereby attracted them to the sites for a whole day.

1.1.5. Provide support to FUE/UMA and selected partners to implement the school HIV prevention program

In Year 4, HIPS continued to support partner companies to implement the GLAS program. The program utilizes a cascade approach to peer education to reach out to young people aged 12-19 with information and life skills for the adoption of abstinence as an HIV prevention practice. HIPS supported the training of 20 FUE/UMA and HIPS trainers as Master Trainers after which they conducted training of 87 teacher trainers in 30 selected schools, supported by six of the partner companies in peer education and life skills. On average, three teachers were trained in each of the supported schools to ensure continuity of activities even when some of the teachers left the schools or were transferred. The teachers with support from FUE/UMA and HIPS youth volunteers trained 878 students from 29 schools as peer educators. Using the small group, the peer educators reached 12,922 of their peers with information and life skills. Relevant materials were disseminated during the school activities. In order to build a youth friendly environment, teachers in 14 of the supported schools were oriented on youth sexuality and adult-child communication skills during the 4th year.

During the 4th quarter, 9,620 students were reached through the small group based approach. The Ministry of Education conducted support supervision visits to the schools in Kasese district and was satisfied with the quality of the dissemination, data collection and reporting tools and activities under the HIPS school program. The Ministry recommended that other partners to replicate the school materials and activities HIPS is supporting. The Civil Society Fund also consulted with HIPS and recommended that their sub-grantees use the training and data collection tools for the peer education program. One of HIPS partners (Touch Namuwongo) received funding from CSF to replicate the HIPS school program in one district (Wakiso). HIPS supported them to conduct the training of 25 teachers who then trained peer educators in seven schools.

1.1.6. Expand the HIV prevention package to address multiple concurrent sexual partners and Safe Male Circumcision among high risk groups

During Year 4 HIPS extended support to two partners (KCCL and Long Distant Truck Drivers Association) to implement HIV prevention activities targeting fishermen and truck drivers respectively. The fishermen, who operate at three landing sites where KCCL conducts health outreach services, were targeted through peer education activities and men-only seminars. Key prevention practices promoted during the events included; SMC, condom use, reduction of concurrent multiple sexual partnerships and early treatment of STIs. Increased level of risk perception regarding HIV among the fisher folk was reflected in increased motivation and acceptance for SMC by 68 men during an SMC camp conducted at one of the landing sites. A training of peer educators was conducted among the distant truck drivers to mobilize their peers for SMC services. Following this, a referral system was established with one of the HIPS partners (IHK) where 56 drivers received SMC services.

Tailored IEC/BCC materials (audio CDs and vehicle stickers) on SMC, condom use, HCT and STIs were disseminated to the lorry drivers through the peer educators. 933 fishermen from seven landing sites (Kahendero, Kasenyi, Hamkungu, Muhokya, Nakasongola, and Kaiso Tonya, Kyehoro) were reached



through the men-only seminars. 1,068 truck drivers were reached through the peer educators, pre-recorded audio messages and health services for SMC.

The sexual network game/exercise was disseminated to the peer educators and utilized in the small group discussions to increase HIV risk perception levels and provide skills for partner communication, condom negotiation and partner reduction. Audio CDs with discussions on issues of multiple sexual partnerships and the associated HIV risk were disseminated to the peer educators for use in the small groups.

1.1.7 Advocate for Safe Male Circumcision

In Year 4, the HIPS project increased advocacy for SMC services. 42 staff from 14 partners at Kinyara Sugar, McLeod Russel, KCCL, Hima Cement, Kakira Sugar, Family Health Resource Center, Tullow Oil, Wagagai, St. Mary's Clinic, Boots Medical Centre, SCOUL, IAA/Charis Clinic, Old Kampala Hospital and Engari Health Center were trained in the delivery of SMC services. To date, 32 partners are providing SMC services through the static health facilities. In the efforts to scale up SMC services, HIPS partnered with six companies to conduct 12 SMC camps. The men-only seminars were conducted to mobilize and register people for services before the onset of the camps. This approach greatly contributed to 2,414 procedures conducted during the year. HIPS continued to work with JHU, the Water Reed Project, the Rakai Health Services Program and Makerere University School of Public Health to advocate for SMC among policy makers and provide SMC communication materials and services. HIPS disseminated the PEPFAR guidelines for delivery of SMC services to implementing partners.

1.1.8. Conduct operations study regarding the influence of HIPS health communication models on utilization of health services and adoption of healthy practices.

In Year 4, the HIPS project with technical assistance from JHUCCP Uganda designed and conducted a BCC operations study to determine the extent to which the peer education communication models influence service utilization by employees and surrounding community members. In addition, the study sought to document best practices (cost effective, sustainable and popular) among the applied communication models and to explore plausible mechanisms for sustaining demand for health services. Study findings revealed that peer education greatly influences service utilization:

- 83% of the clients interviewed indicated that they had been referred by a peer educator as their primary source of information the first time they visited the facility.
- Respondents who had been exposed to peer education were five times more likely to use a service such as condoms and FP than those who were not exposed. The majority of clients on ART (81%) reported that they had received a home visit by a peer educator at least once in the previous week, implying that support regarding ART adherence is regularly given.
- 49% of the male respondents (exposed to peer education) indicated that they would encourage a friend to go for SMC as compared to 13% of the unexposed male peers.
- The peer education approach has realized a multiplier effect. For instance, 43% of those interviewed reported that they had supported at least one other person to take a health action using the information they had acquired from the peer education sessions.

1.1.9. Disseminate BCC data collection and quality assurance guidelines to FUE/UMA and selected partners

During Year 4, HIPS disseminated the developed BCC quality assurance guidelines and data collection tools to FUE/UMA and partner company focal persons through various workshops. More support on use of the tools was provided during the technical support visits. The key tools disseminated include the BCC quality assurance guide and plan, the small group discussion guide, the revised support supervision tools and the small group peer educators' diaries.



1.1.10. Expand utilization of low cost telecommunication approaches to disseminate health messages and improve referral

During Year 4, HIPS continued to partner with Text to Change to design and implement an SMS mobile texting program to disseminate health messages to employees and surrounding communities of four partner companies reaching a total of 3,183 people. HIPS extended a similar partnership with Airtel. Through the partnership between HIPS and Airtel (mobile telecommunication company), nine partners re-launched the mobile phone referral network program that was piloted with UTL in Year 3. The partners implementing this program include: Wagagai, Tullow Oil, Mpanga Tea, Mabale Tea, New Forest Company, Hima Cement, Kinyara, Kakira, Rwenzori commodities.

1.1.11 Implement joint monitoring activities with FUE/UMA

During Year 4, HIPS conducted integrated support supervision visits to partner programs and sites including the school program. This exercise strengthened FUE/UMA's collaborative relationship with the partners, responsibility over which had been migrated to them the previous year.

Table 2: Number of Individuals Reached through Community Outreach AB Activities

Indicator	Male	Female	Quarterly Total	Cumulative total	Annual Target
Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	2,200	1,766	3,966	12,922	20,000

Table 3: HIV Prevention School Program

Name of Company	No. of Participating schools	Students reached		Total
Kinyara Sugar, Kakira Sugar Works, Mpongo, Hima Cement, Kasese Cobalt Company Ltd.	29	Male 235	Female 1,025	1,260

Table 4: Number of Individuals Reached through Community Outreach Prevention Activities

Indicator	Male	Female	Quarterly Total	Cumulative total	Annual Target
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (ABC clients)	12,299	8736	21,035	61,407	60,000

Table 5: Safe Medical Circumcision

Indicator	<5years	5-17years	18+years	Quarterly Total	Cumulative Total	Annual Target
Number of locations for MMC				8	32	20
Total number of males circumcised as part of the minimum package of MC for HIV prevention service	152	204	862	1218	2514	2000
Number of health workers trained in MCC				21	42	30



Challenges:

- The trained peer educators have increased the number of referrals to health facilities. Referral services among out grower peer educators continue to present challenges as most government health facilities in the rural areas do not provide critical services like SMC.
- HIPS supported partners to collect, analyze and use the data for planning and submission of reports to HIPS. Many of the people coordinating this function at the partner level do not have access to computers so they send raw data, which has to be re-entered to generate project reports.

Recommendations:

- HIPS will support more integrated outreach services including SMC camps to increase access to services among out grower groups and underserved communities.
- HIPS will strengthen technical support visits to address key partner gaps regarding data collection and reporting.

Key Activities Planned for Next Quarter:

- Conduct district stakeholder advocacy meetings for the school program
- Conduct integrated technical support visits with FUE/UMA
- Disseminate BCC best practices study to partners
- Conduct two district master trainer trainings for the school program
- Support SMC training for staff of four partner companies and conduct 36 SMC camps and men-only seminars among partners
- Reproduce IEC/BCC materials for partners

1.2. HIV/AIDS PALLIATIVE CARE AND SUPPORT

Emphasis during the 4th year has been to strengthen the community support systems to promote sustainability of palliative care programs at partner sites. The trained Community Based Caregivers (CBVs) at partners' sites have been instrumental in taking services closer to the community. Working in partnership with the clinical service providers, the CBVs have mobilized communities for outreach and to collect drugs as well as take HIV tests. In the process, the CBVs have also disseminated information leading to a reduction in stigma especially in the fishing communities of Lambu and Buvuma.

During Year 4, the project continued to strengthen collaboration between companies and community based organizations for palliative care. The rationale for these partnerships is to ensure that the trained community caregivers are linked to health facilities where they can be supported with basic supplies for community home-based care, foster linkage, integration and sustainability of services using established community based organizations (CBOs) within the catchment area. The CBO provides overall technical support to the trained caregiver, and monitors the quality of services caregivers provide. The caregivers report to the clinic and provide feedback on quality of services to the clinic.

During the 4th quarter, the project conducted on site visits to partner sites and community based groups. Quarterly review meetings were also held with community based care givers to review progress and identify gaps. HIPS conducted on site support supervision visits and held quarterly review meetings with trained CBVs at TAMTECO (Toro and Mityana), Macleod Russel, Wagagai, Mpanga Tea and KCCL. The review meetings enabled HIPS/Mildmay to motivate the CBVs, learn the best practices and also share basic care and support information.



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

In Year 4, HIPS partners continued to use the services of the trained CBVs to ensure timely access to care. The trained CBVs have been instrumental in making sure that people living with HIV/AIDS (PHAs) access care, delivery of psychosocial support is provided, food at PHA household level is available, and training is given to PHAs in backyard farming and setting up of gardens.

To ensure access to timely care, the health facilities conducted outreach, disseminated information using drama clubs and ensured access to timely care. Outreach sessions have also contributed to the reduction in the number of bedridden clients, stigma and enhanced adherence to drug regimens.

The CBVs in Kinyara, Makonge, Lambu, Double Cure, and St. Francis also formed post-test clubs and used drama to sensitize the community about HIV, drug adherence, and the benefits of disclosure of sero discordance. In the hard-to-reach areas of Buvuma Islands, Lambu landing site and Kyotera, the CBVs conducted awareness campaigns around sanitation and outreach to ensure timely access to care.

During the 4th quarter, the project, in partnership with Mildmay Uganda, trained 57 CBVs in home based care and psychosocial support.

1.2.2 Provide training to private practitioners in palliative care

During Year 4, the project, in partnership with Mildmay Uganda, trained a total of 53 health workers from partner clinics in palliative care and follow up of cases. The trainees ranged from doctors and clinical officers to nurses and nurse aids. **During the 4th quarter**, the project placed 17 health workers at Mildmay Uganda to receive practical skills in clinical care and management of cases.

1.2.3 Establish collaboration mechanisms with local CBOs and NGOs providing palliative care services to facilitate linkages and referral

During the 4th year, HIPS partnered with Makonge Health Center, in Buikwe District, Family Health Center in Kiruhura District, Kinoni Sub-county, areas that are underserved with many PHA clients, and renewed its partnership with St. Francis Health Care, Double Cure, Lambu Health Center, the Royal Van Zanten Ltd and Kyotera medical center to continue scaling up delivery of palliative care in Buikwe, Mpigi, Masaka, Mukono and Rakai Districts respectively.

During the 4th quarter, HIPS renewed its partnership with Double Cure Medical Centre (DCMC) to ensure access to palliative care services in the communities of Muduuma, Kiringente, Mutuba 1 and Mpigi town council. Double Cure was able to use drama groups to mobilize communities for HCT and palliative care, reaching 1,022 clients with palliative care services. Through the partnership with HIPS, DCMC has built the capacity of 84 PHA households in the communities of Kafumu, Nsamu, Kyasanku and Nseke in farming and income generation, and facilitated the formation of eight farming groups for improved household income. The groups have also been trained in backyard farming and supplied with vegetable seeds, namely cabbage, spinach, dodo, carrots, eggplant seeds and sprayers. This helped the PHAs to improve nutrition supplementation and sell off excess food for income.

1.2.4 Organize quarterly review meetings for community care givers at partner sites

During Year 4, HIPS, in partnership with Mildmay, conducted on site support supervision visits and held quarterly review meetings with trained CBVs at TAMTECO Toro and Mityana, Macleod Russell, Wagagai, Mpanga Tea and KCCL. The review meetings enabled HIPS/Mildmay to motivate the CBVs, learn best practices and also share basic care and support information.



1.2.5 Support selected facilities and community care givers with kits and basic supplies for palliative care

During the 4th year, HIPS provided kits and basic supplies to 46 health facilities on a cost sharing basis. The contents of the kits are safe water vessels and aqua safe tablets, gloves, scissors, disposable bags, plaster, cotton, gauze, disinfectants, a mackintosh, Dettol soap and gauze. When used the supplies will ensure improved basic primary health care service delivery and promote infection control at these sites.

Challenges:

- The frequent drug stock outs and inadequate supply of HCT kits, especially among the remote underserved communities, has affected drug adherence and clinic attendance. The PHAs had formed post-test clubs and the transfer of some of the clients to other centers due to the stock outs affects team cohesion and performance.

Recommendations:

- The ARV drug supplies are normalizing. HIPS is also partnering with AAM to enable partners tap into the AAM franchise networks and access quality medicines.

Key Activities Planned for Next Quarter:

- Conduct support visits to health facilities and for community programs
- Renew CBO/Company partnerships for palliative care
- On a cost sharing basis, procure and supply basic kits for palliative care
- Conduct placement of clinicians at Mildmay Uganda for clinical care

1.3. HIV/AIDS TREATMENT/ARV SERVICES

In Year 4, the project worked with all 102 accredited clinics to ensure they are providing quality integrated ART services. All (100%) these clinics have received two supervision visits from the project, MOH, FUE and UMA, and the local districts. In addition the project organized a number of technical visits to partners to strengthen service delivery at these sites. These on-the-job mentorship programs focused on pediatric care, prevention of mother to child transmission (PMTCT), ART monitoring and cohort analysis. The project has also used a combination of classroom and placement programs for health workers to improve their skills. A total of 100 clinicians were placed at Mildmay Uganda to receive practical skills in HIV/AIDS management. An additional 55 clinicians underwent theoretical classroom training at the same institution. Currently of the 102 clinics accredited, 80 (78%) clinics are managing HIV positive clients and providing palliative care. 52 (51%) are providing ART.

1.3.1. Distribute job aids for HIV treatment providers and guidelines on their use

In Year 4, the project printed and distributed job aids as well as the national ART treatment guidelines to be used by the health workers. On-the-job support and follow up has been provided to ensure that the trained health workers are following proper ARV protocol and adhere to set clinical standards.

1.3.2. Provide training and placement to private practitioners in AIDS treatment

In Year 4, the Project in partnership with Mildmay Uganda has trained and placed 155 private practitioners at Mildmay Uganda to receive skills in AIDS treatment. Through these programs HIPS has



been able to create multidisciplinary HIV/AIDS care and treatment teams at partner sites. These courses have targeted nurses, doctors and other health workers from the accredited clinics.

To promote continuous training of health workers in the Private sector, the Project will in year 5, develop a costed training package for partner clinics. This will then be marketed to company managers so that they can continue to send clinicians to Mildmay Uganda after the Project has closed.

1.3.3. Support private practitioners to provide follow up and support of HIV positive children

In Year 4, in partnership with MOH and specialist pediatricians, HIPS followed up 76 health workers in pediatric HIV care, nursing and early infant diagnosis. These trainings were conducted onsite to minimize the need for clinicians to leave their workstations during the training. This onsite training also allowed trainers to assess progress in implementation of agreed work plans made during the support visits and previous training, review gaps and challenges experienced, and identify other support available locally.

Table 6: HIV/AIDS and Palliative Care Training

Indicator	Male	Female	Quarterly Total	Cumulative total	Annual target
Training and placement for palliative care, HIV/AIDS management for doctors, clinical officers and nurses	4	13	17	341	300
CBVs training in home based care and psychosocial support	29	28	57		
On job mentorship in pediatric care			76		
Total			150		

1.3.4. Support on-the-job training and follow up of trained practitioners

In Year 4, in partnership with Mildmay Uganda, FUE, UMA, STF, the local districts and the MOH, the project has provided regular support supervision to all partners at accredited sites. During these visits partner staff received referral information, technical guidelines and identified and filled information gaps and other sources of support. All partner sites were visited twice in the year. This has ensured continuity of services and maintained the quality of services.

During the 4th quarter, the MOH AIDS Control Program team and proficient trainers conducted a support supervision exercise to 102 accredited sites to assess strengths, gaps and challenges in implementation of programs. Some challenges were observed and recommendations made during the MOH visits to these new sites and the project is working with all partners to address these challenges. Notable challenges observed include:

- High staff turnover observed at over 25% of sites visited. There is need for the project to conduct refresher trainings for all new clinicians.
- There is a missed opportunity for PMTCT and early infant HIV diagnosis at many sites. The project should work with all accredited clinics to ensure mothers are recruited into PMTCT programs and that their infants are followed up.
- Some sites still have low laboratory capacity with no collaboration with regional reference hubs. HIPS should provide equipment and training to these sites to improve laboratory capacity to ensure that all health facilities can provide the basic ART tests on site.



HIPS has worked with partners to address the recommendations. A new training program that combines classroom, placement and on-the-job mentorship on topics like ART, EID, and PMTCT has already begun. The project continues to equip partner facilities with basic equipment for diagnosis.

1.3.5. Distribute ART registers, treatment cards, and monthly report forms to partner clinics.

In Year 4, the project printed ART registers, treatment cards and monthly report forms for newly accredited sites. These have all been adopted from the national protocols and have improved partner records and national reporting. All accredited site have the required registers and forms.

During the 4th quarter, the MOH released new HMIS tools for use by clinics. The project will work with USAID and MOH to support the printing and distribution of these tools to all accredited clinics.

1.3.6. Provide assistance with accreditation of clinics in selected companies

In Year 4, emphasis has been to ensure the functionality of all accredited clinics. To achieve this, the project has provided training support, on-the-job mentorship, and support supervision, and has procured basic equipment for the laboratories. In addition, during this year a rapid assessment was carried out among HIPS supported facilities implementing the ART program to determine the cause of the widening variance between current and cumulative clients for ARVs. Findings from the assessment showed that 85% of all facilities assessed had suffered stock outs of ARVs at some point during the year. The sites had either transferred some of the affected clients to government or other sites or asked the clients to buy the medicines from open sources. Others like Wagagai and Macleod Russel had procured the missing medicines. Other causes of variances related to the seasonal or migratory nature of some workers at Sugar and Flower Estates at places like SCOUL, Melisa Flowers, FIDUGA and the Royal Van Zanten who are started on treatment but leave after their temporary stints with the companies.

Table 7: Clients receiving ART from clinics supported by USAID/HIPS

Program Areas	Number of Clients Served											Annual Target
	Children							Adults (15+)			Total	
	<1 Years		1-4 Years		5-14 Years			Female	Pregnant Female	Male		
	Female	Male	Female	Male	Female	Pregnant Female	Male					
Current clients	3	0	33	29	24	0	27	2958	126	2191	5265	4500
New clients receiving ART	4	2	13	17	21	0	14	861	122	599	1531	200*
Cumulative clients	13	8	50	51	66	10	62	4281	376	3200	7731	6000

**The project set a low target for new clients due to the irregular ARV supply chain and asked partners to maintain their current numbers. However once the supply stabilized, mainly in the 4th quarter, partners enrolled new clients.*

Table 8: Clinical Care Services

Indicator	Male	Female	Quarterly Total	Cumulative total	Annual Target
Number of outlets offering ART			0	52	100
Number of Service outlets offering clinical care			0	80	88



Indicator	Male	Female	Quarterly Total	Cumulative total	Annual Target
Clients receiving at least one HIV clinical care and support service	3704	5230	8934	29721	25000

*All the 80 clinics have recruited clients. 52 clinics have clients already on HAART while the rest have clients on prophylaxis. Due to the poor ARV supply chain the project had been reluctant to push all accredited clinics to recruit new clients. However with the support that is now available through PEPFAR drugs, the project will work to ensure full functionality of all accredited clinics.

1.3.7. Re-print and distribute Patients' Adherence Calendar for practitioners

In Year 4, HIPS, in partnership with the Straight Talk Foundation, printed 1,000 adherence cards. These calendars were translated into local languages of Luganda, Lutooro and Luo and were distributed to the partner clinics.

1.3.8. Link HIPS' partner laboratory technicians, dispensers and record-keeping personnel to training in ART logistics and HMIS

In Year 4, in order to improve patient follow up and monitoring, the project supported the MOH ART monitoring team to conduct technical support visits to 46 accredited sites. Partners received support in the use of national HMIS tools including data analysis and use at facility level, organization of patient flow, patient retention and follow up of cases.

1.3.9. Equip labs at selected companies' clinics with basic diagnostic equipment and reagents

In Year 4, through cost sharing, the project has equipped private partner facilities with basic medical and laboratory equipment and supplies required for client monitoring during treatment. Equipment provided includes: machines for chemistry analysis, microscopes, weighing scales, hemoglobinometers and reagents for diagnosis of opportunistic infections such as tuberculosis.

1.3.10. Develop and disseminate an insurance product for HIV/AIDS treatment

In Year 4, HIPS, in partnership with International Air Ambulance (IAA), marketed the developed insurance product for AIDS treatment to companies. Staff and dependents from participating companies are to benefit from a whole range of HIV prevention, care and treatment services provided by IAA and its network of affiliated clinics at an annual cost of \$200 per person for the staff and \$150 for their dependents. Uptake of the product has been slow with only few companies like Uganda Revenue Authority expressing interest. This has been attributed to the uncertainty in the supply of ARVs in the country as the product was based on the premise that the ARVs would be available free of charge. Now that the supply has stabilised, HIPS and IAA will move forward with this product.

1.3.11. Conduct operational research on AIDS treatment in the private sector

In Year 4, the HIPS Project, in partnership with MOH and Boston University, completed a study that examined the cost effectiveness of ART programs in both private and public accredited health facilities in Uganda. The study is a cost-outcome analysis using unlinked, retrospective medical record data to ascertain total resources used in the first year on treatment and patient outcomes at the end of the first 12 months. Costs are measured from the perspective of the treatment facility and start with the date of initiation of ART to the end of the first year after initiation. The primary outcome was the average cost to produce a patient retained in care and responding to ART 12 months after initiating therapy.



In general patient outcomes at these six sites are quite good with total retention rates of 87-98% after the first year on treatment. There is no clear trend or difference in outcomes between the public and private sector sites. (See Annex 1)

Challenges:

- The ART cost effectiveness study showed that though the study sites had good treatment outcomes, majority of the sites had poor laboratory capacity. This affects the monitoring of ART clients.
- Over 25% of HIPS supported sites suffered a high staff turnover. In some of these sites, especially at Hima Cement, Kinyara and UGACOF, the affected staff were key personnel that included doctors and clinical officers. This affected the range and quality of programs delivered.
- The ART supply chain is yet to fully stabilize. During the 4th quarter, some sites reported stock out of drugs like Efavirenz at the JMS.

Recommendations:

- The project is working with MOH to develop a reference laboratory for the private sector. This will enable accredited sites to receive high level support for laboratory services.
- In Year 5 and the 6-month extension period, the project will organize new trainings targeting newly recruited staff at accredited sites. On-the-job mentorship programs will also be organized to strengthen the skill set at partner clinics.
- HIPS will work with the MOH, USAID, NMS and JMS to ensure that all accredited private clinics receive their regular supply of drugs. The new partnership with Access.Mobile will help us better monitor our partner stock levels and enable partners develop early warning signs of drug stock outs.

Key Activities Planned for Next Quarter:

- Conduct integrated support supervision to partner sites, in partnership with MOH, districts, FUE, and UMA
- In collaboration with Mildmay Uganda, design and extensively market a costed training package that is tailored for private practitioners
- Equip selected companies' clinics with basic diagnostic equipment and reagents
- Conduct technical visits on PMTCT services
- In collaboration with the MOH, design and establish an accredited national reference laboratory for ART services in the private sector

1.4. VOLUNTARY COUNSELLING AND TESTING

In Year 4, the HIPS Project, in collaboration with FUE and UMA, has provided support to 102 private partner company facilities and clinics in HIV VCT services located



HIV Treatment Success Story

Charis-IMC health center is a HIPS-accredited private facility situated in Jinja camp, Lira District, and is being set for transformation to a Level IV unit (community hospital). The facility was given a quality of care award for Northern Uganda this year. It has a total of 35 staff. There is an array of services provided including: maternal and child health services, FP, HIV/TB care including VCT, enrollment for care, ART, CD4 testing and other tests. The facility has received training support for SMC through HIPS and the service will start this October.

Walter Ojok, Lab Technologist operating a CD4 machine at Charis-IMC procured for comprehensive HIV/AIDS care with support from HIPS



in 57 districts. HIPS has trained 48 counselors in PICT, provided 69,770 people with VCT services through outreach and onsite clinics. The project, in partnership with JHU/Couples Counseling Project, supported training of 35 counselors in couples counseling and testing, selected from private partners conducting HCT services. In addition, the HIPS Project partnered with Nile Breweries on a cost share partnership basis to implement a home based VCT service for employees and communities, particularly farmers in Katakwi District-Usuk Parish, where 4,400 people were counseled and tested for HIV in their homes. Of these, 175 were found HIV positive, started on Septrin prophylaxis and referred to Katakwi Health Center IV for further diagnostic screening and management.

1.4.1. Support partner sites with VCT forms, registers and client cards

In Year 4, the project procured and distributed forms and registers for VCT to partner sites. These have improved records and partner sites. On-the-job support was provided to partners to ensure proper use of the forms and encourage national reporting. The forms have all been adopted from the MOH protocols for VCT.

1.4.2. Link partner facilities to MOH/JMS to access free or subsidized test kits and accessories

In Year 4, the project has encouraged partners to procure test kits from the open market. Through a cost sharing arrangement, HIPS has procured and supplied test kits to partner clinics.

During the 4th quarter, the project procured HIV test kits and supplied them to partners. Partners that received this support included Wagagai, White Horse Nursing Home, FIDUGA, The Royal Van Zanten, KCCL and Uganda Baati.

1.4.3. Provide training to laboratory technicians in VCT logistics and inventory management

In Year 4, in order to improve partner recording and reporting, the project, in partnership with MOH and staff from CPHL, conducted on-the-job training for 64 records staff and 45 laboratory technicians in ART logistics and HCT inventory respectively. Emphasis during the training was on data quality, drug and VCT logistics, district and national reporting. The course, conducted onsite, was designed to equip laboratory workers and records staff with knowledge and skills needed to conduct a proper VCT inventory and logistics management.

1.4.4. Provide training of 50 private practitioners in HIV testing and counseling

In Year 4, the project, in partnership with MOH and former staff of the Strengthening Counselor Training (SCOT) Program, conducted a PICT Program for 48 health workers. The course was designed to equip health service providers with knowledge, skills and attitudes needed to provide quality PICT services in a hospital or any health care setting. An additional 35 health workers were trained in couple counseling and testing.

1.4.5. Increase utilization of the referral guide for peer educators at partner sites

In Year 4, the project reproduced and distributed the referral guide to newly trained peer educators. This guide captures all partner companies and new programs at existing partner sites.

1.4.6. Home Based Counseling and Testing Program with a Partner company

Please see the below success story for an example of how HIPS is supporting the implementation of an HCT program with a HIPS partner during Year 4.



Success Story: HBCT NBL/HIPS Program

In Year 4, the project in partnership with Nile Breweries and the Katakwi district health services team implemented a Home Testing and Counselling program in Katakwi district, Usuk parish, among farmers who sell sorghum to Nile Breweries and where peer educators have been trained. The initial phase of the program lasted for twelve months where 4,400 people were sensitized, counseled & tested for HIV/AIDS. Out of those tested 170 were HIV positive, representing a 3.9% prevalence rate, which is lower than the national average of 6.7%. All those that have tested positive have been referred to Katakwi Health Center IV for further diagnosis (CD4 tests), care and treatment. All the 170 are on Septrin prophylaxis through Usuk Health Center III. 21 clients have been enrolled on ARV treatment at Katakwi Health Centre IV.

This program will be expanded in Year 5 to provide a comprehensive package to HIV positive people identified through the program. The activities will be integrated into the recently awarded project "Delivering and scaling up HIV/AIDS access to prevention and care for vulnerable and geographically isolated groups in the supply chain of Nile Breweries Limited" that will be funded by USAID Uganda/OGAC.

Robert Adarkun, a peer educator at the Katakwi Home based counseling and testing program in Usuk Parish. He was addressing the UK MPs and the SAB Miller/Nile Breweries' delegates during the program onsite visit on 7th January 2011.

Table 9: HIV Counseling and Testing Results from Health Fairs and Company Clinics

Indicator	<5yrs		+ves		5-17yrs		+ves		18+years		+ves		Quart erly Total	Cumula tive total	Annual Target
	M	F	M	F	M	F	M	F	M	F	M	F			
Trained													0	83	50
Number of service outlets for VCT													5	80*	88
Individuals who receive Testing and Counseling	259	252	17	7	823	1062	28	45	7629	10575	477	757	20600	69,770	45,000

**Some VCT sites have been taken over by MJAP and are now reporting to them.*

Challenges:

- Access to free test kits has remained a challenge. Private partner clinics provide VCT services at no cost to their clients, when the test kits are provided free of charge. MOH/JMS stopped offering free test kits to private sector partners. This has affected testing services at some sites.
- Reporting has been a challenge. Though the project has provided forms and tools for records, the district and national reporting is still low.



Recommendations:

- The project will continue to link partners to sustainable sources of free or subsidized HIV test kits.
- Through support supervision and on-the-job training, the project is strengthening M&E systems at partner sites with a focus on data collection, analysis, forecasting and reporting to the districts and MOH.

Key Activities for the Next Quarter:

- Implement the ‘Delivering and scaling up HIV/AIDS access to prevention and care for vulnerable and geographically isolated groups program’ in the supply chain of Nile Breweries Limited
- Print VCT forms, registers and cards for partner sites. Ongoing support supervision at HIPS partner clinics
- Procure and distribute test kits for partners

1.5 MALARIA

During the last 4 years, HIPS has partnered with the private sector companies to implement workplace and community malaria prevention activities with support from USAID.

In Year 4, the project has supported peer education and BCC/IEC; used IPT for prevention of malaria in pregnancy; and ensured distribution of insecticide treated nets (ITNs) and RDTs for the management of malaria cases under the following activity areas:

1.5.1 Train peer educators on malaria using the Good Life at Work Module

During the 4th year, HIPS has together with FUE & UMA supported training of 2,387 peer educators from 31 companies. Of these 955 were new while 1,433 were refresher trainings.

During the 4th quarter, 755 peer educators were trained, out of whom 501 were male and 254 were female.

1.5.2 Utilize interactive IEC materials to disseminate messages on malaria prevention and interpersonal communication

In the 4th year 27,877 people were reached with prevention messages on malaria at partner companies and communities.

During the 4th quarter, 6,969 people were reached with messages on malaria prevention.

1.5.3 Strengthening of prevention of malaria in pregnancy among selected partner companies and clinics.

In Year 4, HIPS continued to work with up to 50 existing and new company facilities and clinics to implement the intermittent preventative treatment (IPT) program under the President’s Malaria Initiative (PMI), of which 27 (54 %) were company facilities.

1.5.4 Procurement of commodities for PMI IPT Program (drugs, water containers, cups, aqua safe)

During the 4th year, HIPS procured 80,000 tablets of Fansidar, cups, drinking water vessels and water treatment tablets for Directly Observed Treatment (DOTS) at partner ANC clinics.

1.5.5 Distribution of bed nets and mama kits to pregnant women through ANC clinics

In Year 4 HIPS procured and distributed 2,000 mama kits to pregnant women during the IPT2 visit to promote uptake and to ensure safe delivery.

During the 4th quarter, 2,567 ITNs were distributed to pregnant women attending ANC at 19 partner sites.

1.5.6 Train health workers and community mobilizers for ITN/IPTp Program

In Year 4 HIPS supported on the job training of 55 health workers and community mobilizers at 13 partner companies.

1.5.7 Distribution of subsidized bed nets to companies and communities

During Year 4, HIPS sold 11,397 subsidized LLINs to 16 companies under the net subsidy 1:1 match of “buy one get one free.”

In the 4th quarter, HIPS supported distribution of 5,870 subsidized ITNs to 10 companies.

1.5.8 Training of staff on the use of RDTs for malaria

During the 4th year, HIPS supported the training of 52 staff from 40 partner private sector clinics.

1.5.9 Distribution of subsidized rapid diagnostic Tests (RDTs) to partner clinics

In Year 4, HIPS, with support from PMI, embarked on promoting the use of RDTs for diagnosis of malaria and to improve malaria case management among partner private sector facilities.

During the 4th year, HIPS purchased 21, 650 RDTs of which 16,435 have so far been distributed to 25 companies under a cost sharing arrangement.

During the 4th quarter, HIPS distributed 14,100 subsidized RDTs to 25 partner companies.

1.5.10 Conduct operational research on cost - benefit analysis of the use of RDTs in the management of malaria among private sector health facilities

During the 4th year, HIPS conducted a study among 10 private sector facilities which showed no cost savings at prevailing market prices of RDTs could be made to test fever cases before treatment with ACTs. However, benefits included accuracy and reliability of diagnosis as well as rational drug usage for malaria treatment.



The laboratory and staff at Engari clinic in Kiruhura District, which is among the facilities equipped by HIPS. The facility also served as a venue for one of the RDT use trainings in the western region.

Success Story: Use of RDTs for Malaria Case Management

During the 4th year, the project also started the distribution of subsidized rapid malaria diagnostic tests (RDTs) to help them increase number of cases treated with a correct diagnosis.

Initially HIPS supported the training of both 52 clinical and laboratory staff from 40 private sector facilities in the use of RDTs at 10 regional private clinics. Following the training, 25 companies were able to procure 16,435 of these RDTs from HIPS at a 1:1 cost sharing through a pilot program within 6 months. HIPS also linked partner facilities to low-cost ACT through the African Affordable Medicine franchise network in the country.



Table 10: Performance Indicators for Malaria

Indicator	Quarterly Achievement	Cumulative Total	Annual Target
Number of SP tablets purchased	0	80,000	75,000
Number of women receiving IPT2 doses at existing and new workplace sites	5,170	17,606	20,000
Number of health facilities with water vessels and cups for IPTp DOTS	50	50	40
Number of ANC health workers trained in IPTp, IPTp3	0	55	40
Number of people reached with prevention messages on malaria	18,583	120,734	100,000
Number of subsidized LLIN distributed to pregnant women	3,598	18,583	20,000

Challenges:

- Lack of delivery services at some facilities leads to lower ANC attendance by pregnant women.
- The high price of RDTs is still a disincentive towards their full utilization in malaria diagnosis and treatment.

Recommendations:

- HIPS will support ANC facilities to offer comprehensive reproductive health services to include normal deliveries and PMTCT.
- HIPS will assist partner facilities to access low cost commodities for malaria diagnosis and treatment.

Key Activities Planned for Next Quarter:

- Support community sensitization and mobilization for malaria control through Village Health Teams (VHTs).
- Procurement and distribution of supplies for IPT program to partner facilities.

1.6 TUBERCULOSIS

In Year 4 HIPS supported partner facilities on TB control through collaborative activities with emphasis on integration, quality assurance and sustainability of programs in the following areas:

1.6.1 Collaboration with the NTLP for a public-private mix referral system for diagnosis, treatment and supervision of private health facilities.

During the 4th year, HIPS supported the NTLP to carry out activities on support supervision and on-the-job mentoring for 45 private company and clinics involved in TB diagnosis and treatment on a quarterly basis.

During the 4th quarter, HIPS supported the NTLP to reach out to 20 facilities that were accredited but not yet accessing TB drugs. Through this support these facilities were put on the national TB supply chain.

1.6.2 Identify private clinics for NTLP accreditation: conduct assessment of interest and need for TB treatment in selected private clinics

During the 4th year, HIPS identified five partner companies interested in implementing TB care and treatment activities that included KCCL-Muhokya, Luwero Industries, Gwatiro Nursing Home, Mpanga Tea and TAMTECO-Mityana Tea Estates.



1.6.3 Conduct training of clinical personnel on TB diagnostics and treatment

During the 4th year, HIPS, in partnership with Mildmay Uganda, supported the training of 101 clinical staff of which 47 had theoretical classroom training while 54 were involved in practical placements at partner sites offering TB treatment.

During the 4th quarter, 26 clinical staff were trained through placement in clinics, of which 12 were male while 14 female.

1.6.4 Conduct on site performance follow up on trained clinical personnel on TB diagnostics and treatment

In the 4th year, HIPS supported follow up and supervision of 45 staff at 40 partner facilities.

During the 4th quarter, 15 staff at 12 facilities trained in TB/HIV management were followed up.

1.6.5 Assist with accreditation of private clinics for TB care and treatment

During the 4th year, HIPS facilitated the NTLP to carry out inspection of 15 private sector health facilities out of which seven received accreditation for TB treatment, bringing the total number of accredited sites to 45 over the 4 years of the project.

1.6.6 Equip labs at selected companies' clinics with basic diagnostic equipment and reagents

During the 4th year, HIPS procured and distributed basic clinical and laboratory equipment/supplies for 12 private sector facilities to help improve the diagnosis and treatment of TB and HIV patients.

In the 4th quarter, HIPS procured clinical and laboratory equipment/supplies for clinics at SIMs Medical Centre, Mirembe, Kyotera Medical, Kadic, Case and 3 clinics at New Forrest company,

1.6.7 Conduct peer educator training under Good Life at Work Module at selected companies

In Year 4, HIPS trained 2,387 company and community peer educators from 31 companies on TB prevention and control under the Good Life model.

During the 4th quarter, a total of 755 peer educators were trained from 13 companies. Of these, 954 were new while 1,432 participated in refresher training.

1.6.8 Continue to procure and distribute TB registers, logistics and reporting forms for the HMIS at all HIPS partner clinics

In Year 4, HIPS distributed 200 TB treatment cards, 24 unit registers, 28 laboratory registers, and 10 referral booklets to 10 partners for use in strengthening the TB data management system.

During the 4th quarter, unit TB registers were distributed to 2 clinics at New Forest Company and Galilee Hospital.

1.6.9 Active case finding and follow up of TB patients in the community by the partner private facilities

During the 4th year, HIPS supported dissemination of the use of TB intensified case finding and infection control measures at 13 partner private company facilities and follow up of 102 patients receiving TB treatment at 18 partner private sector facilities. Of these only 9 (9%) were lost to follow up.

During the 4th quarter, HIPS worked with the NTLP to follow up patients on TB treatment at eight partner private sector facilities to ensure quality of care.



1.6.10 Conduct operational research on TB treatment outcomes among accredited private sector partner facilities

During Year 4, HIPS carried out an evaluation on treatment outcomes of 86 patients on DOTS at 12 partner accredited sites. Results showed TB treatment success of 86%; defaulters/loss to follow up of 9%; and death rate of 1%.

Table 11: TB Performance Indicators

Table of indicators for TB Control	Quarterly Achievement			Cumulative Total			Annual Target
	Male	Female	Total	Male	Female	Total	Total
Number of workplace sites accredited by NTLP to participate in PPM - DOTS						45	43
Number of workplace healthcare providers trained in PPM DOTS with USAID funding	12	14	26	53	48	101	90
Number of TB cases reported to NTLP by USAID-assisted private workplace providers	215	154	369	662	536	1198	1200
Number of new smear -positive cases diagnosed by non-NTLP providers	96	67	163	213	161	374*	500
Number of new smear positive cases who receive DOTS from non-NTLP providers	71	43	114	168	135	303*	300

**The project significantly increased the TB targets for year 4. It has however taken some time for all accredited clinics to recruit clients and be put on the national TB drugs supply chain. This has meant that some of the targets have not been met this year.*

Challenges:

- The TB accredited sites conduct few patient follow up visits to test for sputum conversion at end of treatment to confirm cure.
- Inadequate supervision from the Districts to private sector facilities affects quality and sustainability of TB programs at sites.

Recommendations:

- HIPS will ensure increased access to TB diagnostic facilities through accreditation of more private partner facilities. The project will also ensure use of the intensified case finding tool among patients in order to identify more cases.
- HIPS will enhance collaboration between the accredited private facilities with NTLP and the Districts to ensure better treatment outcomes.

Key Activities Planned for Next Quarter:

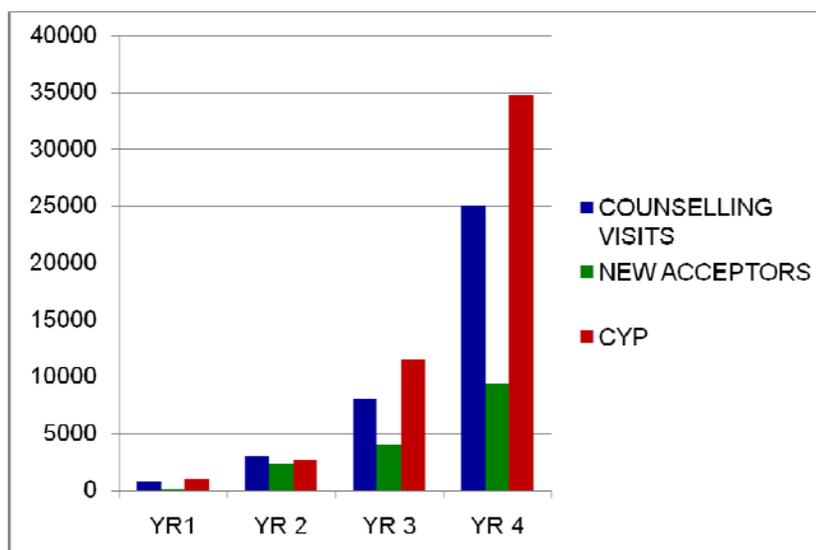
- Support on-the-job mentoring of staff in TB/HIV
- Disseminate use of TB ICF tools
- Accreditation of selected facilities in HIV and TB treatment
- Support training in HIV and TB logistics management



1.7. REPRODUCTIVE HEALTH AND FAMILY PLANNING

During the 4th year, HIPS has emphasized FP integration into all health activities during antenatal, HCT, IPT, outreaches, malaria and the peer education program. Men-only seminars were introduced as a key activity before safe male circumcision camps to allow information sharing and support mobilization efforts for both FP and SMC. The project has also expanded the LTPM program through training and logistical support to 51 sites. Per the table below, there has been an increase in demand for FP services.

Figure 2: FP Service Utilization



Activities towards improving quality of RH through mentorship, commodity support and support supervision undertaken included:

1.7.1 Conduct on-site training and support supervision of health service providers on FP/RH products and services

In Year 4, HIPS, in partnership with MOH, RH consultants and Uganda Health Marketing Group (UHMG), conducted on-the-job site training and support supervision of service providers in order to improve their knowledge and skills using the MOH approved curriculum. A total of 36 service providers were trained in basic FP skills, while 23 benefitted from safe motherhood mentorship and 30 in LTPM training, thereby increasing the range and quality of services delivered.

During the 4th quarter, HIPS, in partnership with the district health officers, conducted training of 20 service providers in FP basic skills with emphasis on proper FP counseling, promotion of dual methods amongst the PHAs, FP logistics and management of FP side effects. The project has realized an increase in the uptake of FP services in particular Depo-provera, oral contraceptives and Jadelle.

1.7.2. Link partners to UHMG, MOH and PACE to access free, low cost or subsidized FP commodities and other support

In Year 4, on a cost sharing basis the project procured and distributed FP products and supplies to 81 partner facilities. In partnership with Marie Stopes Uganda, PACE, UHMG, MOH, a number of FP commodities ranging from Jadelles, Moon beads ,condoms, pills and intrauterine devices (IUDs) were accessed to clients which has resulted in an increase in the number of FP service outlets to 81 facilities.

During the 4th quarter, HIPS, in partnership with UHMG, PACE and the MOH, continued to support 81 clinics with short and long term FP methods for recruited clients. Clinics costs shared the cost of these products. This supply has increased the FP uptake by partner clinics by increasing availability of different methods as required by clients as indicated by 4,713 new FP acceptors.



1.7.3. Conduct training for community /peer educators in selected companies in FH/FP

In Year 4, through FUE/UMA HIPS supported the training of 2,387 peer educators who conducted small group based activities to promote RH/FP and other health practices among their peers.

1.7.4. Print and distribute job aides on FP for practitioners

In Year 4, HIPS, in partnership with JHU/CCP and the MOH reproduced and distributed FP registers, counseling cards, pre-recorded CDs with FP messages and other IEC materials to partner facilities to support partner record keeping and reporting to HIPS and the health sub districts as well support community mobilization and outreach efforts for FP.

During Quarter 4, an assortment of pre-recorded CDs with FP messages were distributed to FP clinics for use during antenatal and outreach activities.

Table 12: Family Planning and Reproductive Health Indicators

Indicator	Male	Female	Quarterly Total	Cumulative Total	Annual Target
Peer educators trained	501	254	755	2,387	1500
Number of health workers trained in FP/HR			102	183	100
Number of new acceptors	1633	3080	4713	9401	4000
Number of counseling visits	3849	8127	11976	25,088	9000
Regularity of contraceptive supply			91%	91%	90
Number of community outreach activities			152	656	400
CYPs			11,865	34,730	13,000
Number of USG-assisted service delivery points providing FP counseling or services			7	81	88
The number of clients using FP/RP services		18528		52,628	40,000

1.7.5. Support the implementation of Men Only clubs

In Year 4, HIPS supported the implementation of 12 men-only seminars through which men were mobilized and encouraged to take an active role in the health of their spouses and families. During the seminars, 3,156 people were reached with condom services while 327 women received contraceptive services that include injectables and implants. Promoted services included HCT, SMC and women clubs for women's health related issues.

In Quarter 4, nine men-only seminars were conducted reaching 500 people with emphasis on SMC and child survival, including PMTCT.

1.7.6. Build capacity of new sites for LTPM through training and logistical support

In Year 4, a total of 66 staff from 22 facilities were trained in LTPM methods. Another 15 facilities were followed up to improve service delivery. Implants and supplies were also provided which has resulted in increased uptake for especially implants in the rural communities and thus a high CYP figure (see indicator table).

During the 4th quarter, onsite LTPM training and follow ups were conducted at 10 partner facilities reaching 36 health workers. All supported facilities received Jadelles and IUDs to provide the service at a subsidized cost, making it more affordable for clients.



1.7.7. Facilitate community radio listenership clubs to promote family planning BCC

In Year 4, small group based pre-recorded radio discussions on FP were conducted by peer educators to promote and motivate their peers for RH/FP services. 3,340 community members benefited from the radio discussions. Among the peers, listenership groups were utilized to determine the effectiveness of the prerecorded radio discussions model in promoting services.

1.7.8. Procure mama kits, basic FP equipment and supplies for selected partner facilities

In Year 4, HIPS procured and distributed an assortment of RH equipment to improve maternal and child health services. A total of 20 partner facilities were equipped with delivery beds, delivery sets, Intrauterine insertion kits, weighing scales, blood pressure machines, autoclaves, sterilizing drums, sundries and infection control materials aimed at improving maternal and child health.

During the 4th quarter, HIPS procured and distributed 2,000 mama kits to 20 partners conducting integrated outreaches and antenatal services in order to increase antenatal attendances. This has been integrated with provision of ITNs, IPTp at outreach sites. These sites were also supported with basic equipment including delivery beds and sets, intrauterine contraceptive device insertion kits, infection control materials, and weighing scales which have both improved clinical assessment of clients for FP and promoted safe delivery at the facilities.

1.7.9. Support safe motherhood initiatives at partner sites through on-site training and logistical support

In Year 4, HIPS, in partnership with RH consultants, carried out on-the-job site mentorship at 40 partner sites to strengthen the use of standardized safe motherhood protocols and guidelines. During this activity, emphasis was laid on management of labor using the partograph, infection control guidelines, management of complications due to labor, post partum care and newborn care.

During Quarter 4, safe motherhood initiatives were followed up during joint support supervisions at 12 facilities offering delivery and post natal services. Integration of FP into PMTCT, HCT, IPT and antenatal clinics was promoted during the visits.

1.7.10. Support to integrated outreach activities (RH/FP, LTPM and HIV /AIDS) to underserved and hard to reach areas

In Year 4, HIPS supported partner facilities to conduct 30 integrated outreach sessions in hard to reach areas in order to bring services nearer to the people. During these outreach sessions, immunization, FP commodity distribution and counseling of clients, treatment of minor illnesses and STIs, HCT, health education and referral were conducted.

During the 4th quarter, HIPS supported nine partner companies to carry out integrated outreaches to reach the underserved communities in remote districts of Mpigi, Kiruhura, Buliisa, Hoima, Masaka, Kasese and Buikwe. During these outreaches, there was integration of FP services especially with the IPT and HIV programs. 24,558 people were reached with FP services and 817 new FP acceptors were served. See the table below:

Table 13: Integrated Outreach Conducted during the 4th quarter

Company	No. of outreach sessions	FP new acceptors
1. KCCL	6	220
2. Tullow	3	78
3. FHRC	6	103
4. Double Cure	3	38
5. Paragon Hospital	3	51
6. Integrated Needs Network-Makonge	6	133

7. Engari Community Centre	6	89
8. Kinyara Sugar	2	40
9. Lambu	4	65
Total		817

1.7.11. Strengthen private sector partners to utilize national HMIS and use generated data for better service delivery

In Year 4, through training and support visits, the project continued to encourage all partners to report to the districts by using the MOH registers. This has enhanced the relationships between the private and public health sectors, and ensured that private sector clinics with community programs continue to benefit from the support available at their districts.

During the 4th quarter, the project carried out joint support supervisions with the MOH/district in order to ensure adherence to performance standards and improve the quality of care for RH services.

1.7.12 Work with company supported secondary schools to support HIV School based program and ensure age appropriate package of information on RH/FP

During the 4th year, HIPS supported partner companies to integrate RH/FP messages in the school sexuality education program. Teachers and students were sensitized on key RH issues through one-day visitations during the refresher trainings.

Success Story: Integrated Outreach among Remote Communities in Kasese District

In partnership with Kasese Cobalt Company (KCCL) located in Kasese district, HIPS has been carrying out integrated outreach in the 4th year with the aim of taking services nearer to the people and increasing FP uptake. Initially, KCCL was only conducting ART and HCT outreach which created a missed opportunity for FP.

HIPS has supported KCCL on a cost sharing basis to conduct integrated outreach. A total of 6 outreach sessions were conducted in which health education, HIV counseling and testing, immunization of under fives, IEC, testimony sharing by satisfied clients, treatment of sexually transmitted infections including other minor illnesses, counseling for FP and commodity distribution, mama kits & mosquito net distribution and referral of complicated case was undertaken. During these outreaches, Couple counseling and testing, safe male circumcision, need to space children and sexual reproductive health have been emphasized.

As a result of these outreaches, there has been an increase in number of new FP acceptors of 220; 1793 condoms distributed, 69 Jadelles inserted, 283 women accessed injectaplan and 169 accessed oral contraceptives while 923 men participated in these outreaches. In addition 789 PHAs were served with dual methods.



Challenges

- Partners are required by MOH to report monthly to the sub health district. However the majority of partners do not get enough support from the district to facilitate the reporting. They use their own report forms and have to transport the paper reports to the districts. In addition, there is usually little feedback sent to the partners in response to the submission of these reports.



-
- LTPM products, in particular Jadelle and Implanon, are not readily available on the open market. This affects the quality of the program when the project supplied commodities run out of stock.

Recommendations

- The project will continue to link partners to districts, AAM and other NGOs for FP commodities and the MOH for sustainability.
- HIPS will lobby the districts for continued support and technical supervision to improve the reporting and working relationship between the district and the private clinics.

Key activities for the next quarter.

- Conduct on-the-job mentoring for safe motherhood and LTPM.
- Support partners companies to carry out timely and routine outreach with companies in hard to reach communities.
- Procure and distribute supplies and FP commodities for selected partner facilities.

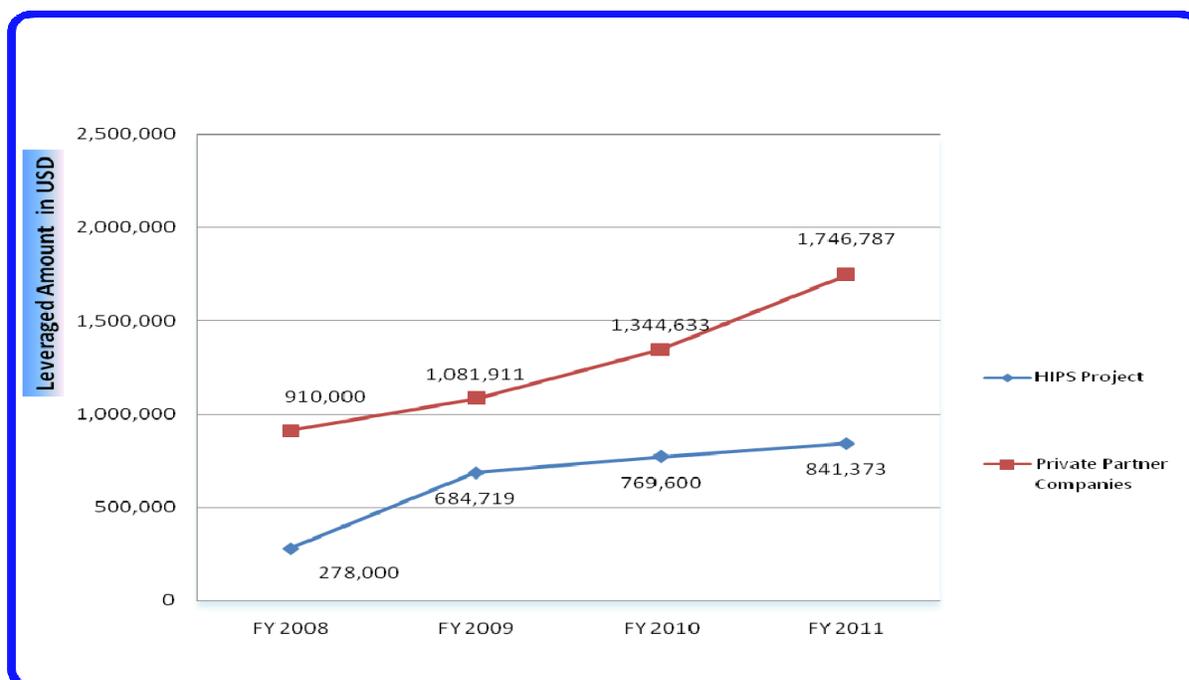
Task 2: Expand the Number of Global Development Alliance (GDA) Partnerships

In Year 4, HIPS continued building alliances with the private sector in collaboration, with its local partners FUE and UMA taking lead in brokering these alliances. Focus was put on developing partnerships that would be sustainable and would have the most impact. The project signed new GDA partnerships with 10 companies, bringing the cumulative total of GDA partners that have worked with HIPS to 50. HIPS and company GDA contributions tremendously increased in FY2011 reaching the US\$2.5 million mark, leveraging US\$1,746,787 in private sector contributions compared to HIPS investment of US\$841,373, a 2 to 1 ratio. (See Annex 5)

To date, HIPS has worked with a total of 101 companies to implement work place and community based health programs since 2007.



Figure 3: Summary of HIPS GDA Contribution over the Last Four Years



During Year 4, HIPS actively facilitated the migration of established partnerships to FUE and UMA for partnership management. Currently, out of the 88 HIPS partners that are eligible for migration and management by FUE and UMA, 65 (73%) of them are being managed by the two associations. Also in Year 4, HIPS held a symposium that brought together HIPS current partners, potential partners and stakeholders. The interactive event, the first of its kind since the inception of the project, provided a platform for the project to share its achievements and successes over the life of the project as well as plan for the remaining 18 months of the project's existence. The major theme of the event was sustaining partner capacities for access and utilization of health services.

Also during Year 4, HIPS sought opportunities to work with companies that would reach out to underserved communities and most at risk groups. HIPS worked with new partners - the Regional Lorry Drivers and Transporters Association and Gulu Chamber of Commerce – to implement health programs for truck drivers and underserved communities in the northern part of the country. HIPS also worked with existing partners such as Hima Cement, Dominion Oil, Tullow Oil and KCCL to expand services targeting fishing communities, the most at risk and underserved populations.

During the 4th quarter, HIPS performed an evaluation exercise on the GDA partnerships to ensure that all the PPPs are meeting each partners expectations and are achieving expected health impacts and that the agreed upon resources are being committed in a timely manner. Partners that were not honoring their commitment to contribute a minimum of \$5000 to the partnership for various reasons were removed from the GDA list. These include: Ankole Coffee Processors, G4S, Centenary Bank, Roofings and UGACOF. HIPS will re-engage these companies in Year 5 to explore ways to revive the partnerships.

2.1.1 Support and collaborate with the HIPS Capacity Building Team to migrate companies from HIPS to FUE and UMA

In Year 4, HIPS continued with the migration exercise which had started in Year 3, in which management of prevention activities among HIPS partners is being shifted to FUE and UMA. The Readiness Assessment tool that was developed in Year 3 to identify those companies that are “ready” for migration



was revised to include an assessment and indicators of a successful migration. On top of the 21 companies that had been migrated by end of Year 3, another six were selected and were successfully migrated during the fourth year. The six companies include: SCOUL, Touch Namuwongo Project, TAMTECO, JP Cuttings, Ugarose and FIDUGA. Also, all new partnerships developed have been directly handed over to FUE or UMA for management. This brings the total number of companies migrated and managed by FUE and UMA to 63.

Also during Year 4, joint review meetings have been held every quarter between HIPS, FUE and UMA, in which progress in implementation of activities with companies migrated, are examined, challenges identified, and support provided for smooth implementation of the migration. Critical to the success and sustainability of this migration approach is that companies are now paying professional fees to FUE and UMA for the services they provide to the companies. 74% of HIPS partner companies under management of FUE and UMA have at least paid the associations in the last 12 months and 70% of these have paid for more than one activity. This is an affirmation that the workplace prevention programs will be sustainable after the exit of HIPS project.

During the 4th quarter, a review meeting to ensure smooth implementation of activities by the migrated companies took place. Out of those migrated; three companies were identified having challenges of paying professional fees to FUE and UMA. These companies include Wagagai, JP Cuttings and Royal Van Zanten. Meetings were organized with the said companies and subsequently, the companies realized the need to pay professional fees and all of them have since scheduled more activities through the two associations next quarter.

2.1.2 Increase the required company contributions to a higher leverage ratio based on their ability to pay

In Year 4, HIPS reviewed the MOUs with its GDA partnerships with the aim of revising the costed menu of services and the cost sharing arrangement. The costed menu of services also took into account the services that FUE and UMA could realistically provide and how much the companies were willing to pay for the associations' services. As a result, the contribution from HIPS GDA partners rose from \$1,344,633 in 2010 to \$1,746,787 in 2011 as indicated in Figure 3 above.

Also in Year 4, HIPS has supported FUE and UMA to develop relationships with other organizations involved in health service provision within HIPS partner companies' catchment. Organizations that HIPS has linked to FUE and UMA include: MJAP, IDI, HCP, YEAH, UHMG, AIC, PACE and Marie Stopes which provide services such as IEC materials, test kits, FP services and health commodities directly through FUE and UMA. This will greatly enhance value addition towards enhancing HIPS partner companies' collaboration with FUE and UMA.

Furthermore, HIPS has facilitated companies to conduct low cost health fairs enabling companies to free up some resources that are channeled to other activities. Also, partners are utilizing their own employees that were trained by HIPS as TOTs for peer education training. Some of the companies that have utilized cost effective approaches include: Kakira, KCCL, NFC, Hima Cement, Dominion, McLeod Russell, Mpanga, Reco Industries, Uganda Baati, FIDUGA, and RVZ.

2.1.3 Develop new GDAs that strategically fit into HIPS partnership models

In Year 4, HIPS together with its local partners UMA and FUE approached 29 private companies for partnership. Out of the companies approached, HIPS brokered 10 GDA partnerships and worked with another five companies. The GDAs developed include: the Regional Lorry and Truck Drivers Association (RLDTA), FIDUGA Flowers, EVOKCOM, Buikwe Dairy Development Authority, Airtel, Jomo Fruit Processors, TAMTECO, SCOUL, BM Steel and AAM. Some of the GDAs that were developed during Year 4 were existing partners of the project who realized the value of the health programs at their companies and decided to increase and structure a GDA with HIPS. These companies include TAMTECO, SCOUL and FIDUGA. All the developed GDAs have been formalized via MOUs clarifying what each party will provide, costs involved, associated timelines and expected results. Evidently this



year, more partners are willing to pay FUE and UMA to conduct prevention activities compared to the previous year. HIPS in Year 5 is to focus on supporting FUE and UMA to create PPPs that have great scale and impact towards enhancing their respective sustainability, but also add value to the respective partners through fostering access to such services as: the mobile phone referral networks (AIRTEL); access to high quality laboratory services through the national reference laboratory; and facilitating distribution and timely access to high quality pharmaceutical products and medical supplies through the AAM franchise network.

Also, during Year 4, HIPS promoted the innovative mobile telephone based programs with more companies cost sharing for these programs. Eskom Limited, Kakira, Kinyara and McLeod Russell re-launched the Text to Change program. Kakira even extended it beyond its employees and community members to reach out to its out growers in Mayuge and Iganga Districts. Through the partnership between HIPS and Airtel (mobile telecommunication company), nine partners re-launched the mobile phone referral network program that was piloted with UTL in Year 3. The partners implementing this program include: Wagagai, Tullow Oil, Mpanga Tea, Mabale Tea, New Forest Company, Hima Cement, Kinyara, Kakira, Rwenzori commodities.

During the 4th quarter, six companies from the HIPS target list were approached for partnerships. These include: Orange Uganda, Tropical Heat Uganda Limited, Mayuge Sugar, Mayuge Sugar growers Association, Swift Commercial Establishment, First Insurance Company and Comprehensive Rehabilitation Services in Uganda (COSU). Partnership discussions with Airtel were also finalized. As a result, one GDA partnership with Airtel was formed and two other partnerships were formed with Mayuge Sugar and Swift Commercial Establishment, who have since been assisted to develop their work place policies.

2.1.4 Work with the Districts and local Sub districts to develop and implement a strategy for integrating out grower peer education activities into existing community health programs:

In Year 4, HIPS piloted efforts to integrate out grower peer educators from a few partner companies into the VHT strategy as a sustainability measure. The companies which have sizeable numbers of community trained peer educators and were targeted include Nile Breweries, Dominion, New Forest Company, Hima Cement, Tullow Oil, Enterprise Uganda and North Bukedi. The efforts were unfortunately challenged by the absence of a budget from the districts to cost share the integration process. However, some of the local sub districts received some funds for VHT training and the communities selected many peer educators from Tullow Oil, Dominion Oil, New Forest Company and Hima Cement as VHTs. HIPS will seek to pursue such opportunities where they exist in other districts and solicit for such sustainable strategies.

2.1.5 Link HIPS partner clinics to sustainable networks

In Year 4, HIPS contacted UHMG, an organization that has a network of private sector clinics to explore the possibility of linking its partner clinics to UHMG's clinic network. A familiarization visit to two of UHMG's supported clinics was carried out to ascertain exactly how HIPS clinics would benefit from being part of this clinic network. It was however observed that UHMG did not put emphasis on the Clinical Service Delivery arm of their partner clinics, but rather on access to subsidized commodities and some supervision and trainings. HIPS will continue supporting its private partners to access subsidized health commodities from UHMG, PACE, MSU, JMS and other sustainable sources of products.

In order to facilitate sustainability of clinical services, HIPS intends to link the partner clinics to functional PPPH district desk offices and their eventual participation in district based PPPH activities that include: joint public-private district level planning; joint support supervision; and improvement of referral mechanisms and reporting between sectors (public – private). To this effect, HIPS has so far supported establishment of district PPPH coordination committees (with private sector representation to coordinate district level PPPH activities) and joint planning exercises in five districts (Kasese, Mityana, Mpigi, Nakasongola, Kyenjojo).



During the 4th quarter, HIPS initiated linkage of its partner clinics to AAM network through which they will be able to access high quality drugs and medical supplies at relatively lower costs from AAM's chain of franchised pharmacies. So far, the six McLeod Russell clinics and the Kinyara sugar clinic have benefited from this partnership.

2.1.6 Partner with Africa Affordable Medicines to scale up franchise network

In Year 4, HIPS partnered with AAM, a chain of franchised pharmacies focused on closing the existing gap in distribution, price and quality of medicines and medical supplies between central and district retailers, and the end-user. The partnership was launched in August at AAM's regional franchise in Soroti. The surrounding communities are subsequently being sensitized about the danger of HIV/AIDS and accessing free VCT and malaria testing services. HIPS has provided technical assistance in the development of IEC materials to increase awareness about the AAM product range amongst partners, as well as a support supervision tool for the AAM franchisees geared towards maintenance of standards and monitoring of partnership progress. A new franchise pharmacy in Naalya is due to be opened next quarter.

During the 4th quarter, AAM secured networked software that enables monitoring of performance and stock levels in all the regional pharmacy outlets at any given time to improve efficiencies in distribution of a wide range of medical drugs and supplies.

2.1.7 Collaborate with Ugandan insurance companies to develop new products

In Year 4, HIPS and IAA rolled out the HIV/AIDS insurance product which was developed in Year 3. This product enables companies to purchase an HIV/AIDS care managed product and is targeted for companies which do not provide health insurance to all employees or have clinics that are not providing HIV/ART services. The roll out of this product on the market has been halted due to the challenge of unreliable supplies of free ARVs from the government on which the product is highly dependent.

2.1.8 Revise the HIPS Menu of Services

In Year 4, HIPS revised and modified the Menu of Services to reflect the new services HIPS can provide to its partners. FUE and UMA also incorporated these changes into their Menu. These services include community education (Health fairs, men-only seminars) and clinical and community based trainings (ART and palliative Care, HCT, SMC and short term and long term FP methods). The modified Menu of Services was then disseminated for use to FUE and UMA during their partnership meetings. (See Annex 6)

In addition, in collaboration with FUE and UMA HIPS designed promotional tools to market HIPS/FUE/UMA services to companies as a means of increasing their membership.

2.1.9 Conduct a Partnership conference with all stakeholders to promote public private partnerships for health

In Year 4, HIPS held a symposium that brought together HIPS current partners, potential partners and stakeholders. The interactive event, the first of its kind since the inception of the project in 2007, provided a platform for the project to share its achievements and successes for the last three and a half years as well as plan for the remaining 18 months of the project.

2.1.10 Integrate HIPS base year research findings (i.e. the company survey, HIV private sector case rate costs, impact of ART on employers cost) to build stronger business case for private sector participation in healthcare.

In Year 4, HIPS continued to utilize the research findings from studies previously undertaken by the project to help make the business case for why companies should invest in workplace health programs and how the private sector can partner with the public sector to extend health services. On a continuous basis, FUE and UMA are using the research findings to make a business case when approaching prospective private companies and negotiating partnerships. HIPS will develop and design specific tools that can be



used by the project and FUE and UMA to market their services to more private companies for increased membership.

Operations Research: HIPS will conduct research to identify opportunities to strengthen involvement of the private sector in health

(The below incorporates activities 2.1.11 Access to Financing for private health providers and 2.1.12 Health Franchising Models from the workplan)

In Year 4, HIPS conducted research projects intended to identify ways that the private sector's role in health service delivery can be strengthened. Research projects completed include:

- 1. Healthcare franchising models in Africa:** HIPS partner, O'Brien and Associates International, Inc. conducted research on health care franchising models in developing countries, the factors contributing to their success, and lessons that can be applied to the Uganda context. The research examined Uganda franchise models and networks, services provided and quality standards, and successes and challenges. Results generated from this research have been documented in a research report and will be used to develop strategies to support the most promising health care franchising model(s).
- 2. Access to financing for private health providers:** HIPS carried out a mini survey among some of its selected health service providers asking whether they would be interested in a loan fund, how much that would be and what they would use the funds for. 100% of the health facilities surveyed said they were interested in such an opportunity. In Year 5, HIPS will work with loan guarantee facilities (including the Development Credit Authority (DCA)) and local financial institutions to explore creation of financial products for the private health sector. HIPS will provide technical assistance to private providers to improve their "bankability" in addition to building their capacity in financial management systems.
- 3.** In partnership with the MOH and Boston University, the HIPS project completed a study that examined the **cost effectiveness of ART programs** in both private (three sites) and public (three sites) health facilities in Uganda. (See Annex 1)

2.1.13 Documentation of Best Practices

In Year 4, HIPS produced a documentary highlighting some of best practices in the private sector. The partners whose activities were showcased in the documentary include Tullow Oil, Nile Breweries, Kinyara Sugar, SIMS medical center and Wagagai Flowers. The documentary was showcased during the partners' symposium that was held in April 2011.

Success Story: Referrals through Use of Mobile Phone Technology; an Approach to Facilitate Critical Information Access in Resource Limited Settings

In August 2011, HIPS project signed a Memorandum of Understanding with Airtel to implement a mobile phone based information and referral network program intended to facilitate critical health information flow between the clinics and community members. In this program, mobile phones are activated on a Closed User Group (CUG) platform and free phone calls are enabled amongst the users in this CUG. These mobile phones are then given to the peer educators, the private clinics in the community and the AIDS Treatment Information Center (ATIC) - the national referral center which medical personnel call when they are faced with HIV/AIDS treatment and care challenges. Having been successfully piloted in three HIPS partner companies in 2010, this program is being expanded to nine HIPS partners which include: Tullow Oil, Hima Cement, Kinyara Sugar, Kakira, Wagagai, Mpanga Tea, Mabale, New Forests Company and Rwenzori commodities.



HIPS/Airtel/FUE management staff handing over Airtel Mobile Handset to Kakira Sugar Limited representative Ms Faridah during the official launch of the program held at Airtel offices on 19th August 2011. A total of 332 mobile handsets were handed over to 9 participating partner companies.



In this partnership, Airtel and HIPS have cost shared purchase of mobile phones and the monthly user charge fee for each of the phones. The 12 month program, worth \$33,000, is expected to satisfy health needs of community members through provision of critical health information flow by promoting communication between community-based peer educators, private health clinics, and the National AIDS Treatment Information Center through the CUG platform. HIPS firmly believes that effective use of technology tools such as mobile phones in low resource settings will change the lives of people living at the bottom of the pyramid. This mobile phone program is expected to transform people's lives in rural communities by facilitating critical information access.

Table 14: Indicators for Global Development Partnerships

Indicator	Quarterly Achievement	Cumulative Total	Annual Target
Number of workplace sites collaborating with USAID to offer expanded HIV/AIDS (treatment) services to include the community	10	55	50
Number of existing and new workplace sites (clinics) with integrated health services RH/FP, TB or malaria	0	53	50
Number of GDA partnerships developed according to USAID principles	3	51*	45

**Includes 10 new GDAs in Year 4 plus 41 GDAs renewed from Year 1, Year 2 and Year 3; however, of 51 GDAs, 42 have invested the minimum of \$5000 in the last twelve months.*

GDA Challenges:

- Most partners whose MOU with HIPS had expired are taking a long time to review and sign the revised MOUs. This has been caused by company management changes and the current financial squeeze in the country resulting in reluctance to commit funds.
- Some GDA partners for various reasons were not able to honor their commitment to contribute a minimum of \$5000 towards partnership activities as previously agreed in the MOUs. This led to the reduction in the number of GDA partners at the year end review.

GDA Recommendations:

- HIPS will continue to follow up with these companies and update new management on the partnership activities and the value of having the MOUs signed.
- HIPS will work to revive activities with former GDA partners. Also, HIPS will carry out regular checks with partners to ensure that all GDAs are meeting their expectations as agreed in the MOUs.

Key Activities Planned for Next Quarter:

- Complete the launch events of the mobile phone referral network program at all nine companies through health fair events.
- Continue supporting FUE and UMA to broker more GDA partnerships and consolidation of existing partnerships.
- Support the scale up of the AAM franchise model. Support the scale up of AAM pharmacy franchise network.
- Provide technical assistance to private sector entities in preparation for the DCA facility.
- Provide technical assistance to Nile Breweries to scale up the health programs along their supply chain.
- Support MOH public private partnerships in health policy.

Task 3: Strengthen Private Sector Employer Organizations to Support Health Initiatives

3.1. DEVELOP SUSTAINABILITY STRATEGY FOR FUE AND UMA

3.1.1 Support to FUE and UMA to develop and implement a business plan

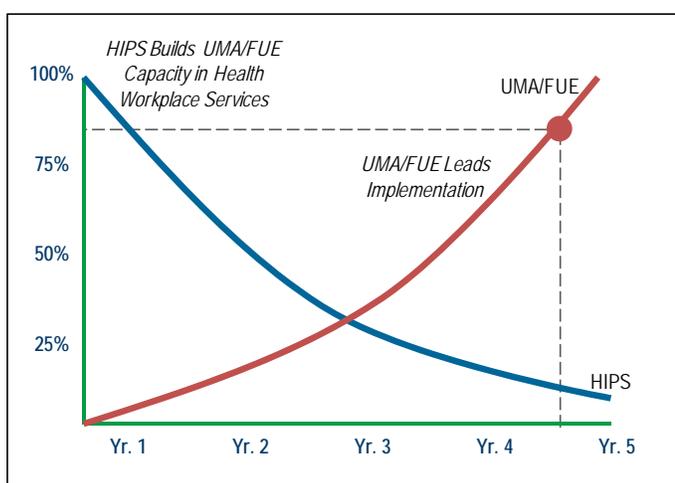
In Year 4, HIPS provided technical assistance to FUE and UMA to develop business plans as a strategy of building up the implementation of workplace health activities as a business model. The business plans are a merger of the sustainability plans and the marketing strategies that both associations have successfully implemented over the last two years to enhance their sustainability. In the business plans, both employers' associations looked at: market analysis; financial analysis of the income and expenditure; costing of different activities (products) that will be provided to their member companies as part of revenue generation; and how they are going to position themselves as a way of increasing their visibility as leaders in the provision of workplace health programs. Implementation of the business plans includes amongst others: promotion and marketing of workplace health activities to different companies; production of promotional materials; organizing regional workshops; and participation in crucial meetings and workshops for networking purposes with increased visibility as leaders in workplace health initiatives.

3.1.2 Strengthen FUE's and UMA's capacity to generate revenue from an updated menu of services and also increase the overall membership

In Year 4, both employer associations had a remarkable increase in the income generated from workplace health programs compared to last year. FUE and UMA earned a total of \$27,477 from workplace health programs implemented for different companies, compared to last year's \$18,633. This represents an increment of 47.5% from the income both associations earned last year. UMA earned \$12,495 as professional fees from 16 partner companies, while FUE earned \$14,982 from workplace health activities. It is worth noting that 70% of the companies paid for more than one activity. As a result of HIPS related activities, FUE recruited the following companies as their members: Proray Investment, Abacus Parental Drugs, Orange Uganda Limited, Comprehensive services Limited and SDC Uganda, which paid total of \$1,945.

During the 4th quarter, FUE and UMA realized an increase of 67% in income, compared to the third quarter. Both associations earned \$12,155 as professional fees earned from workplace health programs conducted for a number of companies. UMA earned \$6,909 as professional fees from the following companies: Uganda Co-operative Crane Creameries Union, Kyagalanyi Coffee, Tullow Oil and Eskom (U) Limited. FUE earned \$5,246 as professional fees from services to FIDUGA Flowers, Century Bottling Company, GIZ, Macleod Russel Uganda Limited, Nile Breweries, Hima Cement and New Forests Company. It's also important to note that the newly approached private companies are more increasingly likely to pay for workplace health activities – an indication that will contribute towards FUE and UMA future sustainability.

Figure 4. Strategic Partnership Approach: The Evolution of Support vs. Lead Role





3.1.3 Support FUE and UMA to update a target list of potential companies to partner with

In Year 4, HIPS supported FUE and UMA to update a target list of potential companies to partner with. Both employers' associations took leads in approaching some of the companies targeted and were successful in sealing some partnerships. UMA approached and sealed partnerships with the following companies: Unga Millers, Steel and Tubes and Sadolin paints, while FUE approached and sealed a partnership with Marirye Flowers, Wartisila, Uganda Wildlife Authority, Uganda National Roads Authority, Munyonyo, Commonwealth Resort Hotel, Feed the Children. With the support of the HIPS Project, FUE was able to seal a GDA partnership with FIDUGA and BM Steel Group of Companies.

3.1.4 Strengthen FUE and UMA's capacity to win other grants for workplace health activities

In Year 4, HIPS assisted FUE and UMA to respond to a number of requests for applications from the Civil Society Fund, MSH/STRIDES Project, USAID/RESPOND Project, the Uganda AIDS Commission and the Uganda National Roads Authority. Unfortunately, submission to the Civil Society Fund by both associations and to MSH/STRIDES by FUE, were unsuccessful. In principle, the USAID/RESPOND Project is in the final stages of signing grant agreements with FUE and UMA, worth \$70,000 for a period of seven months to implement a pilot project aimed at building the capacity of the private sector in disease surveillance and outbreak response. FUE also received \$5,000 from the Uganda AIDS Commission to conduct activities aimed at co-coordinating the private sector response to the fight against HIV/AIDS. FUE on the other hand is still in contention for the UNRA bid to conduct HIV/AIDS prevention activities on three selected highways.

During the 4th quarter, HIPS assisted FUE and UMA to successfully conduct a breakfast meeting under the theme "*Health at the workplace and community*" held on October 15th 2011 at Protea Hotel, Kampala. The meeting was aimed at bringing together development partners in order to explore partnership opportunities for FUE and UMA, and also market both associations as leading providers of workplace and community health services. As a result of the meeting, the International Labor Organization is in the process of signing a funding agreement with FUE worth \$10,000 for the following activities: meeting for Private Sector HIV/AIDS Committee coordination; launch of the national action plan on implementation of the national policy on HIV/AIDS and the world of work; and an annual CEO testing event.

3.1.5 Strengthen the capacity of FUE and UMA to implement a Monitoring and Evaluation system

In Year 4, HIPS conducted a monitoring and evaluation training that drew 19 participants selected from different projects implemented by both associations. The training, preceded by a needs assessment, was aimed at increasing the participants' and FUE/UMA's understanding and appreciation of program monitoring with data analysis. As a result of the training, there has been a remarkable improvement in the way both associations compile, handle and use data to make important business decisions.

3.2. EXPAND THE SCOPE OF PRIVATE EMPLOYER ORGANIZATIONS FOR WORKPLACE INTERVENTIONS

3.2.1 Support FUE and UMA to lead in development of HIV/AIDS workplace policies among companies

In Year 4, FUE and UMA assisted 53 companies and trained 140 individuals in HIV/AIDS workplace policy development. FUE assisted a total of 12 companies and trained 72 individuals in HIV/AIDS workplace policy development which included: Uganda Wildlife Authority, Regional lorry Drivers Association, Uganda Electricity Distribution Company Limited, Feed the Children Uganda, Marirye Estates, FIDUGA Flowers, Multitec Business School, Munyonyo Commonwealth Resort Limited, Swift Commercial Establishments, Wartisila, SAIL Uganda Limited and Exclusive Cuttings. UMA assisted RECO industries to train a total of seven individuals in HIV/AIDS workplace policy development. In addition, both associations conducted a joint HIV/AIDS workplace policy development workshop that attracted 42 participants from 40 companies.



During the 4th quarter, FUE assisted Swift Commercial Establishments and Exclusive Cuttings and trained a total 18 individuals in policy development. Both associations spent the fourth quarter following up the companies that participated in the policy development workshop in the third quarter.

3.2.2 Provide assistance to FUE and UMA to train and supervise peer educators

In Year 4, FUE and UMA trained a total of 1,452 peer educators of which, 618 were refreshers and 834 were new trainings. This represents an increase of 28% from the peer educators trained in the third year. FUE trained and refreshed 891 peer educators from the following companies: Macleod Russell (U) Limited, Dominion Oil, Century Bottling Company, Nile Breweries, Hima Cement, GIZ, Kirikwera Drama Group, Rwenzori Commodities, Uganda National Roads Authority and New Forests Company. UMA trained and refreshed 561 peer educators from Eskom (U) Limited, Tullow oil, Uganda Baati, Sadolin Paints, Uganda Fishnet Manufacturers, Quality Chemicals, Nytil & Picfare, Kyagalanyi Coffee, Uganda Clays Limited and Steel & Tubes Limited. A number of companies have adopted peer education as a key workplace health activity, hence the increase in demand for peer education courses.

During the 4th quarter, FUE and UMA trained a total 545 peer educators of which, 210 were refreshers and 335 were new peer educators. FUE trained 205 new and refreshed 51 peer educators from the following companies: Macleod Russel (U) Limited, FIDUGA Flowers, Century Bottling Company and GIZ. UMA trained 130 new and refreshed 159 peer educators from Tullow Oil and Kyagalanyi Coffee. Both associations also conducted an open peer education course for companies that could not afford an in-house peer education. The FUE course attracted 25 participants while the UMA course attracted 13 participants.

3.2.3 Support FUE and UMA to conduct company, regional and national health fairs

In Year 4, FUE and UMA conducted a total of 21 health fairs where 8,845 were reached out with health messages and 4,782 individuals accessing VCT services including a CEO event conducted by FUE. Health fairs continue to be very popular among companies and more health fairs are expected in the forthcoming quarter, especially as we approach World AIDS Day on December 1 and as more companies launch the Airtel Phone Referral Network.

During the 4th quarter, HIPS supported FUE and UMA to conduct seven health fairs where 3,297 people were reached out with health messages and 1,559 individuals accessed VCT services. FUE conducted health fairs for the New Forests Plantations of Kiboga and Mubende, while UMA conducted health fairs for Uganda Baati, Uganda Co-operative Crane Creameries Union, RECO Industries and Kinyara Sugar works. Most of the health fairs conducted in fourth quarter coincided with the launch of the AIRTEL phone referral program in the respective implementing companies. Also, in the fourth quarter UMA conducted the 3rd annual nutrition, safety and health fair that attracted a total of 6,000 show goers, of which 2,351 people accessed a wide range of medical services from the medical camp. UMA earned \$3,351 as income from sale of exhibition space to 25 exhibitors.

3.2.4. Strengthen FUE and UMA's capacity to develop relationships with their member companies on a cost share basis to leverage resources on a 1:1 match

In Year 4, FUE and UMA cost shared, on a 1:1 match, with a total of 40 companies to implement workplace health activities – an increase from 16 cost shared with in Year three. The new partners that FUE and UMA cost shared with this year include: Gulu Chamber of Commerce, FIDUGA Flowers Limited, Royal Van Zanten, Uganda National Roads Authority, Feed the Children, Marirye Flowers Estate, Watsila, Sail Uganda, Munyonyo Commonwealth Resort, Swift Commercial Establishments, Exclusive Cuttings, Regional Lorry Drivers Associations, Munyoyo Speak Resort, Malaria Consortium, Sadolin Paints, Uganda Fishnet Manufactures, Royal Van zanten, Steel and Tubes Limited, Kinyara Sugar and Kakira Sugar works. It is worth noting that 28 of the companies that cost shared with FUE and UMA also paid professional fees thus contributing to the associations' financial sustainability.



3.2.5 Support FUE and UMA to conduct Regional conferences

During the 4th year, FUE and UMA conducted two regional workshops aimed at marketing workplace health programs and increasing the associations' overall membership. UMA held a networking event for human resource managers, company doctors and corporate social responsibility managers. Under the theme of *Increasing Productivity through Appropriate Occupational Health and Safety Programs*, the event was aimed at increasing UMA's visibility, market workplace health and occupational health and safety programs to the private sector companies.

A total of 41 participants from 31 companies attended this one-day event. Also, both associations conducted a joint regional HIV/AIDS policy development workshop that attracted 42 participants from 41 companies. The aim of the workshop was to take the participants through the process of HIV/AIDS policy development and also market workplace health programs.

3.3 STRENGTHEN INVOLVEMENT OF PRIVATE EMPLOYERS' ORGANIZATIONS IN NATIONAL HEALTH POLICY ISSUES

3.3.1 Leverage PSFU's network to assist their member associations in policy development and HIV prevention programs

In Year 4, HIPS provided Private Sector Foundation – Uganda with financial and technical support to hold the annual association and community awards which attracted over 300 business associations and community development organizations. HIPS successfully inserted the “presence of HIV/AIDS workplace programs” as one of the criterion in the awards. In addition HIPS held discussions with Uganda Women Enterprises' Association (UWEAL) and the Association of Micro-Finance institutions in Uganda (AMFIU), two of the winners of the PSFU's Association and Community of the Year award, on the possibility of partnering them with FUE and UMA for workplace health programs. A final decision from both associations on the modalities of the partnership is still being discussed.

3.3.2 Scale-up collaboration with the Ministry of Gender, Labor and Social Affairs (MGLSD)

In Year 4, HIPS finalized a concept on collaborating with the MGLSD. Areas of partnership include: conducting joint support supervision on OVC and re-printing and distribution of the National Policy on HIV/AIDS and the World of Work. Furthermore, the Ministry of Gender officials also actively participated in a number of meetings and workshops that were organized by FUE and UMA, namely: the private sector forum, where the Commissioner for Labor officiated at the opening ceremony, and other officials made presentations on how the private sector can integrate HIV/AIDS issues in their workplaces. Still in the fourth year, the joint workplace policy development workshop, where Mr. Edward Mujimba, the HIV/AIDS focal person at the MGLSD attended and presented the National Policy on HIV/AIDS and the World of Work, together with the Human Resource and Company Doctors networking event that was officially opened by the Commissioner for Labor from the MGLSD.

3.3.3 Support to the MOH's roll out of the Public Private Partnership for Health Policy

In Year 4, HIPS, in collaboration with Italian Cooperation, assisted the MOH to disseminate the National Policy on Public Private Partnership in Health. HIPS supported two successful policy dissemination workshops in Mbarara and Fort Portal each attracting on average 87% of targeted participants from the public and private sectors. Additionally, HIPS, in collaboration with the Italian Cooperation, assisted the MOH to train and orient District Health Officials (DHO and PPPH desk Officers) from 20 pilot districts on implementation of the National Policy on Public Private Partnership in Health, Terms of References of the PPPH desk officers and PNFP/PHP Coordination committees. Each team invited from the districts comprised of the District Health Officer, the District PPPH Desk Officer, a representative from the PHP subsector, and a representative from the Private-Not-For-Profit (PNFP) subsector. A total 80 participants from the 20 selected districts attended the orientation.

3.3.4 Support PPP Desk Officers within District Health teams to roll out PPPH policy and conduct joint planning between sectors

In Year 4, HIPS, in close collaboration with the MOH, Italian Cooperation and Private Sector Umbrella Organizations supported joint district planning exercises in five selected districts (Mpigi, Nakasongola, Kasese, Kyenjojo & Mityana). This is the first phase of implementation framework for the PPPH Policy that is planned to be piloted in 20 districts country-wide. HIPS has closely worked with the respective PPPH Desk Officers to mobilize district based representatives from the PNFP's and PHP's sub-sectors that are to constitute the PPPH District Coordination Committees within the 5 districts. The main objectives of this exercise is to support the respective districts to prioritize partnership activities, have them included in their annual district plans and enhance collaboration between the public and private sectors at district level. Furthermore, HIPS equipped eight district PPPH Desk Offices with computer hardware and furniture to assist them in carrying out their activities more efficiently and effectively. The supported districts include Mityana, Mpigi, Nakasongola, Kabarole, Kyenjojo, Kasese, Lira and Masindi.

3.3.5. Support creation of or strengthen existing umbrella organization for private medical practitioners

In Year 4, HIPS supported formation of the “Uganda Healthcare Federation – UHF.” This has been registered as a company limited by guarantee. This federation, modeled on the Kenya Healthcare Federation, is earmarked to represent Uganda’s healthcare interests within the East African Healthcare Federation and intended to provide a platform to lobby on behalf of the health sector. Furthermore, HIPS supported UHF to hold its first annual general meeting which also acted as its launch. 40 participants from the public and private health sector attended the event including members from pharmaceutical manufacturing and distribution companies, hospitals, large clinics, MOH and NGOs. UHF has now established committees, participated in regional meetings and will form part of the board that will manage the self-regulation and standards mechanism still to be established.

Success Story: HIPS Contribution to the Roll Out of the PPPH Policy



In the year 2000, the process of drafting the national Policy on Public Private Partnership in Health (PPPH) started and 11 years later the policy is still in draft form. The failure to secure an approved policy on PPPH has far reaching implications – public private collaboration is on an ad-hoc basis and partnership dialogue within the health system is not mainstreamed.

In October 2010, a series of meetings were held between the MOH, the HIPS Project and Italian Cooperation with the major aim of exploring avenues of how the HIPS project can contribute and support the national PPPH policy implementation process. Key identified areas of support included:

Regional dissemination workshops: HIPS organized and sponsored two highly successful workshops, with an 87% attendance rate, in Mbarara and Fort Portal. The workshop in Mbarara was attended by 88 of 100 participants invited from the targeted districts,

namely: Mbarara, Kabale, Ibanda, Bushenyi, Kanungu and Rukungiri. The Fort Portal workshop attracted 85 of 100 targeted participants from Kabarole, Kasese, Kyenjojo, Kamwenge and Bundibugyo districts. The main objective of the workshops was to disseminate the Public Private Partnership in Health Policy. The key message coming out of these workshops was that the government, to a great extent, has collaborated with the Private-Not-For-Profit (PNFP) sub-sector through the Medical Bureaus and has only had ad-hoc collaboration with Private Health Practitioners (PHP) at all levels. Implementation of the PPPH policy will go a long way to formalize these relationships.

Orientation for District PPPH Desk Officers: As mandated by the National Policy on PPPH, the PPPH Desk Office is a key coordination structure at the district level tasked with streamlining and harmonizing PPPH activities. HIPS, in collaboration with Italian Cooperation, PNFP Umbrella Organizations and PHP Umbrella Organizations, assisted the MOH to mobilize, train and orient 80 District Health Officials (DHO and PPPH Desk Officers), PHP and PNFP representatives from the 20 pilot districts, on their respective TORs and the implementation process of the National PPPH policy. The main aim of the training was to equip the districts with the necessary tools to effectively implement PPPH, and to enhance dialogue and collaboration with the private sector at local government level. One salient task of the PPPH Desk Officers is to coordinate PPPH activities and serve as the focal point of the PPPH secretariat at district level.



Dr. Runumi, MOH Commissioner planning handing over Computer equipment to the Lira PPPH desk officers

Support PPPH desk officers to roll out PPPH policy and conduct joint planning between sectors: HIPS equipped eight district PPPH Desk Offices with full sets of computer hardware and furniture to support them to carry out their tasks Efficiently and effectively. The supported districts include Mityana, Mpigi, Nakasongola Kabarole, Kyenjojo, Kasese, Lira and Masindi .Furthermore, HIPS, in collaboration with the MOH, PHP and PNFP umbrella organizations supported the PPPH desk officers from five districts (Mityana, Mpigi, Nakasongola, Kyenjojo and Kasese) to identify, mobilize and engage members of both the public and private health sectors in the districts (especially PNFPs and PHPs) in joint planning of activities that will foster PPPH policy implementation. Consequently, the five districts have draft PPPH plans ready for implementation.

Table 15: Policy Systems Strengthening Indicators

Indicators	Quarterly Achievement	Cumulative Total	Annual Target
Number of local organizations provided with technical assistance by USAID for HIV related policy development	2	53	40
Number of individuals trained in HIV related policy development	18	140	80
Number of local organizations provided with technical assistance by USAID for HIV related institutional capacity building	0	5	4
Number of individuals trained in HIV related institutional capacity building	0	27	25
Number of companies paying professional fees to FUE/UMA for workplace activities	10	28	30
Percent of FUE/UMA health workplace implementing team costs covered by professional fees	UMA 108% FUE 96%	UMA 48% FUE 69%	75% 75%
Amount of money generated as revenue from workplace health activities by FUE and UMA(USD)	UMA 6,909 FUE 5,246	12,495 14,982	30,000 20,000
Amount of grant/project funds (USD) accessed & utilized by FUE & UMA for workplace/community health activities.	FUE-70,000 UMA-70,000	FUE-75,000 UMA-213,000	
No. of workplace & community health grants/project proposals awarded to FUE & UMA through TA by USAID	FUE-1 UMA-1	FUE-2 UMA-2	FUE-1 UMA-1
Functional District based PPP Offices supporting collaboration between sectors	5	5	8



Challenges:

- Though both associations earned more income compared to their earnings last year, they were unable to hit the targets they set in the business plans. This could be attributed to the economic strain in the country that has affected companies' expenditure on workplace health programs as well as the political turmoil, early in the year, which forced most companies to cancel and scale down scheduled workplace health activities.

Recommendations:

- The HIPS policy and capacity building team will support FUE and UMA to develop five year strategic plans that will look into avenues of broadening their visibility and revenue generation streams.
- Also, HIPS has engaged a consultant who will provide a number of business related trainings to FUE and UMA that are geared towards sharpening their business outlook and acumen. These include trainings on resource mobilization and sustainability development among others.

Key Activities Planned for Next Quarter:

- Offer continuous support to FUE and UMA in peer education trainings, policy development, revenue generation and management of health fairs.
- Support UMA and FUE to develop 5-year strategic plans
- Support FUE to conduct the 2nd annual CEO testing.
- Support FUE and UMA to conduct support of all prevention activities.
- FUE and UMA to promote integration of health services within company clients/members.
- Provide technical assistance in implementing the joint public-private work plan activities in eight districts.
- Monitor the performance of and support PPPH activities at district level in the eight HIPS-supported districts.

Task 4: Developing Innovative and Proven Approaches to Support Orphans and Other Vulnerable Children

During Year 4, HIPS focused on assessing how the technical and financial support provided under this task has helped transform the lives of OVC and their families. In addition, the project conducted a review of the programs of KCCL and Nile Breweries, KORD, Kinyara Sugar and Farmers' Center Ltd to assess gaps, successes and lessons learned. HIPS partners also continued to use the recreation activities approach and games – emotionally and psychologically transforming the lives of children, empowering them with information and communication skills.

Food and nutrition interventions focused on enhancing access of OVC and their households to food, improved farming methods, school feeding programs and setting up demonstration gardens both at school and community level, including provision of seeds. Education assistance improved children's access to education and included purchase and distribution of scholastic materials, and follow up of OVC at school to ensure regular school attendance and to minimize school dropout.

During the 4th quarter, HIPS and its partners focused on building the capacity of partners in financial management, project planning and management as well as resource mobilization. HIPS built the capacity of 11 partners (Kakira Sugar Works (KORD), Cornerstone Development (African Children' Mission),



Kinyara Sugar Ltd (Kinyara Client Group), Bead for Life, Caring Hands, Mpongo Company Ltd (Fishing Communities Health Initiatives), Farmers' Center, MTN/ MLISADA, Buikwe Dairy Development (International Needs Network), Jomo Fruit Processing (Action for Behavioral Change) and EVOCKOM (Ngora Development Association)) in basic financial management, resource mobilization and project planning and management.

HIPS partners continued to use the 1:1 match to enhance access to care for 3,273 children: 1,599 were male, while 1,674 were female. The children received education support, food and nutrition, psychosocial support, health care services, and socio-economic security at OVC household level and apprenticeship skills training. In addition, the project supported interventions to mitigate child abuse especially for children living in abusive situations.

4.1 EXPAND ACCESS TO COMPREHENSIVE OVC CARE AND SUPPORT SERVICES

4.1.1 Psychosocial support: Implement cognitive and life planning age specific interventions for OVC

During the 4th year, HIPS partners implemented psychosocial support interventions focusing on provision of basic counseling, recreational activities like music and drama, school debates, home visits, life skills and peer support group activities. HIPS psychosocial support delivery interventions focused on scaling up cognitive and life planning skills for both in school and out of school children. Through peer support groups, Mpongo Company/ FICHI, KORD, Bead for Life, Buikwe Dairy Development/INN, Kinyara Sugar Ltd, Caring Hands, Cornerstone/ACM, MLISADA and Farmers' Center were able to facilitate debates in their respective schools. Through the debates, children were able to develop skills in problem solving, decision making and communication. Using the peer support groups, children engaged in recreation activities, debates, and dissemination of reproductive and sexual health information including HIV and AIDS.

During Year 4, HIPS built the capacity of 40 teachers from Buikwe Dairy Development Association/ INN and Jomo Fruit Processing Company/ ABC in behavioral change in a five-day training workshop organized at Buikwe and Kumi respectively. The trained teachers were selected from both secondary and primary schools and have been instrumental in organizing students in peer support groups and coordination of debates. The trained teachers and peer educators used the peer support group approach to address the physical and psychosocial needs of children, hence meeting the psychosocial needs of children at their schools, home and during sports. During the school sports events, children were sensitized on behaviors that put them at risk of HIV infection and STIs. They also received messages and information on life skills, child abuse and protection.

During the 4th quarter, cognitive and life planning skills were passed on to children using the teachers, peer educators, and through recreation activities and debates. Using home visits, the partners imparted psychosocial support skills to the caretakers of OVC, and provided emotional support to all children in the household. On the other hand, children who were trained in cognitive and life planning skills disseminated information using the peer-to-peer approach and ensuring that they support other children to stay in school. The children have also learnt how to express themselves, organize and conduct their own activities and communicate among themselves and with adults. Debating and recreational activities have brought OVC issues to the forefront and played a key role in creating awareness on issues like child abuse, children's rights, parent's responsibilities and roles, and HIV/AIDS. Marked improvement has been realized in the lives of schoolchildren in decision making, self awareness, confidence and general acceptance of OVC as peers. The activities have also enhanced the teachers involvement with children, creating an opportunity for them to counsel and offer psychosocial support.

4.1.2 Enhance child participation and child protection initiatives in OVC care and support

During the 4th year, HIPS partners used drama and debates to disseminate information to children. The use of debates and poems has also opened up children to child participation and communication. Child



participation skills building processes focused on supporting the peer support groups to build their communication skills and social support skills. Children in peer support groups were guided on how to conduct debates to enhance their communication and persuasion skills. Mpongo, KCCL, KORD, Caring Hands, Kinyara Sugar and Farmers' Center each supported their peer groups to develop these skills to enable children learn how to address public gatherings and empower them to make their case.

During the 4th quarter, child participation and protection initiatives of the partners targeted empowering of children to organize and manage their own events. HIPS partners continued to use sports, drama, debates and one-to-one peer approach to reach out to their fellow children with messages and information. HIPS partners (Kakira Sugar Works/ KORD, Kinyara Sugar Ltd/ KCG, Mpongo Company Ltd/ FICHI, MTN/MLISADA, Buikwe Dairy Development / INN and Jomo Fruit Processing / ABC) engaged children in drama activities and debates. Using drama and debates, the children were able to develop their communication skills, learn more about sexual and reproductive health, decision making, and HIV and AIDS.

4.1.3 Enhance economic strengthening in OVC households

During Year 4 HIPS' socio-economic strengthening activities included supporting groups for income generation (IGA) and village savings and loans associations (VSLA) as well as apprenticeship skills training for OVC. HIPS partners continued to support OVC to acquire apprenticeship skills training in KORD, Kinyara, Mpongo, Buikwe, MLISADA, Jomo and Beads for Life, for carpentry, tailoring, sweater knitting, carpentry, masonry, driving and mechanics. Further still, the VSLA approach in Mpongo/FICHI, Kinyara Sugar/KCG, Kakira Sugar/KORD, Cornerstone Development/ACM and Farmers' Center has enabled OVC households to improve household incomes. MLISADA has been able to start a liquid soap making project, selling its finished products to Shoprite, a leading supermarket chain and other local shops.

During the 4th quarter, HIPS socio-economic strengthening activities focused on expanding the VSLA approach as well as apprenticeship skills training for OVC who had dropped out of school. KORD, KCG, Mpongo Company Ltd/FICHI, and Jomo Fruit processing/ABC supported 107 OVC to access apprenticeship skills training. At the household level, VSLA groups at Kinyara Sugar/KCG, Mpongo Company Ltd/FICHI, Farmers' Center Ltd, Buikwe Dairy Development Association/INN, and Jomo Fruit processing/ABC, and caring hands continued to carry out saving and loaning activities. This improved group cohesion through working together, and ensured easier access to money to pay school fees and other dues. Members have access to soft loans without the need to go to the banks where the interest rates and the criteria used are quite prohibitive. These lessons have enabled them start businesses and the profits realized have improved the household income.

4.1.4 Enhance access to health services for OVC

During Year 4, access to health care services was enhanced through referral for children in need of health care identified especially during home and school visits. Similarly, HIPS partners have supported HIV positive children by facilitating transport to access specialized care services at health facilities within their vicinity.

In Quarter 4, HIPS partners continued to conduct school HIV sensitization discussions. HIV prevention information has been disseminated through trained peer educators, trained teachers and using the peer support group activities and recreation activities. Access to clinical health care services during the quarter was also enhanced through referral for children in need of health care identified especially during home and school visits.



4.2 ENHANCE THE CAPACITY OF COMMUNITIES TO PROVIDE CARE AND TREATMENT FOR OVC

4.2.1. *Enhance OVC Caregivers' technical capacity to provide care and support to OVC*

During the 4th quarter, HIPS built the capacity of 40 caretakers in OVC care and support at EVOCKOM/Ngora development association. The trained caretakers have been responsible for dissemination of information, identification of OVC, provision of psychosocial support and conducting referrals. In addition, 40 teachers at Kinyara Sugar Ltd/ KCG were trained in behavioral change communication for children. The trained teachers have supported children to engage in debates, disseminated information, provided psychosocial support and supported children who are HIV positive for adherence.

To make schooling attractive, the school gardening approach has enabled children to acquire farming skills. For example, at KORD supported schools of St. Jude Buwekula and Musoli Primary school, the children have replanted cassava and maize and expanded on banana gardens. Both schools have also started harvesting cassava and matooke from the gardens on a regular basis, and have formed school garden clubs for maintaining gardens during the farming seasons. The harvested food is used to feed children while at school. Using the school gardening approach, the capacity of the children in farming has been improved. Children have been trained on how to set a vegetable garden at home and are have established community groups to engage in group farming activities as an approach to ensure availability of food at OVC household level. The interventions have enabled the community to access food, and have improved household income through the sale of surplus and sharing of seeds among the community members.

4.2.2. *Scale up teachers' involvement in OVC care and support and child protection*

During the 4th quarter, HIPS built the capacity of 40 teachers in behavioral change communication (BCC) at Kinyara Sugar Ltd. The teachers have been instrumental in supporting children to organize and conduct debates, sexual and reproductive health discussions and organizing competitions for dissemination of HIV prevention information dissemination. For example, one teacher earnestly wrote a play on child abuse for the children to dramatize.

4.2.3 *Train local community leaders in child protection*

During the 4th year, HIPS built the capacity of 80 community local and religious leaders in child protection through training and logistical support. The training focused on identification, follow up and ensuring timely referral of identified children for child protection support services.

4.2.4 *Promote sustainability and quality of care through community capacity building and development of linkages*

In the 4th year, HIPS conducted support supervision visits with MGLSD for MLISADA, Cornerstone Development and KCCL. The support visits enabled HIPS, MGLSD and the partners to collectively look at the achievements, challenges and plan for the way forward.

4.3 IMPLEMENT SMALL GRANTS PROGRAM THAT FOCUSES ON COMPREHENSIVE OVC CARE AND SUPPORT USING CORPORATE ENGAGEMENT MODELS (PUBLIC PRIVATE PARTNERSHIPS)

During Year 4, HIPS continued to engage partners in delivery of OVC care and support services. HIPS renewed grant agreements with MTN/ MLISADA, Farmers' Center, Caring Hands, Kinyara Sugar /KCG and Kakira Sugar Ltd/KORD. HIPS also identified a new partner EVOCKOM/Ngora Development Association to provide care and support services to OVC in Ngora District.



4.3.1 Identify new companies and renew current OVC matching grants using the corporate engagement models

During the 4th year, HIPS identified Jomo Fruit Processing Company, a local fruit processing company established and registered in 2007 by Kumi organic farmers, as a potential HIPS partner. Jomo processes the fruits, adds value to the fruit and sells them on the local markets in Tororo, Kumi, Malaba, Soroti and Kampala. HIPS approached another company, EVOCKOM Enterprises Ltd, which promotes socio-economic empowerment of youth through hire purchase business, and builds the capacity of youth in business enterprises and trading in general merchandise. EVOCKOM was provided with a matching grant to support OVC interventions in Ngora district.

4.3.2 Request and review proposals and work plans from companies and community based organizations

During Year 4, HIPS requested and reviewed workplans and proposals from Jomo Fruit processing company, EVOCKOM, MTN/MLISADA, Farmers' Center, Caring Hands, Kinyara Sugar/KCG and Kakira Sugar Ltd/KORD.

4.3.3 Conduct pre-award assessment on community organizations

During the 4th year, further to activities described in 4.3.1, HIPS conducted pre-award assessments to Jomo Fruit Processing Company Ltd. and EVOCKOM enterprises Ltd. HIPS also conducted a pre-award assessment visits to examine the financial, organizational and capacity systems of the organization prior to entering into agreement.

4.3.4(a) Sign 'new' and 'renewed' matching grant agreements with companies that support community organizations for OVC services

During Year 4, further to activities described in 4.3.1, HIPS signed two new grant agreements with Jomo Fruit Processing Company Ltd. and EVOCKOM Enterprises Ltd. HIPS continued to engage partners in delivery of OVC care and support services through renewal of grant agreements with MTN/MLISADA, Farmers' Center, Caring Hands, Kinyara Sugar /KCG and Kakira Sugar Ltd/KORD.

4.3.4(b) Implement comprehensive OVC grants and provide technical assistant to grantees to ensure appropriate management of grants according to USAID regulations

During the 4th quarter, HIPS built the capacity of its partners in strategic planning, project planning, design and management, financial management, grant-writing and budgeting. The training in finance management focused on building the partners' capacity in the basic concepts of finance and accounting including: an interpretation of financial statements to arrive at correct decisions and resource mobilization; how to take control of the project finances, and monitor the OVC projects; and how to ensure efficiency, clarity, and accountability in the organization's financial systems as well as resource mobilization. Similarly, the training in project planning and management enabled the partners to understand how to review and prioritize problems; how to translate the prioritised problems into actionable OVC projects and activities for specific communities; as well as how to undertake an assessment of feasibility of initiatives. The partners also learned how to make project action plans with the community; to reflect actions that they intend to take; and how, when, and what resources are needed in order to combat the problem of HIV/AIDS in their localities.

Table 16: HIPS OVC Partners Indicators

Company	Male	Female	Total	Year	Period	HIPS Contribution	Company Contribution	Total Grant Amount
Kakira Sugars Ltd / KORD	259	282	541	Yr. 4	July 2011- June 2012	39,539,900		93,131,600
Cornerstone/ ACM	294	303	597	Yr. 2	Sept. 2011- Aug.2012	37,867,000		91,471,000



Company	Male	Female	Total	Year	Period	HIPS Contribution	Company Contribution	Total Grant Amount
Beads for Life	231	235	466	Yr. 2	Sept. 2010-Aug.2011	43,927,500		99,996,250
Caring Hands	82	89	171	Yr. 3	June 2011-May 2012	42,158,000		96,038,000
Kinyara Sugar Ltd/ KCG	128	136	264	Yr. 3	July 2011-June 2012	46,775,600		100,740,000
Mpongo Company / FICHI	119	133	252	Yr. 2	Sept. 2010-Aug.2011	43,990,000		95,967,000
Farmers' Center	114	134	248	Yr. 2	June 2011-July 2011	46,875,000		101,116,900
MTN/ M-LISADA	102	79	181	Yr 2I	May 2011-June 2012	45,501,000		132,869,000
Buikwe Diary Development/ INN	85	81	166	Yr. 1	Sept.2010-Oct. 2011	43,881,000		89,195,000
Jomo Fruit/ ABC	88	94	182	Yr. 1	Feb.2011-Mar. 2012	43,841,500		88,657,000
EVOCKOM/ Ngora Development Association	97	108	205	Yr. 1	July 2011-June 2012	46,991,000		103,833,000
Total	1,599	1,674	3,273			481,347,500	611,667,250	1,093,014,750
US\$						181,640.57	230,817.83	412,458.40

Table 17: OVC indicators

Indicator	Year 1	Year 2	Year 3	Year 4	Cumulative Total	Year 4 Target
Number of OVC served disaggregated by gender	1,468	1,622	920	613	3273*	4,500
Number of providers/caretakers trained in caring for OVC	143	458	748	395	1,744	500

**The total number of OVC served during this quarter does not include 1,350 OVC (660 Male, 690 Female) from KCCL, EGPAF and Nile Breweries Ltd, hence the reduction in the number of OVC served. These partnerships were either cancelled (EGPAF) or are still on hold pending review.*

Success Story: "Kyebaja tobona" Group

'Kyabaja tobona' group is supported under the Kakira Sugar Works/KORD Partnership. With 30 members, the group commenced its first round of activities in April 2010 after receiving training in VSLA. During weekly meetings, members contribute UGX 200 for to the welfare fund and UGX 1,000 as mandatory savings with a maximum of UGX 5,000, which is counted as shares. Each share of UGX 1,000 is stamped into the pass book with a total of five shares maximum per member.

At the end of the 1st cycle, the group had collected UGX 320,000 as welfare funds and UGX 6,426,750 as savings. With support from the Community Development Officer, the shares due to each group member were calculated and recorded, and the members decided not to share out, but to use the savings to buy a jaggery mill worth Ushs 4,500,000. The jaggery mill will be used to add value to the sugar cane they produce by making molasses. The group decided to use the balance of the funds to rent 10 acres of land for six years - an undertaking that will cost them a total of UGX 3,000,000. The group has already planted sugarcane and intercropped it with maize. The group is in the process of registering a CBO under the name "Busalaama Sugarcane Growers Association". This, they say, will enable them access to funding and support as a group.

The group commenced the second cycle of saving and loans in June 2011, and has to date saved UGX 1,487,700. The group's future plans include buying a lorry to transport their sugar cane and the production of molasses for the ready market in Lira. The group has also nurtured two other groups - "Tibakwina" and "Kibike Kiryamugenzi" - each with 30 members, who are also engaged in VSLA activities.



The chairperson of "kyebaja tobona" group explaining how the jaggery machine they procured operates

Challenges:

- There are still widespread cases of child abuse reported in the communities.
- OVC being relocated by the caregivers from one homestead to another without informing partner organizations is making follow up of children and ensuring regularity of school attendance difficult.

Recommendations:

- Child protection interventions will require strong support from local community leaders. The project will scale up child protection sensitization and awareness interventions at community level.
- Continuous home visits and school visits will enable the partners to know which children have been transferred and will help ensure timely follow up.

Key activities planned for next quarter:

- Conduct cognitive and life planning skills trainings for the Jomo, EVOCKOM and Caring Hands programs.
- Conduct trainings for child protection.



MONITORING AND EVALUATION

Build the capacity of partner companies to manage and utilize BCC data

In Year 4, monitoring activities have focused on building the capacity of partner sites to collect, analyze and use accurate and correct data for behavior change activities. Key issues addressed in data management included elimination of double counting of individuals reached with messages, data validation at partner sites, data storage at partner sites, ownership and use. 33 partner sites were supported to collect, analyze, report and use data for program and management decisions. Primary data collection tools and secondary summary data report formats for behavior change and communication activities were developed. 91% of the supported sites have been able to report accurate and summarized data.

In Quarter 4, regional review meetings to share experiences on data quality and management were conducted. 62 participants from 33 partner sites directly involved in behavioral change and communication activities attended. Partners shared their experiences in implementing the small group strategy in relation to data collection, use and timely reporting. Action plans and a way forward for ensuring data quality were drawn and discussed.

Monitoring and evaluation support to health facilities

In Year 4, 100% of sites were given monitoring and evaluation support either on site or during the monitoring and evaluation review meetings. Support has been mainly in understanding USAID clinically based next generation indicator definitions, use of MOH registers, harmonization of data reported to the MOH and HIPS project and timely reporting. Partner health facilities have been trained in quality of care and monitoring of ART patients, client follow up and cohort analysis. Two monitoring and evaluation trainings were conducted, bringing a total of 97 health facilities, which is 95% of all HIPS supported sites. There is a remarkable improvement in the quality of data reported as well as timeliness of reporting from partner sites compared to the previous year.

Challenges

- Staff turnover continues to be a challenge among HIPS supported sites in Year 4. 25% of the HIPS supported sites lost staff. This requires continuous mentoring and retraining of new staff in terms indicator clarifications, data collection and reporting.
- There were a lot of clinical referrals for clients on ARVs as a result of stock out of ARVs, and this disrupted the number of current clients reported throughout the year. However, by the end of the third quarter, partner sites received ARVs through PEPFAR support and this has been very helpful.

Recommendations

- The project will conduct an assessment of partner sites to ascertain monitoring and evaluation training needs. Through support supervision the project will strengthen data analysis and capture at the sites.
- HIPS will continue to work with JMS and PEPFAR to ensure that accredited clinics continue to receive ARVs for eligible clients.

Key Activities Planned for Next Quarter

- Launch a mobile phone based reporting system among 35 partner sites as a way of addressing the challenges of paper based reports and late reports from partners.
- Support the use of the revised HMIS tools through monitoring and data management meetings at partner sites.



ANNEX 1: COSTS AND OUTCOMES OF DELIVERING ANTIRETROVIRAL THERAPY (ART) IN THE PRIVATE AND PUBLIC SECTORS IN UGANDA

Executive Summary

Uganda developed a pioneering program under which private clinics accredited by the Ministry of Health receive government or donor funded antiretroviral drugs at no cost, provided that they do not charge for these drugs. However, the clinics can charge for laboratory tests, consultations or other drugs. Both employer based clinics and free standing private providers participate in this program, often receiving technical support from the USAID HIPS Project. This study analyzes the outcomes and unit costs of first year ART care at selected public clinics and private clinics participating in the accreditation and ARV distribution program. We have estimated the savings to the government and donors which occur when a patient receives antiretroviral therapy (ART) at these private clinics.

The study was conducted using a methodology developed by Rosen et al and previously applied to ART in facilities in South Africa, Zambia and Kenya. Medical record data was obtained for the first twelve months of ART at three public clinics (150 patients per clinic) and three private clinics (50 patients per clinic). This data indicated all drugs (ARV and non-ARV) and lab tests received, and the different providers seen at each visit. Unit costs were determined for each drug, test or service, and the fixed costs of the facility allocable to the ART program were added. Patient outcomes were determined from the medical record, with patients in the sample classified as:

- Lost (dead or no longer in treatment at the end of the year),
- In treatment and not responding (as indicated by CD4 or viral load, or, in the absence of such tests, the lack of a WHO stage 3 or 4 AIDS-defining condition, or
- In treatment and responding.

Average annual treatment costs were determined for each category of patient at each of the six facilities. In addition, the total annual cost of treating the cohort of study patients was divided by the number of patients in treatment and responding at the end of the year. This gives a measure of cost per unit of outcome that takes into account both the efficiency of the clinic and the patient outcomes achieved, and is referred to here as the “production cost.” Finally, we calculated the value of the private resources leveraged when patients were treated at private clinics using the publicly supplied ARVs.

The patients at the different clinics were generally similar in age and more than 50% female, except at one agricultural employer clinic, where male patients were 52% of the sample. Average CD4 count on starting ART varied between 90 and 142, except at one urban private clinic where it was 201. Patient outcomes in the first year of treatment were generally very good. Between 77% and 88% of patients were in treatment and responding at the end of the year at four clinics. One public clinic had 97% in treatment and responding, and one private clinic 94%. But these clinics performed the fewest monitoring tests, and may not have identified patients who were developing resistance.

Treatment regimens were generally similar and consistent with national protocols. However, only the private urban clinic had an appreciable portion of patients on tenofovir. Great variation was observed in the average number of lab tests per patient year, with the urban private clinic recording 12 tests per year, while patients at a rural public clinic and an agricultural employer clinic had one test per year or less. All clinics had between 10.5 and 13.5 patient visits per year. Differences in costs per patient between clinics were driven by the difference in the number of lab tests, the type of provider visits and resultant costs, and the use of tenofovir at the one private clinic.

The annual cost per patient in treatment and responding varied from a low of \$202 at the rural public clinic to \$494 at the private urban clinic. The other two public sites (\$240, \$253) had annual costs very



similar to the two employer clinics (\$264, \$239). Taking into account patient losses and apparent treatment failures, the production cost per year for patients in successful treatment varied from a low of \$206 at the rural public clinic to a high of \$566 at the urban private clinic. The other two public sites (a referral hospital clinic and a large urban clinic) actually had higher “production costs” (\$302 and \$321 per year) than the two employer clinics (\$295 and \$250).

The distribution of publicly sourced ART in Uganda is saving public and donor funds. In the two employer clinics, private resources amounting to \$99 and \$95 per patient per year are expended on the non ART costs of caring for each patient alive and in treatment. In two public facilities (excluding the rural clinic that did little testing), annual expenditures on items other than ART were \$89 and \$94 per patient alive and responding to treatment. The private sector is contributing between 35% and 40% of the total cost of a year of ART when it receives ARVs for free. The public and private sector expend similar amounts per patient on non-ART services. If the patients were not being treated at these private clinics, the government would need to expend \$90 or more to absorb each additional private patient into the public system.

Summary of Findings

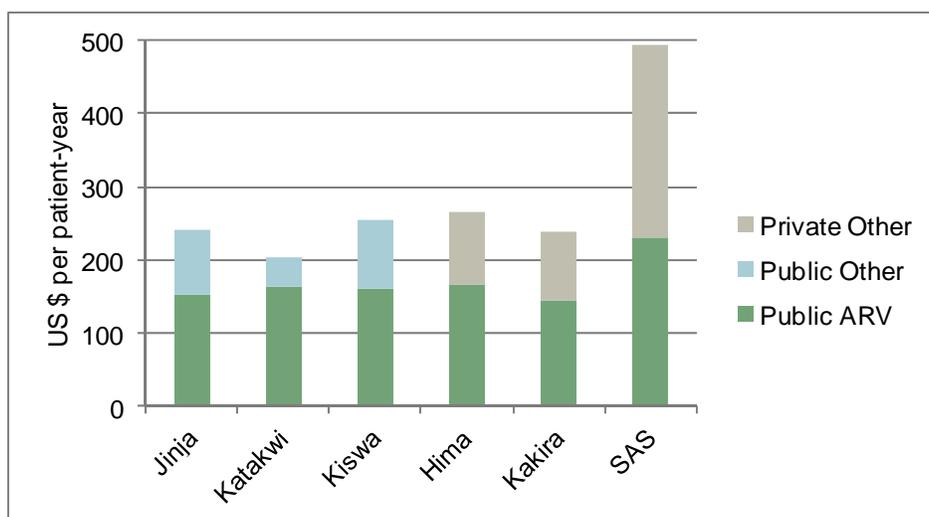
Patient Outcomes

Outcome	Public Sector Sites			Private Sector Sites		
	Jinja Referral	Katakwi	Kiswa	HIMA Cement	Kakira Sugar	SAS Foundation
n =	150	150	150	50	50	49
In care and responding	77%	97%	78%	88%	94%	84%
Undetectable viral load	0%	0%	0%	0%	0%	4%
Sufficient CD4 change	9%	5%	7%	20%	2%	0%
No condition	68%	92%	71%	68%	92%	80%
In care and not responding	10%	1%	12%	8%	4%	8%
Detectable viral load	9%	0%	6%	0%	0%	4%
Insufficient CD4 change	0%	1%	0%	0%	4%	0%
WHO condition	1%	0%	6%	8%	0%	4%
No longer in care	13%	3%	10%	4%	2%	8%
Died	5%	2%	4%	2%	0%	2%
Stopped attending	8%	1%	6%	2%	2%	6%

There is no clear trend or difference in outcomes between the public and private sector sites. Each sector has one site with remarkably low attrition (3% at Katakwi and 2% at Kakira). The excellent outcomes at Katakwi are attributed to the fact that it is the only ART site in the district and they have managed to have less ARV stock outs than some other areas or sites.



Breakdown of Public and Private Treatment Costs, in Care and Responding Patients



Because of the Uganda accreditation and ARV distribution program, ARV costs per patient at all public sites and two private sites were relatively similar---within 10% of the median for these sites. The third private sector site had higher per patient ARV costs because of its more extensive use of Tenofovir. Non ARV costs at two private sites (\$99, \$94) were only slightly higher than at the referral hospital (\$89). Public provision of ARVs leveraged private contributions to care that were similar in cost to the public expenditures for non-ARV costs at the referral hospital. At the third private site, non ARV costs were substantially higher for several reasons; including higher visit frequency, additional non-ARV drugs, many more laboratory tests, and higher costs per visit.

Conclusion

The proportion of patients who were in care and responding at the end of 12 months was generally better in the private facilities (88%, 94%, 84%) than at two of the public facilities (77%, 78%). The third public facility had an extraordinary result – 97% of patients in treatment and responding. However, this facility used few laboratory tests and recorded no new WHO Stage III/IV defining conditions around the 12 month endpoint. Staffs at this isolated site report a high degree of patient commitment, which may result in high rates of treatment adherence. It is likely though that if more diagnostic tests were performed some of the 97% of in care and responding patients would be re-categorized as in care but not responding.

The study shows that provision of ARVs from government/donor stocks to accredited private providers results in ART reaching additional patients without increasing the roles and costs at Government treatment sites. Employer clinics are incurring the non-ARV costs of treating patients, spending \$80-\$100 per year for the necessary staff, tests, etc. This is similar to expenditures for the same things at two public sector clinics (referral hospital, large urban clinic). In other words, the Government saves \$80-\$100 per patient per year for every patient treated in a private clinic. The outcomes are similar, as measured by the percentage of patients alive and responding to treatment at the end of the first year of ART. In fact, these outcomes are better in the two employer clinics than at some of the public clinics.

ANNEX 2: A STUDY TO DOCUMENT THE COST, SAVINGS AND BENEFITS THAT ARISE FROM THE USE OF RDTs IN THE TREATMENT OF MALARIA AT 10 SELECTED PARTNER PRIVATE SECTOR COMPANIES

During the 4th year, the HIPS Project piloted the use of RDTs among partner private sector facilities. Prior to this the project carried out a baseline study to assess the cost, benefits and savings of using RDTs in malaria case management among 10 partner private sector company facilities with the following main objectives:

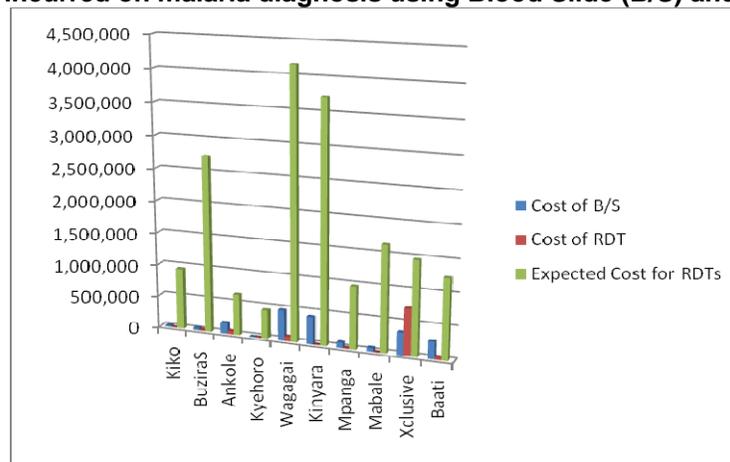
- 1) To assess the cost incurred by private sector companies in diagnosis of malaria.
- 2) Determine the cost and savings in the use of RDTs in the management of malaria patients?

Summary of Findings

List of Participating Companies and Malaria Endemicity

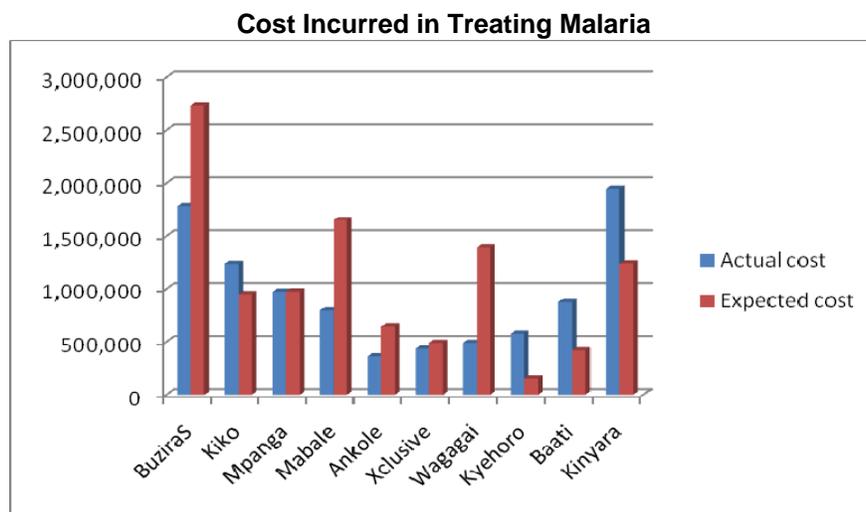
ID	Name of Facility	District	Malaria Endemicity
1	Kiko	Kabarole	Low
2	Rwenzori Buzirasagama	Kabarole	Low
3	Ankole Tea Estate Clinic	Bushenyi	Low
4	Kyehoro HC II	Buliisa	High
5	Wagagai Health Center III	Wakiso	High
6	Kinyara Sugar HC	Masindi	High
7	Mpanga Tea Clinic	Kabarole	Low
8	Mabale Tea Clinic	Kabarole	Low
9	Exclusive cuttings	Wakiso	High
10	Uganda Baati	Kampala	High

Cost incurred on malaria diagnosis using Blood Slide (B/S) and RDTs





The majority of malaria tests at facilities were B/S except for Xclusive Cuttings. The cost of RDTs on the market was at least UGX 3,000/= per dose which was believed to be very high while the B/S was at UGX 1,000/= each.



Monthly Cost Saving Expected (in Ugandan Shillings) of Using RDTs in Malaria Case Management

Facility	Cost of treating malaria cases required (Diagnosed)	Total cost of RDTs required	Total Amount for treatment of malaria required	Total expected cost of treating un diagnosed Malaria(Clinical)	Cost saving expected on treating malaria after diagnosis with RDTs
	A	B	A+B	C	C-(A+B)
Kiko	950,000	950,000	1,900,000	1,583,333	-316,667
BuziraS	2,732,000	2,732,000	5,464,000	4,553,333	-910,667
Ankole	640,000	640,000	1,280,000	1,066,667	-213,333
Kyehoro	149,333	448,000	597,333	746,667	149,334
Wagagai	1,386,667	4,160,000	5,546,667	6,933,333	1,386,666
Kinyara	1,240,667	3,722,000	4,962,667	6,203,333	1,240,666
Mpanga	975,000	975,000	1,950,000	1,625,000	-325,000
Mabale	1,649,000	1,649,000	3,298,000	2,748,333	-549,667
Xclusive	490,000	1,470,000	1,960,000	2,450,000	490,000
Baati	416,667	1,250,000	1,666,667	2,083,333	416,666

The above expected expenditures projections are based on the assumption that the average costs for each RDTs and ACTs on the market were UGX 3,000/= and UGX 5,000/= respectively. At these prices, the expected expenditure on RDTs among facilities in hypo endemic areas would be equal to the cost of treating the diagnosed malaria cases.

Conclusions

1. Companies were spending less funds on malaria diagnosis particularly RDTs than expected as opposed to treatment.



-
2. Facilities were not adequately using RDTs to test for malaria due to its high price.
 3. Unless the costs of RDTs were reduced below the prevailing prices, there would be no savings realized on using RDTs in malaria diagnosis for facilities in the hypo-endemic areas while on the other hand savings would accrue for those facilities in the hyper-endemic areas.
 4. Use of RDTs was useful reducing the use of anti malarial drugs and preventing side effects and drug resistance.

Recommendations

1. Companies with support from HIPS and other partners should have access to low cost RDTs in order to reduce expenditure hence increase utilization for proper malaria case management.
2. There is need to sensitize companies on the needs and benefits of RDTs.

ANNEX 3: EVALUATION OF TB TREATMENT OUTCOMES AMONG HIPS PARTNERS

At 71% TB treatment success rate, Uganda is still below the 85% target mainly due to the high default rates of 16% and loss to follow up of patients on treatment (<http://www.tbcta.org/Country/23/Uganda>, 2011 update)

In partnership with the NTLP, HIPS has over the last four years accredited 45 private sector facilities as TB treatment centers and supported them on TB control activities through equipping and providing TB supplies, training and support supervision.

In order to improve quality of care, during Year 4, HIPS instituted an evaluation of TB treatment outcomes among patients receiving care from HIPS partner accredited TB diagnostic and treatment units.

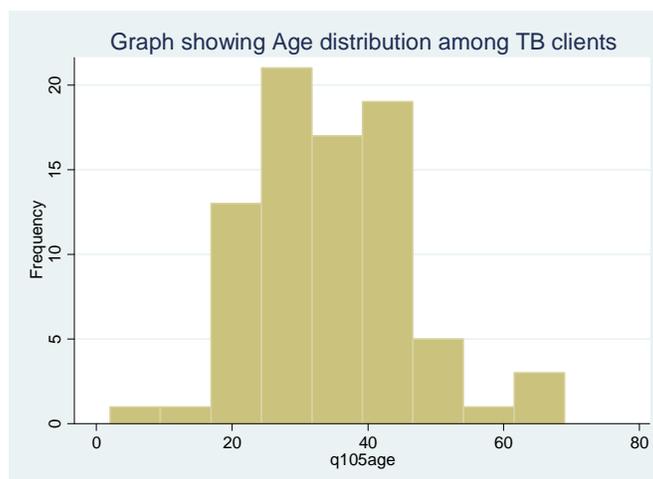
The main objective of the evaluation was to determine TB treatment outcomes of patients receiving care from HIPS partner accredited TB diagnostic and treatment units in a period of one year.

The specific objective of the evaluation was to:

- 1) Describe the socio-demographic characteristics of patients accessing TB treatment from HIPS partner facilities.
- 2) Assess the implementation of TB treatment service delivery at HIPS partner facilities.
- 3) Determine the TB treatment outcomes rates at HIPS partner facilities.

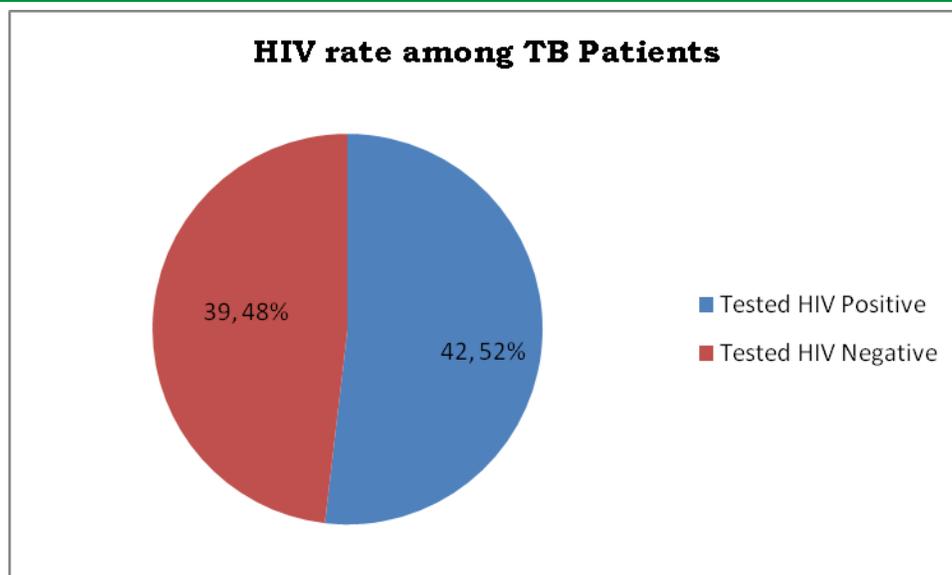
Summary of Results and Conclusions

A cross sectional study was conducted of new pulmonary smear positive patients that initiated TB treatment between July 2009 and June 2010. A total of 111 patient records were reviewed.



The disease distribution indicates that most TB cases occurred among young adults, mostly women of reproductive age (15-45 years). It was also noted that the majority of TB registers (59/86, or 69%) lacked District TB numbers.

Only 81 patient files had data on HIV testing. 42 (52%) of these files had results showing that the TB clients were also positive for HIV.



The TB treatment outcomes for the 86 patients indicated the following:

1. TB treatment success rate was 86% (74/86), which is above the national target and performance of 85% and 71% respectively.
2. Defaulters/loss to follow up were 9% (8/86), which was less than 10% as expected¹

¹ See page 44 of Uganda NTLP TB DOTS Guidelines 2002



ANNEX 4: STATUS OF HIPS PARTNER COMPANIES

No.	Name of company	Association Migrated To:	
		FUE	UMA
HIPS Managed 1-2/3 Years; Migrated to FUE and UMA (These are partners that were initially managed by HIPS only and then migrated to FUE and UMA)			
1	Coca Cola	✓	
2	Eskom Uganda		✓
3	Hima Cement	✓	
4	James Finlay's Uganda (Mc Leod Russell)	✓	
5	Kakira		✓
6	KCCL	✓	
7	Kinyara		✓
8	Luwero industries	✓	
9	New Forest Company	✓	
10	Nile Breweries	✓	✓
11	Roofings Uganda Limited		✓
12	Royal Van zanten Flowers	✓	
13	Rwenzori commodities	✓	
14	Shell Uganda	✓	
15	Southern Range Nyanza Limited		✓
16	Tullow oil	✓	
17	UGACOF		✓
18	Uganda Clays		✓
19	Wagagai	✓	
20	Toro And Mityana Tea Company (TAMTECO)		✓
21	Sugar Corporation of Uganda (SCOUL)		✓
22	Xclusive Cuttings	✓	
23	Touch Namuwongo Project		✓



No.	Name of company	Association Migrated To:	
		FUE	UMA
24	Ugarose		✓
Total 24 Companies			
HIPS Initiated; FUE and UMA Managed (These are partnerships that were brokered by HIPS but whose management was immediately transferred to FUE and UMA right from the onset.)			
1	Ankole Coffee Processors		✓
2	Centenary Rural Development Bank	✓	
3	JP Cuttings	✓	
4	Dominion Uganda	✓	
5	IITA (Research to Nourish Africa)/FUE	✓	
6	Reco Industries		✓
7	Kenya Commercial Bank (KCB)	✓	
8	Mpanga Tea growers limited		✓
9	Uganda Crane Creameries Cooperative Union Ltd		✓
10	Uganda Baati		✓
11	Fiduga Flowers Limited	✓	
12	Regional Lorry Drivers and Transporters Association	✓	
13	BM Technical services Mbarara	✓	
Total 13 companies			
FUE and UMA Initiated and Managed (These are partnerships that have been brokered by FUE and UMA directly.)			
1	Ericson AB Limited	✓	
2	Fish Ways Uganda Limited	✓	
3	Ken group		✓
4	Kengrow		✓
5	Kyagalanyi Coffee Limited		✓
6	Mabale Tea Growers Company		✓
7	Multitech Business School	✓	
8	Quality Chemicals		✓



No.	Name of company	Association Migrated To:	
		FUE	UMA
9	Sadolin		✓
10	SAIL Uganda	✓	
11	TIC Plastics		✓
12	Toyota Uganda	✓	
13	Uganda National Road Authority	✓	
14	Unga Millers		✓
15	Watsila	✓	
16	Wispro		✓
17	Swift	✓	
18	Munyonyo Common Wealth Speke Hotel	✓	
19	Orange Uganda Limited	✓	
20	Comprehensive services ltd	✓	
21	SDC Uganda Ltd	✓	
22	Tropical Heat Uganda Ltd	✓	
23	Uchumi Supermarket (u) Ltd	✓	
24	Emirates Airlines	✓	
25	Esco (U) Ltd	✓	
26	First Insurance Company	✓	
27	Child Fund International	✓	
28	Steel and Tube	✓	✓
Total 28 companies			

No	Name of company	OVC Matching Grant	PMI & Special Projects
HIPS Initiated; Still under HIPS Management (These are partnerships that have been brokered by HIPS. Most are unique, i.e. OVC partners, PMI partners and special projects. Most are not eligible for migration/management by FUE and UMA.)			
1	Beads for Life	✓	
2	Caring Hands	✓	



No	Name of company	OVC Matching Grant	PMI & Special Projects
3	Cornerstone Foundation	✓	
4	Crown Beverages Limited*		
5	Enterprise Uganda**		✓
6	Farmers Center Uganda Limited/FACE	✓	
7	Liberty Development Trust clinic	✓	
8	MLISADA/MTN	✓	
9	Mpongo Limited	✓	
10	Rakai Community Health Dev. Project	✓	
11	AIRTEL Uganda**		✓
12	Africa Affordable Medicine**		✓
13	EVOCKOM/Ngora Development Association	✓	
14	Jomo Fruit Processing Company	✓	
15	Buikwe Dairy Development Authority	✓	
16	Nakigalala Tea Estate/Kajjansi Roses*		
17	Neptune Oil*		
18	Tororo Cement		✓
19	Gulu Chamber of Commerce*		
20	Tilda Rice Uganda		✓
21	Melisa Flowers*		
Total 21 companies			
* Still under HIPS management			
** Unique projects, i.e. OVC partners, PMI partners and other special projects			

No.	Name of company
Ever Worked with/Currently Not Active Partners, but HIPS Initiated; (These are partners who implement one-off activities from time to time; not active.)	
1	Boda Boda Transporters
2	Dunavant Cotton
3	Group 4 Security



No.	Name of company
4	Mid North private sector development
5	P&O Technical services
6	Parambot breweries
7	Mt. Elgon orchards
8	North Bukedi Cotton Ginnery
9	Uganda Telecommunications Company
10	Acholi private sector organization
11	Blue Hackle
12	Housing Finance Bank
13	Kaweri Coffee
14	Mairye flowers
15	UGAPRIVI association
	Total 15 companies

Note: Out of all the 101 HIPS partner companies, 88 partners are eligible for migration/management by FUE and UMA and so far 65 are already under the associations' management, indicating 74% of those eligible for migration are being managed by FUE and UMA.



ANNEX 5: HIPS – COMPANY ANNUAL LEVERAGE 2011

No	Company	Trade	Employees	Catchment Population		MOU (1 = Yes)	HIPS' contribution (USD)	Company Contribution (USD)	Leverage ratio
				By Parish	By Sub county				
1	Africa Affordable Medicine	Medical Services	40	5,500	31,200	1	101,278		1:3
2	Tullow Oil	Oil exploration	200	56,400	109,900	1	40,000		1:7
3	McLeod Russel (James Finlay's Tea)	Tea	5,000	60,900	249,000	1	30,025		1:3
4	Hima Cement	Cement	1,742	39,000	39,000	1	32,535		1:4
5	The New Forests Company	Tree plantation	1,900	9,600	75,600	1	32,135		1:3
6	Kakira Sugar Works Limited	Sugar production	10,000	32,500	32,500	1	39,392		1:2
7	Nile Breweries Limited	Brewery	9,640	151,100	531,300	1	54,615		1:1
8	Kinyara Sugar Works Limited	Sugar	9,000	54,800	54,800	1	48,316		1:1
9	Bead for Life	NGO	467	5,600	*	1	19,994		1:3
10	Kasese Cobalt Company Limited	Mining	400	8,500	38,100	1	23,662		1:2
11	Wagagai Flowers	Flower export	1,700	14,900	42,500	1	27,972		1:1
12	Mpongo Company Limited	Fisheries	456	16,700	22,400	1	32,000		1:1
13	Toro and Mityana Tea Company	Tea	4,108	20,540	25,700	1	20,519		1:2
14	EVOCKOM/Ngora Development Association	Services	150	2,400	*	1	23,496		1:1
15	Farmers Center Uganda Limited/FACE	NGO	246	32,900	*	1	23,438		1:1
16	Caring Hands	NGO	171	7,600	*	1	21,079		1:1
17	BM Group of Companies	Manufacturing	300	26,600	41,400	1	8,122		1:3
18	Cornerstone Development Ltd	NGO	597	23,600	*	1	16,091		1:2
19	MLISADA/MTN	NGO	179	10,100	-	1	19,130		1:1
20	Buikwe Dairy Dev't Authority	Dairy farming	165	8,000	*	1	21,973		1:1
21	Sugar Corporation of Uganda Limited	Sugar	6,000	35,500	-	1	15,941		1:1
22	Jomo Fruit Processing Company	Fruit Processors	162	3,700	*	1	19,928		1:1



No	Company	Trade	Employees	Catchment Population		MOU (1 = Yes)	HIPS' contribution (USD)	Company Contribution (USD)	Leverage ratio
				By Parish	By Sub county				
23	Eskom Uganda	Power generation	200	-	-	1	8,212		1:3
24	Airtel Uganda	Telecom Company	400	3,500	-	1	15,393		1:1
25	Luwero Industries Ltd	Manufacturing	400	6,700	6,700	1	7,608		1:2
26	Fiduga Flowers Limited	Flower Farm	626	3,130	4,300	1	13,607		1:1
27	Uganda Baati	Manufacturing	400	11,900	-	1	10,040		1:2
28	Uganda Telecom	Telecom Company	200	-	-	1	10,044		1:1
29	Mpanga Tea Limited	Tea	1,285	25,700	7,500	1	10,653		1:1
30	Royal VanZanten Flowers Limited	Flower export	500	6,900	47,300	1	6,377		1:2
31	Tororo Cement	Cement	4,000	42,100	42,100	1	9,302		1:1
32	Shell Uganda	Petroleum products	120	-	-	1	7,886		1:1
33	Rwenzori Commodities Limited	Tea	2,007	21,300	55,400	1	6,921		1:1
34	Liberty Development Trust clinic	Health services	36	3,800	380,600	1	9,719		1:1
35	Southern Range Nyanza Limited	Textile Stationery &	1,806	35,700	61,300	1	5,591		1:2
36	Xclusive Cuttings	Flower export	200	10,000	74,000	1	9,099		1:1
37	Dominion Uganda	Oil exploration	110	1,700	29,300	1	9,124		1:1
38	Uganda Crane Creameries Cooperative Union	Dairy farming	13,688	64,100	-	1	5,640		1:2
39	Uganda Clays	Brick Laying	800	19,200	180,900	1	6,500		1:1
40	Rakai Community Health Dev. Project	Health services	12	5,600	8,600	1	6,276		1:1
41	Regional Lorry Drivers and Transporters Assns.	Transport Services	446	9,400	-	1	5,848		1:1
42	Reco Industries	Food Processing	150	12,900	-	1	5,892		1:1
TOTAL			80,009	910,070	2,191,400	42	841,373	1,746,787	1:2



ANNEX 6: HIPS MENU OF SERVICES

HEALTH SERVICES	HIV/AIDS	TB	MALARIA	FP/RH	OVC	DESCRIPTION
WORKPLACE POLICY DEVELOPMENT	✓	✓	✓	✓	✓	Development of workplace health policies. Enhancing local organizations' capacity to implement workplace programs
PEER EDUCATION	✓	✓	✓	✓	✓	Training of Trainers, training of employees, support staff and community members to share health information
COMMUNITY EDUCATION Health Fairs Men-only Seminars	✓	✓	✓	✓	✓	Employee & community entertainment & education forums focused on health issues and products. Includes VCT
HIV COUNSELING & TESTING	✓					Community outreaches, onsite facility-based VCT
HEALTH COMMUNICATION MATERIALS	✓	✓	✓	✓	✓	Handbooks, Job Aids, Brochures, Posters, Banners, Leaflets, Charts, Flyers, DVDs, Cassettes
LOW COST HEALTH COMMODITIES	✓	✓	✓	✓	✓	Contraceptives, condoms, moon beads, long lasting treated mosquito nets, Water purifiers, Oral Rehydration salts
PRIVATE CLINICS MOH ACCREDITATION	✓	✓				Linkages with Ministry of Health for private health facility accreditation for ART and TB diagnosis, treatment and provision of free drugs. Establish referral systems
ACCESS TO FREE ARV'S/TB DRUGS/IPT2 FOR MALARIA	✓	✓	✓			Linkages, trainings & technical assistance to receive free MOH ARVs & TB drugs. Support for pregnant mothers in prevention of malaria
LABORATORY EQUIPMENT & TRAINING	✓	✓	✓	✓		Equipment (e.g. microscope, colorimeter), Reagents for diagnosis & treatment of TB, malaria & some STIs
CLINICAL & COMMUNITY BASED TRAININGS -ART & Palliative Care -VCT -Safe Male Circumcision -Short Term and Long Term Family Planning	✓	✓	✓	✓	✓	Trainings in the use of ARVs, TB, palliative care, SMC, LTPM, Counseling & Testing. Also entails Training of OVC caregivers. Provision of basic equipment



ANNEX 7: HIPS PMP INDICATOR TABLE

Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of community health and para-social workers who successfully completed a pre-service or in service training program	Pre-service* training comprises training that equips CHSWs to provide services for the first time. Include anything from a WEEK up to 6 months of training- and work under the supervision of a professional social worker, nurse or physician. Excludes those trained to cater for individual clients or a single household, e.g. Treatment Buddies and OVC Care-givers	OGAC / Cardno/	training records	Quarterly	2007	0	1500	1,502	2000	2174	2,500	2507	1500	2,387
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (ABC clients)	clearly defined audience or target groups, clearly defined goals and objectives , based on sound behavioral and social science theory, focused on reducing specific risk behaviors, activities that address the targeted risk behaviors, employ instructionally sound teaching methods, provide opportunities' to practice relevant risk reduction skills, Delivered in a group of less than 25 people	OGAC/ Cardno	peer educator and training records, attendance numbers for outreach events	Quarterly	2007	0	260,000	174,405	184000	193584	150,000	109,171	60,000	61,407
Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	<u>Definition of 'Primarily focused':</u> The messages and content of the activities for the majority of the time are focused on ; increasing individual & group self-risk assessments; building skills; & other supportive behavioral, cognitive and social components to increase AB behaviors	OGAC / Cardno	peer educator and training records, attendance numbers for outreach events	Quarterly	2007	0	0	0		0	50,000	34,655	20,000	12,922
Number of locations providing MC surgery as part of the minimum care	<i>Minimum package - On site HIV CT, STI treatment, HIV prevention messages, surgical operation, post-operative wound care; abstinence instructions, safer sex, provision of</i>	OGAC, Cardno/ MOH	service outlet and USAID reports; patient records	Quarterly	2007	0	0	0	5	5	10	15	20	32



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
package of MC for HIV prevention services within the reporting period	<i>condoms [consistent & correct use Location may be fixed / permanent or mobile / temporary</i>													
Total number of males circumcised as part of the minimum package of MC for HIV prevention services in USAID supported outlet disaggregated by Age	Following national standards, In accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision under Local Anesthesia	OGAC/ Cardno/ MOH	service outlet and USAID reports; patient records	Quarterly	2009	0		0	0	0	1,000	1,449	2,000	2,514
Number of health care workers who successfully completed an in-service training in Male Circumcision		OGAC/ Cardno/ MOH		Quarterly	2009	0					15	36	30	42
Number of targeted condom service outlets	Fixed distribution points, mobile units with fixed schedules, Condoms may be free or for sale. Measurement is sum	/ Cardno/ MOH	USAID reports, site visits	Quarterly	2007	22	22	22	25	28	50	80	75	81
Number of service outlets working with USAID that provide HIV-related care, including TB/HIV	A service outlet refers to the lowest level that offers at least one palliative care service. For clinical care activities, the lowest level that should be counted as a service outlet is typically a hospital, clinic or mobile unit. For community-based or home-based services, the lowest level that should be counted is a service delivery location of the company or private facility providing palliative care, e.g. office or mobile unit. Services include: clinical/medical care for opportunistic infections, psychological, spiritual, social or prevention care services for HIV+ patients and their families.	OGAC/ Cardno/ MOH	service outlet and USAID reports	Quarterly	20008	19		28	88	35	100	77	88	80



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of unique health care workers trained Clinical care through trainings organized by USAID or collaborating companies	This measure will be a count of the number of people trained for HIV-related clinical care for HIV-infected individuals (diagnosed or presumed) and includes those trained in facility-based, community-based and home-based care, including TB/HIV. Training on HIV-clinical care should include one or more of the following service areas: clinical/medical including TB/HIV;	OGAC/ Cardno/ MOH	registration records, attendance sheets	Quarterly	2007	0	200	203	250	250	300	309	100	110
Number of HIV-positive adults and children receiving a minimum of one clinical service – Subset of Umbrella Care	Clinical Care Services (for HIV positives only): Treatment and prevention of OIs, including Malaria -Pain management and treatment of skin infections Management of urinary and respiratory problems, Therapeutic food interventions, Provision of ARVs and Adherence monitoring, NB: Includes Assessment / Provision of interventions	OGAC/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2007	695	2500	2,946	3500	11,756	12,000	28161	25,000	29,669
Number of HIV-positive persons receiving Cotrimoxazole/ Dapsone prophylaxis – Subset of Clinical Care Services	Subset of clinical care indicator , "Receipt" = prescribed and obtained by the patient, Counts as long as the client received Cotrimoxazole/Dapsone at some point during the reporting period	OGAC/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2010	0		0	0	0	5000	5611	10,000	25,365
Number of HIV positive patients who were screened for TB in HIV care or treatment settings (Screened for TB at last visit)	All HIV positive patients in a clinical care setting	OGAC/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2010	0		0	0	0	4500	2778	9,000	9,035
Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings (Screened for TB at last visit)	<u>Numerator</u> : Number of HIV-positive patients who were screened for TB in HIV care or treatment settings <u>Denominator</u> : Number of HIV-positive adults and children receiving a minimum of one clinical service	OGAC/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2010	0		0	0	0	80	61	80%	52%



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment		OGAC/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2010	0		0	0	0	150	101	300	335
Percent of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	Numerator : Number of HIV-positive patients in HIV care who started TB treatment Denominator : Number of HIV-positive adults and children receiving a minimum of one clinical service	USAID/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2009	8%		0	0	0	5	58	10%	1%
Number of TB patients who had an HIV test result recorded in the TB register		USAID/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2009	0		0	0	0	300	334	600	462
Number of HIV positive incident TB cases that received treatment for TB and HIV (ART) during the reporting period	Total number of TB patients recorded in the TB register during the reporting period	USAID/ Cardno/ MOH	service outlet and ; patient records	Quarterly	2009	0		0	0	0	80	63	160	206
Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	The total number of unique individuals receiving Clinical care from facilities and companies or community/home-based organizations working with USAID. Care services include: clinical/medical, psychological, spiritual, social and prevention care (refer to PEPFAR guidance for definition of services). To be counted an individual must be receiving at least one type of service. The indicator includes HIV-infected individuals receiving treatment for TB	OGAC/ Cardno/ MOH	patient and service site records	Quarterly	2007	1019	2363	3150	3500	4,125	4,500	4,326	4500	5,265
Number of naive adults and children with advanced HIV-infection who ever started on ART	ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. The indicator refers to the cumulative number of all those who have reported ART treatment status over the life of the USAID-supported activity	OGAC/ Cardno/ MOH	patient and service site records	annual	2007	1631	3500	2,931	4000	5,585	6,000	6943	6000	7,731



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of adults and children with advanced HIV infection newly enrolled on ART during the reporting period as a result of USAID-supported interventions	ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. The indicator refers to a count of new naive clients - those who initiated antiretroviral therapy during the reporting period. Measurement sum	OGAC/ Cardno/ MOH	patient and service site records	Quarterly	2007	332	1500	1,371	1500	1,445	1,500	1319	200	1,531
Number of health facilities that offer ART	This indicator refers to the number of partner company clinics accredited by the Ministry of Health working with USAID that are providing ART services to employees according to national or international standards, dependents or community members.	OGAC/ Cardno/ MOH	patient and service site records	Quarterly	2007	19	25	28	50	70	100	55	60	52
Number of unique individual health workers trained to deliver ART services according to national and/or international standards	The number includes both certified clinical and lay health workers who contribute to the development and implementation of ART services. The health workers should be sufficiently trained to take up a direct function in support of scaling up of ART services. Training includes training or retraining courses conducted according to national/international standards. Health workers include: physicians, medical officers, nurses, midwives, clinical officers, other health workers and lay staff in clinical settings, laboratory technicians and staff, pharmacy/dispensing staff, community treatment supporters (peer educators, outreach workers, volunteers, informal caregivers)	OGAC/ Cardno/ MOH	training records	Quarterly	2007	0	150	151	200	254	200	254	200	270
% adults & children with HIV known to be on treatment 12 months after initiation of ART	Numerator: Number of adults and children who are still alive and on ART at 12 months after initiating treatment Denominator: Total number of adults and children who initiated ART 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	OGAC/ Cardno/ MOH	patient and service site records	Annual	2010	88%	0	0	0	0	0	94	90%	95%



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of Service outlets providing Testing and Counseling (T&C) services according to national and international standards working with USAID	Number of Service Outlets providing Testing and Counseling services (Excludes Outreaches). They should be fixed locations	OGAC/ Cardno/ MOH	USAID records, site visits for quality assurance	Quarterly	2007	20	20	29	50	88	100	85	88	80
Number of health care workers who successfully completed an in-service training program in counseling and testing for HIV according to national and international standards	This will be a count of the number of locations providing basic counseling and testing for HIV. A service outlet refers to the lowest level of service - a health center, hospital, clinic, stand alone VCT center, or mobile unit. Counseling and testing activities include activities in which both HIV counseling and testing are provided to those who seek to know their status (as in traditional VCT) or as indicated in other contexts (STI or workplace clinics, diagnostic testing, etc.) The indicator does not include VCT services provided as part of a PMTCT program.	OGAC/ Cardno/ MOH	training records	Quarterly	2007	0	50	51	50	53	50	50	50	83
Number of individuals who received Testing and Counselling (T&C) services for HIV and received their test results at VCT sites working with USAID.	The indicator will be a count and will require a minimum of counseling, testing and the provision of test results.	OGAC/ Cardno/ MOH	site records, patient records	Quarterly	2007	601	2500	11441	2500	41236	45,000	61024	45,000	69,770
Number of SP tablets purchased	Number of SP tablets purchased with USG funds	S08 /PMI Cardno/ MOH	Stock cards, procurement delivery notes	Quarterly	2007	15000	15000	15000	15000	19800	15,0000	150100	75,000	80,000
Number of women receiving 2 or more doses of IPTp	Measures the number of pregnant women to whom 2 or more doses of IPTp were dispensed to as a result of HIPS assistance	S08 /PMI Cardno/ MOH	ANC register, reports	Quarterly	2007	648	10000	648	10000	7310	20000	19789	20,000	17,606
Proportion of women who received 2 or	Proportion of pregnant women who have received 2 or more doses of IPTp	S08 /PMI	Activity reports review	Quarterly	2009	70%	0	0	73%	100%	100%	98	80%	70%



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
more doses of IPTp		Cardno/ MOH												
Number of Health facilities with a functioning water vessel and cups for IPTp DOTS	Measures the number of Health facilities with a functioning water vessel and cups for IPTp DOTS	S08 /PMI Cardno/ MOH	Activity reports review	Quarterly	2007	3	3		12	16	25	40	40	50
Number of ANC health workers trained in IPTp, IPTp 3	Measures the number of ANC health workers trained in intermittent prevention of malaria in pregnancy	S08 /PMI Cardno/ MOH	Activity reports review	Quarterly	2009	0	60		120	128	150	152	40	55
Number of people reached with prevention messages on malaria	Measures the number of individuals who attended community outreach or training activities, organized and sponsored by companies working with the project, that focus on malaria prevention. The indicator may also estimate the number of viewers/listeners/readers reached through various media channels.	S08 /PMI Cardno/ MOH	training records, event attendance estimates, circulation/subscription data for publications and printed materials	Quarterly	2007	1300		45450	50000	53748	170000	171,773	100,000	120,734
Number of ITNs procured	Number of ITNs procured using USG funds. Measurement: sum	S08 /PMI Cardno/ MOH	procurement documents	Quarterly	2008	685	5000	685	5000	5500	100000	33,500	20,000	30000
Number of ITNs distributed or sold		S08 /PMI Cardno/ MOH	distribution reports	Quarterly	2008	685	10000	685	10000	9380	100000	19,450	20,000	18,583
Number of workplace healthcare providers trained in PPM DOTS with USAID funding.	USAID will target both existing company partners and new company partners. Health care providers include all staff providing health services, such as physicians, nurses, nurse aides, laboratory technicians, dispensers and clinical assistants.	SO8/ Cardno/ MOH	workplace site records (referral logs and patient records)	Quarterly	2008	0	40	62	75	98	90	102	90	101
Number of TB cases reported to NTP by USAID-assisted	This indicator will describe the number of cases, referred by private sector providers working with USAID. Non-NTLP providers refer to providers	SO8/ Cardno/ MOH	workplace site records (referral logs and patient records)	Quarterly	2007	15	50	62	100	566	650	1038	1200	1198



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
private sector workplace providers	in the private sector and workplace programs outside the mainstream MOH system who have been given the skills to support the national program.													
Number of new smear-positive cases diagnosed by non-National Tuberculosis and Leprosy Program (NTLP) providers	This indicator will describe the number of cases, diagnosed by private sector providers working with USAID. Non-NTLP providers refer to providers in the private sector and workplace programs outside the mainstream MOH system who have been given the skills to support the national program.	SO8/ Cardno/ MOH	workplace site records and patient records	Quarterly	2008	10	30	57	75	176	250	423	500	374
Number of new smear-positive cases who received DOT from non-NTLP providers	Non-NTLP providers refer to providers in the private sector and workplace programs outside the mainstream MOH system who have been given the skills to support the national program. Received DOT implies the patient was supervised regularly and observed routinely while taking medications, according to national protocol.	SO8/ Cardno/ MOH	workplace site records and patient records	Quarterly	2008	8	20	53	65	138	200	265	300	303
TB treatment Success Rate		SO8/ Cardno/ MOH	workplace site records and patient records	Quarterly	2008	66.4%	0	0	0	0	0	84	85%	86%
Number of counseling visits for Family Planning/Reproductive Health as a result of USAID assistance.	This indicator measures the number of persons who attend family planning sessions at HIPS-partner sites and receive information on birth spacing, method choices, available products and proper instructions for use.	SO8/ Cardno/ MOH	clinic/health service center records	Quarterly	2007	0	300	850	2000	3,059	3500	8087	9000	25,088
Number of new acceptors to family planning registered at health service sites supported by USAID.	New acceptors are defined as individuals who have not used family planning methods in the past three years. Modern family planning methods include: hormonal pills, injectaplan, condoms, moon beads, IUD, Norplant, and permanent methods (vasectomy and tubal ligation).	SO8/ Cardno/ MOH	clinic/health service center records, Social Marketing Company (UHMG) reports	Quarterly	2007	0	500	600	900	2,350	2500	3951	4,000	9,401
Couple years of protection (CYP) through USAID-supported private	Estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that	SO8/ Cardno/ MOH	records from sites	annual	2007	934	120	934	2000	2,703	3,500	11559	13,000	34,730



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
sector sites	period.													
Number of community outreach activities to improve knowledge about family planning and contraception organized and sponsored by companies working with USAID.	Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC). This indicator will be a simple numerical value give by a count.	SO8/ Cardno/ MOH	USAID reports	Quarterly	2008	97	50	97	120	492	250	350	400	656
Regularity of contraceptive supply in USAID-supported sites	Regularity measured as % of time partner clinics do not experience stock-outs of regularly stocked family planning items. The numerator will be the number of days reported with no stock outs of one or more FP items per quarter. The denominator will be the number of days per year (365).	SO8/ Cardno/ MOH	USAID reports, site visits	Quarterly	2008	80%	90%	80%	90%	90%	90%	90	90%	91%
Number of people trained in FP/RH	Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH (including training in service delivery, communication, policy and systems, research, etc.). Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	SO8/ Cardno/ MOH	Training reports	Annual	2009	0	0	0	0	86	90	90	Dropped 50/ adjusted 100	183
Number of USG-assisted service delivery points providing FP counseling or services	This will be a count of the number of locations providing basic family planning counseling and services. A service outlet refers to the lowest level of service - a health center, hospital, clinic, stand alone FP center, or mobile unit.	SO8/ Cardno/ MOH	USAID reports, site visits	Quarterly	2008	22	25	22	30	88	100	88	88	81
Number of clients using FP/RH services													40,000	52,628



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of workplace sites collaborating with USAID to offer expanded HIV/AIDS services to include the community	Workplace sites may include employers HIPS is currently working with or new businesses. The menu of services provided by employers will vary and will depend on the level of commitment, willingness and ability to invest in healthcare services and support, and technical skills. Services may include counseling and testing, ART, palliative care. measurement: sum	Cardno / USAID / FUE / UMA	MOUs, partner spread sheet	Quarterly	2008	13	10	13	17	38	30	44	50	55
Number of existing and new workplace sites with integrated health services RH/FP, TB or malaria tailored to specific company needs, disaggregated by types of services	The number includes workplace sites supported by USAID. Integrated health service provision includes the ability to provide more comprehensive services at the premises of the health service site or the ability to refer patients for additional services to other facilities with which the sites have established a relationship and a procedure to track and follow up on referrals.	Cardno / USAID / FUE / UMA	health service site and USAID reports	Quarterly	2008	28	25	28	35	44	45	42	50	53
Number of GDA partnerships developed according to USAID principles		Cardno / USAID / FUE / UMA	MOUs, partner spread sheet	Quarterly	2008	9	5	9	12	20	35	41	45	51
Number of Companies provided with technical assistance by USAID for HIV-related policy development	Number of companies, workers' organizations, programs and other institutions to which USAID has provided assistance in the development of HIV/AIDS policies such as workplace policies, advocacy initiatives, protection of patient privacy policies, etc.	Cardno/ USAID/ FUE UMA	registration forms at FUE/UMA.	Quarterly	2008	2	20	51	25	30	35	37	40	53
Number of individuals trained in HIV-related policy development	Number of individuals, who have participated in policy development trainings, peer education, workplace-based or community-based training activities related to HIV-policy development organized by USAID.	Cardno / USAID / FUE / UMA	registration forms at FUE/UMA.	Quarterly	28	17	20	107	50	67	70	97	80	140
Number of companies provided with technical assistance by USAID for HIV-related institutional capacity building	Technical assistance provided by USAID will be based on a needs assessment of the companies.	Cardno/ USAID	registration forms at FUE/UMA.	Quarterly	2008	2	3	3	4	3	4	4	4	5



Performance Indicator Title	Indicator Definition and Unit of Measure	Data User	Data Source	Frequency of data collection	BL Year	BL Value	Year 2008 Target	Year 2008 Value	2009 Target	2009 Value	2010 Target	2010 Value	2011 Target	2011 Value
Number of individuals trained in HIV-related institutional capacity building	The training provided by USAID will be based on needs assessment and may cover topics such as development and operationalization of HIV-related policies, cost-benefit analysis, donor policies and best practices in HIV/AIDS programming, facilitation of relationships between public and private sector organizations, health product procurement practices and international procurement mechanisms, among others.	Cardno/ USAID	Registration forms at FUE/UMA.	Quarterly	2008	3	9	9	15	18	20	23	25	27
Number of eligible children (OVC) provided services in 3 or more OVC core program areas beyond Psychosocial/spiritual support during the reporting period	Services provided by companies or grantees may include food/nutrition, shelter and care, protection, health care, psychosocial services, education and vocational training, and economic strengthening (per PEPFAR guidelines). This will be a count of OVCs receiving 3 or more core program areas beyond psychosocial of these services	OGAC/ Cardno/	site records, patient records	Quarterly	2008	1468	1000	1,468	1500	3,090	4,000	4010	4500	3,273
Number of OVC care givers trained in comprehensive HIV management	Training provided by USAID may include formal training or peer education supported by USAID. The focus of the training will depend on an initial assessment of needs and capacities and will cover topics such as food/nutrition, shelter and care, protection, health care, psychosocial services, education and vocational training, and economic strengthening (per PEPFAR guidelines)	OGAC/ Cardno	health service records	Quarterly	2008	0	50	143	100	458	400	748	500	395