



# CIVIL SOCIETY FUND

Strengthening civil society for improved HIV & AIDS  
and OVC service delivery in Uganda



## ANNUAL REPORT JULY 2012 - JUNE 2013

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***Cover Picture: A community dialogue session convened by CSF sub-grantee Bishop Masereka Christian Foundation in Kasese District.***

## ACRONYMS

ADP	AIDS Development Partner
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
BCC	Behavioral Change Communication
CBO	Community-Based Organization
CM	Cryptococcal Meningitis
CSF	Civil Society Fund
CSO	Civil Society Organization
DFID	Department for International Development (UK)
EMTCT	Elimination of mother-to-child transmission of HIV
FMA	Financial Management Agent
FP	Family Planning
GIS	Geographical Information System
GoU	Government of Uganda
GPS	Global Positioning System
HCT	HIV Counseling and Testing
HIV	Human Immune Deficiency Virus
IEC	Information Education Communication
JSS	Joint Support Supervision
LA	Lead Agency
LQAS	Lot Quality Assurance Sampling
MARP	Most at risk population
M&E	Monitoring and Evaluation
MIS	Management Information System
MoH	Ministry of Health
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
NSP	National Strategic Plan
OCAT	Organization Capacity Assessment Tool
OI	Opportunistic Infection
OVC	Orphans and Other Vulnerable Children
PACT	Partnership for Accountability and Capacity Transformation
PLHIV	People Living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	Prevention of mother-to-child transmission of HIV
RFA	Request for Application
RTA	Regional Technical Assistance
SRH	Sexual and Reproductive Health
TASO	The AIDS Support Organization
TB	Tuberculosis
TMA	Technical Management Agent
UAC	Uganda AIDS Commission
UGANET	Uganda Network of Law Ethics and HIV
UNASO	Uganda Network of Service Organizations

## EXECUTIVE SUMMARY

The Civil Society Fund (CSF) was established in 2007 to address the burdens posed by HIV/AIDS and orphans and other vulnerable children (OVC) in Uganda. This unique funding mechanism has enabled civil society organizations (CSOs) to respond to these challenges in a harmonized way. Currently the Fund is contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency, and Swedish International Development Cooperation Agency.

This report highlights CSF accomplishments during the 6<sup>th</sup> Fiscal Year (July 2012-June 2013) during which CSF sub-grantees consisted of 23 HIV3 sub-grantees and eight NNGOs. The sections are divided by the strategic plan's three key result areas: 1. CSF management strengthened; 2. Institutional and technical capacity of CSF sub-grantees strengthened; and 3. Service delivery in the National Strategic Plan for HIV/AIDS (NSP) program priority areas increased.

In line with national policies, CSF sub-grantees use the combination HIV prevention approach that entails behavioral, structural, and biomedical interventions. To optimize service delivery, sub-grantees refer beneficiaries for biomedical services not readily available at base.

Some of the notable achievements were as follows. Sub-grantees provided health education through community based initiatives including small group discussions, peer education, one-on-one interventions and community dialogues. The total number of beneficiaries that received messages in the year was 962,889 (48.3% female). This performance exceeded the annual target by 92.6%.

A total of 315,921 individuals (47.4% female) received HIV counseling and testing (HCT) and were given results. Thus the CSF annual target was exceeded by 5.3% and the number constituted approximately 9% of the national annual target for 2013. Of this number, 10,275 individuals (47% female) tested HIV positive and they were referred for care and treatment services.

To promote safe sexual practices, CSF sub-grantees distributed 5,180,617 condoms (3.5% female) and this constituted 35.7% of the annual target.

In terms of safe male circumcision (SMC), 5,877 males were circumcised, and this was 59% of the CSF annual target and 0.6% of the national target.

Clinical and non-clinical care, support and treatment services were provided to 63,211 people living with HIV (PLHIV), representing an achievement of 115% of the target for the year which is significantly higher than achieved (75%) the previous year. This performance is attributed to the use of effective strategies to recruit PLHIV into care programs, such as the formation of referral partnerships between government hospitals and private health facilities.

CSF also prioritized involvement in strengthening systems and policies to support the delivery of quality HIV and AIDS services. In this regard, it collaborated with strategic partners including line ministries, the private sector and local governments, which helped to avoid service overlaps. In addition, it enabled services to reach under-served populations such as fishing communities in Kalangala District and Hoima in the western Rift Valley. In order to improve the functionality of district and lower level networks, CSF provided financial and technical assistance to a consortium comprising the Uganda Network of Service Organizations (UNASO), the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) and the Uganda Network of Law, Ethics and HIV (UGANET). As a result, 19 district networks have developed human resource and financial manuals, and coordinators from 25 districts have been empowered with M&E skills.

A highlight of the year was the celebration of CSF's fifth anniversary which was held in December 2012 with the theme *CSF@Five: Celebrating Achievements, Embracing the Future Together*.

To ensure the effective utilisation of data, CSF revised its data collection tools and their corresponding database modules. The tools, which are now better aligned to the revised national HIV indicators, were distributed to all CSF sub-grantees. CSF also modified the database to enable the production of online real-time reports. The reports are available on the CSF website and sub-grantees can view them when they use their database login credentials.

CSF continued building the capacity of its sub-grantees. Not only did it provide startup training for new sub-grantees, but it also carried out supportive supervision visits. An important milestone accomplished during the year was finalizing the evaluation of the decentralized capacity building models and dissemination of the findings. These findings are currently being used to realign CSF's capacity building programs. In order to improve the process of organizational self-assessments, CSF also designed an automated OCAT to enable sub-grantees to enter results from organizational assessments online and generate reports. This innovation will enable both sub-grantees and CSF to keep track of their technical and institutional growth.

## KEY RESULT AREA 1: CSF MANAGEMENT STRENGTHENED

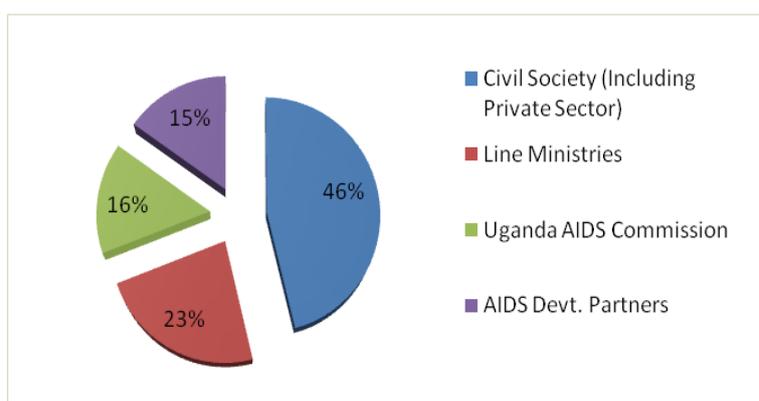
This section focuses on strengthening the management of CSF, which is an important prerequisite to attaining the goal of such a unique funding mechanism with multiple stakeholders. It covers the main accomplishments of the governance systems and structures, the management of the funding resources, and the use of CSF data to improve programming. In the course of this fiscal year, the CSF governing body continued to make key decisions which guided the operations of the three management agents, one of which closed out at completion of its contract. CSF also marked its fifth anniversary, carried out research, and submitted manuscripts for publication in national and international journals. CSF used program data to generate abstracts that were presented at the XIX International AIDS Conference in Washington D.C., U.S.A. The Child Status Index (CSI) was evaluated and CSF also issued two new Requests for Application (RFA), receiving 245 responses October 2012.

### A. CSF governance systems and structures strengthened

During the course of this year, the CSF Steering Committee (and effective 24 January 2013 the CSF Board of Directors) continued to perform its governance role. The governance sub-committee of the CSF Board convened three times while the finance sub-committee met once.

The new 13-member CSF Board reports directly to the Uganda AIDS Commission (UAC) Board and is composed of the following representatives: UAC – 2 members; line ministries – 3 members; civil society, including private sector – 6 members; and ADPs – 2 members. Figure 1 shows the percentage share of the 13 slots per constituency.

**Figure 1: Constituency representation on the new CSF Board of Directors**



Examples of key decisions taken by the Board included the approval of the FY 2012/2013 work plan; the appointment and supervision of consultants to lead the operationalization of the CSF management study; and the approval to contract successful applicants under RFA 11- 001 (HIV3). Approval was also given to continue funding 23 HIV sub-grantees from the basket fund beyond October 2013 despite DFID declaring that they would no longer be contributing to the CSF basket. In addition the Board approved the issuance of Requests for Applications (RFA) 12-001 and 12-002 for Community Based Organizations (CBOs) and district-based Non-Governmental Organizations (NGOs) respectively, and the authorization to extend National NGOs current contracts for one year after the expiration of their

contracts in December 2013. The extension of the NNGOs invoked the clause in the CSF Governance Manual that allows sub-grantees a maximum contract period of four years, beyond which they would have to go through a competitive process for subsequent contracts.

On December 13, 2012, the Monitoring and Evaluation Agent (MEA) project under the management of Chemonics International Inc. closed out. The Technical Management Agent (TMA), also under the management of Chemonics International Inc., was extended for another two years and will end on February 3, 2015. Furthermore, the Financial Management Agent (FMA) under the management of Deloitte Uganda Limited, whose nine-month contract with DFID expired at the end of March 2013, was extended to January 21, 2014.

In December 2012, CSF celebrated five years of existence. The theme for the occasion was *CSF@Five: Celebrating Achievements, Embracing the Future Together*. The overarching aim was to continue to advocate for the strengthening of the combined effort of all key stakeholders to ensure the GoU's HIV and AIDS commitment of "zero new infections; zero discrimination and zero related deaths." As part of the celebration, a variety of communication products showcasing CSF's success stories, lessons learnt and challenges over the five-year period were produced and disseminated to key stakeholders. CSF further continued to keep its audience updated about its activities and achievements through quarterly reports, monthly activity updates, and *The Link* e-newsletter. These were distributed by email and uploaded on the CSF website. During the year the website was redesigned to make it more user-friendly and interactive.

This year, CSF participated in several national decision making processes and collaborative interactions. One key highlight was collaboration with the Makerere University School of Women and Gender Studies. They are using the CSF gender blended learning module to roll out gender training in all courses offered at the university. Significant fora that CSF participated in included the UAC 7<sup>th</sup> Joint AIDS Review meeting, the Partnership Committee meetings; the technical working group (TWG) that reviewed the indicator handbook for the M&E plan of the National HIV and AIDS Strategic Plan 2012 -2015; and the National OVC M&E TWG meeting hosted by Ministry of Gender, Labor and Social Development in August 2012. Others were the bi-annual Health Management Information System (HMIS) stakeholders meeting; and the technical review panel meetings that are guiding the implementation of the baseline and impact evaluation of combination HIV prevention in the six focus districts of Arua, Gulu, Kabale, Kasese, Mayuge and Rakai. CSF also participated in the process to introduce a national score card for HIV and AIDS CSOs, which was led by UNASO; and the AMICAALL<sup>1</sup> Second Urban Leaders AIDS Forum and annual general meeting.

This year, CSF extended the contracts of eight NNGOs for 18 months from July 2012 to December 2013. These included the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL), Straight Talk Foundation (STF), The AIDS Support Organization (TASO), Joint Clinical Research Center (JCRC), AIDS Information Center (AIC),

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<sup>1</sup> AMICAALL: The Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level

Programme for Accessible Health Communication and Education (PACE), Infectious Diseases Institute (IDI), and Uganda Network of AIDS Service Organizations (UNASO).

Contracts were also signed with 23 CSOs under RFA 11-001 (HIV3) to operate in the six aforementioned focus districts. The theme of the RFA was *Reduction of New HIV Infections through Enhanced Community Engagement in Combination HIV Prevention*.

CSF, in partnership with Ministry of Health (MoH), the AIDS Development Partners (ADPs), UAC, the Ministry of Gender, Labor and Social Development (MoGLSD), UNAIDS, the World Bank and Makerere University School of Public Health developed two HIV and AIDS related Requests For Applications (RFAs). These were entitled *Scaling up Comprehensive Evidence-based HIV Prevention through Community Engagement*. RFA 12-001 (HIV4) specifically targeted the district based NGOs while 12-002 (HIV5) targeted the CBOs including Faith Based Organizations (FBOs) in 30 districts. A summary of the RFA activities during the year is given in Table 1.

**Table 1: Summary of the RFA activities during FY2012-2013**

RFA No.	Type of CSO	No. of Sub-grantees	Status	Geographical Coverage
10-001	NNGOs	8	Contracts extended for 18 months (Jul 2012-Dec 2013)	Nationwide
11-001 (HIV3)	Various categories of CSOs	23	Awarded 3 year grants effective October 2012	6 districts
12-001 (HIV4)	CBOs/FBOs	63 (Estimate)	Not yet awarded (solicitation report ready)	30 districts
12-002 (HIV5)	District-based NGOs			

## B. CSF multi-donor resources managed

During the year, UGX 26,628,964,046 was disbursed to NNGOs and HIV3 sub-grantees to implement their projects and of this UGX 23,322,221,378 had been accounted for by June 30, 2013.

An expenditure review exercise was commissioned by the ADPs to cover the period from May 2010 to December 2012. The objective of the assignment was to perform an expenditure verification review, test the design and operating effectiveness of controls over financial reporting and verify the financial management systems and internal control/governance systems being used by the fund manager (FMA) to manage the CSF and Partnership Fund (PF) on behalf of the ADPs. The report from the auditors, KPMG, found that Deloitte (Uganda) Limited had put in place an internal control system that can prevent, detect and correct material errors in fund accountability and ensure compliance with the terms and conditions of the FMA terms of reference and ultimately safeguard the assets and resources from loss and misappropriation. This conclusion further reaffirms the strength of the systems employed by FMA in the management of the donor funds.

### **C. CSF-generated data utilized to improve HIV and AIDS programming**

To ensure the effective utilization of data collected, CSF data collection tools and report formats were revised. The revised tools were pre-tested with the sub-grantees and the suggested changes incorporated during a validation meeting. The tools are now better aligned to the revised national HIV indicators. The revised data collection tools and required report formats were distributed to all CSF sub-grantees. Additionally, all database modules corresponding to the revised data collection tools were revised. CSF has further modified the database to ensure that it produces online real-time reports. The reports are available on the CSF website and sub-grantees can view them when they use their database login credentials. The sub-grantees can also filter their respective program reports from the database. All reports can be exported to Microsoft Excel for further analysis, thus increasing data utilization by sub-grantees.

CSF used the Geographic Information System (GIS) to perform spatial analysis of CSF program data. Thematic maps depicting spatial coverage of the different interventions were shared with NNGOs, which enabled the sub-grantees to avoid overlaps and duplication of services during the cost extension proposal development. In addition, GIS was used to analyse service coverage per district, sub-county and parish levels. The results were used to focus interventions in the development of RFA 12-001 (HIV4) and RFA 12-002 (HIV5).

During the year, CSF conducted five studies to address knowledge gaps that had been identified through the analysis of CSF-generated data. Each of the studies was conducted by a joint team of CSF staff and research firms including Makerere University School of Public Health and Makerere University School of Social Sciences. Ethics clearance was obtained from accredited ethics review boards and the National Council of Science and Technology. The five studies are:

- i. Factors associated with adoption of safer sexual behavior among PLHIV in care in selected civil society organizations – implications for positive prevention (PP) programs in Uganda.
- ii. Factors affecting male involvement in family planning in communities and populations served by CSF supported organizations.
- iii. Determinants of HIV counseling and testing among couples in long term sex relationships: A case of Kampala and Soroti.
- iv. Factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda.
- v. Effectiveness of OVC Interventions towards Improvement in Food and Nutrition Security and Economic Strengthening among OVC Households in Uganda.

To ensure that the findings of the CSF research benefit the wider community, the CSF team in collaboration with the consultant firms that participated in the research, embarked on the development of manuscripts for submission to the appropriate national and international journals for publication. So far, one abstract and four manuscripts have been developed and submitted to selected journals for peer review and publication.

**Table 2: Manuscripts and abstracts from CSF researches submitted for international dissemination**

Title of Abstract /Manuscript	Conference/Journal of Submission
a) Male involvement in family planning in communities and populations served by civil society organizations in fifteen Ugandan districts	Submitted in May 2013 to the 3 <sup>rd</sup> International conference on Family planning scheduled for November 2013 in Ethiopia; it was accepted for oral presentation
b) Association between safer sexual practices and alcohol use among people living with HIV in care in Uganda	International Conference on AIDS and STIs in Africa (ICASA) 2013
c) Safer sexual behavior among persons living with HIV in Uganda	International Journal of AIDS Society ( IJAS)
d) Factors influencing safer sexual behaviors among people living with HIV in Uganda: A qualitative study	Global Health Action (Journal)
e) Determinants of Prior Couples' HIV Counseling and Testing Uptake among Individuals in Long-term Relationships in Kampala and Soroti Districts, Uganda	Journal of Acquired Immune deficiency Syndromes

In addition, CSF used program data to generate abstracts that were presented to an international audience at the XIX International AIDS Conference in Washington D.C., U.S.A. in July 2012. The abstracts included: a) *Bridging Gender Gaps in Access to Services through Improved Data Use by Implementers*; b) *Harnessing SMS technology to Monitor and Scale up Access to Youth Friendly Services*; c) *Strengthening Civil Society Contribution to the National HIV and AIDS Response through a Harmonized and Coordinated Funding Mechanism*; and e) *Trends in People Testing for HIV Among Civil Society Organizations in Uganda: Implications for Expanding HIV testing*. Another abstract entitled *Measuring Outcomes of HIV and AIDS and OVC Interventions using the CSF model* was accepted for presentation by the American Evaluation Association for presentation in Minneapolis, U.S.A. in October 2012.

During the year, an evaluation of the CSI was undertaken. The evaluation focused on assessing the utilization of the data collection tools, the utilization and functionality of the database and relevance of the analytic outputs in monitoring trends in children's well-being. It also explored the bottlenecks and gaps that emerged from the implementation of the CSI database. The evaluation showed that the CSI tool and database should be considered for use by all OVC service providers. This would help in determining the national OVC situation—by highlighting the regional and community specific problems. It would also generate useful data for research, policy formulation, advocacy, resource allocation and planning.

## **D. Lessons learned and challenges**

### ***Lessons Learned***

- CSF has a role to play in building on the evidence base for HIV Prevention, Care and OVC programming in Uganda especially among civil society organizations through conducting high quality research. The results from these researches have been shared nationally and internationally as highlighted in Table 2 above. In addition the

results from the researches have been used to guide HIV programming the CSF sub grantees.

- There is need to review the criteria for assessing and grading community based organizations (CBOs) during the CSF award solicitation process. This will significantly increase the number of CBOs eligible for CSF funding.

### **Challenges**

- There were interruptions in the disbursement of funds to sub grantees due to uncertainty regarding the continuation of the FMA contract beyond March 31, 2013. This has resulted in most of the sub grantees being behind schedule in the implementation of their projects.

### **E. Priorities for Year Seven**

- In the next fiscal year, CSF plans to contract HIV 4 and 5 CSOs; and to extend the contracts of the NNGOs.
- CSF will also conduct project reviews, assessments and evaluations for the 8 NNGOs; and develop and implement a comprehensive CSF quality assurance plan.
- Collaboration with strategic partners including line ministries, CSOs, the private sector, local government and other key stakeholders will continue to be a priority.
- CSF also plans to share experiences at national and international fora.

## KEY RESULT AREA 2: INSTITUTIONAL AND TECHNICAL CAPACITY OF SUB-GRANTEES STRENGTHENED

During this fiscal year, CSF capacity building interventions aimed to strengthen the institutional, technical and financial management capacity of its sub-grantees in order to improve the quality of HIV and AIDS services. The capacity building interventions were guided by the CSF capacity building strategy which included capacity interventions conducted by the management agents and through five lead agencies. The implementation approaches included training workshops, onsite mentoring and coaching, blended learning (self-administered), Compliance School (topical) articles, experiential learning through attachments and offsite technical support email, telephone and office discussions. One important milestone accomplished during the year was the finalization of the evaluation of the decentralized capacity building models and dissemination of the findings. These findings are currently being used to realign CSF's capacity building programs. During this year CSF brought on board 23 new sub-grantees and conducted capacity assessments.

### A. CSF decentralized capacity building models evaluated

Between January 2011 and June 2012, CSF piloted three decentralized capacity building models namely Partnership for Accountability and Capacity Transformation (PACT); Lead Agency (LA) and Regional Technical Assistance (RTA). This was a learning phase to determine the feasibility of the models, in regard to variability in outcomes; what resources were needed for each model; the logistical



**Figure 2: TMA Chief of Party, Sheila Marunga Coutinho, making remarks during the seminar**

and coordination benefits; and the challenges associated with any of the models. In October 2012, CSF conducted an external evaluation of these models. The purpose of the evaluation was to provide evidence on their performance with respect to capacity outcomes and the replicability of the models.

#### **Key findings**

The findings of the evaluation were disseminated in a February 2013 seminar to provide stakeholders with feedback and validate the findings of the report.

The models were found to be relevant and replicable, particularly the LA and RTA models. It was, however, recommended that the PACT be recognized for its central coordination function rather than a decentralized model. It was also noted that all the models contributed to the strengthening of sub-grantee systems, which was evidenced by an overall

increase in individual Organizational Capacity Assessment Tool (OCAT) scores across all models.

Each of the models realized the majority of the planned number of achievements (outputs). Each model contributed to the strengthening of sub-grantee capacity, especially in monitoring and evaluation, planning, finance management and HIV programming.

The evaluation also established that all of the sub-grantees utilized the CSF adapted OCAT to assess their capacity levels before and after capacity building interventions and that they found it to be beneficial.

Of the 64 organizations that had an OCAT baseline and reassessment, 55% had a percentage improvement in the total OCAT score above 10%, while 40% had a percentage change between 10% and 5%. One sub-grantee did not register any changes and two registered negative change.

Sub-grantees identified some of the benefits of the models to be an enhanced culture of self-assessment and learning; improved M&E systems; the development of relevant new policies; and improved partnerships.

Overall, the RTA model was slightly less costly than the LA model per sub-grantee by about 40%.

Allowing different implementers flexibility in their approaches resulted in significant differences in the quality of interventions.

There were gaps in the articulation of the startup processes, sharing of experiences, implementers' documentation and important differences in expectations by various stakeholders.

### **Key recommendations**

The evaluation recommended that CSF should review and re-package the models using the findings of the report to improve its overall capacity building strategies by clearly articulating techniques, start-up processes, capacity building standards, data flow, and relationships among actors. It also recommended that the linkage between capacity building and improved service delivery, transition management and sustainability of capacity building benefits be spelled out. It further recommended that CSF should always provide adequate time (not less than 12 calendar months) for implementation of capacity building plans for meaningful and sustainable impact. It was also proposed that CSF organizes joint review and planning meetings between various implementers to harmonize and consolidate efforts.

### **The CSF OCAT – A self-diagnosis tool**

*"We had never realized that our M&E system was this incomplete, we have always submitted reports to donors previously without much trouble. This self-assessment exercise exposed us to what a good M&E system should be like. Our strategic plan had also expired but we had never noticed because it was never thought of as important. We now feel more poised to take this organization to the next level if what was agreed upon during the development of the capacity building plan is fully implemented. The OCAT opened our eyes and helped us to identify our capacity gaps and the solutions to address them."*

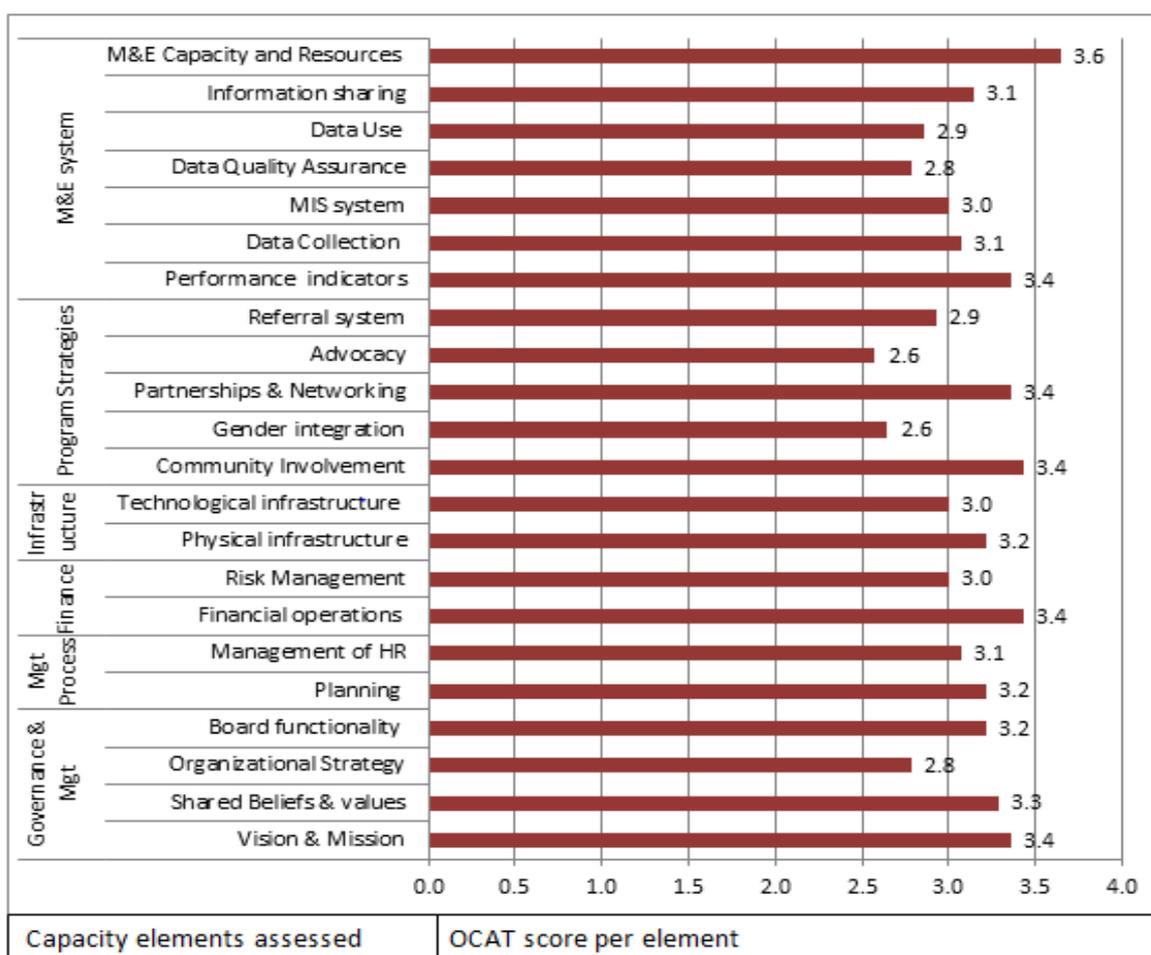
Quote from a participant in the organizational self-assessment in Kasese district.

It is expected that the positive attributes of each model will remain relevant and attractive to all capacity building stakeholders.

## B. HIV3 sub-grantee institutional and technical capacity assessments conducted

During this year, CSF conducted detailed capacity assessments for 23 HIV3 sub-grantees using the revised CSF OCAT. These assessments were facilitated by the CSF lead agencies namely: The AIDS Support Organization (TASO), Joint Clinical Research Center (JCRC), Infectious Disease Institute (IDI), Program for Accessible Health Communication and Education (PACE) and Straight Talk Foundation (STF) and were aimed at identifying capacity strengths and weaknesses. Subsequently, the assessments were used to develop capacity building plans. It is envisaged that the findings of the assessments will be used as a baseline to measure future organizational capacity progress for these sub-grantees. CSF has set a target of achieving at least 15% improvement in the OCAT score after one year of capacity building by both the management agents and the lead agencies. The graph below shows these sub-grantees' quantitative gap analysis (average rating) for 22 capacity elements under the organizational development section of the OCAT.

Figure 3: Quantitative gap analysis of 22 capacity elements of CSF HIV3 sub-grantees



\*Maximum possible score on each element is 4 and lowest rating is 1

The assessment showed that the capacity elements of M&E systems and financial management systems scored the highest overall with mean scores of about 3.2. The capacity elements of crosscutting program strategies including gender integration, advocacy, partnership and networking, community involvement and the referral system scored the least, with an average score of 2.9. The assessments also showed that none of the organizations scored the maximum total possible score of 172. The highest score was 148 and lowest 64. In light of the above findings, CSF worked with the lead agencies to develop tailor-made capacity building plans for each HIV3 sub-grantee. These are currently being rolled out and will continue in FY 2013/14.

### **C. Improved financial management capacity of sub-grantees**

In an effort to strengthen the financial management capacity of sub-grantees, Compliance School articles on relevant topics such as budget preparation and monitoring, and commingling of funds, were written and disseminated electronically to the sub-grantees. This was in response to capacity gaps that were noted during the first monitoring visit to the HIV3 sub-grantees. These articles aimed to equip the sub-grantees with a standard understanding of global best practices in budget preparation and monitoring and making them aware of the pitfalls of commingling CSF funds. Feedback from the sub-grantees showed that the content was highly appreciated, and this was subsequently reflected in the quality of their financial reporting. Following the article on budget monitoring, the sub-grantees were able to demonstrate that they were tracking budgets. This has enabled them to keep track of their costs and improve their budgeting efficiency. CSF also provided onsite support to ensure that these new skills are consolidated and institutionalized by the sub-grantees.

Financial management training for the HIV3 sub-grantees was conducted following their contract signing in October 2012. This one-on-one training was conducted at the sub-grantees' premises and the exercise occurred over a two-week period. The training focused on the CSF financial reporting tool, procurement procedures, financial documentation and internal controls. As a result, all sub grantees are using the financial reporting tools, as required.

Overall, there has been improved compliance with the CSF financial management guidelines and the adoption of best practices.

### **D. HIV3 sub-grantees supported to start up and equipped with skills in combination HIV prevention**

In October 2012, CSF conducted a training workshop for the HIV3 sub-grantees program staff. The aim of the workshop was to orient the sub-grantees on the National HIV Prevention Strategy and support them in defining how they would effectively implement their CSF-supported projects.

The training gave the participants an opportunity to reflect on how they intended to implement Combination HIV Prevention. They also evaluated their readiness for implementing the projects, identified gaps in their strategies and proposed issues they

would address so as to refine their respective implementation strategies. Each sub-grantee developed an action plan identifying what they would do to enhance their effectiveness. The participants also assessed the sustainability of their projects and identified areas that need improvement, for instance, the level of involvement by other stakeholders, leadership competencies, adequacy of funding, level of program flexibility and program impact.

In June 2013 the CSF management agents conducted Joint Supportive Supervision (JSS) visits with these sub-grantees and found that 64% of them are implementing interventions fully aligned to the NPS. The JSS also showed that there are still gaps in the understanding of combination HIV prevention. To address this, CSF will follow up with MoH to ensure sub-grantees are oriented on combination HIV prevention implementation guidelines currently being developed.

**Reflections (on gender and SRH integration into HIV&AIDS) by participants in the startup training:**

- Most of the time the service providers in charge of Family Planning are women therefore we need to bring on board male peers to mobilize men.
- We have learnt to build on what is already in the district to ensure that they do not re-invent the wheel in the areas of gender mainstreaming.
- When we revisited our proposal we learned that the gender element was not clearly handled. We have analyzed and identified a number of issues that will be sorted out when we go back to our organization.
- We had not emphasized the selection criteria on gender and how enrolling the beneficiaries on the program will affect their needs and roles in society.
- We did not take into account the SRH component in the proposals; however we have the privilege of implementing a project that emphasizes SRH so we are

## E. Strengthened sub-grantee capacity in monitoring and evaluation

Sub-grantee M&E capacity has been strengthened through data management trainings, data quality assessments, M&E technical support supervision, and on-the-job mentoring and coaching.

A Data Quality Assessment (DQA) exercise conducted in the seven NNGOs shows a marked improvement in the quality of data reported and counted, taking into consideration the four quality assurance standards (validity, reliability, integrity and timeliness), although some variations of over and under reporting were



**Figure 4: CSF regularly organizes training for sub-grantees**

discovered between the NNGO implementation sites and the headquarters, and data reported to CSF. With respect to quality assurance all eight NNGO proposals met the required standards (technical, targeting, and value for money). Follow up visits conducted during the June 2013 JSS with current sub-grantees also showed that 57.5% demonstrated capacity to collect, analyze, report and use data collect. Specifically 90% were using

appropriate data collection tools, 60% were reporting in a timely manner, while 60% demonstrated satisfactory levels of data analysis. Performance on these indicators is lower than last year and this is mostly because CSF brought on board new sub-grantees (HIV 3), this year whose M&E capacity is still developing.

## **F. Sub-grantees project and organizational communication skills improved**

During this year, sub-grantees also received training to improve their communication skills. A total of 41 participants drawn from the NNGO and HIV3 sub-grantees were trained. Participants were challenged to put in practice all the skills



**Figure 5: A small group discussion during a CSF workshop**

obtained, and for those who did not have communications strategies, to develop them in order to improve their organizational communication. A blended learning module has been developed and rolled out to be used as a reference and further support the process of improving communication capacity among sub-grantees. Topics include *Understanding Communication; Public Relations; Developing Active Listening Skills; Understanding an Organizations' Publics; Communication and Management Support; Enhancing Photography Skills; Writing Quality Reports and Success Stories; Documentation and Knowledge Sharing; Communication and Gender; and Designing an Organizational Communication Strategy.*

## **G. Innovations**

### ***Improved data capture and monitoring of capacity building interventions***

In order to improve the process of organizational self-assessments, CSF has designed an automated OCAT that will allow sub-grantees to enter results from organizational assessments online and generate reports. This innovation will enable both sub-grantees and CSF to keep track of their technical and institutional growth over a period of time. Ultimately, the automated OCAT will be a key learning and evaluation tool for individual organizations. CSF will also be able to compare sub-grantees' performance and provide evidence based support to those who need targeted interventions to enhance their capacity to deliver quality services.

### ***Improved capacity assessment process***

Through a consultative process CSF revised the OCAT to include sections that assess institutional and technical components for both the HIV and AIDS and OVC sub-grantees; and, as recommended, in the capacity building evaluation report. To make the revised tool more user-friendly, it was compiled into a booklet that includes users' notes, guiding

questions, an action plan template, a glossary and a 'CSO Journal' which serves as a monitoring tool to complement the OCAT. This systematic and user-friendly version of the OCAT was used by HIV3 sub-grantees to conduct capacity assessments. It is expected to facilitate better quality assessments and improved utilization of the results to make evidence-based decisions that will improve the capacities of their organizations.

### ***Enhancing quality of CSF capacity building interventions***

CSF has developed a Pocket Guide for Capacity Building Facilitators to support trainers, coaches and mentors in ensuring that minimum standards are met during the implementation of capacity building interventions. The pocket guide prescribes key roles, qualities and standards and provides practical insights on how trainers, coaches and mentors can manage their work in different settings. It also provides key guidelines to follow under each of the three CSF capacity building approaches, with the aim of enhancing their effectiveness. The use of this guide is expected to result in improved quality and the standardization of approaches to capacity building within CSF.

## **H. Lessons Learned and challenges**

### ***Lessons Learned***

- Using the revised OCAT and assessment process was useful in creating a sense of ownership of capacity building interventions. This was mainly because the new format catered to inclusion of roles for both the capacity building service provider and the sub-grantee benefiting from the service rendered.
- It is important to involve Lead Agencies in the selection of sub-grantees for capacity building. Doing this resulted in greater efficiency, compared to the previous process in which they were not involved in the allocations.

### ***Challenges***

- The anticipated FMA close out process, although it was later reversed, resulted in the majority of planned activities not being undertaken. Some of the planned activities not implemented include experience sharing workshops and bi-annual JSS.

## **I. Priorities for Year Seven**

- CSF will redefine and repackage its capacity building strategy in view of the evaluation findings and will share the revised approaches with other implementers of capacity building programs. This should promote the use of relevant, cost-effective evidence-based approaches. Key components of this strategy will include: onsite and offsite technical support from the management agents, implementation of the capacity building plans developed jointly by HIV3 sub-grantees and the lead agencies, and setting up regional capacity building teams.
- Start-up training for the new HIV4 and 5 sub-grantees on combination HIV prevention, finance, communication as well as M&E including web-based and off-line data entry will be provided.

- CSF will roll out the automated OCAT.
- Compliance School articles on crosscutting capacity gaps identified in June 2013 JSS in financial systems will be produced and shared with sub-grantees. These will be complemented by onsite supportive supervision.
- To ensure coordination and mutual learning, CSF will organize experience sharing workshops where sub-grantees will share experiences and learn from one another.

## KEY RESULT AREA 3: SERVICE DELIVERY IN HIV AND AIDS INCREASED

This section covers the service delivery achievements of CSF sub-grantees between July 2012 and June 2013. The areas of focus include HIV prevention, care, treatment and support services in targeted communities in line with the revised National HIV Strategic Plan 2011/12-2014/15 and the Uganda National HIV Prevention Strategy 2011-2015. It also covers advocacy and networking initiatives carried out by CSF sub-grantees.

Currently, CSF sub-grantees comprise 23 HIV3 sub-grantees and eight NNGOs.

### A. Promoted access and utilization of HIV prevention services

In line with the NPS, CSF sub-grantees offered combination HIV prevention services<sup>2</sup> entailing behavioral, biomedical and social structural services. Behavioral prevention primarily focused on health education on safer sexual behavior and working with targeted high risk populations to change their behaviors to lower risk levels of infection.



**Figure 6: A sub-grantee project officer giving health education on HCT to a group of deaf beneficiaries through a sign language interpreter in Kabarole district**

The biomedical component included the provision of HIV counseling and testing (HCT), promotion of correct and consistent use of female and male condoms, integration of sexual and reproductive health (SRH) into HIV and AIDS including screening and treatment of sexually transmitted infections (STIs). It also included family planning (FP); Safe Male Circumcision (SMC); and community elimination of mother-to-child transmission of HIV (EMTCT). The structural prevention dimension primarily addressed sociocultural and economic issues that are contributing to the HIV and AIDS epidemic.

Due to the fact that biomedical services such as EMTCT, STI screening and treatment, FP services, and SMC could not always be offered in their entirety by each provider, CSF sub-grantees partnered with other biomedical service providers such as health centers, hospitals and NNGOs (non-CSF sub-grantees) to enable their clients access comprehensive services.

**Promoted access to social and behavior change interventions and engaged communities to address structural drivers of the epidemic**

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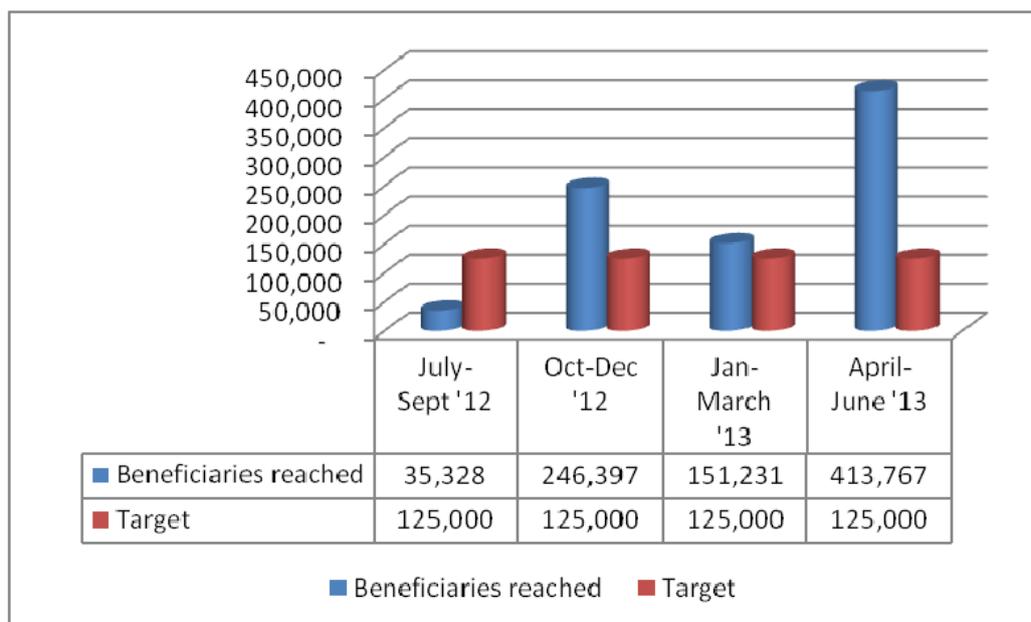
<sup>2</sup> The combination HIV prevention approach involves implementing multiple HIV prevention interventions with known efficacy in specific area at a scale, quality and intensity to impact the epidemic. Combination HIV prevention comprises behavioral, biomedical and structural interventions.

To contribute to the reduction of new HIV transmissions in the country, all CSF sub-grantees were not only involved in providing HIV and AIDS information but they also engaged beneficiaries in discussions that were intended to reduce high risk behavior. The total number of beneficiaries that received messages in the year was 962,889 (48.3% female). This performance exceeded the annual target by 92.6% but represented a 75.6% decline of the number reached in FY 2011/2012. The FY 2012/2013 performance was attributed to good community mobilization efforts employed by CSF sub-grantees. The health education given by sub-grantees centered on HIV risk factors; Abstinence, Be-Faithful, and Condom use Model (ABC); HCT; EMTCT; SRH including STIs and condom use; cross-generational sex; and multiple concurrent relationships. It is anticipated that these outputs will result in improved knowledge levels on ways to prevent HIV and promote safer sexual practices. Future population based surveys are planned to assess this. Age categories targeted included 10-14 years, 15-24 years as well as individuals aged 25 years and above. Health education was conducted through community based initiatives including small group discussions of 25 people or less, peer education, one-on-one interventions and community dialogues. BCC messages were provided in 658 sub-counties of 109 districts.

In the course of this year, sub-grantees also distributed information, education and communication (IEC) materials as part of health education on HIV and AIDS. IEC/ behavior change communication (BCC) materials were used alongside BCC messaging to improve beneficiary understanding of key HIV and AIDS messages. A total of 1,691,802 assorted IEC materials on sexually transmitted diseases (STDs), condom distribution, EMTCT and HCT were distributed to beneficiaries; this accounted for approximately 55% of the CSF annual target. The target was not achieved due to low supplies of IEC/BCC materials in the country.

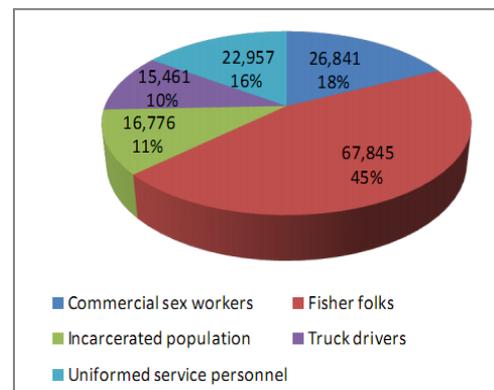
According to sub-grantee reports, as a result of BCC messaging and community mobilization beneficiaries were motivated to receive condoms and seek out other services including HCT, SMC, as well as care and treatment services.

**Figure 7: Trends in BCC messages delivered to beneficiaries from July 2012 to June 2013**



CSF sub-grantees are required to target high risk populations with HIV prevention interventions since HIV prevalence is highest in these populations. During the year, the high risk groups specifically targeted included: fisher-folks, long distance truckers, commercial sex workers and their partners, incarcerated populations and uniformed personnel. The aggregate number of key populations reached was 149,880 and this transcended the CSF target by 3 times and constituted approximately 15.6% of all message recipients. The number of these populations reached in FY 2012/2013 was 22.6% higher than the number for the same populations in FY 2011/2012 due to the increased focus on these population groups. Other populations targeted included pregnant women, people with disabilities and youth out of school.

**Figure 8: Message recipients by key population categories for July 2012 - June 2013**



To address the sociocultural and economic drivers of the epidemic, sub-grantees mobilized opinion leaders and oriented them on basic HIV and AIDS facts as well as the drivers of the epidemic. The opinion leaders were then tasked to support the interventions as change agents: they engaged targeted beneficiaries in community dialogues focusing on harmful cultural practices such as early marriages, polygamy, and sexual gender based violence, stigma and discrimination, traditional circumcision and challenges in economic empowerment affecting women and girls. During the year 562,038 individuals benefited from discussions to address socio-cultural drivers of the HIV epidemic.

**Provided information on correct and consistent condom use and access to condoms**



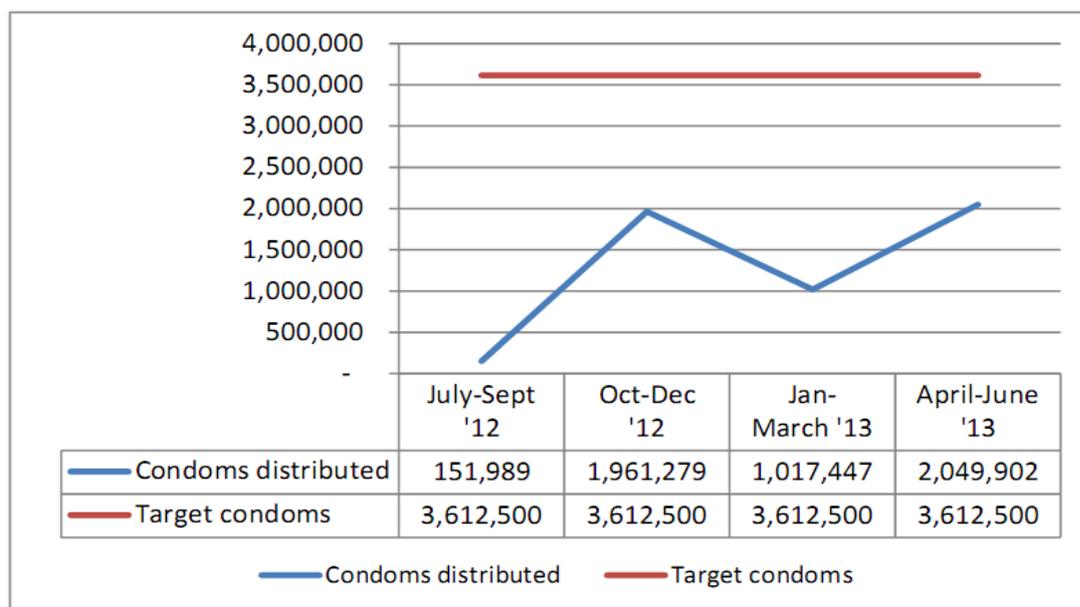
**Figure 9: Commercial sex workers demonstrating stages in condom use to their peers**

One of the ways in which CSF sub-grantees promoted safer sex among targeted beneficiaries was by increasing access to both male and female condoms. CSF successfully negotiated for condom supplies from UHMG to enable sub-grantees provide these commodities to targeted beneficiaries. During this year, CSF sub-grantees provided education on and distributed 5,180,617 condom pieces of which 3.6% were female condoms. The number of condoms distributed in the year constituted 35.7% of the annual target and only constituted 49%

of the condoms distributed in FY 2011/2012. The low distribution was attributed to the

irregular and low supplies of condoms in the country which was more severe this year compared to last year. Fewer female condoms than male condoms were distributed not only because supplies in the country were few, but because of the limited community awareness and acceptance among beneficiaries.

**Figure 10: Trends in condom distribution between July 2012 and June 2013**



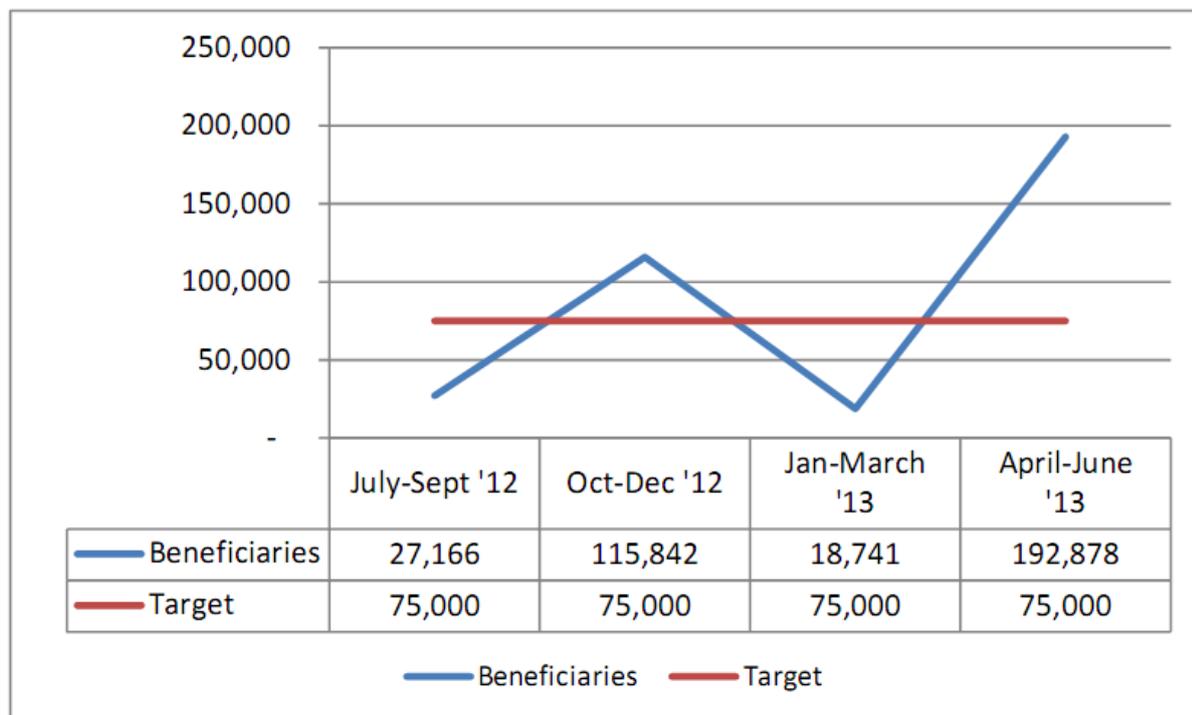
### Increased access and utilization of HCT services

During the year, 315,921 individuals (52.6% female) received HCT and were given results. Thus, the CSF annual target was exceeded by 5.3% and this number constituted approximately 9% of the national annual target for 2013. However, the number of people who were counseled, tested and received results in the FY 2012/2013 was 34.1% lower than the number that received similar services in the previous year. The decline in HCT performance between the two periods was largely attributed to delays in the remittance of funds to sub-grantees, which in turn constrained community mobilization. Another factor cited was the intermittent supply of HIV test kits. Of the total number that was counseled, tested and received results, 10,275 individuals (47% female) tested HIV positive and were referred for care and treatment services. A total of 24,208 individuals tested as couples and this constituted approximately 7.6% of the individuals that tested. The number of couple testers was low because some couples were wary of family conflicts that could erupt with different test results; low health seeking behavior among men; and the fact that some individuals believed that their partner’s results were testimony of their own sero-status. HCT services were delivered in 475 sub-counties located in 87 districts both in community outreaches and facility based levels.

HCT services were provided in combination with other services such as health education on SRH including FP, condom distribution, PMTCT education, distribution of IEC materials.

Post-test club activities included risk reduction counseling for HIV-negative individuals, referral of men for SMC, referral of HIV-negative women for antenatal care (ANC) and mobilizing communities to go for HCT.

**Figure 11: Trends of individuals counseled, tested and given results (July 2012-June 2013)**



The graph above shows low performance in the July-September 2012 quarter because the 23 HIV3 sub-grantees had just received their funding and were embarking primarily on project start up activities. In the same period, the 8 NNGOs had just ended their previous funding cycle and their contracts were being extended. There was noticeable improvement in performance in the October-December 2012 and April-June 2013 quarters. The improvement was attributed to the fact that all sub-grantees had received funds and activities were being implementing as planned. However, the noted underperformance in the January-March 2013 quarter was due to the fact that fund disbursement for activity implementation had stalled as the management agents prepared for the anticipated close out of the FMA at the end of March 2013.

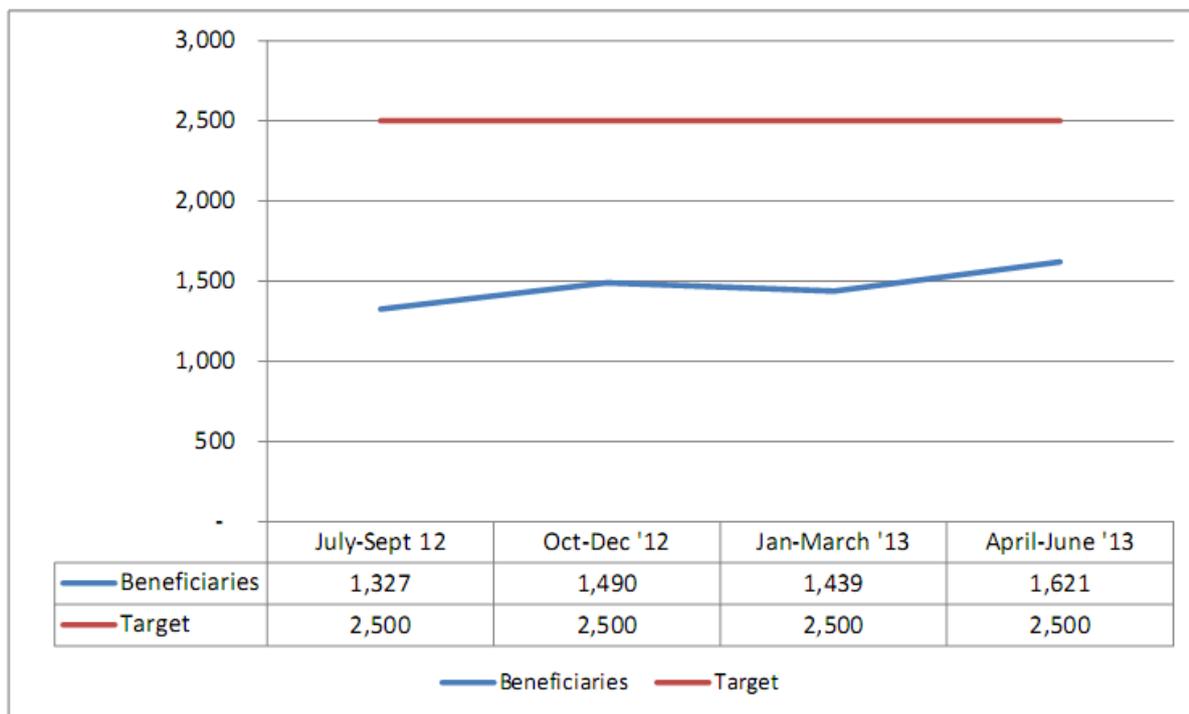
### Safe Male Circumcision

During the year, 5,877 males were circumcised at eight sites. This represents a 51.3% increase over the number circumcised in the previous year. Nevertheless the number circumcised in FY 2012/2013 was approximately 59% of the CSF annual target and 0.6% of the national annual target for 2013. As a pre-requisite, all male beneficiaries received pre-surgery counseling, were screened for STIs and tested for HIV. In addition, post circumcision counseling was provided, and the health workers monitored all beneficiaries for any adverse events through telephone calls. No severe adverse events were reported.

The AIDS Information Centre (AIC) was the sole sub-grantee that provided the full package of SMC that includes; mobilization, HCT, pre-operative exam, operation, post-operation care, and follow up. USAID provided SMC kits using funds outside the CSF basket. The graph

**Figure 12: Trends in SMC at CSF-supported sites (July 2012-June 2013)**

below shows low SMC performance in all quarters partly because of delayed funding disbursement as well as having only one service provider the entire year.



### Integration of Sexual and Reproductive Health into HIV and AIDS Prevention

All 23 HIV3 and 8 NNGOs were involved in the provision of health education on SRH to sub-grantees including messages on FP. Health education was delivered to male and female beneficiaries in separate small groups; and the issues covered included sex and sexuality in relation to HIV transmission, signs and symptoms of common STIs, cervical cancer, education on consistent and correct condom use and distribution of female and male condoms. AIC, AMICAALL, RAIN, BACHI, STF, and PACE were the sub-grantees whose health workers provided varied FP products to female beneficiaries. Thus, 357 women received Jadelle® implants, 137 received Implanon® implants, 1,496 received Depo-Provera, 238 received intrauterine devices while 15 individuals received emergency contraceptives. This is an area that CSF will continue to foster and track to ensure that all sub-grantees include it in the HIV and AIDS package.



**Figure 12: A woman in Mayuge district receiving an injectable form of FP by choice**

## **Community based elimination of Mother-to-Child transmission of HIV services**

During the year, 30 sub-grantees conducted a variety of community EMTCT activities essentially targeting women of reproductive age to support facility based EMTCT services at health facilities. Health education on EMTCT was delivered to 453,029 individuals. A total of 16,579 pregnant women were referred to health facilities for ANC services. This constituted 33% of the CSF annual target and 7,009 pregnant women were referred to health facilities for safe delivery. A total of 1,207 mothers were referred to health facilities for post-natal services. To enhance male involvement, sub-grantees mobilized 4,610 men to accompany their spouses to ANC facilities where they received HCT services and were given test results. A total of 5,551 pregnant women were referred for FP services. All HIV+ mothers were given health education on option B+ and were referred to accredited sites for highly active antiretroviral therapy (HAART) and their babies followed up for early infant diagnosis at 6 weeks of age. The total number of mothers and their babies who were followed up was 2,046. Working in conjunction with health centres in 19 focus districts, the Joint Clinical Research Centre (JCRC) facilities successfully developed the capabilities of Mama Clubs<sup>3</sup> to mobilize pregnant women, provide them with PMTCT messages, refer them to EMTCT accredited health centres and provide peer support.

## **B. Promoted access and utilization of HIV care services**

This year, a total of 63,211 PLHIV were reached with clinical and non-clinical care, support and treatment services. This represents an achievement of 115% of the target for the year and is significantly higher than the achievement (75%) of the previous year. This is probably because during this year sub-grantees employed effective strategies to recruit PLHIV into care programs. An example of these effective strategies is the establishment of formal referral partnerships between the public hospitals and the private health facilities like medical and dental clinics, maternity centers, pharmacies and drug shops. Among all of the people in care, the individuals who were newly enrolled into HIV Care constituted 37% (23,415). Of these, 40,855 (64.6%) were women while 4,176 (9%) were children. This is in line with the observed trends at national level. The services were provided to the target communities through four national NGOs namely, JCRC, The AIDS Support Organization (TASO), Infectious Diseases Institute (IDI) and AIC that worked in 31 districts in Uganda. The achievements in key care indicators are described below.

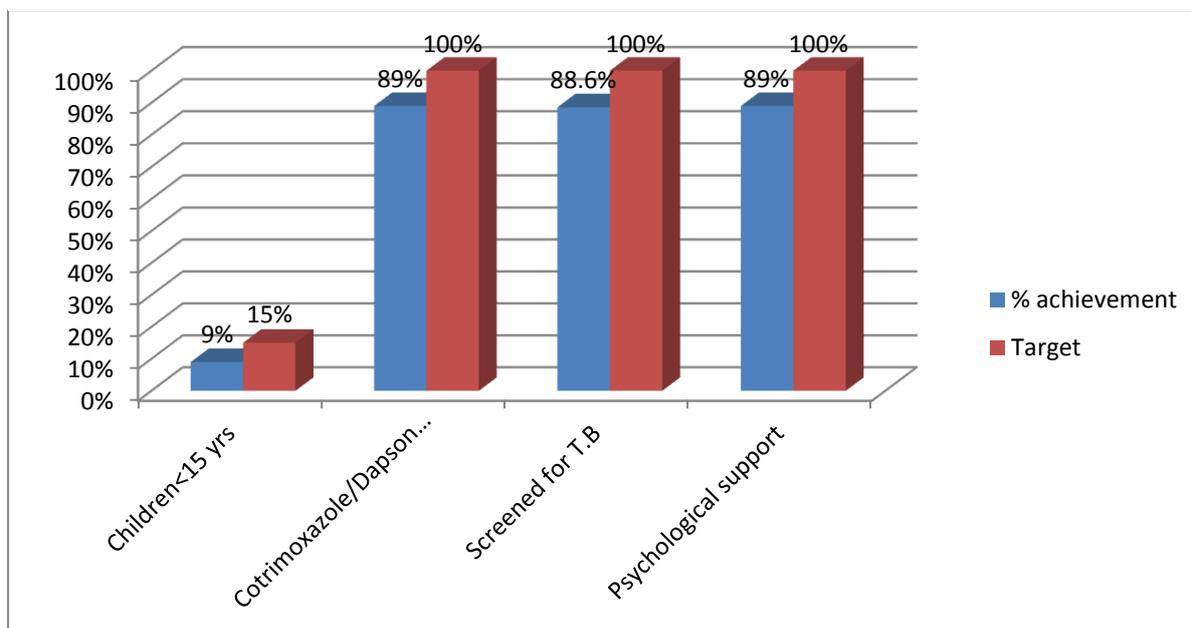
### **Access and utilization of clinical care services**

Among the PLHIV who received care, 56,117 (89%) were provided with Cotrimoxazole (Septrin) for the prevention and management of opportunistic infections (OIs) through the CSF grant. In addition, 56,045 (88.6%) PLHIV in care were assessed for Tuberculosis (TB). All these are in line with the national picture where approximately 80% of all people in care receive Cotrimoxazole and are screened for TB. All PLHIV found to be positive for TB (1,180) were initiated on TB treatment and followed up as per the Ministry of Health guidelines.

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<sup>3</sup> Mama clubs are exclusively women support groups that not only provide HIV and AIDS and reproductive health education to pregnant women but also mobilize them to access services in HCT, antenatal care, nutrition education, and PMTCT.

**Figure 13: Key performance indicators for access and utilization of clinical care services**



During this year, two CSF sub-grantees supported laboratory diagnosis and monitoring improvement at nine regional referral hospitals and lower level health facilities where a total of 16,300 patients were provided with complete blood count tests, 2,989 patients with Chemistry tests, and 23,283 patients with Cluster of Differentiation 4 (CD4) count tests. In order to ensure the provision of comprehensive care services by the CSF sub-grantees, all the clients who were eligible for ART and those who were in need of other complementary services were appropriately referred to other projects, both within and beyond the CSO network. In all the care sites, joint planning meetings were held between the CSF sub-grantees, the regional referral hospital management and other existing care implementing partners to avoid duplication of care services.

Through one of its sub-grantees, CSF also implemented a number of clinical care strategies to achieve its objective of increasing the retention of patients in care programs at nine regional referral hospitals from 56% to 75% at 6, 12 and 18 months. The strategies included: i) Rigorous screening of all ART eligible patients for Cryptococcal Meningitis (CM) by use of a newly invented cost-effective and simple ‘rapid diagnostic dipstick test’. As a result a total of 1,440 PLHIV were tested and treated for CM throughout the year thus averting deaths associated with this life threatening infection; ii) Supporting the acceleration of the initiation of ART among TB co-infected and severely immuno-suppressed (<100 CD4 cells/ul) PLHIVs; and iii) Screening all PLHIVs for Inflammatory Reaction Immune Syndrome (IRIS) events in the first 6 months after starting treatment as a way to contribute to the reduction of ART associated morbidity and mortality. In an effort to further improve the retention of patients in care programs, CSF through one of the sub-grantees, supported the implementation of “decision support meetings” held by the health workers based at the regional referral hospitals. These meetings are premised on case discussions and help health workers to make collective and appropriate decisions to initiate or switch to ART medication especially in complex cases. They also foster learning and experience in OI management and HIV

treatment, thus reducing morbidity and mortality. As a result of all these strategies, the retention rate at 9 months among PLHIV in ART cohorts since July 2012 has improved to a range of 64% - 92% across different regions. This is a great leap towards the national target of 90% retention at 12 months.

Approximately 17,473 PLHIV in care were referred and accessed specialist services that included terminal or palliative care; cancer treatment; surgical services; psychosocial and mental health services as well as specialized physical pain management. This achievement is attributed to the robust referral and tracking practices where sub-grantees leveraged resources and monitored clients via mobile telephone to ensure they reach the places where they were referred.

#### **Access and utilization of non-clinical care to PLHIV**

CSF has tremendously increased access to psychosocial support as a way of addressing the unique psychosocial challenges of PLHIV. This year, a total of 42,370 (89% of clients supported) PLHIV and their families were provided with psychological support in the form of counseling. The focus was on promoting positive living, disclosure, positive health, dignity and prevention (PHDP) interventions, adherence to medication regimens, as well as addressing unique psychosocial challenges. This achievement is higher than the previous year (which was 20% of clients supported).

During this year, CSF also employed non-clinical care strategies to increase the retention rate for PLHIV on ART. For instance, community members or family members of PLHIVs were trained in simple methods of identifying and referring PLHIVs with symptoms and signs of major OIs and suspected IRIS events. Sub-grantees also used peer-support programmes, and made phone calls to remind patients about their drug refill appointments; and they regularly updated client contact information to ensure efficiency. Expert clients were also used to follow up individuals on ART.

Social support services were provided to 1,508 PLHIV in the form of insecticide treated nets, safe water vessels, spiritual support, social support and therapeutic nutrition support.

### **C. Strengthened systems and policies to support HIV and AIDS services**

#### **Engaged in the dissemination of the NSP, NPS and other policies**

The CSF team oriented all 23 HIV3 sub-grantees in combination prevention as part of their start up package. In addition, soft copies of the National Strategic Plan 2011-15, the National HIV Prevention Strategy 2011-15, the Uganda HCT Policy 2011, the Uganda Gender Policy 2007 and the Safe Male Circumcision Policy 2010 were disseminated to the 8 NNGOs and 23 HIV3 NGOs.

#### **Collaborated with strategic partners including line ministries, the private sector, local governments and other stakeholders**

CSF convened a meeting for all the 23 HIV3 NGOs, the district Chief Administrative Officers, the District Health Officers and the District HIV Focal Point Persons to allocate areas of operation in districts according to needs. A similar meeting was convened for the 8 supported NNGOs to improve harmonized operations at sub-county level. These meetings have not only enabled the sub-grantees to avoid implementation overlaps but also to work

out possible collaborations and to provide services to under-served populations such as fishing communities in Kalangala district and in Hoima near Lake Albert in the western Rift Valley.

Public-private partnerships have been found to be beneficial, as in the case of the JCRC which has partnered with local governments and the MoH. In this model, SCIPHA has signed memorandums of understanding (MOUs) with the District Health Officers in 19 districts to enable the project to engage 38 health centers to deliver biomedical services and 21 CSOs to mobilize communities through village health teams and to provide health education to beneficiaries in an integrated manner. HIV and AIDS services delivered include STI and TB screening, HCT, health education, condom education and distribution, and dry blood spots for EID. In addition JCRC has generated 38 service providers' directories to help the 19 districts of Kabarole, Hoima, Masindi, Kasese, Bundibugyo, Tororo, Soroti, Katakwi, Kiboga, Mpigi, Mityana, Kalangala, Agago, Amolatar, Lira, Arua, Nebbi, Koboko and Moyo. It has also placed a data entry clerk at each of these districts to enter project data into the District Health Management Systems (DHMIS).

### **Working with a selected network to improve the functionality of district and lower level networks**

CSF provided financial and technical assistance to a consortium of three partners namely; UNASO, NAFOPHANU and UGANET. The consortium's prime role was to build the capacity of district networks in policy advocacy, coordination and networking to respond to the effects of HIV and AIDS. There were 25 targeted districts namely; Nebbi, Arua, Gulu, Kitgum, Moroto, Nakapiripirit, Jinja, Mbale, Kapchorwa, Busia, Mayuge, Soroti, Kaberamaido, Kabarole, Masindi, Hoima, Mbarara, Kabale, Ntungamo, Bushenyi, Rakai, Masaka, Wakiso, Mityana, and Mpigi. The target groups were district and lower level networks and their members are CSOs, local government leaders, the media, and community.

To establish the level to which district networks had implemented action plans arising from organizational capacity assessments conducted in the previous funding cycle, UNASO conducted an organizational capacity assessment review. The exercise involved 19 districts namely; Kabarole, Mityana, Jinja, Mayuge, Busia, Kabale, Ntungamo, Bushenyi, Mbarara, Mbale, Kapchorwa, Soroti, Kaberamido, Masindi, Hoima, Gulu, Kitgum, Nebbi and Arua. The assessment revealed that district networks had not addressed key gaps in programming, governance, finance management as well as monitoring and evaluation. The consortium mentored 19 district networks to develop policy documents including human resource and financial manuals.

As a result of the consortium capacity building activities, 25 districts established office locations with basic furniture and office equipment. UNASO conducted regional M&E trainings for 25 districts in the 4 regions of Western, Eastern, Central and Northern Uganda. In effect, all the network coordinators and members of the executive committees have been equipped with data collection, analysis and reporting skills.

UNASO also convened a coordination meeting for NNGOs on June 13 2013. At this meeting the current coordination status among HIV and AIDS CSOs was discussed, information on the current funding status was shared and key recommendations on improved coordination made. The meeting involved 50 stakeholders from the ADPs, the CSOs and the media. UNASO conducted a follow on e-forum on coordination involving NGOs. As a further activity to improve coordination, UNASO printed 200 copies of the NNGO membership directory that were disseminated to sub-grantees, the district networks, the ADPs and the district local governments. To strengthen district networks capabilities in results based reporting, UNASO trained coordinators from 20 districts and 18 NNGOs on Results Based Management. However, interventions are yet to be undertaken to measure the trainees' performance improvement in this area. Finally UNASO and its consortium partners conducted quarterly supervision visits focusing on both program and financial performance among the district networks to provide technical guidance.

The Nebbi district network identified legal and policy issues that the district needed to address. They included inappropriate disposal of condoms, uncensored video shows to children and adults, stigma and discrimination by health personnel towards PLHIV, limited access to HIV and AIDS services in the district due to unequal distribution of health services within the district and limited access to socio-economic services by PLHIVs. All these issues were brought to the attention of the District AIDS Committee and to the sub-county finance and planning committee. As a result the distribution of ART services at Health Centre III level has improved, by-laws for censoring videos have been made and health workers have been trained in the management of Option B+. In Wakiso, Kaberamaido and Nebbi the district networks successfully lobbied for the availability of CD4 machines

## **D. Lessons learned and challenges**

### ***Lessons learned***

- Provision of non-monetary rewards such as certificates to couples in sex relationships increased the number of couples accessing HCT services.
- Pediatric HIV enrollment and retention can be increased through proactive steps like increasing number of trained child counselors and pediatric HIV clinical care staff; and ensuring child-friendly HIV care, treatment and support settings.
- The use of simple viral load testing technologies (viral load dry bloats) is feasible and can improve the quality of care given to PLHIV as those who experience failure with ART are quickly detected and their ART regimen is switched to 2<sup>nd</sup> line or salvage therapies.
- Establishing public-private referral partnerships with the local private health service providers like drug shops, medical clinics, pharmacies and maternity centers can be an effective means of increasing the number of PLHIV who enroll and access care, support and treatment services. The likelihood of keeping people on ART and in care programs can be enhanced by making reminder phone calls for drug refill appointments, and using expert clients and peer support groups to follow up individuals on ART.

- Working with and through *Mama Clubs* provides an opportunity for pregnant women to get vital information on safe motherhood, in addition to being a good mobilization platform for motivation to access PMTCT services. Supporting the development and strengthening of self-sustaining community groups like these can boost the sustainability of HIV and AIDS prevention interventions in the target communities even in instances when donor funding is interrupted.

### **Challenges**

- District local governments lacked up-to-date and translated IEC/BCC materials on HIV and AIDS. Sub-grantees will continue monitoring available supplies from the MoH through the District Health Educators' offices. Additionally, CSF intends to work in partnership with MoH and UAC to identify appropriately translated materials and messages. Sub-grantees will then be allowed to reproduce such materials for their programs.
- The current demand for SMC exceeds available services and supplies including consumables like lignocaine, sutures and disposable SMC kits especially for community-based SMC services. CSF will support its sub-grantees to source for necessary supplies and work closely with accredited providers and partners to ensure that the most underserved areas receive outreach services.
- Stock outs of HIV test kits and condoms in the country constrained the implementation of HIV prevention activities. On the advice of the MoH, CSF linked sub-grantees to UHMG to enable sub-grantees to access condoms through a second window.
- Delays in disbursement of funds impacted the pace of implementation during the July-September 2012 and October-December 2012 quarters. The delays were attributed in part to delays by sub-grantees in fulfilling the requirement to account for the funds they had received before, and longer than expected contract negotiations. Sub-grantees will have to re-plan and speed up activities to catch up with the work-plan timeframes.
- The outbreak of the Marburg hemorrhagic fever in Kabale region during October-December 2012 quarter delayed the start of activities in this region due to fear of possible infection among beneficiaries and sub-grantee implementers.

### **E. Priorities for Year Seven**

- CSF will increase the provision of behavioral change messages to 950,000 individuals from 500,000 in year six. CSF also plans to provide HCT to 550,000 individuals.
- Condom distribution will be increased to 15,000,000 condoms, which will be 500,000 more than year six. CSF will provide SMC to 10,000 men.
- CSF will ensure that SRH is integrated into all HIV and AIDS activities.
- CSF plans to mobilize 15,000 pregnant women for EMTCT services, and to follow up with 3,350 mothers and their babies.

# APPENDICES

## Appendix 1: Selected success stories

### Certificates boost couple counseling and testing



*A couple receives their HCT certificate of recognition from a counselor at AIC Arua Branch.*



*A man signs the certificate as his wife looks on.*

Couple HIV counseling and testing (CHCT) has been recognized as a cost effective HIV prevention intervention which reduces HIV risk behavior among couples, facilitates partner disclosure, and improves couple communication and male partner participation. Despite its known benefits and promotion, CHCT rates are low in Uganda at about 5%, and national surveys have revealed a high incidence of HIV among married couples (6.3%). The Uganda HIV Prevention Response and Modes of Transmission Analysis of 2009 indicated that 43% of new infections in the country occurred among people in mutually monogamous heterosexual relationships. To mitigate this situation, the AIDS Information Center (AIC) started awarding certificates of recognition to couples who seek HIV counseling and testing (HCT) together.

With support from the Civil Society Fund (CSF), AIC delivers HIV prevention, care, support and treatment services in 14 districts in Uganda. CSF is a basket fund contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency and the Swedish International Development Cooperation Agency.

The experience of the Dufile community in Moyo District, West Nile region, illustrates the success of the certificate for couples counseling program. In January 2012, AIC conducted a three-day outreach in Dufile. On the first day, very few couples sought out the HCT services provided by AIC. But when one couple showed up and was publicly recognized with a certificate of recognition, people went back home to get their spouses. By the third day, 22% of those tested benefited from the service as a couple. Prior to issuing HIV test results, AIC counselors helped couples make commitments to each other, to continually communicate regarding HIV/AIDS and to adopt healthy lifestyles.

“My husband was very indifferent about HIV/AIDS issues, but this became history the day we received a certificate. It acted as a spark for us to discuss his movements. Whenever I point at our risk reduction plan we jointly signed, he reaffirms his commitment to it,” a member of the AIC couple club says.

From January to March 2012, 20.5% of those who sought HCT from AIC in the West Nile region came as couples up from 18.7% in the same period in 2011.

CSF sub-grantees as a whole have witnessed an increase in the proportion of people who opt for HCT services as couples. Of the people tested by CSF sub-grantees in 2010, 6.1% were couples. In 2011, the proportion increased to 14.9%.

## Peer education increases adherence to HIV treatment



*Florence testifying at one of the community awareness events on ART in Kiboga Town Council.*

Peer educators working with people living with HIV (PLHIV), who are also known as expert clients, have proven to be instrumental in promoting the adherence to HIV treatment for PLHIV. The expert clients, who are also HIV positive, help to reduce the stigma and improve HIV/AIDS awareness by sharing their personal stories and being open about their HIV status.

Florence Namuli, one of the 23 expert clients working with the *Strengthening Civil Society for improved HIV/AIDS and OVC service delivery in Uganda* (SCIPHA) project in Kiboga district travels around the district to different villages to share her story, encourage PLHIV to live positively and adhere to treatment.

The SCIPHA project, implemented by the Joint Clinical Research Center (JCRC) in partnership with Uganda Health Marketing Group (UHMG) is supported by the Civil Society Fund (CSF) in providing HIV Counseling and Testing (HCT) services in 19 districts of Uganda. CSF is a basket fund contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency and Swedish International Development Cooperation Agency.

Patient records at the HIV/AIDS clinic at Kiboga Hospital, supported by JCRC, indicated that between January 2010 and December 2011, 891 PLHIV had stopped going for treatment. To address this problem, JCRC trained and facilitated expert clients to support other PLHIV in the community. The expert clients, through home visits, reached out to PLHIV experiencing challenges with adherence, educated them on the importance of adhering to treatment and provided useful information on coping strategies in dealing with challenges they encounter.

“I thank SCIPHA for giving us the opportunity to encourage other people by sharing our life experiences,” says Florence an expert client trained by JCRC. Two years after she disclosed her status to her husband, he went for an HIV test.. They are now living positively with HIV and have a three-year old daughter who is HIV-negative.

Since the establishment of CSF in 2007, its sub-grantees have provided HIV care and treatment services to 66,946 clients (44,339 female, 22,607 male) countrywide, accounting for 8% of the national response to HIV/AIDS.

## Partnerships improve HIV/AIDS services in Kaberamaido



*A member of Kaberamaido Network Service Organizations addresses a meeting of representatives of ASOs.*

Rural communities in Kaberamaido District have gained better access to HIV/AIDS care and treatment services thanks to a partnership between the district local government and AIDS service organizations (ASOs) brought together by the Uganda Network of AIDS Service Organizations (UNASO). ASOs have jointly extended services to rural areas of the district hence increasing the number of people receiving HIV care and treatment from 4,400 to 10,295 between July 2011 and June 2012.

UNASO is supported by the Civil Society Fund (CSF) to strengthen the capacity of 25 district networks in policy advocacy, coordination and networking to respond to the challenges of HIV/AIDS. CSF is a basket fund for civil society organizations contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency and Swedish International Development Cooperation Agency.

Until July 2011, only Alwal Hospital and Kaberamaido HCIV provided HIV/AIDS care and treatment services in the district, thus excluding the majority of communities. On average, people living with HIV used travel 25 km to the two health facilities to receive treatment. To address this challenge, UNASO convened a meeting of district political and religious leaders and ASOs operating in the district to call for a collective effort to address the service gap.

In response to this initiative, the partners who attended the meeting agreed to work together to improve HIV care and treatment services. Child Fund International (CFI), in partnership with Baylor Uganda, started conducting weekly antiretroviral therapy (ART) outreach clinics at five health centers located in rural areas of the District. CFI offered to construct a laboratory at Alwa Health Centre while Baylor sponsored the training of two nurses and six laboratory technicians to support the establishment of ART clinics in seven health centers. The Programme for Accessible Health and Communication (PACE), a CSF sub-grantee, offered to fund advocacy and community mobilization activities in Kaberamaido District.

Between January 2011 and June 2012, UNASO organized public platforms on issues such as human rights in the context of HIV; the level of reporting on human rights violations; and the status of HIV/AIDS service delivery. Information sharing platforms were also held on issues of social accountability, drug stock-outs, poor adherence to HIV/AIDS treatment, and limited funding. The sessions brought partners together to work on an improved HIV/AIDS service delivery strategy.

Since its inception in 2007, CSF has extended grants to 123 civil society organizations, seven technical service organizations and 79 district local governments to improve service delivery for HIV/AIDS and orphans and other vulnerable children.

## Appendix 2: CSF Performance Management Plan Indicator Tracker (July 2012-June 2013)

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>4</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
<b>CSF GOAL: To ensure that civil society provision of OVC and HIV/AIDS prevention, care, treatment and support services are harmonized, streamlined and effectively contribute to the attainment of GoU NSP, NSPPI and other relevant national plans and policies</b>																		
1.	Percentage of service delivery targets met by CSF	Service delivery targets include annual targets for the various services funded by the CSF: OVC, HIV prevention, HCT, PMTCT, palliative care. <b>Numerator:</b> number of people who received at least one CSF service and <b>Denominator:</b> CSF target group (youth, couples, MARPS) <b>Unit of measure: % people reached</b>	Service, Sex	CSF database, CSF quarterly and annual reports	MEA	2008	OVC=0% BCC =0% HCT=0% HIV Care =0% SMC=0%	N/A	90% 71% N/A N/A	95% 80% 85% 90%	97% 82% 76% 79%	95% 85% 90% 95%	121% 87.1% 32% 157%	95% 85% 90% 95%	106.39% 204.91% 159.73% 133.9%	N/A 85% 90% 95%	N/A 192.6% 105.3% 114.92%	Overall FY13 service delivery targets were achieved. The good achievement above the target for BCC and HCT is attributable to the good community mobilization by sub-grantees. The increase in HIV care is due to increased enrollment of new PLHIV onto care through good strategies like private/public partnerships
2.	HIV Prevalence	Proportion of people with HIV at a given point in time per base population <b>Numerator:</b>	Sex	UDHS and Sero-behavioral survey 2011 HIV/AIDS Epidemiolo	MEA	2004	6.2%	n/a	6.4%	n/a	6.4%	n/a	6.3%	n/a	6.7%	n/a	7.3%	HIV prevalence is highest among women at 7.7% compared to 5.6% among the men

<sup>4</sup> Baseline years vary from 2004 to 2010 depending on source of information, time of contracting of the responsible agent, and when the indicator was agreed upon

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		Number of people testing positive nationally in a year <b>Denominator:</b> Total number of people tested annually <b>Unit of measure:</b> % of people testing positive		gical Surveillance Report 2010 AIDS indicator survey 5 yearly reports,														
<b>KRA 1: CSF MANAGEMENT STRENGTHENED</b>																		
3.	Dollar amount of funds raised and managed through the CSF annually	These include funds commitments to sub grantees only <b>Unit of Measure:</b> USD	n/a	FMA financial records	FMA	2008	11m	11m	18m	22m	22.09m	23m	20.06m	25m	20.1m	31m	8.1m	
<b>Sub Result 1.1: CSF governance systems and structures strengthened to deliver service delivery targets by the end of June 2013</b>																		
4.	Number of Steering Committee (SC) meetings held to review CSF performance and make decisions	The Steering Committee (SC) of the CSF is a twelve member committee (donors, sub-grantee representatives ) that oversees the performance of the Civil Society Fund. The committee meets regularly (quarterly) to plan, review and make program decisions. <b>Unit of measure:</b> # of	n/a	SC/CSF Board minutes	TMA	2009	12	12	12	4	12	4	07	4	15	4	8	There were 4 ordinary meetings and 4 extra ordinary meetings

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		meetings																
5.	Number of joint outputs/activities successfully accomplished	The indicator tracks joint outputs/activities that the three management agents produce or work on jointly including: quarterly/annual reports, work plans, capacity building plans, strategic plan, support supervision, proposal reviews, and pre award/post award workshops <b>Unit of measure: # of Joint Outputs</b>	n/a	CSF program activity reports	MEA	2009	9	6	9	10	09	10	13	10	16	10	8	These included the annual review and work planning, 3 quarterly review and planning meetings, CSF@5 event, joint support supervision and RFA 12 solicitation process related events
<b>Sub Result 1.2: At least \$31 million of multi-donor resources managed annually while ensuring efficiency, transparency, timeliness, and value for money by June 2013</b>																		
6.	Average lead time for contracting	Lead rate here refers to the average time (months) taken to process a solicitation, that is, from the release of an RFA to actual contracting of the selected sub grantees. <b>Unit of measure: average time in months</b>	Nature (Competitive or Cost Extension)	FMA records	FMA	2008	6	6	7	4		4	6	4	6	4	11	RFA 12 solicitation has taken much longer than expected because of challenges related to FMA contract extension delays and expected transitioning to new management structure

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
7.	Average number of days taken to process grantee quarterly disbursements	Processing here refers to receipt and review of sub-grantee accountabilities, addressing any issues arising, approval of accountabilities and preparation of wire transfer funds.. Quarterly disbursements refer to the funds due to each organization quarter by quarter. <b>Unit of measure:</b> Average number of days	n/a	FMA records	FMA	2008	0	20	Not tracked	20	35	20	19	14	16.7	14	24	This average was increased by the disruption in the FMA contract that caused a halting and advancing of funds in Q2
<b>Sub Result 1.3: CSF's contribution to the national response to HIV/AIDS and OVC measured and disseminated by June 2013</b>																		
8.	Existence of a functional CSF M&E system	Functional M&E system here refers to existence and utilization of qualified staff, standardized data collection and reporting tools; and a database. It also consists of data analysis procedures and timelines, data flow plan as well as a DQA plan	n/a	CSF quarterly reports	MEA	2008	0	Tools designed & rolled out	Tools rolled out Data base designed	Data analysis & DQA planned	DQA conducted. Analyzed Data	Data analysis & reporting	01	01	01	01	01	M&E system is now fully functional with standard indicators, data collection and reporting tools and a functional web based management information system

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		Unit of measure: n/a																
9.	% of sub-grantees utilizing CSF standardized primary data collection and reporting tools	This indicator measures the proportion of sub-grantees that have adopted and are using the CSF standardized primary data collection tools that include the OVC register, OVC service tracking tool, OVC service providers training register, HIV prevention people reached register, people trained register, and any other tools that may be developed overtime. <b>Numerator:</b> Identified number of sub-grantees using these tools at any given time. <b>Denominator:</b> Total number of sub-grantees funded by CSF at that given time.	n/a	JSS reports	MEA	2009	0	100%	100%	100%	92.6%	100%	92%	100%	68%	100%	81%	This is a 14% improvement from last year. This was due to the issuance of new guidelines at the start of the projects for the 23 HIV 3 sub-grantees
10.	% of sub-grantees submitting quality data on	Quality of data is determined during the data quality	n/a	JSS reports	MEA	2009	33%	50%	55%	75%	59.1%	100%	45.8%	100%	66%	100%	60%	This drop was due to a new set of sub-grantees who were still

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments	
	a timely basis	assessments and Joint Support supervision (JSS) visits by CSF to the sub-grantees. <b>Numerator:</b> Identified number of sub-grantees that submitted quality data to CSF. The data set considered could be quarterly, semi-annual, or annual data. <b>Denominator:</b> Total number of CSOs where CSF has conducted DQA assessments or JSS during the exercise.																	new to the CSF reporting systems and late disbursement of funds especially in quarters 2 and 3
<b>Sub Result 1.4: CSF-generated data utilized in order to improve HIV/AIDS and OVC programming at all levels by June 2013</b>																			
11.	Percentage of sub grantees making program implementation decisions based on analyzed data	The indicator measures the number of sub-grantees that make informed management decisions based on analyzed programmatic data. Achievement of this indicator implies that the data is analyzed and used to make decisions. <b>Numerator:</b>	Type of CSO (NNGO, District based NGO /CBO)	CSO program reports	MEA	2009	24.3%	50%	64%	70%	64.18%	80%	54.4%	80%	57.5%	80%	35%	Refer to comment in indicator above 10	

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		CSF sub grantees who made program decisions based on analyzed data, <b>Denominator:</b> all CSF sub grantees <b>Unit of measure:</b> % of sub-grantees																
<b>KRA 2: INSTITUTIONAL/TECHNICAL CAPACITY OF SUB GRANTEES STRENGTHENED</b>																		
12.	Percentage of CSF sub-grantees showing increased capacity to collect, analyze, report and use data	Proportion of sub-grantees demonstrating increased capacity in performing data management functions (collect, analyze, report and use). This is a composite indicator that measures all the capacity components of the result above. The various elements of capacity under each component (collection, reporting, and data use) will be determined in the assessment tool that was developed for the baseline	Program area (HIV prevention BCC, HCT, PMTCT, HIV Care, OVC)	MEA records/ capacity Assessment reports	MEA	2009	23.4%	50%	54%	60%	54%	70%	71.3%	80%	-	80%	57.5%	There has been a drop in this indicator this year. This was mostly due to the fact that CSF contacted a new set of 23 sub-grantees whose M&E systems are still developing

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		M&E capacity assessment. An appropriate sample of indicators will be assessed across all grantees. <b>Numerator:</b> CSF sub-grantees demonstrating increased capacity for these M&E elements; <b>Denominator:</b> All CSF sub-grantees. <b>Unit of measure:</b> % of sub-grantees																
13.	Percentage of CSF funded sub grantees yielding unqualified audit opinion annually	The unqualified audit opinion has no reservations concerning the financial statements. This is also known as a clean opinion meaning that the financial statements appear to be presented fairly in accordance to the generally accepted accounting principles. <b>Numerator:</b> Sub-grantees attaining an unqualified audit opinion; <b>Denominator:</b>	RFA	Audit reports	FMA	2009	70%	n/a	70%	80%	70%	90%	87%	90%	89%	90%	90%	For the audit reports reviewed in the year, sub-grantees have had clean audits highlighting issues to be addressed by management which the FMA has endeavored to follow up.

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		All CSF funded sub-grantees. <b>Unit of Measure:</b> % of sub-grantees																
<b>Sub Result 2.1: Financial management capacity of sub grantees strengthened by June 2013</b>																		
14.	Percentage of sub-grantees using CSF financial reporting tools correctly	This indicator measures proportion of sub grantees that adopt and correctly use the harmonized financial reporting format designed by FMA. <b>Numerator:</b> Sub-grantees using CSF financial reporting tools correctly; <b>Denominator:</b> all CSF sub-grantees. <b>Unit of measure:</b> % of sub-grantees	Program area (HIV prevention BCC, HCT, HIV Care, OVC)	FMA records	FMA	2008	0%	100%	92%	100%	100%	100%	72%	100%	87%	100%	100%	financial reporting tool has been reviewed to limit the level of manipulation and only requires data entry for transactions and all other functions are automatically performed. This has increased the accuracy of use of the tool for the sub-grantees
15.	Percentage of sub-grantees achieving an average monthly burn rate of 70% computed and reported quarterly	The funds burn rate refers to the level of utilization of the released funds by a given sub grantee on planned activities in a given period. <b>Numerator:</b> Funds used in a given quarter (computed into monthly	n/a	FMA records	FMA	2008	80%	100%	90%	100%	100%	100%	92%	100%	81%	100%	82%	Reasons for low burn rates range from delay in receipt of funds which affects the implementation schedule, not aligning activities to community events, and the general culture of lack of vigilance to make timely accountability of funds by the

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		averages); <b>Denominator:</b> Total funds received from FMA for that quarter computed into monthly averages and reported quarterly. <b>Unit of measure:</b> % of sub-grantees																organization.
16.	Percentage of sub-grantees complying with financial regulations.	Sub-grantees fully complying with the financial regulations as stipulated in the CSF financial and account manual <b>Numerator:</b> Number of compliant sub-grantees <b>Denominator:</b> Total number of sub-grantees receiving financial support through the CSF <b>Unit of measure:</b> % of sub-grantees	Program area (HIV prevention BCC, HCT, HIV Care, OVC)	FMA Records/ CSO records	FMA	2008	50%	80%	65%	90%	68%	100%	84%	100%	76.3%	100%	98%	There has been an improvement since the start of the financial year as the sub-grantees have gained more understanding of the use of the tools
<b>Sub Result 2.2: Technical and institutional capacity of sub grantees to deliver quality services strengthened by June 2013</b>																		
17.	Proportion of sub grantees who demonstrate a 15% improvement	The CSF sub grantees under the different CSF capacity building models will be	Program area (HIV prevention BCC, HCT, PMTCT, HIV Care, OVC)	Annual Organizational Capacity Assessment Tool	TMA	2011							The Mean Score on OCAT was 161	80%	-	80%	75%	This is based on the findings of the evaluation of the decentralized capacity building

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
	on the CSF OCAT score annually	assessed annually on the 10 capacity elements which are Aspirations; Strategy; Governance; Leadership and Management; Programme design implementation, monitoring and evaluation; Human Resources; Finance; Infrastructure; External relationships and partnerships and Culture. <b>Numerator:</b> Number of sub grantees who demonstrate a 15% improvement on the CSF OCAT Score <b>Denominator:</b> All CSF Sub grantees <b>Unit of measure:</b> proportion of CSF Sub grantees		report														models that was completed in January 2013
18.	Percentage of sub-grantees that have mainstreamed gender in their programs according to	Gender mainstreaming is the process of assessing the implications for women and men of sub-	Program area (HIV prevention BCC, HCT, PMTCT, HIV Care, OVC)	CSO reports/ CSF reports	TMA	2008	0%			54%	-	100%	100%	100%	100%	100%	51%	Only 51% of sub-grantees met the criteria. This is a decline from last year and is attributed to the fact that the new

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
	CSF criteria	grantee actions and programs. It is aimed at ensuring that both women and men benefit equally and inequality is not perpetuated. <b>Numerator:</b> Number of sub-grantees mainstreaming gender in their programs; <b>Denominator:</b> All CSF sub-grantees. <b>Unit of measure:</b> % of sub-grantees																23 HIV3 sub-grantees have not yet undertaken the CSF gender training. The training will be rolled out to the sub-grantees in year seven as part of the revised decentralized capacity building interventions
<b>RESULT 3: SERVICE DELIVERY IN THE NSP/NSPPI PROGRAM PRIORITY AREAS INCREASED</b>																		
19.	Proportion of individuals utilizing CSF supported services.	This indicator focuses on the proportion of individuals receiving at least one service under CSF's thematic areas which are HIV prevention (BCC), HCT, HIV care and treatment and OVC <b>Numerator:</b> Total number of people who utilize CSF services: HIV prevention (BCC), HCT, HIV care and treatment and	Sex, Age	CSF data base and (UBOS census reports for population estimates)	MEA	2011	50%	-	-	-	-	56.2%	50%	54.5 %	46.8%	-	2.7%	Please refer to indicator specific comments under indicator No. 1

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		OVC <b>Denominator:</b> Target population in CSF's targeted geographical areas. <b>Unit of measure:</b> Proportion of individuals																
20.	Number of individuals utilizing CSF supported services.	This indicator focuses on the number of individuals receiving at least one service under CSF's thematic areas, that is, HIV prevention (BCC), HCT, HIV care and treatment and OVC <b>Numerator:</b> Total number of people who utilize CSF services: HIV prevention (BCC), HCT, HIV care and treatment and OVC <b>Unit of measure:</b> # of individuals	Sex, Age	CSF database	MEA	2009	HIV Prev – 183,767 HCT- 154,257 HIV care – 93,287  OVC – 13,204  SMC - 0	707,678  - 21,207  45,000  N/A	620,678  154,257 93,287  13,204  N/A	775,848  169,682 46,400  55,000  N/A	638,513  129,740 36,672  53,260  N/A	853,433  718,846 30,000  75,000  N/A	743,287  232,288 47,075  90,674  N/A	825,161  300,000 66,946 79,795 50,000 3,060	1,690,872  479,209 66,946 79,795 0 3,360	500,000  300,000 55,000 0 10,000	962,889  315,921 63,211 0 5,877	Please refer to indicator specific comments under indicator No. 1
<b>Sub-Result 3.1 Access to and utilization of HIV/AIDS prevention services increased</b>																		
21.	Percentage of individuals who both correctly identify at least two ways of preventing the sexual transmission of	<b>Numerator:</b> Number of individuals who both correctly identify at least two ways of preventing the sexual	Sex, Age	LQAS AIDS Indicator Survey	MEA	2012	28.9%	-	-	-	-	-	-	38%	28.9%	-	-	LQAS round two is yet to be done

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments	
	HIV and reject major misconceptions about HIV transmission	transmission of HIV and reject all major misconceptions about HIV transmission <b>Denominator:</b> Number of individuals in the survey. The ways of preventing sexual transmission of HIV include: 1) Abstinence, 2) Being faithful and 3) condom use. The major misconceptions about HIV transmission include: 1) Mosquito bite, 2) Touching an infected person, 3) Sharing food with an infected person, 4) sharing utensils with an infected person and 5) sharing toilets with an infected person. <b>Unit of measure:</b> percentage of individuals																	
22.	Percentage of individuals who had sexual intercourse	<b>Numerator:</b> Number of individuals who had sexual	Sex, Age	LQAS AIDS Indicator Survey	MEA	2012	72.18%	-	-	-	-	-	-	77%	72.18%	-	-	Please refer to indicator specific comment under indicator No. 21	

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
	with a non-marital or non-cohabiting sexual partner in last 12 months and used a condom at last higher risk sex	intercourse with a non-marital or non-cohabiting sexual partner in last 12 months and used a condom during high risk sex. <b>Denominator:</b> Number of individuals who had sexual intercourse with a non-marital or non-cohabiting sexual partner in last 12 months. Higher risk sex is defined as sex with non-marital, non-cohabiting partner. <b>Unit of measure:</b> percentage of individuals																
23.	Number of individuals reached with social and behavioral change communication interventions on HIV/AIDS	Total number of individuals reached with BCC messages given in individual or small groups (less than 25) settings: abstinence, be faithful, condom use, HCT, PMTCT, and other prevention messages. People reached	Sex, Age	CSF database	MEA	2009	183,767	707,678	620,678	775,848	638,513	853,433	743,287	825,161	1,690,872	500,000	962,889	Please refer to indicator specific comment under indicator No. 1

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		<b>Unit of measure: # of individuals</b>																
24.	Number of CSF supported condom outlets	This indicator refers to a count of condom distribution points facilitated by CSF CSOs. Service outlets include facility based like health units/clinic and community based <b>Unit of measure: # of service outlets</b>	n/a	CSF database/ CSO reports	MEA	2009	9,068		13,247	15,000	19,062	20,000	22,229	3,500	2,314	3,500	5,159	Please refer to indicator specific comment under indicator No. 1
25.	Number of condoms distributed by CSF sub grantees	This indicator refers to a count of condoms distributed through CSF facilitated distribution points. Please note that CSF does not procure condoms but rather facilitates their distribution. <b>Unit of measure: # of condoms</b>	n/a	CSF database/ CSO reports	MEA	2009	4,588,408	6.5m	6,713,719	8m	11,648,254	10m	8,118,849	14,000,000	10,582,726	14,500,000	5,180,614	The drop in performance of this indicator compared to FY12 is attributable to condom stock outs during the year in the districts of implementation.
26.	Number of individuals who were counseled and received an HIV test in last 12 months and	Individuals who were counseled and tested in last 12 months and know their	Sex, age	CSF data base	MEA	2009	154,257		154,257	210,000	169,682	718,846	232,288	300,000	479,209	300,000	315,921	Please refer to indicator specific comment under indicator No. 1

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
	know their results	results. (and received results) <b>Unit of measure:</b> Number of individuals																
27.	Percentage of individuals who know two or more benefits of HCT	<b>Numerator:</b> Number of individuals who know two or more benefits of HCT <b>Denominator:</b> Number of individuals in the survey The benefits of HCT includes: 1) Plan future, 2) Avoid infection, 3) Protect unborn child, 4) Go for ART, 5) Learn to live positively <b>Unit of measure:</b> Percentage of individuals	Sex, Age	LQAS reports	MEA	2012	66.9%	-	-	-	-	--	-	77%	66.9%	-	-	Please refer to indicator specific comment under indicator No. 21
28.	Percentage of individuals who tested for HIV and received their results and disclosed to partners/spouses in the last 12 months	<b>Numerator:</b> Number of people who receive HIV counseling, Testing and received results and report disclosing to their partners. <b>Denominator:</b> Total numbers of people tested for HCT, know their	Sex, Age	LQAS Reports	MEA	2012	77.2%	-	-	-	-	--	-	85%	77.2%	-	-	Please refer to indicator specific comment under indicator No. 21

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		results, and are participating in the survey. <b>Unit of measure:</b> Percentage of individuals																
<b>Sub Result 3.2: Access and utilization of HIV/AIDS care and support services in targeted communities increased through CSF sub-grantees by June 2013</b>																		
29.	Proportion of PHA receiving a minimum of one clinical service in the last 12 months	<b>Numerator:</b> Number of HIV positive adults and children receiving facility, community or home based assessment of need for interventions, alleviation of HIV-related symptoms and pain, and nutritional rehabilitation for malnourished PHA <b>Denominator:</b> All individuals testing positive in the target population. <b>Unit of measure:</b> Proportion of PHA	Sex, Age	CSF data base and the AIS	MEA	2011	46%	-	-	-	-	29%	46%	49%	66%	100%	90%	Please refer to indicator specific comment under indicator No. 1
30.	Percentage of individuals who know at least two signs or symptoms of TB	<b>Numerator:</b> Number of individuals who know at least two signs or symptoms of TB. <b>Denominator:</b>	Sex, Age	LQAS Reports	MEA	2012	50.03%	-	-	-	-	-	-	65%	50.03%	-	-	Please refer to indicator specific comment under indicator No. 21

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		Number of individuals in the survey. TB signs and Symptoms include: 1) Cough for two weeks or more, 2) Pain in the chest, 3) Coughing blood/Sputum, 4) Weight loss, 5) Loss of appetite, 6) Evening fever, 7) Sweating at night. Note: Cough must be mentioned. <b>Unit of measure:</b> Percentage of individuals																
31.	Number of positive individuals receiving HIV care	Total number of people who are HIV positive that receive facility, community or home based assessment of need for interventions, alleviation of HIV-related symptoms and pain, and nutritional rehabilitation for malnourished PHA <b>Unit of measure:</b> # of HIV positive individuals	Sex, Age	CSF database/ CSO reports	MEA	2009	93,287	21,207	93,287	46,400	36,672	30,000	47,075	50,000	66,946	55,000	63,211	Please refer to indicator specific comment under indicator No. 1

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
<b>Sub Result 3.3: Access and utilization of OVC services increased among OVC and their households as outlined in the NSPPI by June 2013</b>																		
32.	Percentage of OVC receiving a comprehensive package of services	Comprehensive package refers to an OVC receiving at least a service in three or more core programme areas of the NSPPI <b>Numerator:</b> Number of OVC receiving a comprehensive package <b>Denominator:</b> Total number of OVC receiving external support <b>Unit of measure:</b> % of OVC	Sex, Age	CSF database and LQAS reports	MEA	2011	-	-	-	-	-	100%	51%	100%	54.84%	-	-	No OVC specific interventions were executed during the year
33.	Number of OVC receiving at least one service in any core programme area beyond PSS	Number of eligible orphans and vulnerable children aged 17 years and below provided with at least a service in a CPA beyond. <b>Unit of measure:</b> # of OVC	Sex	CSF database/ CSO reports	MEA	2009	13,204	45,000	13,204	55,000	53,260	75,000	90,674	75,000	79,795	0	0	Please refer to indicator specific comment under indicator No. 32
34.	Percentage of OVC 5-17 experiencing cases of child abuse	There is no evidence of abuse or neglect, child does not carry out inappropriate labour/work,	Sex, Age	LQAS	MEA	2012	32.51%	-	-	-	-	-	-	20%	32.51%	0%	0%	Please refer to indicator specific comment under indicator No. 32

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year <sup>a</sup>	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	FY 13 Target	FY 13 Actual	Comments
		child is not being exploited in any other way. <b>Numerator:</b> Number of OVC reporting child abuse. <b>Denominator:</b> Total number of OVC in the survey. <b>Unit of measure:</b> % of OVC																
35.	Percentage of OVC households that are food secure	By Food Secure, we mean the household at all times has both physical and economic access to sufficient food to meet the dietary needs of all OVC in the house hold for a productive and healthy life. <b>Numerator:</b> Number of households with food at all times <b>Denominator:</b> Total number of households surveyed <b>Unit of measure:</b> % of households	Sex, Age	LQAS	MEA	2012	46.4%	-	-	-	-	-	-	55%	46.4%	-	-	Please refer to indicator specific comment under indicator No. 32

### Appendix 3: Summary Quarterly Statistics by Program Area (July 2012-June 2013)

SERVICES PER PROGRAM AREA	Jul - Sep 2012			Oct - Dec 2012			Jan - Mar 2013			Apr - Jun 2013		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<b>HIV PREVENTION</b>												
<b>Behavior Change Communication (BCC)</b>												
# of people given BCC Messages	<b>18,124</b>	<b>17,204</b>	<b>35,328</b>	132,975	113,422	<b>246,397</b>	77,236	73,907	<b>151,231</b>	<b>214,063</b>	<b>199,704</b>	<b>413,767</b>
# of MARPs given BCC messages	4,644	3,504	<b>8,148</b>	21,540	17,367	<b>38,907</b>	6,890	5,998	<b>12,888</b>	35,472	27,568	<b>63,040</b>
MARPs %age			<b>23%</b>			<b>15.7%</b>			<b>8.5%</b>			<b>15.2%</b>
<b>Condom programming</b>												
# of condoms distributed to service outlets	151,989	0	<b>151,989</b>	1,880,600	58,992	<b>1,939,592</b>	984,889	32,558	<b>1,017,447</b>	1,806,688	210,159	<b>2,240,917</b>
Female condom %age			<b>0%</b>			<b>3%</b>			<b>3.1%</b>			<b>9.4%</b>
# of people counseled & tested for HIV and given results (C,T & R)	14,398	12,768	<b>27,166</b>	59,325	56,517	<b>115,842</b>	8,779	9,962	<b>18,741</b>	79,085	71,472	<b>150,557</b>

# of Couples C,T & R	<b>1,294</b>	<b>1,294</b>	2,588	5,948	5,948	<b>11,896</b>	490	490	<b>980</b>	4,162	4,178	<b>8,340</b>
# of people HIV Positive	541	636	<b>1,177</b>	1,772	2,195	<b>3,895</b>	225	291	<b>516</b>	2,027	4,282	<b>6,309</b>
HIV Sero Prevalence			<b>4.3%</b>			<b>3.4%</b>			<b>2.8%</b>			<b>4.2%</b>
<b>Safe Male Circumcision</b>												
# of males medically circumcised	1,327		<b>1,237</b>	1,490		<b>1,490</b>	1,439		<b>1,439</b>		1,621	<b>1,621</b>
<b>Community PMTCT</b>												
# of pregnant and lactating females mobilized from the community for PMTCT		3,248	<b>3,248</b>		358	<b>583</b>		1,050	<b>1,050</b>		4,838	<b>4,838</b>
<b>HIV CARE</b>												
# of PLHA given a minimum one clinical HIV Care service	8,668	16,384	<b>25,052</b>	14,293	26,061	<b>40,354</b>	17,296	30,178	<b>47,474</b>	22,356	40,855	<b>63,211</b>
# of PLHA given Cotrimoxazole prophylaxis	625	884	<b>1,509</b>	7,226	14,929	<b>22,155</b>	15,107	23,351	<b>38,458</b>	19,652	36,465	<b>56,117</b>
%age on Cotrimoxazole			<b>6%</b>			<b>54.9%</b>			<b>81%</b>			<b>88.7%</b>

## Appendix 4: Civil Society Fund Income And Expenditure Statement As At 30th June 2013

	Annual results to 30 June 2013 UGX	Cumulative results to 30 June 2013 UGX
<b><u>Income</u></b>		
Grant income	20,769,639,874	216,099,947,916
Interest Income	1,401,903,282	3,890,936,135
Other income	(1,952,705,302)	24,766,341,438
<b>Total Income</b>	<b>20,218,837,854</b>	<b>244,757,225,489</b>
<b><u>Project Expenditure</u></b>		
National NGOs	3,127,682,335	66,718,940,924
HIV Prevention round 1	1,133,168,225	21,679,655,318
HIV Prevention round 2	2,626,236	9,441,148,621
OVC round 1	97,163,154	13,160,860,392
OVC - Local Governments	12,739,047	1,785,214,160
Paed aids	11,744	2,593,714,694
OVC round 2	106,867,457	5,452,609,482
TSO	0	2,630,585,991
NNGO2	20,756,682,646	43,942,028,044
HIV 3	2,565,538,732	2,565,538,732
	<b>27,802,479,576</b>	<b>167,404,757,626</b>
Other expenditure	981,661,676	26,778,263,798
<b>Total Expenditure</b>	<b>28,784,141,251</b>	<b>194,183,021,424</b>
<b>Surplus of Income over Expenditure</b>	<b>(8,565,303,397)</b>	<b>50,574,204,065</b>

Represented by:

### Project Advances

National NGOs	(3,129,374,467)	(11,252,956)
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HIV Prevention round 1	(1,151,436,178)	14,830,914
HIV Prevention round 2	(15,638,107)	(6,772,965)
OVC round 1	(108,291,014)	(1)
OVC - Local Governments		5
	(12,739,047)	
Paed aids	(11,744)	-
OVC round 2		885,499
	(109,758,981)	
TSO	3	-
NNGO2	142,914,195	9,046,346,427
HIV 3	3,163,828,473	3,163,828,473
	<b>(1,220,506,867)</b>	<b>12,207,865,396</b>
Bank Accounts	(7,344,796,531)	38,366,338,670
	<b>(8,565,303,397)</b>	<b>50,574,204,066</b>

**NOTES**

		<b>Year to 30 June 2013</b>	<b>Cumulative results to 30 June 2013</b>
		<b>UGX</b>	<b>UGX</b>
<b>1</b>	<b>Grant Income</b>		
	DFID	-	55,041,631,733
	DANIDA	3,532,200,000	40,983,774,862
	USAID	-	35,320,751,606
	IRISHAID	13,747,500,000	73,214,195,619
	ITALIAN COOP	-	152,347,500
	SIDA	3,489,939,874	11,387,246,596
		<b>20,769,639,874</b>	<b>216,099,947,916</b>

**2 Interest income**

This is interest earned on funds held on the CSF bank accounts.

**3 Other income**

These are refunds to USAID for fees and disbursements.

**Project Expenditure (period to 30 June 2013)**

**4 National NGOs**

These are funds advanced to the nine NGOs and respective accountabilities received to date.

<b>Name</b>		<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>
1	STF(a)			-
2	TASO			-
3	PSI			-
4	HOSPICE AFRICA			-

5	URCS			-
6	AIC			-
7	UNASO	3,127,682,335	(1,692,132)	(3,129,374,467)
8	NAFOPHANU			-
9	UGANET			-
		<b>3,127,682,335</b>	<b>(1,692,132)</b>	<b>(3,129,374,467)</b>

UNASO clear its outstanding balance from the previous contract which is why it is presented as a negative balance.

#### 5 **HIV Prevention round 1**

These are funds advanced to the 31 successful grantees for the round 1 HIV prevention solicitation and respective accountabilities received to date.

	<b>Name</b>	<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>
1	RACA-CSF	32,450,725		(32,450,725)
2	REACH THE CHILDREN-CSF	49,373,798		(49,373,798)
3	KAMPALA DIOCESE-CSF	164,812,387	(848,565)	(165,660,952)
4	NUDIPU-CSF		(20,992)	(20,992)
5	OCBO-CSF	29,849,201		(29,849,201)
6	UYDEL	52,629,443		(52,629,443)
7	COU-EDUCATION CSF	38,268,696		(38,268,696)
8	TPO-CSF	21,764,227	(2,632,825)	(24,397,052)
9	FPAU-CSF	48,487,693	(939,157)	(49,426,850)
10	FTCU-CSF	55,721,837	(219,610)	(55,941,447)
11	UGANDA YOUTH FORUM-CSF	29,942,702	(1,086,529)	(31,029,231)
12	KIND INITIATIVE-CSF	23,388,059		(23,388,059)
13	Ma-PLAY-CSF	53,774,474		(53,774,474)
14	AGENCY for ACC.Reg.DEV-CSF	43,611,117		(43,611,117)
15	SAVE FOUNDATION-CSF	47,702,651		(47,702,651)
16	SOUTH RWENZORI DIOCESE-CSF	27,405,465		(27,405,465)
17	COU HEALTH DEPT	15,244,145	(1,010,381)	(16,254,526)
18	RUGADA-CSF	28,942,667	(88,600)	(29,031,267)

19	AMMICAAL-CSF	54,114,573		(54,114,573)
20	SPW-CSF	53,154,890	(35,197,649)	(88,352,539)
21	UPIMAC/CSF	164,000		(164,000)
22	ACORD-CSF Project			-
23	DSW Civil Society Fund	10,824		(10,824)
24	UEC-HIV/AIDSfocalpoint/CSF	67,794,664		(67,794,664)
14	THETA-CSF		(2,344,647)	(2,344,647)
15	IMF-CSF	54,034,882		(54,034,882)
16	RICH Consult	13,050		(13,050)
17	Build Africa Ug.-CSF	1,229	34,305,277	34,304,048
18	InterAid-CSF	41,679,638	(665,977)	(42,345,615)
19	Mayanja Mem Hosp.-CSF	44,805,837		(44,805,837)
20	IDI-CSF	54,025,351	(7,518,298)	(61,543,649)
		<b>1,133,168,225</b>	<b>(18,267,953)</b>	<b>(1,151,436,178)</b>

**6 HIV Prevention Round 2**

These were funds advanced to 54 organizations to carry out HIV related activities

<b>Name</b>		<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>
1	Soroti Rural Development Agency	(55,748)		55,748
2	Abola Youth			-
3	Acholi Private Sector Dev't Co Ltd			-
4	ActionAid			-
5	Apyen Nyang Child& Family Prog			-
6	Baitambogwe Community Healthcare			-
7	Can Opwonya Widows			-
8	CARITAS MADD0, Masaka			-
9	CAWODISA			-
10	Community Awareness & Response on AIDS			-
11	COFCAWE			-
12	CEPAP Moyo	490,042		(490,042)
13	Diocese of Kinkizi			-

14	Family Support Group Inc			-
16	GECODA			-
17	Gwokke Ber Two Pe Yero			-
18	Gwokke Keni PHA&OVC			-
19	Huys Link Comm. Ini'tive			-
20	IDAAC-Bugiri			-
21	Integrated Dev't Alliance for Health	28,900		(28,900)
22	Integrated Dev't Options	(14,963)		14,963
23	Kaberaido Operation Save the Needy	8,965		(8,965)
24	Kagumu Devt Org			-
25	Kasilo Community Based Health Care Prog	478,587	(1,825,256)	(2,303,843)
26	Kawempe Division Disabled Community			-
27	Kind to the Women & Orphans Devt Agency			-
28	Kitgum District Forum of PHA Network			-
29	Mbarara Post test Club			-
30	Nagongera Youth Dev't Prog			-
31	Nacwola Arua	(500)		500
32	Nyapea Safe Motherhood	727,890		(727,890)
33	Ochero Women's Effort against HIV/AIDS			-
34	Orungo Youth Integrated Devt Org			-
35	Pamoja Africa Reflect Network	8,000		(8,000)
36	PAG SOROTI MDP			-
37	Rakai AIDS Information Network (RAIN)			-
38	Rural Community Strategy for Development			-
39	SAIL Uganda			-
40	Uganda Rep. Health Bureau			-
41	Youth anti AIDS services			-
42	WEI/BANTWANA-CSF			-
43	YELEKENI CHILD&FAM. PROJ.	(15,249)		15,249
44	RACOB AO-CSF	(103,250)		103,250
45	Masaka District Union-CSF			-
46	Kayunga Dist.N/W	910,042	(11,186,615)	(12,096,657)
47	Ug. Rural Dev't Tr'g prog. CSF			-
48	MAWDA	(26,387)		26,387
49	NIFAED			-
50	Aids Educ.Group-CSF	189,907		(189,907)

51	MAKOCADA-CSF			-
52	ICOBIC-CSF			-
53	Kalamba Com Dev Org			-
54	Meeting Point Hoima			-
55	Surface Uganda			-
		2,626,236	(13,011,871)	(15,638,107)

## 7 Orphans and Vulnerable Children

These were funds advanced to 28 organisations to carry out OVC related activities

Name		Expenditure	Advances	Outstanding balance for the year to 30 June 2013
1	Action for Children	212,025		(212,025)
2	ANPPCAN Uganda Chp			-
3	Ankole Diocese- Ibanda	(3)		3
4	Arua Rural Com'ty Dev't			-
5	Build Afr.Ug-CSF/OVC			-
6	CARITAS NEBBI	2,746,950		(2,746,950)
7	Family Life Educ Prog	99,805		(99,805)
8	Feed the Children- Amuru	28,797,500	(11,127,860)	(39,925,360)
9	Feed the Chn (U) Ltd	3,248,504		(3,248,504)
10	Friends of Christ Rev. Min.			-
11	Friends of Christ -Busia			-
12	Kabale Diocese OVC	13,204,194		(13,204,194)
13	Kibaale dist civil society org	(5,100)		5,100
14	Kitovu Mobile AIDS Org.	19,603,124		(19,603,124)
15	Kiyinda -Mityana Diocese			-
16	Kumi PAG/PDS			-
17	Lango Samaritan Initiative	33,420		(33,420)
18	LWF - Pader	78,500		(78,500)

19	LWF - Sembabule	1,372,111		(1,372,111)
20	LWF - Katakwi	189,975		(189,975)
21	Rakai Counselors' Association (RACA)			-
22	TASO Dev't Unit			-
23	TASO Dev't Unit 2	(91,550)		91,550
24	Uganda Society for Disabled Children -Hoima			-
25	Uganda Society for Disabled Children -Soroti	27,673,100		(27,673,100)
26	UWESO			-
27	Young Women's Christian Association	599		(599)
28	Youth Social Work Association			-
		<b>97,163,154</b>	<b>(11,127,860)</b>	<b>(108,291,014)</b>

**8 Orphans and Vulnerable Children - local governments**

These were funds advanced to local governments to carry out OVC related activities

Name	Expenditure	Advances	Outstanding balance for the year to 30 June 2013
1 Abim District LG			-
2 Adjumani District LG			-
3 Amolatar District LG			-
4 Amuria District LG			-
5 Amuru District LG	11,698,000		(11,698,000)
6 Apac District LG			-
7 Arua Dist. LG	54,200		(54,200)
8 Budaka District LG			-
9 Bududa District LG			-
10 Bugiri District LG			-
11 Bukedea District LG			-
12 Bukwo District LG			-
13 Buliisa District LG			-
14 Bundibugyo Dist LG	850		(850)
15 Bushenyi District LG			-
16 Busia District LG			-

17	Butaleja District LG		-
18	Dokolo Dist. LG		-
19	Gulu District LG		-
20	Hoima District LG		-
21	Ibanda District LG		-
22	Iganga District LG		-
23	Isingiro District LG	3,154	(3,154)
24	Jinja District LG		-
25	Kaabong District LG		-
26	Kabale District LG		-
27	Kabarole District LG		-
28	Kaberamaido District LG	90,200	(90,200)
29	Kalangala District LG		-
30	Kaliro District LG		-
31	Kampala District LG		-
32	Kamuli District LG	(42,136)	42,136
33	Kamwenge District LG	892,814	(892,814)
34	Kanungu District LG	(15,553)	15,553
35	Kapchorwa District LG		-
36	Kasese District LG		-
37	Katakwi District LG		-
38	Kayunga District LG		-
39	Kibaale District LG		-
40	Kiboga District LG		-
41	Kiruhura District LG	204	(204)
42	Kisoro District LG		-
43	Kitgum District LG		-
44	Koboko District LG		-
45	Kotido District LG	40,386	(40,386)
46	Kumi		-
47	Kyenjojo District LG	100	(100)
48	Lira District LG	(41,286)	41,286
49	Luwero District LG		-
50	Lyantonde District LG		-
51	Manafwa District LG		-
52	Maracha/T LG		-

53	Masaka District LG			-
54	Masindi Dist. LG			-
55	Mayuge District LG			-
56	Mbale District LG	500		(500)
57	Mbarara District LG			-
58	Mityana District LG			-
59	Moroto District LG			-
60	Moyo District LG			-
61	Mpigi District LG	60,019		(60,019)
62	Mubende District LG			-
63	Mukono District LG	(2,405)		2,405
64	Nakapiripirit LG			-
65	Nakaseke District LG			-
66	Nakasongola District LG			-
67	Namutamba District LG			-
68	Nebbi District LG			-
69	Ntungamo District LG			-
70	Oyam District LG			-
71	Pader District LG			-
72	Pallisa District LG			-
73	Rakai District LG			-
74	Rukungiri District LG			-
75	Sembabule District LG			-
76	Sironko District LG			-
77	Soroti District LG			-
78	Tororo District LG			-
79	Wakiso District LG			-
80	Yumbe District LG			-
		<b>12,739,047</b>	<b>-</b>	<b>(12,739,047)</b>
<b>9</b>	<b><u>Paediatric aids</u></b>			
	<b>Name</b>	<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>

1	Mildmay International			-
2	Mayanja Memorial Hospital Foundn.(Paed Aids)	11,744		(11,744)
3	Save the Children Norway			-
		<u>11,744</u>	<u>-</u>	<u>(11,744)</u>

**10 Orphans and Vulnerable Children 2**  
**Name**

	<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>
1	World Educ Inc Bantwana		-
2	CARA Kayunga	31,500	(31,500)
3	CEFORD		-
4	CEPAP	2,500,000	(2,500,000)
5	Sebei Diocese CODE	2,580,000	(701,525)
6	MUCOBADI	1,008,361	(1,008,361)
7	PAG Karamoja	27,093,073	(27,093,073)
8	War Child UK	25,673,620	(25,673,620)
9	Concern Girl Child		-
10	THETA		(2,032,567)
11	Kasana-Luwero	980,023	(107,600)
12	Reach the Children	(4,000)	4,000
13	UHMG	32,106,454	(32,106,454)
14	ACORD OVC	14,898,426	(49,832)
15	CHUSA		-
16	URHB		-
17	Katalemwa Cheshire		-
		<u>-</u>	<u>(2,891,524)</u>
		<u><b>106,867,457</b></u>	<u><b>(109,758,981)</b></u>

11	<b>TSO Name</b>	<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 31 Dec 2012</b>
1	UPIMAC TSO			-
2	Africare Uganda TSO	(3)		3
3	UWESO Eastern			-
4	UWESO Teso			-
5	Save the Children in Uganda			-
6	Pathfinder			-
7	TPO - Arua			-
8	TPO - Moroto			-
9	ACCORD			-
		<b>(3)</b>	-	<b>3</b>

12	<b>NNGO2 Name</b>	<b>Expenditure</b>	<b>Advances</b>	<b>Outstanding balance for the year to 30 June 2013</b>
1	STF	2,018,707,502	2,173,757,706	155,050,204
2	TASO	2,140,138,371	3,027,823,305	887,684,934
3	PSI	1,213,436,147	1,289,599,560	76,163,413
4	IDI	3,192,172,256	3,720,346,132	528,173,876
5	JCRC	4,821,848,656	2,812,616,505	(2,009,232,151)
6	AIC	2,572,397,234	3,243,767,163	671,369,929
7	UGANET/NAFOPHANU/UNASO	2,284,552,281	1,556,538,616	(728,013,665)
8	AMICALL	2,513,430,199	3,075,147,854	561,717,655
		<b>20,756,682,646</b>	<b>20,899,596,841</b>	<b>142,914,195</b>

13 **HIV 3**

Name	Expenditure	Advances	Outstanding balance for the year to 30 June 2013	
1	PREFA - ARUA	171,136,936	347,769,999	176,633,063
2	Wellshare International	96,891,419	599,659,234	502,767,815
3	APSEDEC	138,656,100	179,486,787	40,830,687
4	Health Alert Uganda (HAU)	67,301,640	210,346,333	143,044,693
5	PACE Gulu	141,131,327	326,810,038	185,678,711
6	Straight Talk Foundation (STF)	167,941,209	269,190,625	101,249,416
7	Kabale Diocese	102,935,100	209,523,091	106,587,991
8	PACE Kabale	107,612,216	329,631,186	222,018,970
9	Mayanja Memorial Hospital Foundation (MMHF)	197,298,266	355,677,706	158,379,440
10	Bishop Masereka Christian Foundation (BMCF)	157,000,925	244,181,700	87,180,775
11	IBFAN	75,839,470	161,213,000	85,373,530
12	NACWOLA-Kasese	77,679,801	229,634,500	151,954,699
13	UHMG	83,693,723	294,736,663	211,042,940
14	UNASO – Kasese	113,176,322	192,612,222	79,435,900
15	BACHI	68,418,592	142,329,505	73,910,913
16	CARA Mayuge	137,066,833	223,431,500	86,364,667
17	MUCOBADI	91,957,575	178,898,899	86,941,324
18	Restless Development	60,163,276	183,957,793	123,794,517
19	Community Integrated Development Initiative (CIDI)	48,673,853	162,033,058	113,359,205
20	Orphans Community Organization (OCBO)	127,259,002	225,091,100	97,832,098
21	Rakai Aids Information Network (RAIN)	93,253,700	189,058,600	95,804,900
22	Rakai Counselors Association (RACA)	144,017,624	229,995,916	85,978,292
23	RACOB AO	96,433,823	244,097,750	147,663,927
		<b>2,565,538,732</b>	<b>5,729,367,205</b>	<b>3,163,828,473</b>
		<b>27,802,479,573</b>	<b>26,581,972,706</b>	<b>(1,220,506,867)</b>

14 **Other expenditure**  
Funds for Disbursements and fees.

