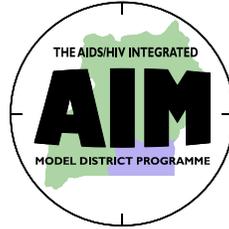


# The AIDS/HIV Integrated Model District Programme



## Annual Report Program Year 3 + July 2003 to September 2004



**AIM is a USAID-funded Project**

**Implemented by JSI Research and Training Institute, Inc.  
with World Education, Inc. and World Learning**



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## **LIST OF ACRONYMS**

<b>ACP</b>	AIDS Control Programme of the MOH
<b>AIC</b>	AIDS Information Centre
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>AIM</b>	AIDS/HIV Integrated District Programme
<b>ART</b>	Anti-retroviral therapy
<b>ARV</b>	Anti-retroviral
<b>AVSI</b>	Association for Voluntary Service International
<b>ASO</b>	AIDS Service Organization
<b>BCC</b>	Behavior Change Communication
<b>CA</b>	Cooperative Agreement
<b>CHBC</b>	Community and home-based care
<b>CBOs</b>	Community Based Organizations
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDFU</b>	Communication for Development Foundation Uganda
<b>CTT</b>	Central Training Team
<b>DAT</b>	District AIDS Task Force
<b>DDHS</b>	District Director for Health Services
<b>DAC</b>	District AIDS Committee
<b>DLFP</b>	District Laboratory Focal Persons
<b>DHS</b>	Demographic and Health Survey
<b>DOPs</b>	District Operations for AIM
<b>DOTS</b>	Directly Observed Treatment, Short course (TB)
<b>DRI</b>	District Response Initiative
<b>DTLS</b>	District TB and Leprosy Supervisor
<b>EGPAF</b>	Elizabeth Glaser Paediatric AIDS Foundation
<b>FBOs</b>	Faith-Based Organizations
<b>FPAU</b>	Family Planning Association of Uganda
<b>GOU</b>	Government of Uganda
<b>HBC</b>	Home-based care
<b>HIV</b>	Human Immunodeficiency Virus
<b>IC</b>	Infection Control
<b>IDP</b>	Internally Displaced Persons
<b>IEC</b>	Information, Education and Communication
<b>IGAs</b>	Income Generating Activities
<b>JIA</b>	Joint Institutional Assessment
<b>JSI R&amp;T</b>	JSI Research and Training
<b>LC</b>	Local Councils
<b>LRA</b>	Lord's Resistance Army
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MOESC</b>	Ministry of Education, Sports and Culture
<b>MGLSD</b>	Ministry of Gender, Labour and Social Development
<b>MOH</b>	Ministry Of Health

<b>MOLG</b>	Ministry Of Local Government
<b>MTR</b>	Mid-Term Review
<b>NA</b>	Needs Assessment
<b>NACWOLA</b>	National Association of Women Living with AIDS
<b>NGEN +</b>	National Guidance and Empowerment Network
<b>NGOs</b>	Non Governmental Organizations
<b>NMS</b>	National Medical Stores
<b>NTLP</b>	National TB and Leprosy Programme
<b>NYC</b>	National Youth Council
<b>OI</b>	Opportunistic Infections
<b>OVC</b>	Orphans and Vulnerable Children
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PIASCY</b>	Presidential Initiative on AIDS Strategy for Communication to Youth
<b>PLWHA</b>	People Living With HIV and AIDS
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PSI</b>	Population Services International
<b>PST</b>	Partnership Support Team (AIM)
<b>PTC</b>	Post Test Club
<b>RC</b>	Regional Coordinator (AIM)
<b>RMO</b>	Regional Medical Officer (AIM)
<b>SA</b>	Situational Analysis
<b>SA/NA</b>	Situational Analysis/Needs Assessment
<b>SDU</b>	Strengthening Decentralisation in Uganda Project
<b>STF</b>	Straight Talk Foundation
<b>STI</b>	Sexually Transmitted Infections
<b>TASO</b>	The AIDS Support Organisation
<b>TB</b>	Tuberculosis
<b>THETA</b>	Traditional and Modern Health Practitioners Together Against AIDS and Other Diseases
<b>TOT</b>	Training of Trainers
<b>UAC</b>	Uganda AIDS Commission
<b>UACP</b>	Uganda AIDS Control Project (World Bank)
<b>UBC</b>	Uganda Business Coalition
<b>ULAA</b>	Uganda Local Authorities Association
<b>UNANM</b>	Uganda National Association for Nurses and Midwives
<b>UNASO</b>	Uganda Network of AIDS Service Organisations
<b>UPHOLD</b>	Uganda Program for Human and Holistic Development
<b>USAID</b>	United States Agency for International Development
<b>UWESO</b>	Uganda Women's Effort to Save Orphans
<b>VCT</b>	Voluntary Counselling and Testing
<b>WEI</b>	World Education, Inc.
<b>WL</b>	World Learning
<b>YA</b>	Youth Alive
<b>ZTLS</b>	Zonal TB & Leprosy Supervisor

## Executive Summary

In many respects, this was a watershed year for the AIM Programme. The grants program managed by the DACS and AIM blossomed during this period, with 200 grantees and partners supported by AIM delivering critical HIV/AIDS services in 16 districts to thousands of beneficiaries. To support expanded service delivery, AIM placed additional staff and resources in the regional and cluster offices and reorganized key departments at headquarters. AIM became a key partner in the US Government's consolidated plan to support HIV/AIDS interventions in Uganda, funded through a new mechanism known as the Emergency Plan for AIDS Relief. In June, an external team of experts conducted a mid-term review of AIM that clearly acknowledged progress against targets while identifying areas for greater emphasis or reconsideration.

This report covers AIM's third year of implementation, plus an extra quarter. By adding a quarter, AIM will be in alignment with the reporting cycle of USAID and the Emergency Plan, both of which adhere to US government fiscal years. Adopting this new reporting cycle should streamline reporting and facilitate target setting in the future.

The primary means through which AIM supports service delivery is grants. Following an initial round of awards in 2003, AIM instituted a revised approach to grants solicitation and award that is based on a district-led process of service gap analysis, targeted solicitation, transparent review and award. Through September 30, 2004 a total of 200 district and 38 national grants have been awarded by AIM, at a total value of \$8,568,891.

AIM grantees and partners deliver a range of clinical and community services in the districts. In addition to monetary support and the provision of equipment, AIM helps develop the capacity of grantees and partners to deliver quality services. This is done through training and mentoring, regular supervision using checklists, and the use of program data to identify problems and monitor solutions. AIM works through key district structures such as the DAC and DDHS to effect these improvements. The box below summarizes a sample of key services delivered with AIM support, highlighting the progress made since the start of FY 04.

<b>Service or Clients</b>	<b>Start FY 04</b>	<b>End FY 04</b>
VCT sites	<b>46</b>	<b>83</b>
VCT clients tested	<b>2,513</b>	<b>105,204</b>
PMTCT sites	<b>16</b>	<b>54</b>
PMTCT clients tested	<b>320</b>	<b>48,168</b>
Labs renovated	<b>0</b>	<b>30</b>
Lab tests conducted	<b>14,436</b>	<b>524,369</b>
TB cases detected	<b>8,000</b>	<b>17,408</b>
District Grants	<b>109</b>	<b>200</b>
Award value district grants	<b>\$3,556,653</b>	<b>\$5,441,492</b>
OVC programs	<b>49</b>	<b>55</b>
OVC beneficiaries	<b>1,683</b>	<b>56,817</b>
# persons trained (all areas)	<b>2,608</b>	<b>11,915</b>

A key aspect of AIM's approach is the development and support of referral networks for comprehensive HIV/AIDS services. AIM has worked closely with district and health sub-district (HSD) officials to help create and/or formalize these linked services, and to date 31 such networks have been launched. AIM will support this approach in all 67 HSD by the end of the five year program, and estimates that about 60% will achieve an acceptable level of functionality.

It is not sufficient to simply increase the number of services delivered—the services must meet minimum quality standards if they are to be effective and valued. AIM's approach to quality improvement is based on targeted training or re-training, regular support supervision, and the use of tools, instruments and supporting materials to help managers and providers maintain their performance. AIM has made considerable progress in developing tool kits this year, focusing initially on PMTCT, VCT, OVC and Adolescents. These kits have been developed with government and NGO partners and will be introduced to the districts in FY 05. AIM has also worked with districts to improve the quality and timeliness of data collection and reporting. A new data summary form introduced by AIM has found acceptance in the districts, and AIM is helping to build district capacity to record, aggregate, analyze and use service data for decision making.

The AIM concept of a model district has evolved this year to include clear measures of district capacity to plan and coordinate services, attract required funding, and transparently solicit and award grants. Further, a model district must offer key HIV/AIDS services at an acceptable level of quality that reach a defined and significant proportion of the population. The AIM districts are at varying stages of meeting the requirements of being a model, and the challenge for AIM will be to help the districts address the gaps in the remaining years of the program.

AIM operates in a fluid, challenging environment. Since AIM began three years ago, there have been significant changes in the constellation of programs offering HIV/AIDS services, the source and level of funding for HIV/AIDS, the availability of antiretroviral therapy and, indeed, at AIM itself. To help AIM and USAID take stock of these changes, and to determine the extent to which AIM is making progress towards fulfilling its objectives, AIM invited an external team to conduct a mid-term review (MTR). The six-person team of international and Ugandan consultants spent three weeks conducting the review, during which time they met donor agencies and partners at national level and visited six districts. The team issued a set of recommendations, which include:

- base the model district concept on support for GOU structures and package of services for HIV/AIDS and TB
- strengthen district capacity to independently plan, coordinate and monitor delivery of HIV/AIDS/TB services
- build on the referral network concept to expand and integrate services
- continue to transfer ownership of grant mechanism to districts and focus greater resources/effort on 'good performers'
- strengthen technical leadership and approach
- shift staff resources from center to districts
- strengthen linkages and coordination at program, district and national levels areas

AIM has used the MTR team's insights, findings and recommendations to stimulate both technical and programmatic debate internally and with USAID. The draft AIM work plan for the final years of the program was developed in consideration of the MTR team findings as well as factors related to Emergency Plan funding and directives.

AIM approaches the coming year with great anticipation and optimism. AIM will work with partners and grantees to consolidate the important gains in organizational development, planning and coordination, service delivery and infrastructure improvements realized during PY 3. AIM will seek innovative approaches to meeting the multiple, and at times opposing, challenges inherent in this complex program. AIM will support an expansion of services coupled with the application of a quality assurance program. Both clinical and community services require expansion and improvement, and they also need to be linked through referrals so that a client's full range of needs may be met. The need to quickly scale up services in response to the epidemic must be balanced against the longer term imperative of building capacity to sustain high quality services. AIM will revisit its approach to strengthening services in conflict areas and changes may well be suggested. AIM will continue to engage appropriately at national level all the while maintaining its focus and emphasis on the districts. Increasingly, AIM will rely on cross-cutting services such as IEC/BCC, M&E, training and quality assurance to support both the quality and quantity of services supported.

## Section 1: Progress against Objectives

### 1.1 Objective 1

*To strengthen the capacity of government and NGOs, CBOs, FBOs and the private sector to plan, implement and manage integrated services at the national, district and sub-district levels*

#### **Highlights:**

- Fully-staffed regional teams support districts, partners and grantees
- HIV/AIDS strategic plans increasingly integrated into district development plans
- Grants to DACs spur greater involvement in planning, monitoring, grant review
- Study on DAC and DAT functionality and mid-term review to inform AIM work
- Strategy for conflict area refined, in line with larger effort to provide support
- Revised grants process empowers districts to greater degree
- 200 district grants awarded by end of FY 04
- Extensive OD support provided to strengthen national partners
- Curriculum development, training and TA support to numerous partners

#### **Work Plan Activity 1.1 Support all target districts to maintain a viable HIV/AIDS/TB coordinating structure**

AIM continued to work with districts to strengthen district HIV/AIDS planning, management and coordination capacity. AIM consolidated its presence in the districts by strengthening its field offices and recruiting resident staff in the regions. Throughout the year, the regional teams were supported by HQ so that they could, in turn, support the districts and grantees more effectively. As part of headquarters support to the regions, Resource Centres were set up in each of the regional offices to provide information to both AIM staff and partners.

During the year, AIM completed needs assessment exercises for the Phase II districts of Yumbe, Arua, Nebbi, Pallisa, Mubende and Kibaale and helped these districts launch their HIV/AIDS strategic plans. The same districts were supported to develop M&E plans to guide the monitoring of the Strategic Plans. AIM staff have worked with all districts to ensure that the strategic plans are integrated into the district development plans. By the close of FY 04, 10 districts had, in some form, integrated parts of their HIV/AIDS plans into the Development plans. In the last quarter of FY 04, AIM worked with each district to support a process of reviewing and updating the strategic plans in preparation for the District HIV/AIDS work plan for the period 2004/2005.

AIM awarded grants to each district to help the DACs and DATs perform their coordination and planning roles more effectively. Though the district grants were fairly generic, several districts have managed to adapt them to their own unique situation. As a result, DACs have been able to carry out activities such as conducting their own meetings, holding joint meetings with the DATs, and convening grantee and stakeholder

coordination meetings. One area where DAC participation has not been as active as envisaged was in the on-site monitoring of grantees and their activities. Though some DACs made attempts during the year to visit and guide grantees, most did not, citing inadequate funds as the major reason for the low performance in this area. AIM staff have been working with several DACs to revise this line item in their grant.

AIM further supported the DACs and DATs by developing with them a monitoring tool for grantees, supporting them to allocate responsibilities to their sub-committees and, in several districts, lobbying districts to include as members of the DAC individuals who were seen to be more active and committed to HIV/AIDS issues in the district.

In the grants arena, DACs were actively involved in the process of identifying service gaps, identification and guiding potential service providers in proposal preparation and participating in the review of the grant applications. This process has further strengthened the relationship between DACs and AIM and, in some districts, has helped improve the relationship between the DAC and DAT.

AIM commissioned a study by SDU on the functionality of DACs and DATS. The SDU team developed an interview guide and data collection instruments and applied these tools in the AIM-supported districts of Tororo and Rukungiri. The team identified areas of reasonably good DAC/DAT performance, as well as others where little or insufficient progress had been made. Substantial variability in performance was noted in the two districts. Key findings include:

- Some DAC members have managed to integrate their additional HIV/AIDS responsibilities into their routine functions
- The DACs have taken on an active role in grants management in the districts
- The distinction between the policy making roles of the DAT and the implementation oversight role of the DAC is not always clear in the districts, resulting in areas of overlap
- In both districts there seems to be a chronic lack of financial resources to support HIV/AIDS coordination activities
- There is need to develop guidelines for integration of HIV/AIDS issues into the development plans and for sustainability of HIV/AIDS activities.

The external team conducting the AIM mid-term review visited six districts and in each instance met with members of the DACs and DATs. They also noted variable engagement and effectiveness of these coordination structures and highlighted the following points:

- The process of analysing service gaps, involving DACs and civil society organisations (CSOs), was found to be useful and it had helped in establishing an embryonic participatory planning process that could provide the basis for future public-private partnerships
- There is need to support DATs and sub-county structures as effective coordination will depend on the functioning of these structures

- There is need to work with district governments to ensure that coordination mechanisms are institutionalised within district structures, plans and budgets
- AIM needs to take a more active role in encouraging the representation of NGOs, CBOs, PHA and the private sector on the DACs
- There is need to assist DACs to develop strong links with District Technical Planning Committees (DTPCs) or District Planning Units (DPU)s, which are responsible for district development plans, to ensure that HIV/AIDS strategic planning is harmonised with district planning cycles
- There is need to direct tailored capacity building support to DACs to follow up initial generic training provided to all DACs, and to link this to MOLG capacity building processes.

The findings and recommendations from both of these exercises have helped inform the direction and type of capacity building assistance AIM will provide in the final years.

In the last quarter, AIM developed a vision of what a model district would look like at the end of the period of AIM support. This vision is encapsulated in a set of indicators. In several districts, discussions have been held to validate these indicators and seek consensus on the specific targets for the districts. By September 30, four districts (Arua, Apac, Mubende and Rukungiri) had defined and agreed on indicators and targets for an HIV/AIDS model district.

**Work Plan Activity 1.2: Identify, develop and implement strategies to build capacity to respond to HIV/AIDS and TB needs in conflict districts**

At the beginning of the year, the conflict situation in the East was tense and activities in the districts of Katakwi, Kumi and Soroti were affected. AIM facilitated a series of stakeholders' meetings in Soroti and Lira which provided input into AIM's conflict strategy. To help operationalize the strategy, AIM awarded grants to several organizations to provide HIV/AIDS services to the rapidly growing IDP populations in Soroti; these grants were, however, of a short duration. The activities supported under the grants included IEC/BCC activities by DDHS office, VCT outreach services for camp populations, OVC support and home-based care for PHAs in camps.

In Lira district, following several rebel attacks on IDP camps, a huge number of people fled to Lira town. AIM responded to the immediate district need by procuring infection control materials for the Regional hospital to support its capacity to cope with the increased pressure of the displaced persons. In the last quarter, grants were awarded to two HSDs in Lira for provision of VCT outreach services in IDP camps.

AIM awarded a grant to Pader (DDHS) for provision of services to displaced populations. Though communication with the district has been a big challenge during the period, the recent improvement in security has facilitated phone links and it is now possible to monitor AIM-supported DDHS activities.

AIM also participated actively in the USAID-led coordination initiative known as the Statement of Collaboration (SOC) in partnership with other organizations. As part of the SOC activities, AIM organized regional SOC member meetings in Soroti and Lira to discuss coordination of HIV/AIDS activities in the conflict districts of the region and to get feedback on the support required by the districts.

A joint USAID/AIM/district assessment mission to some of the camps in Soroti and Katakwi revealed the dearth of all services (including HIV/AIDS) in these camps. With the relative improvement in the security situation, more concerted and proactive steps have been planned in FY 05 to address the problem of HIV/AIDS services in IDP camps.

**Work Plan Activity 1.3: Assist Districts, NGOs, FBOs and CBOs to implement a partnership of HIV/AIDS/TB services through selective grants**

AIM's first solicitation of grants, resulting in 109 grants awarded in the districts by the end of September, 2003 was conducted with great urgency in order to provide a foundation of HIV/AIDS services in the districts. Following this initial round of grant proposals AIM, in 2004, was able to construct a more systematic approach to grants solicitation and award through development of its targeted solicitation of proposals (TSP) system. By the end FY 04, 200 district-level grants had been awarded.

The TSP began with a preliminary district by district analysis of service gaps. The gap analysis was then shared with DACs and DATs in each of the 16 districts for vetting and further refinement. At the same time, the DACs and DATs worked with AIM regional staff to plan for the overall solicitation process. This process included the organization of a forum in each district to present the gap analysis to key HIV/AIDS service providers and organizations, go over the newly-developed grant application form and procedures for submission of the application, screening of applications by the DACs, technical review by AIM and eventual processing of grant agreements for applicants who made the grade. This entire process was completed, except for the in-depth technical review by AIM staff, by mid-July 2004. Technical refinements and administrative processing of the last TSP grant applications will be completed in November and we expect final disbursements of these last grants to take place in December.

The TSP resulted in 587 grant applications being submitted to the DACs out of which 383 or 65% passed the initial screening. Of these, 97 were rejected via a second AIM screening, leaving 286 or 49% of the submittals for detailed technical review by AIM technical managers and DAC representatives. With these further reviews, 129 were rejected leaving 157 grant applications for final corrections, negotiations, refinements and processing that would lead to funding. All told, about 27% of the proposals submitted will receive funding. The targeted solicitation process thus resulted in applications that catered to the actual and particular needs of each district.

The grants team also cleared a backlog of over 150 grant proposals that had been received between the initial round and the TSP period, 35 of which were funded. Finally, a special effort was made during the last quarter of the reporting period to solicit, on an

exceptional basis, health sub-district proposals for funding. This was part of a greater strategy to support increased clinical interventions at the sub-district level, which until recently was provided primarily through DDHS district government based grants.

AIM experienced problems at one time in releasing funds to grantees on time, but this problem consistently diminished over the months. A backlog of previously scheduled disbursements was eliminated and currently disbursements are now made consistently on time. However, timely liquidation on the part of grantees is still a problem and grantees require constant surveillance to ensure that implementation is done according to grant agreement plans.

Joint visits by DAC members and AIM regional and HQ staff initially revealed significant performance shortcomings among many grantees. These included poor record keeping, divergence from the signed Memoranda of Understanding, inadequate pace of implementation, failure to report back to AIM, and other issues. AIM addressed these issues through increased presence and technical assistance in the districts, especially once the regional teams were fully staffed. There has been marked improvement in the overall performance of the majority of grantees over the (approximately) one year period of implementation, as measured by the increased number of clients served.

- **Training and Capacity Development**

#### **General Support to National NGOs:**

AIM continued to build the institutional capacity of ten national NGOs to a level where they are able to provide quality HIV/AIDS services at district level. As part of the process of OD that started with the Joint Institutional Assessment (JIA) exercise, AIM provided TA in the following areas:

*i) Strategic Planning:*

Eight<sup>1</sup> NGOs out of the 10 have completed developing their strategic plans to guide their strategic thinking and decision making at both national and district level. Straight Talk Foundation revised their strategic plan with funding from other donors while Uganda Business Coalition (UBC) is in the process of reviewing their strategic plan to accommodate issues that have emerged from the organization's growth.

*ii) Financial management:*

AIM supported IMAU and NACWOLA to develop their financial management systems. Each of the organizations was supported to develop a financial accounting system. Training was offered to the Finance person, management and board members of each of the organizations to help them understand and use the system.

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<sup>1</sup> UPMA, CHUSA, THETA, UNASO, NGEN+, NACWOLA, IMAU, UWESO,

*iii) Human Resource Management*

IMAU was supported to produce a Human Resource Manual while CHUSA and UNANM were each supported to recruit an Administrative/Finance Assistant. UPMA was also supported to recruit a District Liaison Officer. Support for the recruitment process was provided through grants.

*iv) Monitoring and Evaluation*

THETA and IMAU have been assisted to complete development and/or revision of their M&E systems.

**National level Organizational Development manuals**

The national level OD manuals were developed and completed this year through a joint effort between AIM and UNASO. The manuals incorporated training materials used earlier during the OD workshops for national level NGOs. UNASO's experience of working with various AIDS service organizations in the country provided valuable input into the manuals. The manuals, which include a trainer's guide and a participant manual, are currently being printed and UNASO will be disseminating them in the first two quarters of FY 05. The five manuals cover the areas of strategic planning, human resource management, M&E, resource mobilization, and financial management.

**Planning and implementation of the district level OD program:**

The second phase of the organizational development process entails strengthening institutional capacity of the district-based organizations. This year the process started with a curriculum review workshop intended to generate content for the district manuals. Participants in this workshop included national level NGOs, district grantees, district trainers, and AIM regional and headquarters staff. AIM worked closely with UNASO to develop and finalize the district OD manual which will be field tested in the first quarter of FY 05. In preparation for district OD workshops, AIM has worked with UNASO to identify and select district level organizations (AIM grantees) to benefit from the first phase of OD training in the model districts.

▪ **Lead organizations at district level**

With a steady increase in the number of grantees in AIM-supported districts, AIM is exploring alternative ways to provide them critical, timely support that depends less on AIM staff and more on viable local organizations. To this end, AIM is working to identify and support a small number of lead organizations that can be strengthened to provide support to less robust grantees. AIM conducted an initial assessment of 12 organizations to determine which might become candidates to serve in this capacity. To qualify, they must be organizations with strong management systems, implementing multiple AIM-supported HIV/AIDS services, with the capacity and interest to mentor and strengthen community-based organizations in the region. AIM hopes to identify four such groups, one each in the West Nile, North, Southwest and East. The OD manual described above will be tested with the 12 candidate organizations in FY 05.

## **Training and TA support to AIM technical staff and grantees:**

During FY 04, the training and capacity building (TCB) unit at AIM provided support to AIM technical teams and grantees. The TCB unit and AIM staff can point to a number of achievements, including the design of the M&E training module for grantees, development and field testing of the Community and Home-Based Care and OVC manuals, pre-testing the VCT counselor training manuals, orientation for health workers on PMTCT, and facilitating training in planning and management of training activities for AIM grantees.

Training support to grantees included linking them to competent trainers to conduct training within the parameters of their grants, identification and adaptation of training manuals needed by grantees, and development of training manuals for areas where none existed. For example ASDE in Arua, an FBO working with Imams, benefited from AIM assistance in the development of a manual to train Imams as community AIDS educators.

### **1.2 Objective 2:**

*Increase integration and quality of comprehensive HIV/AIDS and TB interventions at the district and sub-district levels*

#### **Highlights:**

- Evolution and refinement of referral network concept
- Agreement that health sub districts (HSD) are the hub of referral activities
- Coordination teams formed at HSD level for referral networks
- Creation of referral directories at HSD level
- Technical assistance provided to districts and HSD to stimulate referral networks

#### **Work Plan Activity 2.1: Assist districts, NGOs, FBOs and CBOs to implement and support integrated and active HIV/AIDS services through a referral network of services**

AIM collaborated with districts to develop an integrated network approach for the delivery of quality services. This concept of the referral network for AIDS (RNA) evolved during the year in light of field experience and guidance from PEPFAR. The emerging focus is on supporting families and the community to seek early entry into the continuum of care services and to re-integrate them into communities that offer a wide range of mitigation, supportive, and preventive services. The DACs and DATs in eight districts received TA from AIM to develop the network model approach and plan.

AIM staff provided TA to HIV/AIDS stakeholders in 31 counties (catchment areas for Health sub-districts with an average population of 100,000) out of 67 counties in AIM-supported districts to discuss the network model approach and develop strategies for successful networking. On average, 35 stakeholders were trained per county/HSD with the major output being election of coordination teams to further the network interests. Government and civil society organizations and interest groups like PHAs are

represented on the coordination teams. The coordination teams have met at least twice since they were formed to discuss important network issues, such as:

- Development of a directory of organizations and the services offered
- Mapping of services, identification of gaps and planning for resources
- Strengthening partnerships between service organizations and between the public and private providers
- Mobilization of HIV positive clients to adopt early health seeking behaviors and enter the continuum of care
- Quality of services and accountability to their clients
- Strengthening the referral system.

AIM also supported pre-existing networks like BUDNET, RUDINET and KIBANET to link to ART services offered by TASO, Arua regional referral hospital/MSF, JCRC and Uganda Cares. The tools developed for referral within and between facilities and communities are already helping clients navigate the maze of needed services. Over the reporting period, there has been an increase in number of clients referred between VCT and TB, OI and TB, STI and VCT, and ANC and PMTCT.

Poor geographical coverage and quality of services remain as challenges to networking although the TSP process continues to bridge some of these gaps. Also, the evolving culture of networks is attracting more partners like TASO and AIC in Soroti and JCRC in Tororo. Commodity security, which is predominantly a function of government, continues to be weak area discouraging clients from seeking services and rendering the referral system ineffective. There is still a problem of record keeping among service providers with resultant difficulty in tracking referred clients.

In conclusion, the network model focusing on delivery of an integrated and comprehensive package of quality HIV/AIDS prevention, care and support services in the communities will continue to be an integral component of the district planning and grant management processes as districts move towards developing model programs. In the coming year, areas of focus will include:

- capacity building in technical and coordination roles and functions
- development of effective IEC/BCC interventions to mobilize communities for counseling and testing (CT) services
- promotion of early entry into the continuum of palliative care services and antiretroviral therapy (ART)
- development of HIV/AIDS services directories at HSD level
- strengthening existing networks and supporting the establishment of new ones;
- sharing of experiences among stakeholders to promote learning and uptake.

It is planned that by the end of project, 40 out of 67 potential networks will achieve an acceptable degree of functionality.

### 1.3 Objective 3

#### *Increase Access to and Utilization of Quality HIV/AIDS Prevention Services in Selected Districts and Sub-Districts*

##### **Highlights:**

- 83 VCT sites received support from AIM
- Over 105,000 persons tested for HIV in FY 04
- Orientation and training provided to 1,755 health workers and aides in VCT
- Supported finalization of VCT/PMTCT policy, guidelines, manuals
- Refurbishment of 11 VCT counselling rooms
- Increased programmatic emphasis on linking TB and HIV
- IEC/BCC strategy developed to increase demand for VCT and PMTCT
- 54 PMTCT sites received AIM support
- Over 48,000 pregnant women tested for HIV
- Over 2,500 pregnant women received ARV prophylaxis
- Over 1,000 persons trained in PMTCT
- Training of 290 health workers in STI management
- Over 125,000 STD cases diagnosed
- Emphasis on HIV counselling and testing for STD patients
- Strong targeted prevention programs launched with national partners
- Programs reach in-school and out of school youth with prevention messages
- 4.3 million condoms distributed through grantees

#### **Work Plan Activity 3.1: Assist DDHS, NGOs, FBOs to implement and monitor Voluntary Counselling and Testing (VCT) services consistent with the national guidelines.**

AIM supported districts to greatly increase access to and utilisation of quality Voluntary Counselling and Testing (VCT) services which conform to the minimum standards set by MOH. By September 30, AIM was supporting 83 static VCT sites, 19 of which were added in the last quarter. Many of these conduct outreach visits as well.

In these sites in FY 04, a total of 164,821 clients were counselled and 105,409 went on for testing (64%). Of those tested, one in six tested positive for HIV. A total of 2,538 HIV positives were then screened for TB. There was a modest decline in VCT services during the final quarter of FY 04, largely attributable to a shortage of test kits. Integration of VCT and TB services increased during the last quarter, and this will be further strengthened in FY 05.

AIM support for VCT has been mainly in the form of regular technical assistance and support supervision by AIM officers or AIM-facilitated district personnel, training of staff both in VCT service delivery and management of HIV logistics, grants for service delivery, support of materials development, and dissemination of IEC materials and implementation guidelines. To address the issue of inadequate counseling space and privacy of clients, AIM has supported refurbishment of counseling rooms at VCT sites. Refurbishment has been completed in 11 of the sites, and is ongoing in 60 more.

For the year, 1,755 persons received training in VCT. While many of these were counseling aides or lower level workers, over 613 operational level health workers were trained to offer quality VCT services. Many more will be trained in the coming year as new sites are opened up, and to strengthen capacity in existing sites. AIM continues to work with MOH, DELIVER and NMS to improve logistics management and forecasting through staff training.

In order to strengthen the capacity of districts to provide quality VCT services, a total of 22 VCT proposals were funded during this period, with many more being processed. These grants support VCT outreach, IEB/BCC activities, M&E, technical assistance, support supervision, and training of staff.

At National level, AIM supported MOH to finalize and disseminate the VCT policy and implementation guidelines, as well as the development of the comprehensive HIV/AIDS counselor training manual. AIM helped fund and participated in several national level meetings to review VCT policy, coordinate VCT activities, and share experiences. Lack of coordination and duplication of VCT services were identified as impediments to service delivery. AIM was requested to take the lead, in partnership with AIC and MOH, in harmonizing the VCT client card and data collection and reporting forms.

In view of the high rates of TB/HIV co-infection, AIM has put in place mechanisms to integrate VCT and HIV services so that as many TB patients as possible get HIV testing, and HIV positive clients get screened for TB. In line with this effort, components of TB are included in the VCT counselor training. In FY 2005, this integration of TB and HIV counseling and testing will be further strengthened in all hospitals, HC IVs, and a few HC IIIs. Furthermore, AIM will promote home-based HIV counseling and testing in a few sites by using already existing community-based resource persons like the community volunteers and community counseling aides. The entry point to the family will be a client with TB, STI, or HIV.

To increase access to HIV counseling and testing in IDP camps, AIM worked with the districts to conduct VCT outreach sessions in the camps. Tents and other materials were procured, and AIM supported trained counselors to carry out the outreach services.

AIM developed a comprehensive IEC/BCC strategy (“Winning through Caring”) to guide IEC interventions aimed at increasing demand for and utilization of VCT services. Key issues to address include stigma and discrimination against those found HIV positive, the benefits of knowing one’s HIV status, and counseling and testing for couples.

Key challenges to VCT implementation include inadequate staff, irregular supply of HIV test kits and insufficient systems to follow up people who have been tested. Therefore, one major area of support in FY 05 will be the strengthening of community support systems for people who have undergone HIV testing to help them live positively but also to avoid re-infection or infecting others, and for those found negative to maintain their sero-status. This will be done by strengthening post-test club activities, and linking them to health facilities that provide counseling and testing services. All HIV positive clients

will also be linked to other care and support services like treatment of TB and other OIs, PMTCT, and ARVs as part of a network model. Routine counseling and testing will be initiated at 30 sites. The target group for this will be all patients with TB, STIs and admitted patients on medical wards.

**Work Plan Activity 3.2: Assist DDHS, NGOs, and FBOs to implement and monitor Prevention of Mother to Child Transmission (PMTCT) services consistent with the national guidelines.**

During FY 04, the number of AIM-supported PMTCT sites increased from 16 to 54, and nine sites received AIM support for the first time during the final quarter. AIM support included training of staff in PMTCT service delivery and logistics management, regular technical assistance, grants for service delivery, support for materials development, dissemination of IEC materials and policy/implementation guidelines, provision of maternity and other medical equipment, and refurbishment of counseling rooms.

During this period, the total number of women who attended ANC was 311,943. This figure includes many women who made ANC visits to health facilities that did not offer PMTCT. Out of this inflated ANC pool, 48,168 women were tested for HIV, and 25,477 (53%) received their test results. A total of 3,901 women tested positive for HIV and 2,567 of these (66%) received ARVs.

AIM has developed a training package for health workers around giving psychosocial support to HIV positive mothers, their spouses and entire families. This is part of a strategy to address the non-medical needs of the HIV positive mothers, their spouses and entire families to cope with HIV. AIM is also working with EGPAF to establish support groups through which HIV positive women who have already gone through the program can give psychosocial support to new ones.

A total of 1,056 operational level health workers were trained in FY 04 to offer quality PMTCT services, and also to provide technical support supervision to other PMTCT implementers. Many more will be trained in the coming year to strengthen capacity in new and existing sites.

One major constraint to PMTCT expansion has been the low staffing levels in all the health units. AIM has continued to advocate for recruitment of more staff in the health units. In a few select cases, AIM has supported recruitment of critical staff, such as counselors and laboratory staff, with the understanding that these positions will be taken up by the districts in the near future.

AIM has collaborated with the DDHS and community organizations to increase utilization of PMTCT services and to strengthen linkages with VCT, STI, OI, TB and other clinical and community-based services. In order to increase demand for and utilization of PMTCT services at established sites, AIM will implement the IEC/BCC strategy (“Winning through Caring”) to guide IEC interventions. Low male involvement and support, stigma, discrimination, and inadequate community support systems for HIV-

positive mothers have been key hindrances to PMTCT service utilization and these will continue to be addressed through the IEC/ BCC strategy.

To strengthen district capacity to plan, implement and monitor PMTCT services, AIM has awarded a total of 23 PMTCT grants to different districts, with others still being processed. Key areas of support through these grants include outreach, purchase of maternity, laboratory and other medical equipment, IEB/BCC activities, M&E, technical assistance, support supervision and training of staff.

As part of its support to MOH PMTCT activities, AIM has provided technical assistance and funding to help develop the PMTCT counselor training and the orientation manuals, as well as the PMTCT support supervision guidelines and data collection tools that are currently being used. These will form part of the PMTCT toolkit to be completed soon. To help the MOH increase its PMTCT training capacity, AIM supported a training of trainers for 25 PMTCT counselors. AIM also provided technical and financial support to several National level meetings to discuss policy and implementation issues.

Shortages of HIV test kits and other materials have caused periodic interruptions of service delivery. In order to minimize this, AIM has continued to work with MOH, DELIVER and NMS to improve logistics management through training of staff and regular technical assistance. General problems related to logistics and supply of kits and Nevirapine have been identified and addressed through site visits and meetings with the relevant district officers, MOH and DELIVER. AIM has on several occasions been called upon by MOH to procure HIV test kits to resolve stock out situations.

Most of the health facilities providing PMTCT services do not have adequate counseling space, thus compromising patient privacy. AIM has, over the last year, completed refurbishment of four health facilities to create counseling rooms and improve laboratory services. Refurbishment is still going on in 29 sites.

The goal for AIM FY 05 is to scale up and strengthen PMTCT sites through staff training, refurbishment, regular support supervision, strengthening of logistics management systems, and improving referral of HIV positive mothers and their families to further clinical, psychosocial and other care and support services within a network of HIV/AIDS services.

**Work Plan Activity 3.3: Assist DDHS, NGOs, and FBOs to implement and monitor interventions for management of Sexually Transmitted Infections (STI) consistent with national guidelines.**

AIM has collaborated with districts to develop a framework to plan, manage and monitor STI services in all health sub districts. This has been done through dissemination of national guidelines and algorithms which were revised by MOH with technical and financial support from AIM. In FY 04, AIM supported the training of over 290 operational level health workers in syndromic management of STI, and has helped create mechanisms for referrals with a network that includes STI management.

Over 125,000 STD episodes were diagnosed in FY 04, with 48,249 seen in the last quarter. There is evidence of increased linkages between STI and other HIV/AIDS services, as seen in the referrals for STI patients to counseling and testing services and in the number of STI clients who have undergone counselling and testing. Nearly 12,000 clients with STIs have been referred out to VCT sites, 6,107 in the last quarter alone, which is 12.7% of all people diagnosed with STDs that quarter. The number of clients with STDs who have undergone counselling and testing was 12,208 in FY 04, of which 6,197 (51%) were accounted for in the last quarter.

AIM plans to build on this during the coming year by providing support for routine counselling and testing within STI sites and by strengthening referral from STI sites to counselling and testing centres. AIM will also support integrated outreach services that include management of STI combined with routine counselling and testing.

**Work Plan Activity 3.4: Assist DDHS, NGOs, FBOs and CBOs to implement and monitor interventions for management for Prevention for Targeted Populations (PTP).**

During FY 04, AIM worked with national and district partners to reach out to adolescents, youth and other targeted populations with deliberate HIV prevention and AIDS control interventions. Three key national partners included Straight Talk Foundation (STF), Youth Alive (YA) and National Youth Council (NYC). District partners, mainly CBOs, FBOs and local NGOs, totaled about 80. Working within the GOU policy framework on Adolescents and Youth as well as the “ABC” approach for prevention of HIV, AIM and its partners have been promoting abstinence among adolescents, faithfulness among married couples and correct and consistent use of condoms among out of school sexually active youth, youth in higher institutions of learning, hard to reach or underserved populations such as fishing communities, tea factory and commercial sex workers under the Adolescent Friendly Services (AFS) and Prevention for Targeted Populations (PTP) core service areas.

AIM’s district partners have been active in information dissemination and life skills building activities for adoption/maintenance of positive behaviors among adolescents, development and production of IEC/BCC materials, interactive community drama, mass media and sensitizations. Over 48,000 adolescents and youth have been referred for HIV/AIDS services and approximately 4.3 million male condoms distributed among out of school sexually active youth and other targeted populations that include fishing communities, boda boda riders, tea factory workers etc.

The goal for AIM in FY 05 is to scale up and strengthen existing prevention interventions. Approaches based on best practices such as peer facilitation will be used to promote abstinence, faithfulness and condom use among specific target groups in addition to mass media, print and interactive theater. Linkages between clinical and community service providers will be strengthened through referral networks and targeted outreaches. AIM will support partners to establish youth friendly, facility-based services

linked to peer education networks in Apac, Arua, Soroti, Kumi, and Mubende in addition to one that has been already supported in Rukungiri. AIM will continue to work with MOH and DELIVER to facilitate access to condoms by grantees

Under the STF/AIM partnership, about 400,000 copies of three local language newspapers (Luganda, Lugbara and Runyankore/Rukiga) have been produced and distributed to out of school youth. Health fairs have been organized to launch the newsletters as well as act as a forum to link IEC to HIV/AIDS services. VCT, condom education and distribution as well as blood donation services have been offered during health fairs. On average, 185 people have undergone VCT during three health fairs. While this has been a strategic approach to linking IEC/BCC to HIV/AIDS services, a major challenge has been that such events have been one-time events and organized at district level. There is need to organize such events that directly link IEC/BCC to service utilization at lower levels, e.g. at HSD or even sub county level where the grantees have their direct activities. Thus, AIM will work with STF to build capacity of district partners/grantees to organize such events at lower levels.

During the year, AIM and partners have focused their youth preventive interventions mainly on out of school youth aged 10-24. This has complemented the activities of other key players such as UPHOLD who is supporting the PIASCY initiative in schools. However, YA has strengthened capacity of their staff and partners in Apac, Rukungiri, Bushenyi, Ntungamo and Soroti to implement abstinence-focused interventions in schools and AIM will support YA to scale up implementation in those districts. Similarly, there are a few district partners that have expressed interest in working with in-school youth. A thorough proposal review process has been done and those that qualify to work in schools by virtue of their mandate, background and staffing will be supported.

Another key national partner that AIM has supported in the past year has been the National Youth Council (NYC). As an organization, NYC falls under the MOGL&SW and has a structure that cascades down to the parish level. Using this structure, NYC has built capacity of 3,308 youth in peer education and life skills at district, sub-county, parish and village levels in the districts of Apac, Kumi, Ntungamo, Lira, Tororo, Rukungiri, Soroti and Katakwi. This resource will be tapped by the different grantees during mobilization, training, implementation and monitoring of HIV preventive interventions with youth.

An external mid-term review (MTR) of AIM indicated that many partners working with adolescents/youth did not clearly understand key concepts such as peer education and life skills. The MTR team recommended that AIM focus its prevention initiatives on populations that have been found, through epidemiological studies, to be driving the HIV epidemic, such as discordant couples and HIV positives. To help address these concerns, implementation guidelines for interventions have been designed and will be disseminated during technical forums. In addition, district resource teams are being strengthened to coordinate and provide technical assistance to grantees offering AFS. AIM will support grantees that target discordant couples, PHAs and IDP camps.

**Work plan activity 3.5: Assist MOH, DELIVER, Districts and relevant partners to facilitate and ensure the availability of male and female condoms in the AIM districts.**

AIM has continued to work with MOH and DELIVER to make condoms available to grantees through the district distribution system. However, there have been a number of challenges that have slowed down the implementation of planned activities:

- A condom mapping exercise was piloted in the district of Lira. The experience suggested that an entire district was a larger area than could be covered by one team of people in the allotted time. Consequently, mapping of condom distribution points in 15 AIM districts did not take off. MOH and its partners are using this experience to work out ways of how best this can be done.
- Engabu condoms, a government brand that AIM promotes, continued to be controversial and were finally withdrawn from the market. Provision is being made to have another brand on the market, and in the meantime the public is advised to use socially marketed condoms.
- The condom strategy and distribution plan was not published as earlier scheduled. A new date will be communicated in line with the editing and printing timetables.

Despite the challenges, grantees continue to integrate condom education and distribution in their IEC/BCC interventions with specific target populations. A total of 1,194,887 condoms were distributed in the final quarter of FY 04. Integration of condom education and promotion will continue by grantees working with mainly out of school sexually active youth, at risk populations such as discordant couples, HIV positives, IDPs and among under-served populations.

A number of proposals focusing specifically on condom education and distribution have been reviewed and activities such as condom mapping of the grantee catchment area have been included. These and other activities will be implemented in close collaboration with the District Condom Focal Persons during FY 05.

**1.4 Objective 4:**

***Increase access to and Utilization of quality HIV/AIDS clinical services in selected districts and sub-districts***

**Highlights:**

- Extensive training for health workers in OI management
- Capacity developed in 323 health centers to treat OI
- Over 27,000 infections treated
- Extension of CB-DOTS to all AIM districts, and over 750 health workers trained
- Training and resource materials developed for health workers
- IEC strategy developed on TB treatment compliance, dual HIV-TB infection
- Over 17,000 TB cases detected
- Strategies developed to target dual-infected individuals

- Grants awarded to districts to improve quality of TB services
- Technical assistance support to NTLP at national level
- 30 labs renovated, and 216 professional lab staff trained
- Developed and started using mobile laboratory kits to promote higher quality
- Over half a million lab tests conducted in AIM-supported labs

**Work plan activity 4.1: Assist DDHS, NGOs, and FBOs to implement and monitor interventions for management of opportunistic infections (OIs) consistent with national guidelines**

AIM provided important support for OI management this year, including development of training materials, training for clinical staff, support for home-based care, mentoring and support supervision for health workers.

**Major accomplishments:**

In FY 04, AIM worked with districts to help improve PHA access to quality clinical care services which include management of opportunistic infections. Capacity to deliver OI treatment has been strengthened in more than 323 health units including hospitals, HC IVs and HC IIIs. Specific achievements include:

- More than 240 operational level health workers trained in OI management
- Collaboration with MOH to develop and pre-test an OI training manual
- Over 27,000 infections treated in FY 04, of which 8,690 in final quarter
- 2,557 clients on OI prophylaxis with co-trimoxazole and 449 PHA have been referred and are accessing ART in the final quarter.

**Key activities for the next year:**

A major challenge is that many clients who test positive for HIV are not subsequently followed up and may not access treatment for their emerging medical needs. In the coming year, AIM will redouble efforts to link HIV positives to the networks of care that are developing at health sub district level. Strong linkages will be built through referrals from counselling and testing to clinical care to PTC and to communities. This will ensure that from the time of diagnosis, a client can access a coordinated continuum of services.

- **Infection Control (IC)**

Although AIM has done some stand alone infection control training, the programmatic emphasis has been to integrate training on infection control into other training courses for operational level health workers.

AIM has continued to support supervision and on-the-job training on IC through selected grants, especially the comprehensive grants to the DDHS. Reports from the Medical Superintendents indicate improved IC practices. A recent MOH evaluation of the Yellow

Star program, which has a strong IC emphasis, showed that the AIM-supported district of Ntungamo was performing at a higher rate than the other (non-AIM) districts included in the review. AIM also procured and distributed infection control equipment to 649 health facilities (level II through hospitals) in FY 04.

**Work Plan Activity 4.2: Assist DDHS, NGOs, FBOs to implement and monitor interventions for management of TB consistent with the national strategy and guidelines.**

As the year began, AIM established a set of ambitious objectives for its TB effort. These were to:

- ✓ Complete the CB-DOTS scale up process
- ✓ Develop an IEC/BCC strategy
- ✓ Promote joint HIV/TB activities, particularly referral for testing
- ✓ Assist the districts to establish more sputum microscopy centers (DTU)
- ✓ Assist NTLP to improve on training and IEC materials
- ✓ Improve the TB logistics supply system and information flow from districts to NTLP and vice versa

Through an effective combination of training, technical assistance, support for planning and coordination, supervision, and award of TB-specific grants, AIM was able to contribute to a number of important achievements.

**Major accomplishments:**

▪ **Capacity building and CB-DOTS roll out**

The number of districts implementing CB DOTs increased from seven in FY 03 to 16 in FY 04. AIM achieved its target of completing start-up training for CB DOTs (over 750 HWs trained) in the 16 districts by the end of June, 2004. To address issues of HIV-TB co-infection, AIM organized training for 41 VCT counsellors on TB and CB-DOTS and 120 health workers received orientation on TB-HIV collaborative activities. The extensive training resulted in an increase in the number of TB treatment sites from 269 at the end of FY 03 to 323 at the end of FY 04. AIM developed a TB training manual for health workers in conjunction with NTLP, WHO and Makerere Medical School as well as an aide memoir for clinicians. AIM also helped formulate a guide on joint TB-HIV activities for use in selected sites.

AIM supported District Tuberculosis and Leprosy Supervisors (DTLS) to attend a month-long course at Buluba Leprosy Center to improve knowledge and skills, and the DTLS and his assistant from Pader participated in a study tour and mentoring visit to Apac district to learn more about their roles as well as the CB DOTs program in Apac, which is one of the best performing districts in the country for CB DOTs.

To strengthen AIM's own capacity to support TB programs, the AIM Regional Medical Officers (RMOs) took part in short courses and the AIM TB manager attended a three-week international TB course sponsored by IUATLD. The National TB officer assigned by AIM to NTLP took part in a WHO-sponsored course in India. In addition, AIM staff made presentations at the International HIV/AIDS Conference in Bangkok and the global TB/HIV working group meeting in Addis Ababa.

- **Quality Improvement**

The AIM RMOs provided ongoing TA to NTLP zones throughout the year, and participated in health sub-district meetings to discuss CB-DOTS implementation challenges and opportunities. AIM awarded grants to each district (DDHS/DTLS) to support TB activities, with an emphasis on supervision. The grants included motorcycles, fuel and allowances for the DTLS and TB focal persons at the HSD level.

The AIM TB team worked with the AIM IEC manager and national partners to develop a targeted IEC/BCC strategy that focuses on improving treatment compliance, service utilization, use of sputum microscopy as the main basis for TB diagnosis, and awareness of the high likelihood of dual HIV-TB infection. Implementation of this strategy has been agreed upon by the NTLP and will form part of the national IEC/BCC strategy on CB DOTS and the joint TB—HIV communication strategy.

AIM participated in a quarterly TB review with REDSO, USAID and AID/W staff. The team met with partners working in tuberculosis and took a field trip to districts supported by AIM to assess TB/HIV activities. The team identified particular strengths of the AIM program in supporting CB DOTS and noted the improvement in key indicators such as case detection and treatment success. The team also encouraged further strengthening of TB-HIV/AIDS collaborative activities.

- **Services delivered**

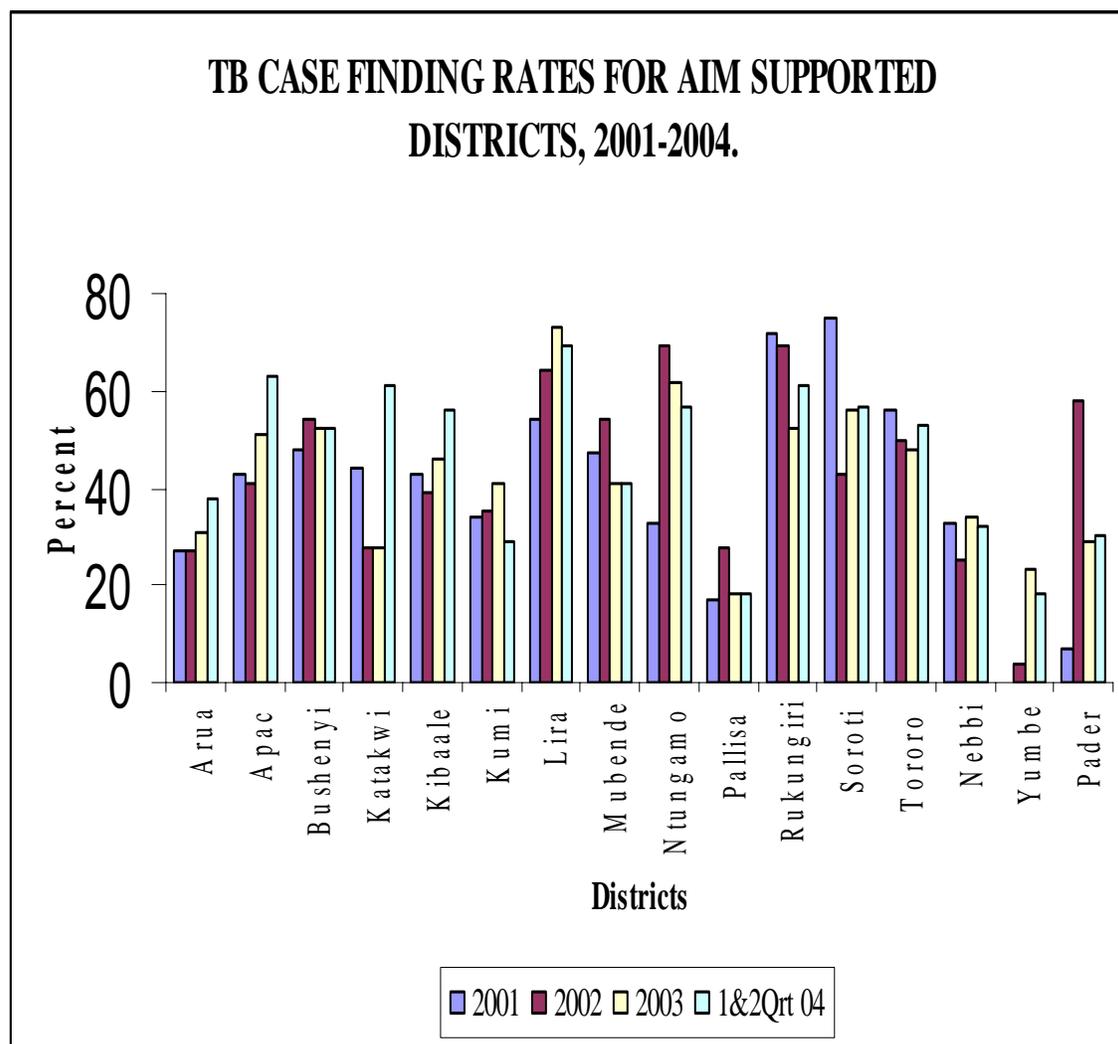
The use of TB services increased throughout the year. A total of 5,196 new TB patients were seen in the final quarter, easily surpassing the quarterly target of 3,625. The proportion of patients on CB DOTS also improved to 59%, well above last quarter's figure of 42%. The number of TB patients testing for HIV increased from 355 to 566, while 740 VCT HIV positive clients were screened for TB. The total number of patients receiving integrated TB/HIV services also increased by about 6%, from 1,224 to 1,306 in the final quarter.

AIM undertook a number of activities to address the still low number of TB-HIV patients. AIM established pilot collaborative sites, defined as having a TB/HIV committee, one that has received training on TB/HIV collaborative activities, and where a functional referral system and patient flow charts for TB/HIV clients exist. Specific achievements in this area include:

- ✓ 12 DHTs sensitized and 120 health workers trained on of the need to link the TB and HIV programs;
- ✓ coordination committees formed in 12 districts and at 23 health facilities;
- ✓ effective referral mechanisms put in place;
- ✓ a content outline/guide on TB/HIV collaborative activities developed and disseminated to implementing sites;
- ✓ key indicators identified for TB/HIV collaborative activities, and;
- ✓ design of IEC/BCC materials to support service delivery.

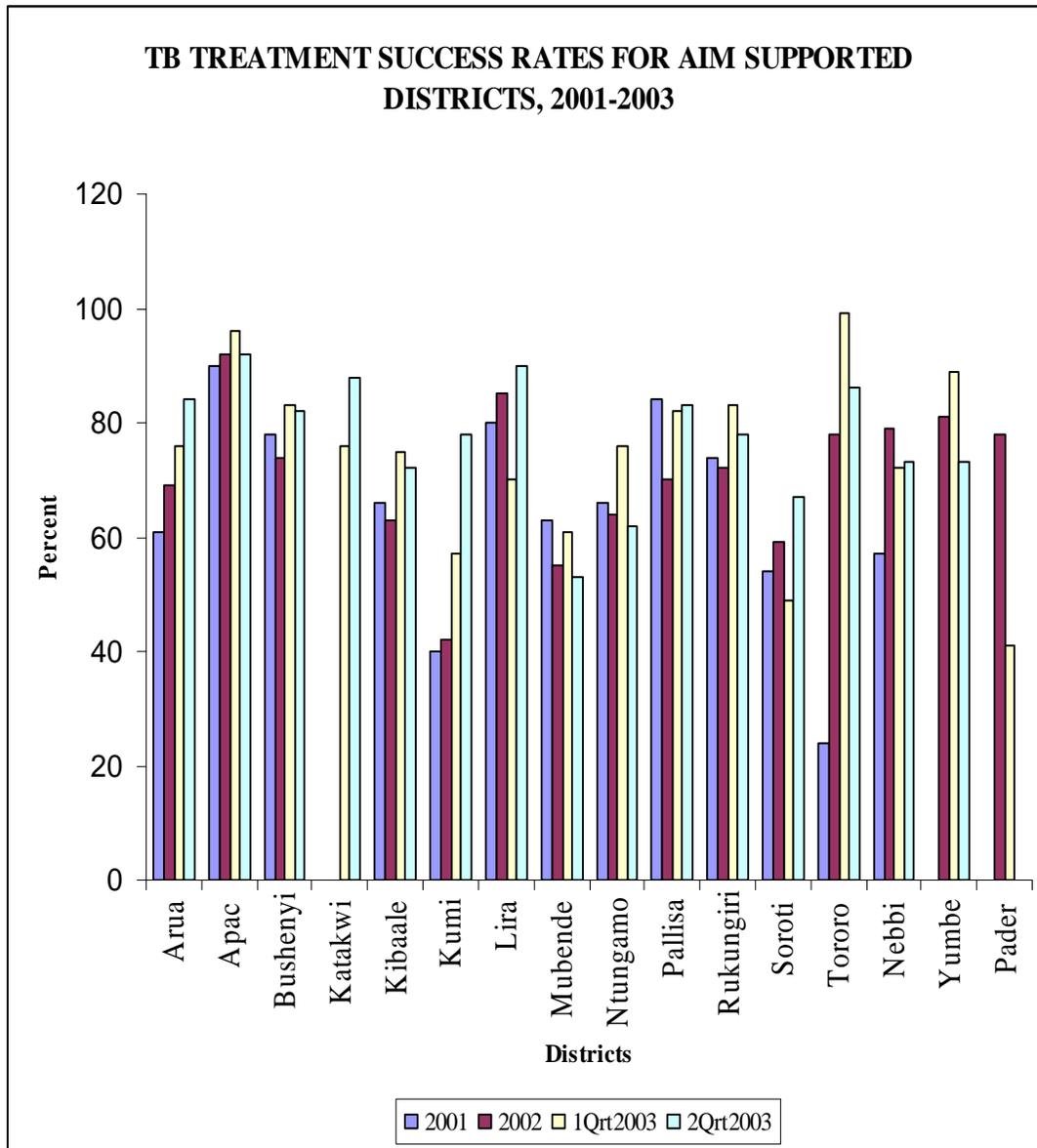
The number of TB cases detected in FY 04 was 17,408, compared to 8,000 in the previous year. Case detection rates improved most sharply in the districts of Arua, Apac, Katakwi, Kibaale and Lira but also Tororo, Nebbi, and Bushenyi. In FY 04, Lira was the only district that steadily improved to reach the target of 70% case finding rate. Yumbe is the lowest performing district with a case finding rate of 18%. A possible explanation for this is that Yumbe borders on Sudan, and cross-border movement affects case detection. See graphs below.

**Figure 1. TB Case Finding Rates**



## TB Treatment Success Rates

Over the years, only Apac has maintained a treatment success rate of over 85%. However, in the 2<sup>nd</sup> quarter of FY 04, Katakwi, Tororo and Lira hit the target. Arua, Bushenyi and Pallisa narrowly missed the target by a few points. Pader remains the lowest performing district with a treatment success rate of 0% by end of 2<sup>nd</sup> quarter 2003 (no reports received).



- **Support for NTLP at central level**

For several years, AIM has been providing support to the National Tuberculosis and Leprosy Program (NTLP) in order to build capacity. One AIM medical officer is assigned full-time to NTLP, and the TB manager at AIM HQ also provides assistance.

General technical assistance activities in FY 04 included:

- ✓ organization of two quarterly national TB stakeholders' meetings
- ✓ participation in the preparations for the launch of the STOP TB partnership
- ✓ participation in meetings for Zonal Supervisors
- ✓ Performance Improvement Assessment introductory workshops
- ✓ Support to Global Fund budgeting activities

AIM also contributed to several other NTLP initiatives, as below:

▪ **Improving Communication**

AIM has helped address communication and information access issues at NTLP. Working with a local ISP, AIM has helped support a local area network for the NTLP that was operational throughout the year. NTLP will be adopting and adapting Epicentre software for use in management of TB data. The AIM staff person at NTLP has coordinated efforts by NTLP, IULTD, and WHO to identify a consultant to adapt the software for Uganda and to train users. AIM has supported modification of key forms used in the routine data collection and procured registers and other printed materials.

▪ **LMIS**

Several AIM staff worked with NTLP and DELIVER in the redesign of the Logistics Management Information System (LMIS) for TB. AIM helped organize a workshop to design the new LMIS and a Training of Trainers workshop for 18 people. The training was then rolled out for the districts of Mbarara, Bushenyi, Kasese, Rakai, Kalangala, Sembabule and Masaka, with other districts to follow. AIM is also funding training of health workers in TB LMIS in the AIM districts.

▪ **CB-DOTS**

Although the AIM focus has been support for CB-DOTS in AIM districts, AIM has also contributed to the expansion and consolidation of CB-DOTS outside the AIM districts through support to the national TB program. AIM worked with Dr. John Walley from the Nuffield Institute for Health, University of Leeds to develop training materials. This involved organizing initial meetings at which the materials were adapted from generic WHO materials, a two-day meeting for materials review by key experts in TB, editing and pre-testing the materials, and final review. AIM contributed to World TB Day activities which included a print media campaign for CB-DOTS and drafting a speech for the Honorable Minister of State for Health on World TB Day.

▪ **Research**

AIM has contributed to the preparation of the upcoming TB-HAART study. This assistance has included participation in preparatory workshops, field visits, development

of standard operating procedures, and other activities. The AIM staff person at NTLP has been assigned data management responsibility for the study, which is scheduled to commence in March, 2005

**Major activities for the next year (FY5):**

AIM will pursue several new, innovative activities in FY 05 as well as continue to support ongoing initiatives. New areas include linking CB DOTS to family/household HIV counseling and testing, to be piloted in a few sub counties. The TB patient will become the entry point to the household and community and to the other HIV/AIDS services. AIM will work with the army to develop Cantonment-Based DOTS. The TB patient will become the entry point to the family and other contacts including the surrounding communities.

AIM will continue to support the following major activities:

- Support for CB DOTS, with particular attention to quality and consistency of supervision, improved smear microscopy, better recording and reporting of data, and fewer missed opportunities for case detection
- Implementing an incentive system that recognizes high performance and improvement of performance (i.e. case detection, treatment success, lab quality)
- IEC activities to increase demand, once lab services are in place and performing adequately to handle the increased volume of smears
- Development of tools and materials with the NTLP and other partners
- Roll out of the Epicentre-based TB electronic registers
- Use of the World TB day to advocate for greater district TB control efforts
- Work with MSH/M&L to complete national TB communication strategy
- Support the National TB reference lab to finalize standard operating procedures
- Continue HW training HW and strengthening the LMIS for TB.

**Work Plan Activity 4.3: Assist DDHS, NGOs, and FBOs to improve laboratory diagnostic capacity at level IV health facilities and above in the 16 districts.**

In 2002, AIM collaborated with the MOH, DELIVER, Macro International and Measure DHS, USAID and CDC to carry out a national health facility assessment. As part of assessing the status of health facilities to deliver HIV, STI and TB care, the study examined the ability of laboratories in the public and NGO sector to conduct basic tests and fulfil basic functions. The study noted:

- 1) an acute shortage of trained laboratory personnel, particularly in rural areas;
- 2) inadequate working space;
- 3) lack of basic equipment, reagents and supplies for laboratory diagnosis;
- 4) lack of supportive supervision and quality assurance tools, and;
- 5) inadequate coordination of laboratory services including refresher training

In response, AIM began to build the foundation for laboratory improvement by carrying out assessments of the physical infrastructure, developing curricula for in-service

training, and formulating standard operating procedures and job aides. In FY04, AIM continued to implement its strategy to enhance lab capacity through procurement of essential equipment, laboratory infrastructure improvement, and human capacity building through training, and improved coordination with partners like DELIVER, MOH infrastructure department, MOH laboratory coordinator and service providers.

**Progress in FY 04:**

1. AIM re-oriented 216 professional laboratory staff on testing for malaria, syphilis, HIV, and TB, and general laboratory organization, safety and laboratory logistics management. This program covered all HC IV and V in government, NGO, and FBO facilities with at least one technical staff to do the above tests.
2. AIM has overseen the refurbishment of 30 labs during the fiscal year. The remaining 49 are in various stages of completion.
3. AIM moved to improve the quality of lab results through improved district-based supervisory systems. AIM trained District Laboratory Focal Persons (DLFP) on QA and supervisory skills, provided each district DLFP with a motorcycle to facilitate supervision of peripheral labs, and shared job aides and protocols for various tests with all labs. This has improved the quality of lab based on results from three support supervision visits (see Annex I).
4. AIM worked to re-vitalize the interest of clinicians in the use of laboratory services by improving the accuracy of laboratory results. During support supervision visits, AIM/AMREF and the extended District Health Teams organized one-day meetings at district level with representatives from the HSDs, clinicians, nurses, and lab persons under the leadership of the DDHS to discuss issues concerning the labs and quality of results. At total of 213 participants participated in the meetings in nine districts.
5. Lab equipment was provided to all HC IV and V in the AIM-supported districts.
6. The MOH designated a DLFP per district to work with the DDHS to help improve the quality of laboratory services. AIM provided each DLFP in AIM districts with a motorcycle and a mobile laboratory kit to promote good laboratory practices. The kit contains essential equipment and minimal quantities of diagnostics and supplies to enable testing for HIV, syphilis, tuberculosis, malaria and anemia plus, quality control materials. The materials are contained in a carrier modeled to fit securely on the motorcycle. The DLFPs conduct monthly support supervision visits of one-day duration with the laboratory staff at each health unit.
7. Service utilization generally increased during the year as shown in the table below

Lab Test	Oct-Dec '03	Jan-Mar '04	April-June	July-Sept	TOTAL
HIV testing	3,833	30,020	62,373	57,351	153,577
TB sputum microscopy	248	4,826	5,868	7,119	18,061
Syphilis test	747	9,069	17,804	16,921	44,541
Malaria slide	8,261	80,887	122,786	96,256	308,190
<b>TOTAL</b>	<b>13,089</b>	<b>124,802</b>	<b>208,831</b>	<b>177,647</b>	<b>524,369</b>

- **Priority activities for the coming year**

AIM's major thrust in the coming year will be consolidation of the quality of laboratory services. Particular emphasis will be placed on follow up and supportive supervision of the laboratory staff of the districts of Arua, Mubende, Pallisa, Kibaale, Nebbi and Yumbe who have not benefited from previous supportive supervision after reorientation training. AIM will also continue to monitor and support the renovation of labs. Issues of continuity and capacity building of the DFLP, and linkages with the regional labs, will be pursued.

### 1.5 Objective 5

*Increase access to and utilization of quality social support services for people infected and affected by HIV/AIDS including orphans, vulnerable children and adolescents*

**Highlights:**

- Support for 11<sup>th</sup> International Conference for PHA
- Grants to national PHA organizations to build institutional capacity
- NACWOLA and NGEN+ open district branches to help PHA networks
- 56,000 OVC received services from grantees (55)
- Developed materials to strengthen psychosocial component of OVC package
- Support to UWESO to open district branches to support OVC programs
- 557 community workers trained in community and home-based care
- Grants awarded to THETA and Hospice to support palliative care
- Collaborated with TASO and MOH to revise manual for home-based care
- Procured and distributed 1,700 HBC kits to needy PHA

#### **Work Plan Activity 5.1 Assist districts NGOs, CBOs and FBOs to design and implement activities to support Persons Living with HIV/AIDS (PHAs)**

AIM supported the 11<sup>th</sup> International Conference of People with HIV/AIDS in Kampala October 26-30, 2003. Most significantly, AIM sponsored a two-day national conference for PHAs which preceded the international conference. Some 260 Ugandan PHA delegates, including 32 children with HIV, gathered for the first time in a national forum to discuss their needs and propose a way forward for the role of PHAs, both in advocacy and service delivery arenas. The national conference created a platform for discussion of

the need to further organize district-based networks of PHAs in order to develop a constituency that can inform and mobilize other PHAs to access services and care.

AIM provided grants to two national PHA networks, NGEN+ and NACWOLA, to build the institutional capacity necessary to support the development of networks at district level. NGEN+ took the lead in advocacy, while NACWOLA led in service delivery. AIM helped both organizations to better articulate roles and responsibilities and to define their core program areas. For NACWOLA this resulted in a more comprehensive strategic plan that was reflected in district-level grants negotiated during the targeted solicitation process. As a result of this process, AIM will fund an additional four NACWOLA district branches<sup>2</sup> bringing the total of AIM-funded NACWOLA branches to six.

AIM support to NGEN+ resulted in the establishment of six new district PHA networks, bringing the total number of district networks launched by Ngen + to nine<sup>3</sup>. The launch process took the form of district-based forums that sensitized both district leadership and PHAs to the need to identify and mobilize the PHA constituency to access HIV care and support services. With the arrival of antiretrovirals (ARVs) to Uganda, it has become more critical than ever to identify and mobilize PHAs who are not accessing services, and to help them become part of a comprehensive care network.

During FY 04, two AIM-supported networks in Bushenyi and Rukungiri successfully mobilized PHA constituents in their districts to be tested and to regularly attend HIV information sessions. For example, over the course of the year, the Bushenyi District Network for People Living with HIV/AIDS (BUDNET), expanded its organizational structure to cover the whole district of Bushenyi. BUDNET now operates at sub-county and parish as well as district level. Furthermore, its membership has increased from 200 to 7,000 PHA members.

Another important development this year was the formalization of the collaboration between NGEN+ and NACWOLA. AIM's work with both NGEN and NACWOLA to define roles and responsibilities served to minimize potential duplication of roles and efforts and ensured that specific needs of women and children were appropriately addressed in the newly established networks.

During FY 05, newly established district networks will be supported to effectively develop and manage networks for PHAs. Networks will develop mechanisms that ensure members access to palliative care activities that span the continuum of care from the time one is diagnosed with HIV infection up to the time of death. AIM will support NACWOLA to provide technical oversight and training to its six district branches in core program areas related to; the memory project, home-based care and organizational development. Additionally, AIM will provide support to establish and strengthen PTCs and to promote networking between them.

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<sup>2</sup> NACWOLA district branches of: Soroti, Kumi, Tororo and Rukungiri will receive AIM funding in FY 05, joining the district branches of Lira and Pallisa .

<sup>3</sup> District Networks launched by Ngen+ are: Soroti, Kumi, Apac, Arua, Kibaale and Mubende town.

## **Work Plan Activity 5.2 Assist districts NGOs, CBOs and FBOs to design and implement activities to support orphans and vulnerable children (OVC)**

AIM has continued to support a basic package of services that includes care and support, socio-economic security for care-givers, education, and psycho-social support for orphans and vulnerable children (OVC). A total of 55 grantees in 15 districts have reached over 56,000 OVCs this year. AIM technical assistance is evolving to support children more holistically by strengthening families, communities and schools to meet the psycho-social and physical needs of children.

An internal OVC mid-term review found that AIM support to grantees was primarily in two areas of basic needs—educational and economic support. Although support provided responded to caregiver and children concerns around limited resources, it only covered a portion of the basic needs package recommended in the National OVC policy. To increase grantee knowledge about an integrated package of OVC support, AIM collaborated with Uganda Women’s Efforts to Save Orphans (UWESO) and District probation officers to conduct a training needs assessment and generate the training content for an OVC manual for community volunteers.

The assessment found that grantees had been trained on different aspects of children’s rights, business management, psycho-social support, income generating activities and organizational development. Training periods ranged from one day to two weeks and were often, at best, an introduction to the subject. Most training was attended by grantee management as opposed to staff directly engaged with the community. To establish specific needs around psycho-social support, AIM supported a team of doctoral students from Howard University (USA) and Makerere University (Uganda) to conduct site visits that assessed the status of psycho-social support to OVC, in particular the psychological and emotional needs of children and caretakers as well as what counseling services were being provided to OVC.

The visits revealed that in programs offering counseling, the services were consistently lacking in meeting the psychological needs of children. Orphans interviewed by the team expressed their fears of being stigmatized, their feelings of being burdened due to limited resources, sadness, helplessness, hopelessness, neglect and isolation from relatives and the community. From these findings the team developed a psycho-social module that formed part of the draft OVC manual. Other modules in the draft include access to basic health, education, food security and nutrition, livelihood security and child protection. These areas were developed with the participation of Mildmay, UAC, TASO, district probation officers, UWESO staff, MOGLSD representatives, and other resource persons.

In addition to manual development, other technical assistance provided by AIM to grantees has evolved to focus on helping them redirect their efforts towards a more holistic OVC support package. No single grantee is able to offer all the elements that constitute a comprehensive social support program for OVC. As a result, grantees are encouraged to link up with other local partners (Government, NGOs, CBOs) offering different services through a system of referrals. The AIM strategy to encourage grantees to support children more holistically has resulted in CBOs and district officials being

more conscious of the multisectoral range of OVC needs, as was reflected in the grant applications received during the targeted solicitation process.

At national level, AIM participated in several review workshops and meetings to develop the PIASCY handbook for primary school teachers. AIM reviewed the message content and age-appropriateness of the 24 messages for school assemblies. A national level grant was awarded to UWESO to develop their capacity to strengthen and establish UWESO district branches as centers of excellence that mentor and support grantees in OVC programming. In addition to developing training materials for grantees, the grant expanded UWESO's OVC community model<sup>4</sup> into three new districts<sup>5</sup> and developed mechanisms that integrated a specific response to HIV/AIDS into the model. The UWESO capacity building process called for a significant amount of technical assistance as well as other organizational inputs. AIM's targeted solicitation process helped UWESO district branches access funds to scale up UWESO's community model in the districts. In FY 05, AIM will fund an additional 5 UWESO district branches<sup>6</sup>, bringing the total number of AIM-supported branches to ten.

There were numerous challenges in the OVC program this year. Two of the biggest were related to the scale of the problem—the sheer number of OVCs as a result of the epidemic—and quality of grantee programs. Grantee quarterly reports have continually reported the fact that there are far more orphans requiring support than grantees are able to cope with. This calls for a strategic approach to scale up interventions to support orphans rather than continuing to provide grants to small organizations that have limited capacity to expand coverage. AIM has responded by seeking out CBOs who can reach more children, and community-based interventions like the UWESO model are being strengthened to scale up.

With regards to the issue of quality, AIM will encourage links between grantees, other development programs and government agencies working core program areas of the National Strategic Program Plan of Interventions for Orphans and other Vulnerable Children (NSSPI). Livelihood security will be a key focus area because many of the problems of OVCs and their households stem from their economic problems. The ability of families to cope with the impact of HIV/AIDS largely depends on their capacity to sustain their income. AIM will also develop implementation guidelines and tools that will help assess the degree to which grantee services achieve a desired level, or standard, of quality. This approach will be spearheaded by the QA unit at AIM.

During FY 05, AIM will focus on strengthening the capacity of communities and families to deliver a comprehensive OVC package. In the area of IEC/BCC, support will go towards integrating preventive and stigma reduction messages into OVC programs. The

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<sup>4</sup> The UWESO model is an integrated package of support for OVC and their caregivers. The package incorporates a savings and credit scheme, community-based training around basic needs and services and youth skills development. The package is administered by UWESO staff and community volunteer committees.

<sup>5</sup> AIM funded the extension of UWESO offices in the districts of Apac, Tororo and Rukungiri

<sup>6</sup> 5 new UWESO branches include; Ntungamo, Kibaale, Kumi, Soroti and Pallisa.

draft OVC training manual will be field-tested and finalized. Community volunteers, attached to each CBO, will be trained to undertake home visits during which they will mentor and support families in the provision of integrated OVC services. Content of the manual will contribute to the development of an easy-to-use tool kit for grantees. Key areas of focus will be in livelihood security, psycho-social support and IEC/BCC interventions to address stigma and discrimination.

- **Community and Home-Based Care**

**Work Plan Activity 4.4: Assist districts, NGOs, CBOs and FBOs to design and implement home-based care (HBC) for people living with AIDS.**

There were two main areas of focus by AIM during FY 04: building the capacity of CBOs, FBOs and NGOs to implement HBC through training and technical assistance, and; scaling up HBC as a means of delivering palliative care by utilizing national level partner organizations to support district and community initiatives.

**Key achievements:**

*Technical support supervision:*

Technical support supervision has been conducted for 38 grantees who offer home-based care as their primary activity. The following challenges were identified among the service providers;

- Limited knowledge and skills in home-based care which compromised the quality of services offered
- Weak referral systems—limited grantee knowledge of what to refer for and where
- Trainings conducted by district trainers for community volunteers were inadequate due to lack of standard training curriculum
- Low literacy levels by community volunteers hindered them from fully benefiting from training conducted in English
- There is an overall shortage of district trainers for community volunteers in HBC in the AIM-supported districts and even those available cannot train in local languages.

These issues were addressed by conducting training, providing standard training curriculum, and individual support to grantees. It is also in the plan to conduct a TOT at district level for grantees supporting community volunteers.

**Training:**

A total of 557 community workers were trained in basic home-based care. Training content included facts about HIV/AIDS, nursing care, nutrition, management of common illness and opportunistic infections, record keeping, referrals and communication. From the larger pool of trained community workers, 18 individuals were trained in psychological support which includes psychosocial support, care of children, memory book writing, will making, dying and death, working with traditional health practitioners,

and grief and bereavement. TASO was contracted to conduct the trainings with the aim of scaling up CHBC for AIM grantees, and district trainers conducted trainings for community volunteers. All the trainings included hands-on learning and field visits designed to build necessary skills and competencies.

### **Granting:**

#### *National grantees:*

Grants supporting palliative care (and HBC) were reviewed and 25 CBOs, FBOs and NGOs received funding during the period. Two national level partners, THETA and Hospice, were awarded grants to implement palliative care by involving traditional health practitioners and health providers, respectively, in delivering services.

THETA collaborates with traditional healers to increase access to HIV/AIDS prevention and care in rural Uganda with AIM's support. Among other activities, they have carried out STD and HIV/AIDS awareness workshops in three districts and community mobilization training. They have offered support to Traditional Healer Associations and carried out patient monitoring in the districts. AIM helped THETA review and update its training curriculum and changes were made to sections on VCT, HBC, HAART, OVC, PMTCT, TB and malaria.

Hospice was awarded a large grant in June, 2004 to support OI management, CHBC, PHAs and palliative care. The grant will help improve access by PHAs to the range of palliative care services they need, and to empower health and non-health professionals with the knowledge and skills to deliver these services.

Since June, Hospice has moved quickly and recorded the following achievements:

- A one-day coordination meeting to introduce palliative care and the use of morphine. The meeting was attended by partners from MOH, TASO and Mildmay Centre.
- A community caregiver course was conducted for 31 participants, imparting knowledge on palliative care and how it is implemented in the community.
- A one-day sensitization workshop for key District health personnel was held to introduce palliative care and the use of oral morphine, and a similar two-day workshop was delivered for operational health workers.
- A course to introduce counseling in palliative care was held for 20 health and allied professionals who work with care organizations and whose roles directly link to patient care.
- A one-day workshop on sensitization of senior ward managers on policy issues in palliative care and morphine use was carried out for 88 senior nursing managers. .

## **Materials development:**

### *Home-Based Care manual:*

To respond to issues identified during support supervision visits, a Home-Based Care manual was developed by TASO. Training content included fundamentals of HIV/AIDS, nursing care, management of OIs, records, referrals and nutrition. A pre test of the manual revealed that it did not address holistic care for PHAs. Consequently AIM, with TASO, MOH and other partners, reviewed the manual to add palliative care, psychosocial issues, child care, preventive care package, legal issues, bereavement, death and dying and working with traditional health practitioners. The final manual is expected to be ready for use by December, 2004.

## **Service utilization:**

### *Home-Based Care kits*

To address material needs of PHAs, AIM procured 1,700 HBC kits for distribution by grantees to needy PHAs. The kits contain bed sheets, mosquito nets, soap, mackintosh protector, gauze, adhesive tape and gloves. AIM, TASO and MOH will review the HBC kit effectiveness to determine whether additional kits should be distributed.

### *Clients reached by the service providers:*

During the period, 43,499 PHAs received HBC services from AIM HBC grantees.

## **Major activities for FY 05:**

- Completion, dissemination and operationalization of home-based care manual
- Work with other stakeholders to incorporate the basic preventive care package in the home-based care program
- Support THETA to build capacity of traditional health practitioners in HIV prevention, care, and referral
- Support Hospice to integrate palliative care in grantees' activities
- Build the capacity of grantees and community volunteers to scale up HBC
- Provide technical support and supervision to grantees
- Procure and distribute additional HBC kits.

## **Section 2: Strategic Information**

Overview: The Strategic Information division at AIM comprises monitoring and evaluation, quality assurance and IEC/BCC services. The division was created during this reporting year in an effort to bring together, under one grouping, many of AIM's key cross-cutting support services. AIM strengthened the capacity of this division during the year through hiring of new staff and effective use of consultants and interns. As described in more detail below, the Strategic Information division has enjoyed a productive year.

### **2.1 Monitoring and Evaluation**

During this period, the AIM M&E unit was engaged in a number of activities both at national and district levels.

- **Measurement issues**

Situational Analysis: The M&E unit worked with its sub-contractors at Makerere University (Department of Social Work and Social Administration and the Institute of Statistics and Applied Economics) to complete the Situational Analysis exercise for the Phase II districts of Arua, Yumbe, Mubende, Kibaale, Pallisa and Nebbi. These analyses have been shared with USAID and the district partners.

Referral assessment: AIM designed and oversaw a study of referral systems in six districts. The final report submitted to AIM identified the need to:

- enhance service providers' capacity to manage and implement referral mechanisms through relevant training;
- develop and disseminate standardized client assessment and referral forms and avail them to service providers (both clinical and community) and;
- formalize provider coordination for HIV/AIDS services in order to transform the existing informal collaboration between the public and private, clinical and community providers into more formal and practical linkages.

The findings from this study are of practical relevance as AIM assists districts to develop referral networks for HIV/AIDS services at health sub-district level.

Individual studies: AIM provided limited support to individual researchers and institutions on topics of mutual interest. AIM, in partnership with the Makerere University Institute of Public Health, provided support for five studies, as follows:

1. A comparison of knowledge, attitude and practices about HIV/AIDS among deaf and hearing students in Kumi district, Dr. Ekirapa Elizabeth; Institute of Public Health, Makerere University

2. Comparative study of the natural causes of death among inmates of Uganda prisons and the community as at autopsy in Mulago, Dr. Sylvester Onzivua; Institute of Public Health, Makerere University
3. Prevention of Mother to Child Transmission of HIV. Kibaale, Dr. Ngobi; Institute of Public Health, Makerere University (still in draft)
4. Factors affecting implementation of CB-DOTS. Kibaale, Dr. Linus Amandu; Institute of Public Health, Makerere University
5. Women caregivers' burden, coping strategies and the psycho-social well being of HIV/AIDS patients, Mary Tushable; Dept. of Psychology, Makerere University

Mid Term Review (MTR): The M&E Unit played a key role in the preparations for the mid-term review (MTR) that took place in June, 2004. This included preparing the briefing book, working with all staff to refine targets for different program indicators, and making presentations to the MTR team on the overall M&E processes and approaches. Frequent discussions with the MTR team helped to shed light on key progress and accomplishments to date, the appropriateness of different M&E approaches as well as the challenges to be addressed in the years ahead.

#### ○ **Training**

During the year, the M&E unit conducted the following trainings;

Training for HMIS focal point persons: Realizing the need for a sustainable system for data collection, management and use at the district level, the M&E unit worked with the District Directorates of Health Services (DDHS) in all the 16 districts to strengthen the existing HMIS to ensure timely and complete reporting on HIV/AIDS service provision. To this end, AIM jointly developed and installed a simple MS Access database to ease the process of data analysis and use in decision making at the district and other levels.

District HMIS training: Participants included district health management information system focal persons, statisticians, surveillance focal persons, records assistants and selected staff from District Planning Units. The objectives were to equip participants with basic computer skills and techniques of data management and analysis, and to introduce participants to improved techniques of report writing and data utilization.

Data quality improvement: To follow up the data quality audit, AIM worked with MOH and UPHOLD to organize training to improve data quality, self-monitoring and feedback.

Training for DACs: AIM provided M&E training for DAC members in several districts to build capacity to develop appropriate indicators for the district strategic plans and to monitor the implementation of HIV/AIDS interventions in the district.

- **Support to grantees and partners**

As part on the on-going mentoring process to build grantee capacity, the M&E team worked with grantees during the year to develop appropriate M&E indicators, keep appropriate records, do simple data analysis and use information for decision-making to improve service delivery. Consequently, the M&E unit has been encouraged by the relatively high degree of timeliness and quality of grantee reporting. In the coming year, M&E staff will continue to work with the grantees to consolidate these gains.

- **Reporting**

AIM continued to provide report to USAID on a routine and timely basis:

- 1) TraiNet: quarterly reports on persons trained during the year
- 2) PMTCT bi-annual report: Part of Emergency Plan reporting
- 3) PEPFAR reports: These reports focused on progress against indicators and the cumulative progress made by AIM-supported grantees and partners
- 4) Milestones: AIM prepared and submitted a summary report on progress against these indicators in April. AIM also developed a new set of milestone indicators for the year beginning April 1, 2004 in response to a request by USAID.
- 5) Quarterly Reports: These reports have primarily reflected AIM's achievements and progress against set targets.

- **External engagement**

Staff from the M&E unit played an active role in a number of activities both at national and district levels, including:

- Mid-term review exercise of the Uganda AIDS Commission
- Mid-term review exercise of the CHAI program under Uganda AIDS Control project using the Local Quality Assurance Sampling Methodology
- The National Task Force for the on-going national HIV/AIDS sero-prevalence survey.

- **Dissemination**

The M&E unit collaborated with district partners to conduct a series of feedback sessions to promote quality data and use for decision making at the district and lower levels. This effort will be amplified in the remaining years of the project should contribute substantially to improved planning, both operational and strategic.

- **Challenges**

AIM faces a number of challenges in its efforts to improve data collection and reporting among districts and grantees. AIM is mindful that it is but one of many organizations

requiring performance data, and therefore seeks collaborative approaches and solutions to the problems below in line with MOH plans and directives:

- Lack of uniform, standardized data collection formats
- The national health and management information system does not routinely capture many of the service elements supported by AIM and required by PEPFAR
- AIM faces multiple reporting requirements that change over time in response to donor imperatives
- AIM-supported districts and grantees may become over-burdened by reporting requirements

## 2.2 Quality Assurance

The Quality Assurance section continued to support districts in quality monitoring and improvement this period through collaboration with AIM initiatives providing direct assistance to districts and grantees. QA contributed to Partnership Support/grants, referral networks, IEC/BCC, M&E, Clinical Services, and Community and Preventive Services. The QA section provided particularly intensive support to Community and Preventive Services Department this year in development of strategies, guidelines and tools.

In addition to providing supportive services to AIM service delivery efforts, the principal areas of focus for the QA section were a) development of HIV/AIDS Service Toolkits and b) launching an initiative to develop district level Quality Assurance systems.

- **HIV/AIDS/TB Service Toolkits**

Work on a set of HIV service “toolkits” began this fiscal year. The toolkit initiative was initially conceived to provide AIM staff, partners and grantees with tools to guide and strengthen the delivery of services. However, after consultation with national partners, the design was adapted to be appropriate for a broader range of implementing agencies.

The QA section is working with the MOH and other partners to ensure stakeholder participation, ownership, and use of the final products. AIM had originally planned to develop seven toolkits (on VCT, PMTCT, TB, CHBC, OVC, targeted prevention programs, and adolescents) but may ultimately reduce this number or otherwise combine, modify or simplify elements. Each toolkit will provide simple, user-friendly guidance and tools on planning, delivering, monitoring, and promoting the designated service.

AIM is using technical expertise in materials development from World Education to enhance quality of the product and is following a highly consultative process with national and district experts and partners to ensure local relevance and accuracy. To date on the toolkit initiative, the QA Section has:

- Met with and established working linkages with national HIV service partners
- Assembled an extensive resource library

- Developed grantee checklists and tools
- Revised and updated service strategy statements
- Drafted a “blueprint” for a generic toolkit
- Held a national stakeholders meeting to launch the toolkit initiative
- Prepared draft VCT, PMTCT, OVC and Adolescent toolkits
- Conducted formal review sessions for draft OVC, Adolescent and VCT toolkits
- Submitted a draft PMTCT toolkit for review by MOH

Issues that have contributed to a delay in finalization of the toolkits include a) QA section staffing difficulties, and b) consultative process impediments. Regarding staffing, the QA section currently has only one full-time staff person and has relied on local consultants to provide assistance in drafting and compiling the toolkits. The QA section may seek additional consultant staff to increase the pace of progress on toolkits, and expects to see three toolkits finalized and disseminated over the next two quarters.

AIM has conducted necessary and appropriate consultation with MOH on the clinical service toolkits. While critically important for ownership and acceptance, this consultative and inclusive process has, nevertheless, delayed toolkit progress due to the limited number of MOH staff available to properly review and endorse the draft toolkits.

○ **District HIV/AIDS/TB Quality Assurance System Development**

The QA section consulted internally and with a broad range of partners and stakeholders to design an approach for strengthening service quality monitoring and improvement systems at the district level. By quarter three, agreement on the general approach had been achieved and, by quarter four, implementation of the design phase had started. The approach addresses clinical and community service quality separately as follows.

For clinical services, AIM has partnered with the MOH and the Regional Centre for Quality of Health Care (RCQHC), a well-regarded organization founded and supported by USAID/REDSO. RCQHC has started the process of developing performance statements as the first step to an assessment of service quality and ultimately creation of a district-based system for continuous quality monitoring and improvement. JSI is providing high level expertise to support analysis and dissemination of service statistics to identify possible quality problems to inform and guide the district-based system.

For community services, the QA section is partnering with the AIM Community and Preventive Services Department, World Education and national and district partners to launch a community services quality assurance system. AIM will begin with the development of selected service “implementation guidelines” (based on national policies and best practices) which will serve as quality standards for the development of quality monitoring tools.

For quality assurance system development, the QA section has:

- Designed and vetted approaches for development of clinical and community service quality monitoring systems
- Contracted with RCQHC to develop clinical service performance standards using participatory methods
- Initiated analysis of AIM district service statistics for identification of quality issues
- Started a performance statement development exercise
- Planned TA for community services implementation guidelines development

- **Major activities planned for the next year**

The QA Section will continue work on all three major initiatives as outlined above (toolkits, community and clinical service quality systems development), with the following activities planned for the coming quarters:

- Design, layout, pre-testing, printing and dissemination of VCT Toolkit (Dec 04)
- OVC, adolescent and PMTCT toolkits finalized
- National QA Stakeholders' meeting for clinical service quality monitoring
- Conduct assessment of clinical service quality
- Launch field-based approach to community service quality monitoring

### **2.3 IEC/BCC and External Relations**

- **Background**

AIM's focus on IEC/BCC has been to strengthen capacities of partners and grantees to implement effective BCC interventions. This focus is based on findings of the BCC assessment for HIV/AIDS carried out for AIM by Communication for Development Foundation Uganda (CDFU) in 2003 in the 16 districts. Findings indicated major gaps in skills and competencies of local organisations and districts in planning, implementing and evaluating BCC interventions. In addition, coordination of BCC activities was found to be weak, leading to duplication, inconsistencies in message dissemination, and misuse of the limited human and material resources.

Recognising its own internal BCC capacity needs, AIM recruited a BCC specialist to manage this component of the program. The officer started work in May, 2004. Prior to and after this recruitment, the program engaged a number of consultants to undertake different tasks in support of BCC interventions.

- **Participatory Theatre**

A consultant was hired to conduct training in creative theatre skills for community-based groups in the districts of Bushenyi, Lira, Arua, Kumi, Pallisa, Soroti, Rukungiri, Ntungamo and Apac. A total of 16 theatre trainers developed enhanced skills during this consultancy. Two theatre training videos and a draft training manual were produced during the same consultancy. AIM evaluated this intervention to determine effectiveness

of the training and the usability of the materials developed, and found that participatory theatre (drama) is a key BCC intervention with good potential for replication and impact in the Ugandan context.

- **Strategy Development**

AIM addressed a key program gap by developing a comprehensive IEC/BCC strategy to guide implementation in the final two years of the program. The strategy builds on previous work by AIM, notably the study by CDFU and the evaluation of the community theatre work. To further inform the strategy development process, AIM engaged a consultant team to assess the use of radio to promote behaviour change in the AIM-supported districts. An external consultant helped AIM develop an initial draft strategy, which was then further vetted with AIM managers and national stakeholders. To ensure district input and validation, AIM organized and conducted a five-day BCC strategy development workshop in Jinja in July, 2004.

The final, comprehensive strategy emerged out of these consultative processes. The locomotive theme of the strategy is Winning through Caring which calls for participatory, target-specific, gender and culture-sensitive sets of activities that respond to current epidemiological and behavioural trends in HIV and TB infections. For each program area, key target groups, behaviours and message elements are clearly identified.

As part of the implementation of the strategy, an 8-episode radio serial drama, 3 radio spots and 3 sets of brochures and posters addressing key TB behavioural issues are under development in collaboration with NTLP. Three sets of brochures on MTCT originally developed by the MOH in English were translated in five local languages for use in the 16 AIM-supported districts. Some 20 grantee applications have been reviewed and discussed with potential grantees to fit into the current BCC strategic framework. Peer education, participatory theatre, and district-specific radio programs that respond to community needs are the key approaches under implementation.

- **External Relations and Resource Sharing**

AIM has a responsibility for sharing with partners, grantees and other interested groups the work that it supports in the districts. Further, AIM is able to use its resource centers at HQ and regional level to increase access to information materials to individuals and organizations engaged in HIV/AIDS activities. These efforts are described below.

- **Communications**

This unit at AIM is responsible for bringing news of the activities and accomplishments of AIM grantees and partners to the attention of national and district stakeholders. AIM does this in several ways, including disseminating the SCOPE newsletter, the project brochure and other documents, maintaining a simple website, and by liaising with regional and national media to facilitate coverage of important activities. National, Africa regional and international conferences are another opportunity to share project experience, and these have been supported on a limited basis. The final years of the

project offer AIM many opportunities to document and disseminate key project findings, approaches, and lessons learned to multiple audiences both in and out of Uganda.

- **Revision of project brochure**

The AIM brochure has been updated both in graphics and content to provide information on AIM-supported services and principal approaches to providing integrated services

- **SCOPE Newsletter**

AIM developed and disseminated two volumes of SCOPE this period. Volume 6 (September 2003) was released to coincide with the 11<sup>th</sup> International Conference of PHAs held in Kampala in October, 2003. Five thousand copies of this issue were printed and distributed. SCOPE Volume VII was disseminated in June, 2004. This edition focused on the work done by AIM grantees in the context of referral networks. Field work to gather material for the next issue of SCOPE (Volume 8) has started and will be completed in November, 2004.

- **Public Relations**

In early December, 2003 Uganda hosted a large, high-level delegation of visitors interested in seeing how Uganda has responded to the HIV/AIDS epidemic. The delegation, led by the US Secretary for Health and Human Services, included high ranking officials from the Office of the Global AIDS Coordination, CDC, USAID, WHO, CEOs of major multinational companies, academics, and representatives of faith-based organizations. AIM participated in several events organized for the visiting delegation, including a poster-session in Entebbe and two formal receptions in Kampala. In addition, AIM assisted several of its grantees with their presentations to the visiting delegation.

AIM regional and cluster offices received digital cameras and laminating machines to support the production of photos and text material for display within the respective offices and for the AIM grantees in their districts.

AIM staff met with a team of family planning experts from The Gambia in order to discuss integration of services, with a particular focus on PMTCT. AIM HQ staff also assisted cluster and regional offices in their preparations for visiting delegations of officials from USAID, REDSO, AID/W and other international organizations.

- **Media Relations**

Two national newspapers, numerous radio stations, and television have reported on AIM activities and grantees on a fairly regular basis. These media have provided coverage on such areas as capacity building through district grants, laboratory renovations, provision of equipment and supplies, and funding of emergency grants through the district disaster management committees for districts in conflict.

- **Materials Received and Distributed**

AIM supported the distribution of materials to grantees and partners, including copies of YoungTalk, StraightTalk and TeacherTalk, World AIDS Day Campaign materials from UAC/UNAIDS, Reach Out Mbuya publications, and VCT and PMTCT materials.

- **Support for presentations**

AIM had three poster presentations accepted for the XV International AIDS Conference in Bangkok, Thailand, including one for a partner from Rukungiri district. Another presentation on TB was made in September in Addis Ababa at a WHO-sponsored event.

- **AIM website**

The AIM website features documents and reports depicting the work that AIM supports in the districts. Several thousand individuals have visited the website this past year to browse and download copies of SCOPE, annual reports and other documents.

- **Resource Sharing**

AIM has created four fully functional resource centers—one based at headquarters and three housed in the regional offices of Lira, Soroti and Bushenyi. The HQ and Lira centers are co-located and managed with UPHOLD.

- **Achievements**

The regional resource centers have become fully functional this year, serving the needs of program staff, district partners, and other users. All information materials are processed and managed using ResourceMate software. Internet access has been added to the centers, a feature which should contribute to greater use in the months ahead.

The resource centers acquired a variety of information materials (books, newspapers, brochures, newsletters, video tapes, CD-ROM, reports, studies and other documents) from a variety of sources, including headquarters and district partners. The table below gives an indication of the quantity of materials available at each center.

The number of visitors to the resource centers increased steadily during the course of the year. Many information users have given good feedback regarding the organization and relevance of the center as well as the materials available for reading or borrowing. Video tapes are rated among the most useful information materials in the regional offices, and through these communities have been able to learn about HIV/AIDS. Simple materials in local language form part of the regional resource centers holdings (posters, brochures and video tapes) to cater to community members with low levels of literacy.

- **Challenges/Way forward**

There will be a gradual but steady increase in the number of materials available in each center, and AIM will continue to promote the resource centers and seek to expand the user base. This will be done by organizing quarterly exhibitions of available information resources, providing user groups with lists of new acquisitions, encouraging different user groups to organize information dissemination activities at the resource centers and organizing regular user education (especially on internet and CD-ROM). Materials in local languages will continue to form an important part of the holdings of each center.

As AIM winds down, the regional resource centers will be transferred to an appropriate institution to ensure continued access and use. AIM is already in contact with district officials in Soroti Hospital and well-established organizations like the Uganda AIDS Commission to discuss their interest in taking over the centers at the appropriate time.

#### **Summary of Use of Available Services from June 2003 to September 2004**

<b>ACTIVITY/SERVICE</b>	<b>HQ</b>	<b>Lira</b>	<b>Bushenyi</b>	<b>Soroti</b>	<b>Comment</b>
Acquisitions: (books, video tapes, CD-ROM, articles, reports, newspapers, newsletters, journals)	1,397	575	487	584	More materials needed in region
Visitors to Resource Center	618	75	110	124	Not all sign in
Lending/Borrowing information materials	569	51	79	67	Some materials are on reserve and cannot be lent out
Circulation and distribution of brochures, newsletter and newspapers to RCs, partners and grantees	32,675	5,355	5,700	19,620	Distributed to partners including those not registered as RC members
Staff Updates (video shows, presentations, new materials )	8	5	6	7	Provided to staff
Internet services (searches, downloading, printing and circulating articles from internet)	570	17	30	40	Numbers still low because of frequent internet problems
On-line Journals (subscriptions)	20	X	X	X	To be promoted in the regions
Nbr of collaborating partners (TASO, UNASO, WHO, UACP, UAC, AIC, Ministries, etc)	16	6	5	8	Collaboration in the regions is still low

## **Section 3: Program Management**

### **3.1 Collaboration**

AIM collaborated effectively with an array of partners at national and district level. Key areas of collaboration include planning, measurement and assessment, training, policy development, and administrative services (see 3.2 below).

### **3.2 Finance and Administration (F&A)**

F&A went through a marked transformation during the reporting period in response to program growth and organizational restructuring. AIM established new and improved administrative systems and processes, recruited additional regional and headquarters staff, and played a leadership role in harmonizing practices and policies with other JSI Uganda projects. By working together, AIM and the other JSI projects in Uganda were able to take advantage of economies of scale to increase savings and improve operational effectiveness. Finally, in early 2004, F&A officially inherited the grants management functions of AIM (see section 1.3 for grants management reporting.)

- **New systems**

AIM revamped its administrative and accounting systems to link them to the work plan and the new organizational structure. This involved introducing new forms, procedures and ancillary databases for proper program cost tracking and better management of purchasing, fixed assets and vehicle fuel and maintenance.

- **Personnel**

Personnel activities were large in scope. First and foremost, in conjunction with AIM's new organizational structure and in preparation for expanded activities in the districts, 23 new positions were created and filled, including critical new posts based in newly created regional and cluster offices in the districts. F&A was critical in setting up three regional offices and three cluster offices in the districts. It provided logistical, financial and general managerial support in setting these offices up quickly and efficiently.

AIM's Finance and Administration Manager went to JSI headquarters in Boston to become acquainted with the full cycle and scope of JSI's international project management in regard to AIM.

- **Salaries**

AIM analyzed staff salaries in order to root out inequities and to conform to the new AIM organizational structure which had resulted in new job responsibilities for many staff. This exercise also took into account comparisons and consultation with UPHOLD in order to derive a logical and equitable salary structure.

- **Harmonization with UPHOLD**

AIM and UPHOLD pursued a harmonized, standard application of policies and regulations for both projects. On personnel issues, the JSI projects jointly developed and adopted standard policies on staff per diem, relocation allowance (for staff obliged to relocate within Uganda to take up their assignment), driver telephone air time allowance and day travel allowance. Of greatest importance was working with UPHOLD to ensure that the restructuring of AIM salaries was in general alignment with salaries at UPHOLD.

Field efforts centered on the sharing of costs and operations for the Lira Regional Office, which houses both AIM and UPHOLD staff. AIM had gained considerable experience through the targeted solicitation of grant proposals during the first half of 2004. Processes, forms and procedures from AIM have been taken by UPHOLD and adapted for their particular uses. This has saved considerable time and resources for UPHOLD.

Representatives of the three JSI projects (AIM, UPHOLD and DELIVER) worked together to exploit economies of scale and promote the most efficient and effective “JSI Uganda” corporate presence possible. Areas taken advantage of were vehicle dispatch and use, information technology, security, bulk procurements, grants management and a common resource center. One significant example of increased JSI Uganda negotiating power led to Standard Chartered Bank providing preferential exchange rates when transferring funds from US dollar accounts to shillings accounts. This alone will result in savings in the hundreds of thousands of dollars for JSI Uganda projects over the remaining lifetime of the three projects.

AIM and UPHOLD provided administrative and logistical support to the Injection Safety project implemented by JSI and co-located with AIM and UPHOLD in Nakawa House.

**Annexes:**

I. Service Delivery Summaries

II. Grants Summaries

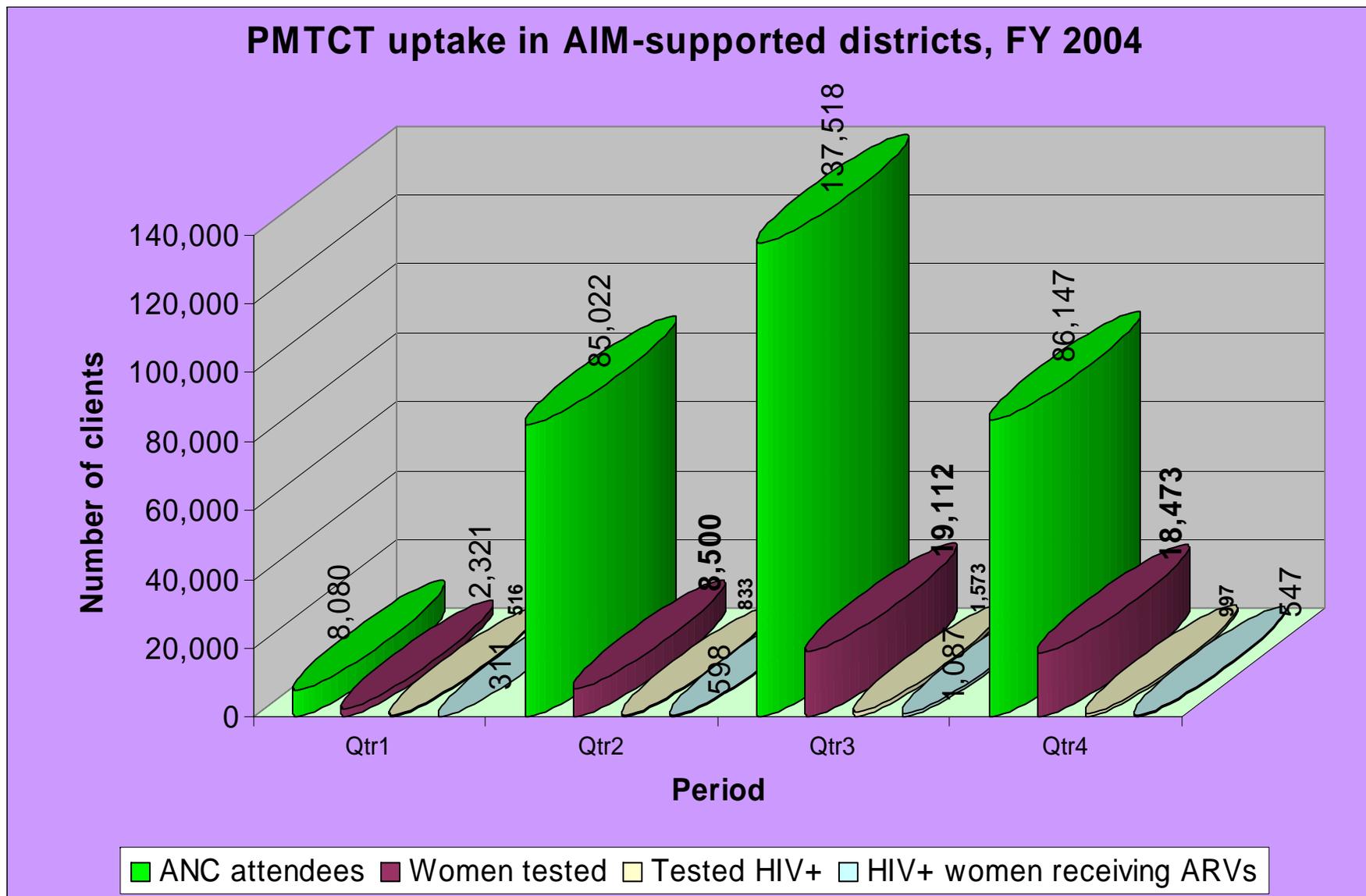
III. Training Summaries:

**Annex I:**

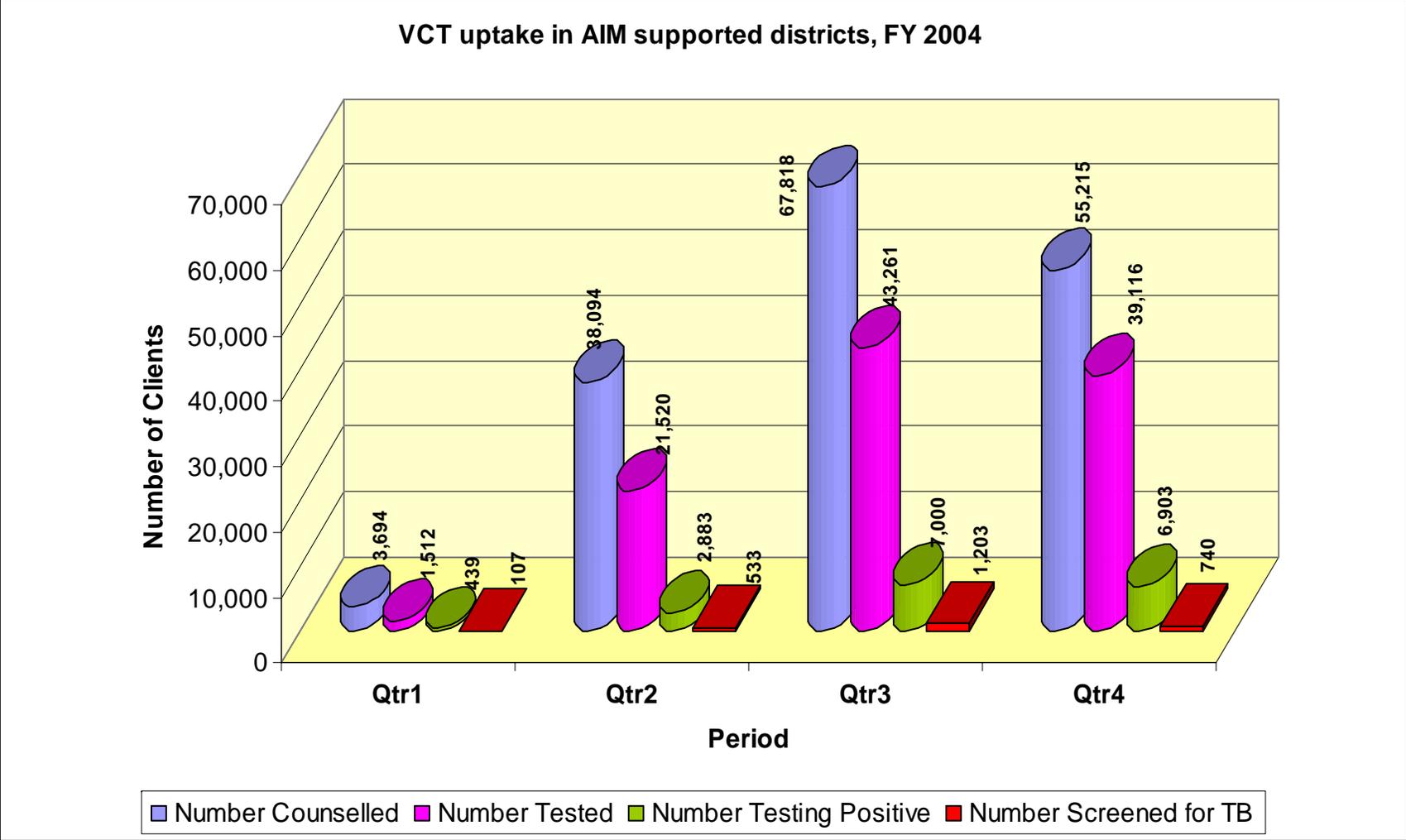
**AIM Performance Summary Sheet**

<b>Service Area</b>	<b>New in 4<sup>th</sup> quarter, FY 04</b>	<b>FY 04 Target</b>	<b>FY 04 Achieved</b>	<b>% of target achieved</b>	<b>Comments</b>
<b>PMTCT</b> # sites supported # clients served # providers trained	9 18,473 458	45 24,100 610	54 48,168 1056	120% 200% 173%	13 sites are run by faith-based organizations
<b>VCT</b> # sites supported # clients served # providers trained	19 39,116 1,300	62 60,000 390	83 105,409 1755	134% 176% 450%	16 of these sites are run by faith-based organizations
<b>Labs Supported</b> # labs supported # diagnostic tests # trained	- 177,647 0	86 - 140	126 524,369 113	147% no target 81%	
<b>TB</b> # sites supported # clients served # providers trained	31 6,760 194	292 14,500 900	323 18,006 766	111% 124% 85%	
<b>Opportunistic Inf.</b> # sites supported # clients served # providers trained	0 62	323 24,600 -	323 29,259 244	100% 119% no target	This is the number of infections treated
<b>OVC</b> # sites supported # clients served # providers trained	4 11,817 284	55 40,000 6,000	55 56,817 613	100% 142%	Most grants were awarded in final quarter of FY 03
<b>STI</b> # sites supported # infections treated # providers trained	0 48,249 30	323 93,000 350	323 125,823 292	100% 135% 83%	This is the number of infections treated

Annex I continued:

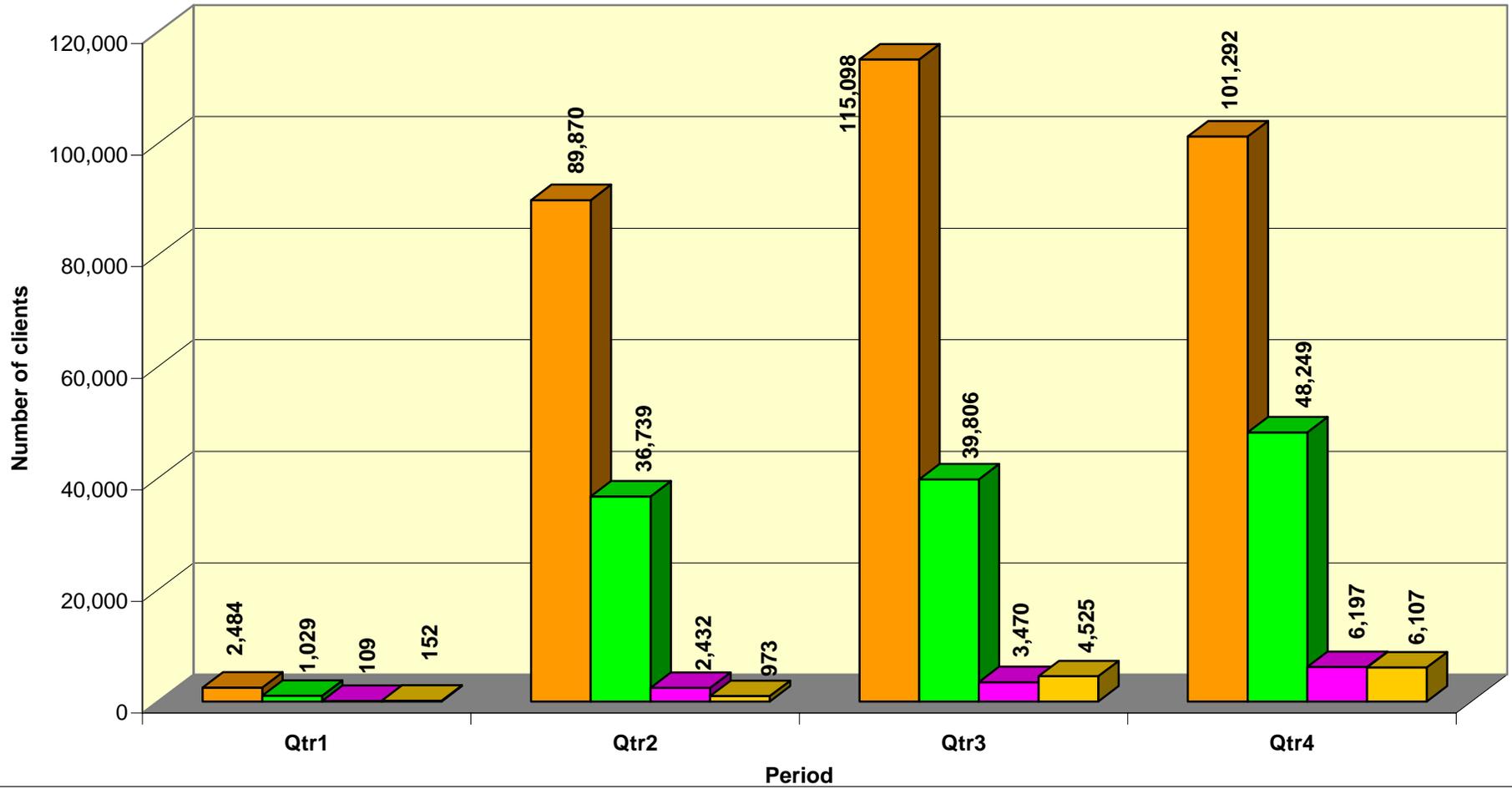


Annex I continued:



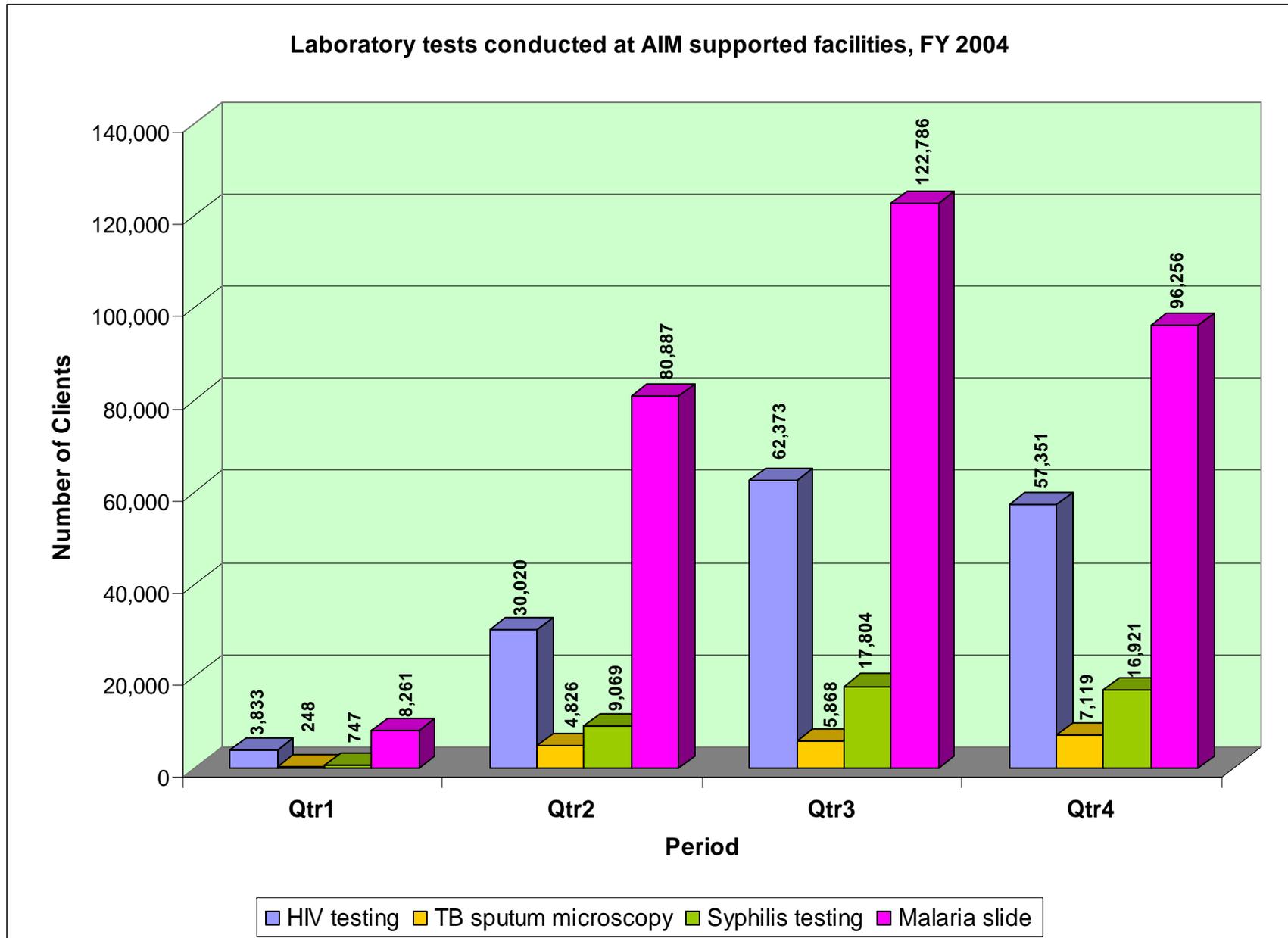
Annex I continued:

Uptake of STI services in AIM-supported districts, FY 2004

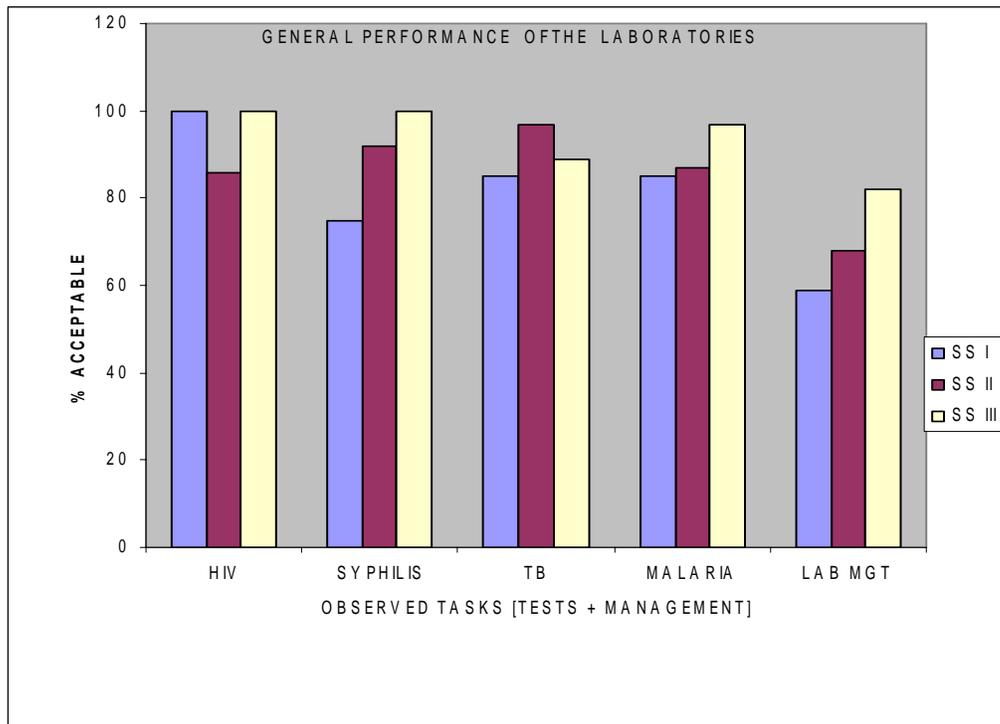


■ Individuals offered STI Counselling & Education  
 ■ Individuals diagnosed and treated for STI  
 ■ STI patients tested for HIV  
 ■ STI patients referred for VCT

Annex I continued:



**Annex I continued:**

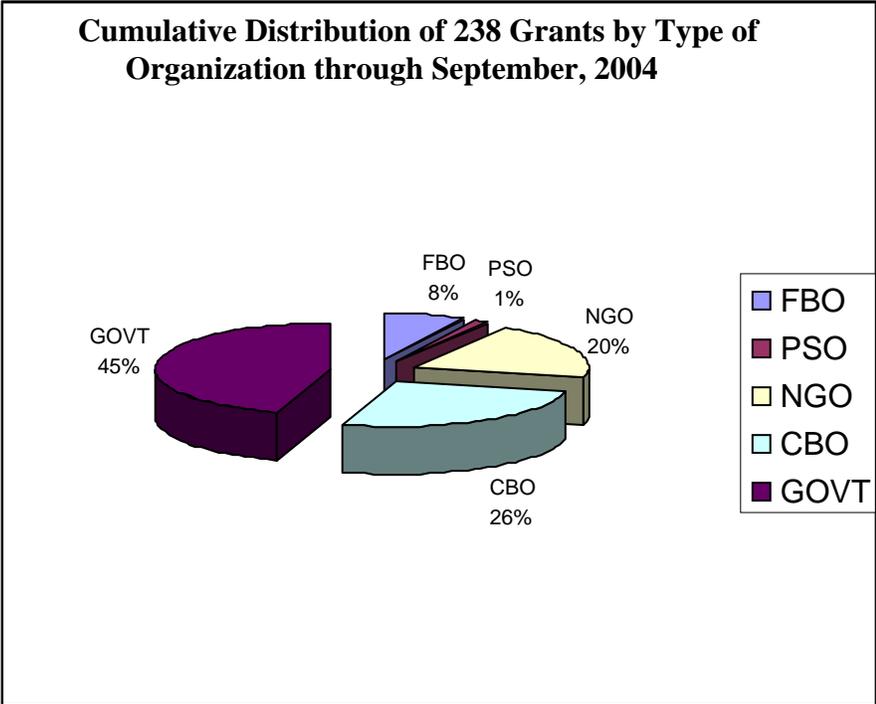


## Annex II:

## GRANTS AWARDED BY AIM THROUGH 30/9/2004

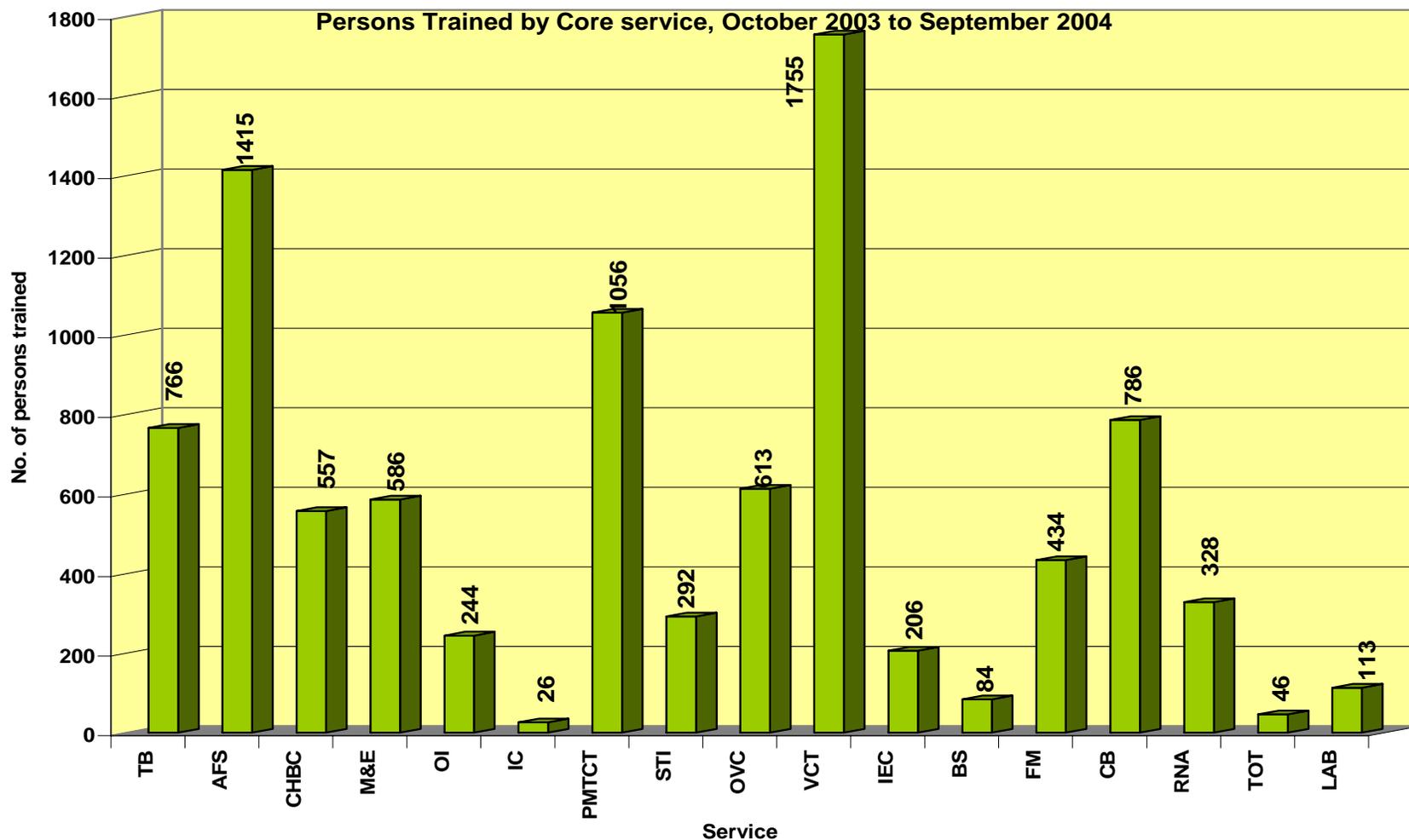
	AIM CORE SERVICES <sup>1</sup>														GRANT AMOUNT	DISBURSEMENTS (July.04 - Sept. 04)		TOTAL DISBURSEMENTS (July.04 - Sept. 04)	
	1	2	3	4	5	6	7	8	9	10	11	12	13	Total Commitments to Date		Grantee Releases	JSI Direct Payments		U. Shs.
DISTRICT	Core PMTCT	A&FP	Blood safety	Safe Injectns.	OP	VCT	ART	CC & S	LAB	OVC	PMTCT Plus	PC	CAP-B	NO. OF GRANTS	U. Shs.	U. Shs.	U. Shs.	U. Shs.	
KATAKWI	0	1	0	0	2	1	0	3	0	3	0	3	1	10	345,393,768	44,484,928	4,155,779	48,640,707	
KUMI	2	4	1	0	2	1	0	2	0	3	0	2	1	11	698,368,038	120,111,874	31,676,310	151,788,184	
PALLISA	0	0	0	0	2	1	0	1	0	1	0	3	1	6	263,256,532	35,036,169	38,140,088	73,176,257	
SOROTI	1	5	0	0	4	2	0	1	0	7	0	6	1	19	697,555,113	43,285,786	15,141,390	58,427,176	
TORORO	2	6	0	0	4	0	0	1	0	3	0	4	1	13	573,351,663	33,357,550	17,159,355	50,516,905	
BUSHENYI	1	3	0	0	4	2	0	2	1	1	0	4	1	13	720,499,152	76,169,745	5,566,590	81,736,335	
RUKUNGIRI	4	7	0	0	10	3	0	3	0	6	0	8	1	16	872,623,471	123,816,591	17,402,083	141,218,674	
NTUNGAMO	4	7	0	0	3	2	0	1	0	2	0	2	1	15	620,653,909	36,866,733	2,956,590	39,823,323	
MUBENDE	2	8	0	0	15	6	0	3	3	7	0	7	1	22	1,378,559,129	150,287,135	40,808,968	191,096,103	
KIBAALE	3	3	0	0	3	2	0	2	0	3	0	2	1	12	675,334,878	62,064,435	7,018,609	69,083,044	
ARUA	3	3	0	1	6	4	0	2	0	4	1	5	1	17	696,696,515	116,733,281	21,769,585	138,502,866	
NEBBI	0	0	0	0	4	1	0	1	0	4	0	4	1	8	269,245,221	20,195,601	12,136,685	32,332,286	
PADER	2	0	0	0	1	2	0	2	1	1	0	0	0	3	324,293,510	-	2,809,625	2,809,625	
LIRA	3	3	0	0	5	2	0	2	0	8	0	11	1	18	908,836,355	52,378,373	74,832,224	127,210,597	
YUMBE	2	2	0	0	2	1	0	2	0	1	0	1	2	7	230,556,400	38,052,429	9,986,733	48,039,162	
APAC	3	1	0	0	3	2	0	2	0	2	0	4	1	10	519,462,274	21,539,046	30,013,595	51,552,641	
<b>SUB TOTAL</b>	<b>32</b>	<b>53</b>	<b>1</b>	<b>1</b>	<b>70</b>	<b>32</b>	<b>0</b>	<b>30</b>	<b>5</b>	<b>56</b>	<b>1</b>	<b>66</b>	<b>16</b>	<b>200</b>	<b>9,794,685,928</b>	<b>974,379,676</b>	<b>331,574,209</b>	<b>1,305,953,885</b>	
<b>NATIONAL</b>	<b>23</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>5</b>	<b>1</b>			<b>1</b>	<b>2</b>		<b>13</b>	<b>38</b>	<b>5,629,317,908</b>	<b>406,264,380</b>	<b>150,823,820</b>	<b>557,088,200</b>	
<b>GRAND TOTAL</b>	<b>34</b>	<b>56</b>	<b>3</b>	<b>3</b>	<b>70</b>	<b>37</b>	<b>1</b>	<b>30</b>	<b>5</b>	<b>57</b>	<b>3</b>	<b>66</b>	<b>29</b>	<b>238</b>	<b>15,424,003,836</b>	<b>1,380,644,056</b>	<b>482,398,029</b>	<b>1,863,042,085</b>	

Annex II continued:



FBO:	Faith-based Organization
PSO:	Private Sector Organization
NGO:	Non-governmental Organization
CBO:	Community-based Organization
GOVT:	Government

**Annex III:**



- |  |   |                        |
|--|---|------------------------|
| TB - Tuberculosis                                  | OVC - Orphans & Vulnerable Children           | IC - Infection Control |
| TOT - Training of Trainers                         | VCT - Voluntary Counseling and Testing        |                        |
| STI - Sexually Transmitted Infections              | IEC - Information Education and Communication |                        |
| AFS - Adolescent Friendly Services                 | BS - Blood Safety                             |                        |
| CHBC - Community and Home Based care               | FM - Financial Management                     |                        |
| M&E - Monitoring and Evaluation                    | RNA - Referral Network for AIDS/HIV           |                        |
| OI - Opportunistic Infections                      | CB - Capacity Building                        |                        |
| PMTCT - Prevention of Mother to Child Transmission | LAB - Laboratory                              |                        |

**Annex III continued:**

**Training by Content and Quarter in FY 2004**

	<b>Oct/Dec</b>	<b>Jan/March</b>	<b>April/June</b>	<b>July/Sept</b>	<b>TOTAL</b>
<b>TB</b>	121	112	339	194	<b>766</b>
<b>AFS</b>	0	0	955	460	<b>1415</b>
<b>CHBC</b>	19	70	160	308	<b>557</b>
<b>M&amp;E</b>	68	70	141	307	<b>586</b>
<b>OI</b>	0	52	130	62	<b>244</b>
<b>IC</b>	0	0	0	26	<b>26</b>
<b>PMTCT</b>	51	362	185	458	<b>1056</b>
<b>STI</b>	29	92	141	30	<b>292</b>
<b>OVC</b>	0	0	329	284	<b>613</b>
<b>VCT</b>	18	0	437	1300	<b>1755</b>
<b>IEC</b>	24	19	93	70	<b>206</b>
<b>BS</b>	0	0	0	84	<b>84</b>
<b>FM</b>	0	20	0	414	<b>434</b>
<b>CB</b>	233	0	530	23	<b>786</b>
<b>RNA</b>	0	0	45	283	<b>328</b>
<b>TOT</b>	46	0	0	0	<b>46</b>
<b>LAB</b>	26	86	0	1	<b>113</b>
<b>TOTAL</b>	<b>635</b>	<b>883</b>	<b>3485</b>	<b>4304</b>	<b>9307</b>

TB—Tuberculosis

CHBC—Community and home-based care

OI—Opportunistic Infections

PMTCT—Prevention of mother to child transmission

OVC—Orphans and Vulnerable Children

IEC—Information, Educations and Communication

FM—Financial Management

RNA—Referral Network for AIDS

LAB—laboratory

AFS—Adolescent Friendly Services

M&E—Monitoring and Evaluation

IC—Infection Control

STI—Sexually Transmitted Infections

VCT—Voluntary Counselling and Testing

BS—Blood Safety

CB—Capacity Building

TOT—Training of Trainers

Annex III continued:

Fourth Quarter and Cumulative FY 04 Training by AIM Objective

Objective/topic	4 <sup>th</sup> Quarter, FY 04	FY 04 Cumulative
<b>1. Capacity Building</b>		
(DAC and DAT roles, M&E, JIA, grants – FM, TOT, CB)	744	1,852
<b>2. Integration</b>		
(RNA orientation, QA)	283	328
<b>3. Prevention services</b>		
(VCT, PMTCTSTI, TPP, AFS)	2,248	4,518
<b>4. Care and Support</b>		
(TB, OI, IC, Lab, BS)	367	1,233
<b>5. Community Services</b>		
(PHA, CHBC, OVC)	592	1,170
<b>6. IEC</b>		
	70	206
<b>TOTAL</b>	<b>4,304</b>	<b>9,307</b>