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## Uganda HIV/AIDS Services Project (UHSP)



*Consolidating the HIV&AIDS Response Through Targeted Interventions*

July  
2009

**End of Project Report**

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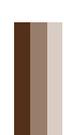


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*Consolidating the HIV&AIDS Response  
Through Targeted Interventions*

## End of Project Report

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## List of Acronyms

<b>AB</b>	'Abstinence' and 'Being Faithful'
<b>AIC</b>	AIDS Information Centre
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>BUCADEF</b>	Buganda Cultural and Development Foundation
<b>CA</b>	Capacity Assessment
<b>CBO</b>	Community Based Organization
<b>CBVs</b>	Community Based Volunteers
<b>CORPs</b>	Community Owned Resource Persons
<b>CSOs</b>	Civil Society Organizations
<b>DHO</b>	District Health Officer
<b>FLEP</b>	Family Life Education Program
<b>GBV</b>	Gender Based Violence
<b>GoU</b>	Government of Uganda
<b>HBHCT</b>	Home Based HIV Counselling and Testing
<b>HC</b>	Health Centre
<b>HCT</b>	HIV Counselling and Testing
<b>HMIS</b>	Health Management Information System
<b>HR</b>	Human Resource
<b>ICOBi</b>	Integrated Community Based Initiatives
<b>IDEAH</b>	Integrated Development Alliance for Health
<b>IEC</b>	Information, Education and Communication
<b>JSI</b>	John Snow, Inc.
<b>KICA</b>	Kisubi Hospital Initiative for HIV Prevention and Care for People Living with HIV&AIDS
<b>KYC</b>	Kitgum Youth Centre
<b>LLINs</b>	Long Lasting Insecticide Treated Nets
<b>MARPs</b>	Most-at-Risk Populations
<b>MDD</b>	Music Dance and Drama
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MEEPP</b>	Monitoring and Evaluation of Emergency Plan Progress
<b>MJAP</b>	Mulago-Mbarara Teaching Hospitals Joint AIDS Programme
<b>MMHF</b>	Mayanja Memorial Hospital Foundation
<b>MoH</b>	Ministry of Health
<b>MTR</b>	Midterm Review
<b>OIs</b>	Opportunistic Infections
<b>OP</b>	Other Prevention
<b>PACE</b>	Program for Accessible health, Communication and Education
<b>PC</b>	Palliative Care
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief

<b>PLHIV</b>	People living with HIV&AIDS
<b>PMP</b>	Performance Monitoring Plan
<b>PMTCT</b>	Prevention of mother-to-child transmission of HIV
<b>PRESCO</b>	Promotion of Rural Extension Services to Community
<b>PTCs</b>	Post-Test clubs
<b>RCT</b>	Routine Counselling and Testing
<b>SRH</b>	Sexual Reproductive Health
<b>STF</b>	Straight Talk Foundation
<b>STIs</b>	Sexually transmitted infections
<b>TB</b>	Tuberculosis
<b>TUKO</b>	Tukolerewamu Club
<b>UHSP</b>	Uganda HIV/AIDS Services Project
<b>UPHOLD</b>	Uganda Program for Human and Holistic Development
<b>UPMA</b>	Uganda Private Midwives Association
<b>URHB</b>	Uganda Reproductive Health Bureau
<b>USAID</b>	United States Agency for International Development
<b>USD</b>	United States Dollars
<b>UGX</b>	Uganda Shillings

## Letter from the Chief of Party

July 2009



**Dear Colleagues,**

It is with great pleasure that I share this final report that highlights in narrative, figurative and pictorial forms, representative achievements of the Uganda HIV&AIDS Services Project (UHSP) and its partners so obtained with funding from the United States Agency for International Development (USAID).

Over the past one and a half years, UHSP was privileged to implement activities in 33 districts in Uganda in partnership with 12 civil society organizations (CSOs) whose selection was based upon proven competence in implementing target activities and a successful previous working relationship with JSI under the UPHOLD project. Indeed the speed and dedication with which our partners achieved the results depicted in this report has made us all proud to associate with them.

During its lifetime, UHSP was honoured to provide financial, technical and organizational development assistance to her 12 partners including the AIDS Information Center (AIC) - one of the biggest HIV&AIDS service delivery organizations in Uganda. Such assistance enabled the scale up of the much needed HIV&AIDS prevention and care services in the country.

Your participation in UHSP's activities has been highly valued and as we close this project, we would like to share with you the results that have been realized during our alliance. As we draw to a close, our hope is that you will continue to participate in efforts to fight against HIV&AIDS hopefully drawing on many of the promising innovations you championed during this project.

Finally, on behalf of John Snow, Inc., I would like to thank USAID for the technical assistance rendered to UHSP and above all for providing the funding that enabled this successful project to happen. I would also like to thank the Ministry of Health for the technical assistance, guidance and support provided to UHSP during the implementation of this project. We are indeed grateful for the opportunity to contribute to improving the access to and quality of HIV&AIDS services in Uganda.

Enjoy the reading!

Sincerely,

A handwritten signature in black ink, appearing to read 'Samson Kironde', written over a light-colored background.

Dr. Samson Kironde  
Chief of Party, JSI/UHSP

## EXECUTIVE SUMMARY

This report presents the key achievements of the Uganda HIV/AIDS Services Project (UHSP). Supported interventions aimed at improving human capacity through increasing access, quality and utilization of HIV&AIDS services in 33 districts of Uganda. UHSP worked in partnership with 12 civil society organizations (CSOs) using a granting mechanism with eleven of them and a fixed price contracting mechanism with one implementing partner.

By the end of the project a total of UGX 1,036,575,408 had been disbursed to the implementing CSOs to carry out planned activities.

Overall, cumulatively throughout this project, UHSP implementing partners achieved over and above the set targets. For example 112% of the HIV counselling and testing target was achieved; 154% of targeted individuals were reached with 'abstinence' and 'be faithful' prevention messages; 138% of targeted individuals were reached with 'abstinence only' messages; and 119% of individuals were reached with 'other prevention' messages (see Table 1).

Some of the approaches and innovations that led to successful implementation of this project included:

- Selecting implementing CSOs with proven high performance and accountability capacities;
- utilizing a system of performance based financing;
- continuously monitoring each grantee and providing timely support;
- utilizing peer-to-peer approaches especially among youth and couples;
- improving the supply of vital logistics notably HIV test kits and related consumables;
- utilizing mainly community based approaches to extend services especially to the hard-to-reach populations; and
- ensuring that community mobilization always preceded actual service provision.

Throughout the project, a lot of effort was put on the training of various cadres of service providers to address the critical shortage of trained service providers necessary for delivering quality HIV&AIDS services. An overall total of 1,319 service providers were trained in provision of HCT services. A total of 791 service providers (506 females and 285 males) were trained on the HIV rapid testing protocol and techniques. These training activities were carried out in 33 districts in the country. In addition, 278 service providers were targeted to be trained in HIV counselling but 281 were eventually trained - that is 101% of the set target.

A total of 575,243 individuals (311,054 females and 264,189 males) were counselled, tested for HIV and received results against a target of 512,000 individuals. Couple counselling was promoted and 36,254 couples were counselled, tested and received results together. HCT services were delivered at 157 static sites and 336 outreach sites while home based counselling and testing was also carried out in many communities.

During the project the AIDS Information Centre (AIC), Kisubi Hospital Initiative for HIV prevention and care for people living with HIV&AIDS (KICA) and Mayanja Memorial Hospital Foundation (MMHF)

provided basic palliative care and support services. A total of 34,202 clients (20,901 females and 13,301 males) received such care.

Three CSOs namely: the TUKO Club, AIC and Youth Alive received grants specifically to promote 'abstinence' and 'be faithful' behaviour change messages and under their interventions, 292,231 individuals (129,381 males and 162,850 females) were reached with 'abstinence' and 'be faithful' messages. Additionally, 265 service providers received training in promotion of 'abstinence' and 'be faithful' messages against a set target of 253.

'Other prevention' messages were also delivered to most-at-risk populations (MARPs) such as: long distance truck drivers; motorcycle riders also known as 'boda-bodas'; discordant couples; commercial sex workers; bar and lodge workers; and out-of-school youth. A total of 668,833 individuals (335,211 females and 333,622 males) were reached with 'other prevention' messages. This was against a target of 560,250 individuals for the duration of the project resulting in a 119% achievement.

During the project, efforts geared towards improving strategic information included training of 215 service providers (compared to the set target of 180); on data capture tools and summary forms as well as data quality assessment audits.

In the area of institutional capacity building, UHSP provided technical and financial support in the drafting and finalizing of the AIC Board of Trustees Operations' Manual. This manual which was developed with active participation of the Board members was intended to give practical advice to the Board of Trustees and Senior Management of AIC on Board operational roles and responsibilities; Board of Trustees and Senior Management relationships; and other key guidelines that would ensure smooth and effective corporate governance of AIC. A Finance Director was recruited for AIC to help build capacity in their finance department. An organizational development capacity assessment for the eleven CSOs excluding AIC was done.

UHSP supported AIC to review its technical and organizational competencies with a view of establishing workable organizational strategies that would enable it to realize greater organizational performance. As a result of these reviews, AIC underwent a strategic repositioning exercise and a research, documentation and communication strategy was developed.

A cumulative total of 2,488 health service providers were re-trained and oriented in policies and guidelines related to HIV activities against a set target of 1,230. Table 1 summarizes UHSP cumulative results over the one and a half-year period of program implementation.

The detailed achievements of UHSP as well as lessons learned, challenges and recommendations are described in subsequent sections of this report.

**Table 1: Uganda HIV/AIDS Services Project Cumulative Results (January 2008-July 2009)**

Intervention Area	Indicator	Year One (Jan - Dec 2008)		Extension Period (Jan - Jul 2009)		End of Project (July 2009)	
		Target	Achievement (%)*	Target	Achievement (%)*	Target	Achievement (%)*
1. HIV Counselling and Testing	Number of individuals who received counselling and testing for HIV and received their results	340,000	374,952 (111)	172,000	200,291(116)	512,000	575,243 (112)
	Number of individuals trained in HIV counselling and testing according to national and international standards	1,230	1,169 (95)	150	150 (100)	1,380	1,319 (96)
2. Palliative Care: Basic Health Care and Support	Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding TB)	17,200	18,197 (106)	11,000	16,005 (145)	28,200	34,202 (121)
	Number of individuals trained to provide HIV-related palliative care (excluding TB)	328	328 (100)	0	0	328	328 (100)
	Number of service outlets providing HIV-related palliative care services (excluding TB)	7	9 (129)	6	S <sup>1</sup> -16 O <sup>2</sup> -14	13	S <sup>1</sup> -16 O <sup>2</sup> -14
3. Abstinence and Faithfulness	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	140,250	232,284 (166)	50,000	59,947 (120)	190,250	292,231 (154)
	Number of individuals reached through community outreaches that promote HIV/AIDS prevention through abstinence only	55,000	73,568 (134)	15,000	23,143 (154)	70,000	96,711 (138)
	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	253	265 (105)	0	0	253	265 (105)

Source: UHSP records

\* Shows percentage achievement for that period

S<sup>1</sup> shows number of static sites

O<sup>2</sup> shows number of outreach sites

<sup>3</sup> Support was given to twelve organizations during the whole period of the project

Intervention Area	Indicator	Year One (Jan - Dec 2008)		Extension Period (Jan - Jul 2009)		End of Project (July 2009)	
		Target	Achievement (%)*	Target	Achieve (%)*	Target	Achievement (%)*
4. Other HIV/AIDS prevention activities	Number of individuals reached through community outreach programs that promote HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	530,250	636,773 (120)	30,000	32,060 (106)	560,250	668,833 (119)
	Number of individuals trained to promote HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	440	849 (193)	0	0	440	849 (193)
5. Strategic Information	Number of local organizations provided with technical assistance for strategic information	12	12 (100)	0	0	12	12 (100)
	Number of individuals trained in strategic information (e.g., M&E, surveillance and/or HMIS)	180	215 (119)	5	22 (440)	185	237 (128)
6. Policy Analysis and Systems Strengthening	Number of individuals oriented/trained on the new/revised HIV/AIDS-related policies and guidelines	1,230	2,488 (203)	0	0	1,230	2,488 (203)
7. Institutional Capacity Building	Number of local organizations provided with technical assistance related to institutional capacity building	12	12 (100)	5	5 (100)	12 <sup>3</sup>	12 (100)
	Number of individuals trained in HIV-related institutional capacity building	30	175 (583)	5	22 (440)	52	197 (378)

Source: UHSP records

\* Shows percentage achievement for that period

S<sup>1</sup> shows number of static sites

O<sup>2</sup> shows number of outreach sites

<sup>3</sup> Support was given to twelve organizations during the whole period of the project

**Table 2: Key UHSP achievements against the set targets (January 2008-July 2009)**

Technical Area	Target	Achievement	Percentage
Individuals counseled and tested for HIV	512,000	575,243	112
Individuals trained in HCT	1,380	1,319	96
Individuals reached with 'Abstinence' and 'be faithful' (AB) messages	190,250	292,231	154
Individuals trained in AB	253	265	105
Palliative care	28,200	34,202	121
Individuals trained in palliative care	328	328	100
Individuals reached with 'other prevention' messages	560,250	668,833	119
Number of CSOs provided with strategic information	12	12	100
Number of individuals trained in strategic information	180	215	119
Number of individuals oriented and trained on HIV related policies and guidelines	1,230	2,488	205
Number of CSOs provided with technical support on institutional capacity development	12	12	100

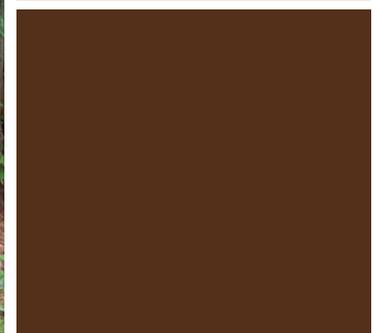
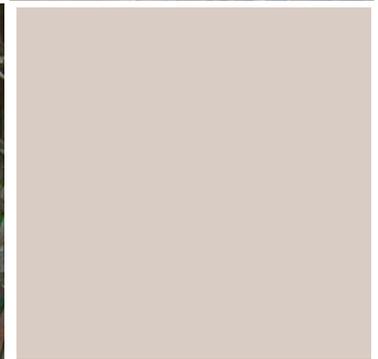
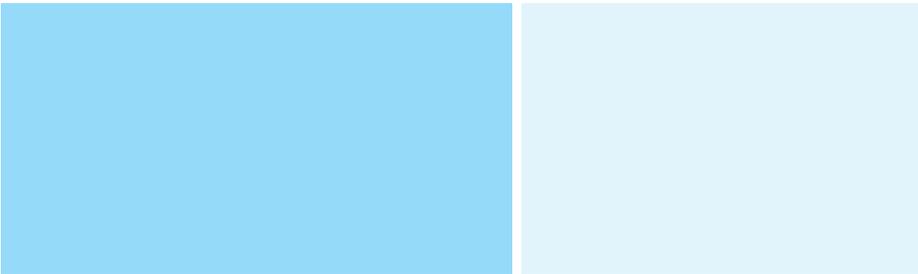
Source: UHSP records

**Table 3 : List of UHSP implementing partners**

Implementing partner	Focus area	Focus districts for implementation
AIDS Information Centre (AIC)	HCT, 'Abstinence' and 'faithfulness', palliative care and support, 'other prevention'	Amuria, Arua, Iganga, Isingiro, Jinja, Kaberamaido, Kaliro, Kampala, Kamuli, Kasese, Kisoro, Kumi, Luwero, Mayuge, Mbarara, Mityana, Mpigi, Mubende, Mukono, Nakasongola, Namutamba, Nebbi, Ntungamo, Soroti, Wakiso, Tororo,
Buganda Cultural and Development Foundation (BUCADEF)	'Other prevention'	Mubende and Mityana
Family Life Education Program (FLEP)	HCT	Kamuli and Kaliro
Integrated Community Based Initiatives (ICBI)	HCT	Bushenyi
Integrated Development Alliance for Health (IDEAH)	'Other prevention'	Mbarara, Ibanda and Kiruhura
Kisubi Hospital Initiative for HIV Prevention and Care (KICA)	HCT and palliative care and support	Wakiso
Mayanja Memorial Hospital Foundation (MMHF)	HCT and palliative care and support	Isingiro and Mbarara
Straight Talk Foundation (STF)	HCT	Kitgum
TUKO Club	'Abstinence' and 'faithfulness'	Wakiso, Rakai, Kamuli, Mpigi, Luwero and Mayuge
Uganda Private Midwives Association (UPMA)	'Other prevention'	Kamuli, Kaliro, Mityana, Mubende and Lyantonde
Uganda Reproductive Health Bureau (URHB)	HCT, 'other prevention'	Bugiri
Youth Alive (YA)	HCT, 'Abstinence only', 'other prevention'	Kaliro and Kamuli

Source: UHSP records

## INTRODUCTION



## 1.0 Introduction



The Uganda HIV/AIDS Services Project (UHSP) was a one-and-a half year project that began in January 2008, and ended in July 2009. It was managed by John Snow Inc. (JSI) and funded by the United States Agency for International Development (USAID). UHSP implemented interventions through partnerships with 12 local civil society organizations (CSOs) and its activities were implemented in 33 districts of Uganda. The project aimed at contributing towards the achievement of the objectives of the US President's Emergency Plan for AIDS Relief (PEPFAR). The focus of support was to ensure continued service delivery of quality HIV counselling and testing, Prevention and Palliative care services to direct beneficiaries, family members and the community through both technical and financial support.

The 12 CSOs that were in partnership with UHSP were: the AIDS Information Centre (AIC), the Buganda Cultural and Development Foundation (BUCADEF), Family Life Education Program (FLEP), Integrated Community Based Initiatives (ICOB), Integrated Development Alliance for Health (IDEAH), Kisubi Hospital Initiative for HIV Prevention & Care for people living with HIV&AIDS (KICA), Mayanja Memorial Hospital Foundation (MMHF), Straight Talk Foundation (STF), TUKO Club, Uganda Private Midwives Association (UPMA), Uganda Reproductive Health Bureau (URHB) and Youth Alive (YA).

The project aimed at improving human capacity through increasing access, quality and utilization of selected HIV&AIDS services. UHSP's objectives were:

1. Increasing the uptake of HIV counselling and testing services
2. Increasing the uptake of palliative care services, especially in the areas of basic health care and support

3. Promoting HIV prevention through increased awareness and through the practice of abstinence and being faithful along with other prevention interventions
4. Undertaking a substantive organizational review of the delivery of HCT services at a national level

During the period of the project, UHSP registered remarkable success managing to meet most of the set targets in the different intervention areas as is highlighted in the respective sections of this report.

### Key Achievements

- 575,243 individuals (311,054 females and 264,189 males) counselled, tested and received HIV test results
- 36,254 couples counselled, tested and received their HIV test results together
- 26,536 youth counselled, tested and received HIV test results
- 307 youth couples counselled, tested and received their HIV test results
- 187,205 received home based counselling, testing and received HIV test results
- 1,319 individuals trained in HIV counselling and testing according to national and international standards
- 34,202 new clients (20,901 females and 13,301 males) received palliative care services
- 292,231 individuals (129,381 males, and 162,850 females) reached with 'abstinence' and 'be faithful' (AB) messages
- 265 individuals trained in provision of AB promotional services
- 668,833 individuals (333,622 male, 335,211 female) reached with HIV prevention messages other than AB

## HIV COUNSELLING AND TESTING



## 2.0 HIV Counselling and Testing



**H**IV counseling and testing (HCT) is an important component of HIV prevention and is an entry point to HIV related treatment and care. It also provides opportunities for people to reduce the risk of acquiring or transmitting HIV. Despite its importance in the fight against the epidemic, in Uganda today only about 23% of the population has accessed HCT yet the desire for people to be tested is approximately 70%. UHSP supported 8 civil society organizations (CSOs) to implement HCT with the aim of improving access and quality of services with emphasis on the rural poor, hard-to-reach populations, potentially most-at-risk populations such as the fishing communities and motorcycle taxi riders ('boda-bodas') in major towns, internally displaced persons, couples, youth and mobile populations. In order for these different populations to be reached, innovative approaches such as 'home-to-home' HCT, 'family based' HCT and 'couple' HCT were promoted to supplement the traditional static site-based HCT. Table 4 shows the number of people tested using the different approaches. A community outreach model of reaching potential clients was used by many of the CSOs. Outreaches prioritized locations near high activity areas such as markets, landing sites for fishing communities, internally displaced people's camps, tertiary institutions and trading centres. Collaborations with other partners promoting prevention especially 'abstinence' and 'faithfulness' were encouraged and couples and persons who already knew their status were utilized to encourage their peers to test for HIV.



*HCT being carried out at one of the landing sites on Lake Victoria in Mayuge district*

### Key Achievements

- 575,243 individuals (264,189 male and 311,054 female) counseled, tested for HIV and received results at UHSP supported sites
- 36,254 couples were counseled, tested and received results together
- 75 % of all those tested received HCT from outreaches and home based HCT
- 1,319 individuals were trained in HCT-related services for example HIV counselling and rapid testing

**Table 4: Percentage of individuals tested for HIV according to service outlets**

HCT Service outlet	Number tested	Percentage
Static	143,202	25
Outreaches	244,836	43
Home based HCT	187,205	32
<b>Total</b>	<b>575,243</b>	<b>100</b>

Source: UHSP records

Communities were also encouraged to take up HCT through the use of media such in radio talk shows; through community dialogue events; and through music dance and drama activities. Seven drama groups, each comprising of 20 members were trained for each of the seven AIC branches. New innovations such as 'community camping' were used to ensure a wider community reach to enable counselors to offer services to community members at whatever time they returned to their homes. 'Community camping' is an approach

that was used by one of the CSOs - Mayanja Memorial Hospital Foundation where the counseling team temporarily stayed in a village in the targeted parish for up to five days providing HCT as well as prevention messages and palliative care services.

A total of 575,243 individuals were counseled, tested and received their HIV results at 157 static and 336 outreach sites supported by UHSP as shown in Table 5. All HIV positive clients were referred to the relevant health facilities for treatment, care and support.

**Table 5: Number of individuals counseled, tested and received results according to CSOs**

Organization	Target for HCT	Actual	% Achievement	Number HIV Positive		Total Positive	HIV Prevalence
				Female	Male		
AIC	320,000	331,347	104	13,289	8,130	21,419	7%
MMHF	85,000	86,906	102	1,078	866	1,946	2%
FLEP*	49,000	78,199	160	899	548	1,447	2%
ICOBI*	20,000	31,573	158	424	290	714	2%
STF	12,000	11,120	93	301	188	489	4%
YA	11,000	13,002	118	653	595	1,248	8% <sup>†</sup>
KICA**	14,000	18,454	131	744	430	1,174	6%
URHB	5,000	4,642	93	134	77	211	5%
<b>Totals</b>	<b>512,000</b>	<b>575,243</b>	<b>112</b>	<b>17,522</b>	<b>11,124</b>	<b>28,643</b>	<b>5%</b>

Source: UHSP records

\* Conducted mainly home based counseling and testing

\*\* Conducted outreaches mainly to tertiary institutions

<sup>†</sup>HIV prevalence is high because mainly fishing communities were targeted

## Couple HIV counseling and testing

Couple counseling and disclosure was promoted by all UHSP supported CSOs carrying out HCT activities at the static sites, outreaches and in homes. UHSP through its partnerships had 36,254 couples (see Table 6) counseled and tested for HIV&AIDS and given results during the course of the project. ‘Be faithful’ interventions for couples were utilized as springboards for promoting HCT among couples.

For example, Youth Alive involved religious leaders in community mobilization and encouraging couples to take up HCT. AIC used ‘be faithful’ campaigns as an entry point to encourage couples to know their HIV status. During these couple sessions, the linkage between knowledge of HIV status, discordance and the rising HIV prevalence among couples were discussed in view of preventing further spread.

Poor male involvement in many of the communities contributed to the low number of couples being tested. It was noted in many communities that male partners tended to use their partners’ results as a proxy to determine their HIV status hence making discordance difficult to detect and also making positive prevention among the HIV positive clients more problematic. In order to increase the number of couples that were being tested, AIC held ‘couple weeks’ where couples were encouraged to go to the different AIC branches and receive information concerning HIV. The couples were then counseled for HIV



HCT being carried out at one of the landing sites on Lake Victoria in Mayuge district

**Table 6: Number of couples counseled and tested for HIV and given results**

Organization	Number of couples tested
AIC	20,150
MMHF	7,850
FLEP	3,497
STF	241
ICOB	3,510
YA	365
KICA*	312
URHB	329
<b>Total</b>	<b>36,254</b>

Source UHSP records

\* KICA intervention is mainly in post-primary institutions

testing and encouraged to receive results together. FLEP, one of the CSOs providing HCT services trained 54 couples in nine sub counties to enhance couple communication for HCT services. This initiative enhanced couple acceptance for HCT services.

## Home based HIV counseling and testing (HBHCT)

Home based HIV counseling and testing was very instrumental in offering HCT to couples and their family members. Five CSOs namely URHB, YA, ICOBI, MMHF AND FLEP carried out HBHCT and 187,205 (96,380 females and 90,825 males) people including 13,816 couples were tested through HBHCT.

**Table 7: Number of individuals counseled, tested and given results using the HBHCT approach**

Organization	Females	Males	Total
FLEP	41,823	36,376	78,199
ICOBI	16,176	15,397	31,573
MMHF	37,333	38,267	75,600
URHB	263	235	498
YA	785	550	1,335
<b>Total</b>	<b>96,380</b>	<b>90,825</b>	<b>187,205</b>

Source: UHSP records

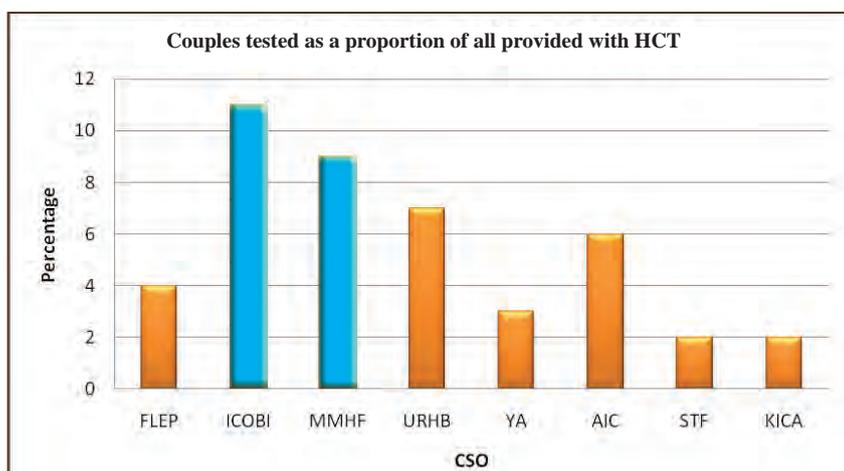


Dr Edgar Mulogo from MMHF supervising HBHCT in Kashongi Sub County, Kiruhura district

Many of the beneficiaries appreciated being counseled, tested and receiving results in the privacy of their homes.

MMHF through its 'community camping' approach was particularly successful in ensuring a wider community reach since it enabled counselors to meet community members at whatever time they returned to their homes.

MMHF and ICOBI that employed HBHCT had the highest proportion of couples counseled, tested and given results together compared to the other CSOS that were implementing HCT (see blue bars in Figure 1). This might be attributed to the use of the HBHCT approach.



**Figure 1: Couples tested as a proportion of all individuals provided with counseling and testing by CSO**

## HCT for Youth

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In-school and out-of-school youth were the target group for CSOs focusing on youth friendly services. A total of 26,536 youth were counseled, tested and received their HIV test results through KICA, STF and AIC. Several mechanisms were used to reach the youth, for example youth centers and corners as well as outreaches to institutions such as universities and schools were employed to provide youth friendly services including HCT.

Apart from medical services, youth centers provided infotainment, music dance and drama, focus group discussions and peer-to-peer counseling and sporting activities. In some communities such as Kitgum, STF conducted parent education and dialogue to educate the youth and communities on the benefits and the need to test for HIV.

It was noted that there is a high demand for dialogue and discussion on sexual reproductive health and behavior change in schools. One of the head teachers in a school expressed the need for dialogue on sex related issues before the youth are tested for HIV.



*Teenage mothers perform a song at Kitgum Youth Centre*



*'Brothers of Peace' perform a dance at Kitgum*

## Training and Support supervision

In order to improve access to and quality of the HCT services, UHSP realized the need to conduct training related to HCT activities. Training was essential to help cover the deficiencies in personnel in the service delivery system as a result of attrition, staff transfers and chronic shortages in the health system. UHSP staff also provided site-based technical support supervision to over 30 CSO staff aiming at strengthening the quality of HCT services and their integration into other services.



Training on HIV rapid testing protocols by AIC in Jinja Town



Counselors attending a training practicum at Kisubi Hospital

UHSP worked with the Ministry of Health (MoH) and trained its partners in HIV counseling, HIV rapid testing and in other areas as shown in Table 8

**Table 8: Number of individuals trained to provide HCT services**

Training Category	UHSP Targets	Implementing Partner						Actual No. Trained
		MMHF	KICA	ICOB	URHB	YA	AIC	
HCT Counselors	278	14	20	21	-	20	100	281
Rapid HIV testing services Providers	863	-	-	-	12	-	50	791
Community Counseling Aides	89	30	-	59	-	-	-	89
HCT Supervisors	100	-	-	-	-	-	-	108
Peer Counselors	50	-	50	-	-	-	-	50
<b>Total</b>	<b>1,380</b>	<b>44</b>	<b>70</b>	<b>80</b>	<b>12</b>	<b>20</b>	<b>150</b>	<b>1,319</b>

Source: UHSP records

## BRIDGING THE GAP IN HCT UPTAKE - A SUCCESS STORY



Bagiare recounting his experience with HIV&AIDS

The Busoga Diocese through its Family Life Education Program (FLEP) conducts home-based counseling and testing (HBHCT) among fishing communities. FLEP scaled up HBHCT services in the Busoga region reaching 41,823 females and 36,376 males who were counseled, tested and received their HIV results. Bagiare, a 50 year old, resident of Bukagabo village in Mayuge district, is one of the beneficiaries of this HBHCT initiative. His wife Joyce passed away in 2007 from an illness he suspected was due to witchcraft. *“She often used to say that she was feeling cold and kept asking me to cover her with more blankets,”* says Bagiare. When his wife finally died, he concluded that it was some evil spirits which had attacked her.

Bagiare also started experiencing recurrent bouts of fever similar to those his wife had suffered. He suspected that the very spirits that had killed his wife had returned to attack him as well. So, he considered visiting a potent traditional doctor in Kyaggwe to exorcise the spirits. Before he could visit the traditional doctor, Bagiare heard the FLEP village health team (VHT) announcing an upcoming HBHCT activity in the area. He got interested and asked for more information about HIV&AIDS from the VHT. He began reflecting on the days when he was a fisherman moving from island to island. Recalling the numerous sexual affairs he had, he decided that he was possibly infected with HIV. Later, he received in-depth counseling from the HBHCT team and concurred with the counselors that his wife had possibly died of HIV&AIDS.

When Bagiare was tested and found HIV-positive, he felt devastated. In spite of the results, he appreciated the fact that he had been tested and told the truth in the privacy of his home. Bagiare is among the 433 people who tested HIV positive in Malongo sub-county.

FLEP provided follow-up counseling support and recommended him to go to Malongo Health Center III for HIV&AIDS-related palliative care. Bagiare enrolled for care and support at Malongo HC III in July 2008 and was given Cotrimoxazole.

*“Before I started taking the Cotrimoxazole, I could not stand upright. I had terrible backache and joint pains. But now I feel much better. I am strong and can get food for all the children unlike that time when I could not even move from my home”* a hopeful Bagiare says smiling.

Bagiare, who is now part of the community health sensitization team, says that the intervention by FLEP, especially the private lessons on positive living, have brought him new hope.

## Lessons learned

- HCT outreaches were an effective way of reaching hard-to-reach populations and MARPs, however it is important for the timing of these outreaches to be tailored to the community that is being reached so as to ensure that as many people as possible are reached
- Provision of HIV counseling services in homes served as a good entry point for care and support. For example pregnant women who would not have otherwise tested for HIV until delivery of their children received HCT services and were appropriately referred for PMTCT services. This however called for building of strong referral net works to ensure that the continuum of care and support was complete
- Home based HCT encouraged more male involvement and couple counseling and testing. It also offered a feasible and socially acceptable strategy of delivering the much needed HCT to the hard-to-reach populations that have poor access to the traditional static services
- The 'community camping' strategy established a bond between the service providers and the community and built trust which may have reduced stigma thus increasing the uptake of HCT services
- Youth were instrumental in providing accurate information regarding HIV&AIDS especially to their peers and encouraging them to test for HIV. The use of infotainment including games, music, dance and drama was a good medium for social mobilization, education and encouraging the youth to take up the HCT services
- Youth friendly HCT sites reported increased parent-child dialogue on prevention of HIV transmission. This was a positive development attributed to intensified grass-root mobilization through community dialogue resulting in social transformation
- Involvement of stakeholders, such as local councils, religious leaders and technical officers like community development assistants in planning and implementation of activities was important in ensuring the success and sustainability of activities. The use of community owned resource persons (CORPs) were essential in mobilizing communities for HCT services
- A continuous supply of HIV test kits and related consumables in the right quantities and quality coupled with rigorous project monitoring and evaluation as well as regular data quality audits was key to the success of HCT services

## Challenges and Recommendations

- Inconsistent supply of HIV test kits experienced by many of the CSOs sometimes led to the slow implementation of HCT activities. There is need to ensure a continuous supply of HIV test kits and consumables especially if implementing partners are not public sector facilities. There is need for close collaboration with other stakeholders especially the Ministry of Health to ensure that whenever possible, they supplement the needs of non-public sector actors

- Staffing constraints remained a great hurdle in the provision of HCT services. Health workers that are not traditionally involved in HCT such as nursing assistants, community health workers and social workers should be trained to provide counseling and testing services as a way of task shifting to address chronic staff shortages
- Due to the long distances involved in referral of HIV positive clients for treatment and care, many of them did not reach the referral centres. It is therefore recommended that providers of HCT services should use a holistic approach to care and also provide services such as palliative care, ART and food support.
- It was difficult to reach the MARPs due the nature of their work, lifestyle and health seeking behaviors which led to them having limited opportunities for counseling and testing. The fishermen who spent most evenings and nights on the Lake and mornings and afternoons selling fish were difficult to offer HCT services. The youth were also reluctant to access HCT services. Tailor made programs to reach such special groups should be made in order to better fight the epidemic
- Couple HIV counseling and testing was still limited due to the fact that most people were reluctant to disclose their HIV sero-status to their partners. Male participation in HCT services remained low which ultimately affected the number of people including couples receiving HCT services. More male involvement should be advocated during community sensitization for HCT services. In order to improve couple counseling FLEP, one of the CSOs trained 54 couples to enhance couple communication and acceptance for HCT services while AIC introduced 'couple weeks' to encourage dialogue on HIV&AIDS related issues including HCT
- It was noted that the awareness on the presence of HIV&AIDS infection was high among the youth but risk perception was still low. Those who got tested took long to accept a positive HIV result. This may have been attributed to gaps in the counseling process, leading to low enrolment rate among the youth. It was therefore necessary to strengthen the skills of the youth counselors and encourage more dialogue with the youth regarding HIV&AIDS and also encourage more interaction between the youth and their parents on issues regarding HIV&AIDS

## PALLIATIVE CARE



## 3.0 Palliative Care



**H**IV&AIDS being an ultimately fatal illness requires palliative care services to be offered to all PLHIV especially in the later stages of the disease. UHSP supported three CSOs to provide palliative care, these included, the AIC, MMHF and KICA. Both home based and facility based palliative care was offered by these CSOs.

The palliative care strategy included;

- Building the capacity of palliative care providers through training and on-job support
- Strengthening the capacity of the CSOs to provide community based palliative care services
- Creating linkages between health facility-based services and home-based care and strengthening the referral systems to ensure that all PLHIV accessed the required services

As part of support for palliative care services, UHSP in collaboration with trainers from the Ministry of Health provided training in HIV&AIDS-related palliative care management to health service providers from the seven AIC branches. A total of 328 health workers (204 females and 124 males) comprising of medical doctors, clinical officers and counselors underwent training in palliative care focusing on TB and HIV interaction; homebased care, ART, prevention among positives and logistics management.

UHSP supported CSOs to provide palliative care to HIV positive clients through community outreaches, home-based care services and health facility based services. Some of the services provided include;

- Ongoing psychosocial support
- Information on nutrition
- Prophylaxis against common opportunistic infections (OIs) especially cotrimoxazole prophylaxis
- Management of opportunistic infections and sexually transmitted infections
- Addressing risk reduction, prevention among



*Participants in a group discussion during a palliative care training by AIC & MoH*

- positives including condom use
- Referrals for CD4 tests and assessment for ART eligibility as well as ART initiation and adherence support
- Malaria prevention including utilization of long lasting insecticide treated nets (LLINs)

In addition to the above mentioned interventions, UHSP provided support to PLHIV groups at AIC branches such as post test clubs and discordant couple clubs to address negative social practices such as stigma and discrimination of PLHIV. Various activities were done including music, dance and drama shows; community dialogue and mobilization; personal testimonies; and home visiting. Group meetings, participation at service delivery points and home visits were undertaken in order to encourage utilization of palliative care services.

UHSP procured and supplied home-based care kits, in response to an expressed need by those clients who were bedridden and needed home care. These were to be used by the caregivers to maintain hygiene and also protect them from infection.

As a way of promoting family-based care and increasing

opportunities to identify new HIV positive clients, UHSP supported the provision of HCT to family members of index clients to ensure that all infected family members are identified and thereby a holistic approach to palliative care is provided to the whole family.

AIC noted a considerable increase in the numbers of people recorded to have accessed palliative care. (see Table 9) This was as a result of two major actions as highlighted below:

- Registration for people attending post test clubs (PTCs) in all AIC branches was strengthened. PTCs are the core centers for provision of palliative care (Basic Health Care). However, the numbers who attended these services were not easily verifiable. On this note, registers were developed and circulated to all PTCs in the 8 branches of AIC. The attendance lists provided adequate evidence to verify the number of people accessing the various services classified under palliative care basic

- Due to improved monitoring of the PTCs activities, enrolment into the PTC activities increased considerably. Most of the people referred to PTCs found them relevant for their situation and hence enrolled into the various programs. Furthermore, more couples were enrolled and this is a positive trend given that 42% of all new infections in Uganda are believed to be taking place among married couples

Referral of clients was encouraged by availing referral cards. This was for services such as nutritional and material support, OI treatment, ART and access to the basic care package.

**Table 9: Number of PLHIV receiving palliative care services by CSO**

Organization	Number of individuals reached
AIC	29,121
MMHF	1,993
KICA	3,088
<b>TOTAL</b>	<b>34,202</b>

## POSITIVE AND PRODUCTIVE LIVING AS A FAMILY LIVING WITH HIV - A SUCCESS STORY



John in his home with his younger wife



John attends one of his goats that is a source of income for the family

Mr. John Batwala is a 51 year old resident of Bufuula Village, in Budondo sub-county of Jinja District. John and his two wives tested for HIV in 2003 when his younger wife was pregnant with their last born child. During one of her antenatal visits, Mary (not real name) was advised by the nurses to test for HIV as a routine laboratory test for pregnant women. On doing so, Mary found that she was HIV positive which prompted her to advise her husband to go for HIV testing. John on learning this information went with his first wife to the AIC Jinja branch where he tested HIV positive, but his first wife tested HIV negative.

Once back home, John and his two wives shared their HIV test results in order to plan for their family and relationships better, however the news of two of the three members being positive caused turbulence and intrigue in the family as a result of the un ending debate on whose fault it was that there was HIV in the family. 'At one time, things were so bad that my older wife had moved out of the house because of the myths and misconceptions she had about HIV. 'She thought that she would contract HIV by sharing space and utensils with us' John narrates

The family through the continuous counseling sessions decided to join the discordant couple and post-test clubs at the AIC Jinja branch. In addition to the ongoing supportive counseling and education on how to live positively, there were sessions on productive living such as modern farming methods and sustainable livelihood which John has used to set up a demonstration farm in his home.

With the additional information, John is now a passionate peer supporter for persons living with HIV in his community and community mobiliser for HIV related outreach activities. It is not rare to find John with a group of men educating them on HIV&AIDS

*'With the information, I received, I have formed an HIV positive persons club called Mwino Kyakuwa HIV orphans and peer support group where I use the information learned to influence positively the lives of other people affected by HIV&AIDS', says John*

On a personal note John says, *'since I tested with my wives, I have reformed, I live positively due to the counseling we have received.'*

## Lessons Learned

- PLHIV are very essential in mobilizing communities and clients for services. If well trained, they are an important resource for the community and a resource constrained health care delivery system
- There is a need to further encourage collaboration between service providers to encourage referral. This was because most of the service providers did not offer the whole palliative care package. For example many of the CSOs were not providing ART, CD4 counts and nutritional support
- Supplementing HCT at outreaches with other services such as medical services and basic care packages to the HIV positive clients in the outreaches enhanced opportunities for addressing the multifaceted needs of people who test when at the advanced stages of HIV infection. This was particularly necessary in hard-to-reach areas that had poor access to treatment and care
- Identifying clients through HBHCT for family members of index clients was very useful as it provided a forum for professional disclosure at household level and an entry point for continued comprehensive psychosocial support for the whole family as opposed to individual support
- In addition to medical services, there was a significant need for supplemental components of palliative care such as: cotrimoxazole prophylaxis; prevention of OIs through use of LLINs; and improving access to safe drinking water
- Community support systems were important in maintaining follow up of clients but there was need to create synergy with health facilities to access clients to professional care and evaluation of treatment outcomes

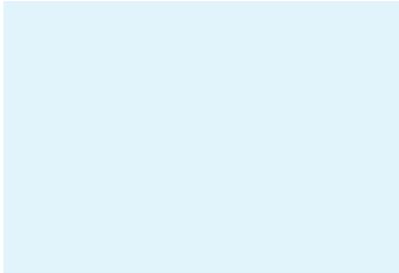
## Challenges and Recommendations

- Identification of new clients for palliative care in the community remained a challenge. Innovative community and household based interventions such as HBHCT, HCT for family members of index clients were necessary. Such approaches also fostered family based counseling thereby encouraging disclosure, stigma reduction and eventually adherence to treatment and care
- It was noted that only a small proportion of people who test positive and were referred for treatment and care actually sought and accessed this care. For example from STF for the month of May, at one of the outreach sites where eighty four people that tested HIV positive were referred for treatment, follow up revealed that only eleven (13%) had enrolled into care. There was a need therefore to make treatment and care including palliative care more accessible to people living in the rural areas who cannot afford to move long distances to seek care. One of the ways was to conduct home based palliative care
- Inadequate supplies of cotrimoxazole and other medical supplies such as laboratory diagnostic materials made provision of comprehensive and integrated services difficult. Facilities should therefore be equipped to adequately provide palliative care
- Clients experiencing food scarcity tended to default on medication and reported adherence

to medication was not adequate. Nutritional support as part of palliative care should be prioritized in this category of clients

- Some clients shifted from their places of residence after their health status improved. This made their continuous follow up difficult and expensive. It is therefore important for CSOs to increase the network of support to PLHIV, and encourage implementing partners to actively involve PLHIV in following up of their peers. This will improve the overall support treatment and care and also improve adherence to medication

## PROMOTION OF HIV PREVENTION THROUGH ABSTINENCE AND BEING FAITHFUL



## 4.0

## Promotion of HIV prevention through abstinence and being faithful



UHSP through AIC, TUKO Club and Youth Alive implemented ‘abstinence’ and ‘being faithful’ promotion activities to enhance HIV prevention behaviours at the community level with emphasis on the youth and married couples.

These partners also targeted and delivered ‘abstinence only’ messages to the in-school and out-of-school youth. Abstinence promotion messages were delivered through music, dance and drama presentations, youth seminars, community dialogue, focus group discussions and peer-to-peer talks to increase their risk perception on HIV infection. The youth were encouraged to abstain from early initiation of sexual activity, practice secondary abstinence or have only one sexual partner. The youth peer educators also imparted life skills to youth and couples to adopt risk avoiding behaviour.

On the other hand, be faithful promotion activities targeted couples and the messages were delivered through community dialogue and education, couple dialogue, counselor-led education talks for couples, and couple review meetings. UHSP supported implementing partners utilized unique approaches to ensure that the message reached the intended beneficiaries.

TUKO Club, one of the UHSP partners, worked through networks by partnering with 10 other community based organizations to deliver ‘abstinence only’ and ‘abstinence’ and ‘be faithful’ messages at the community level. In order to reinforce this approach, UHSP supported TUKO to train 75 peer educators from the CSO partners who in turn passed on messages to youth and the general public. The peer educators also imparted life skills to youth and couples that would enable them adopt risk avoiding behaviour.

An important aspect of the CSO networks was that

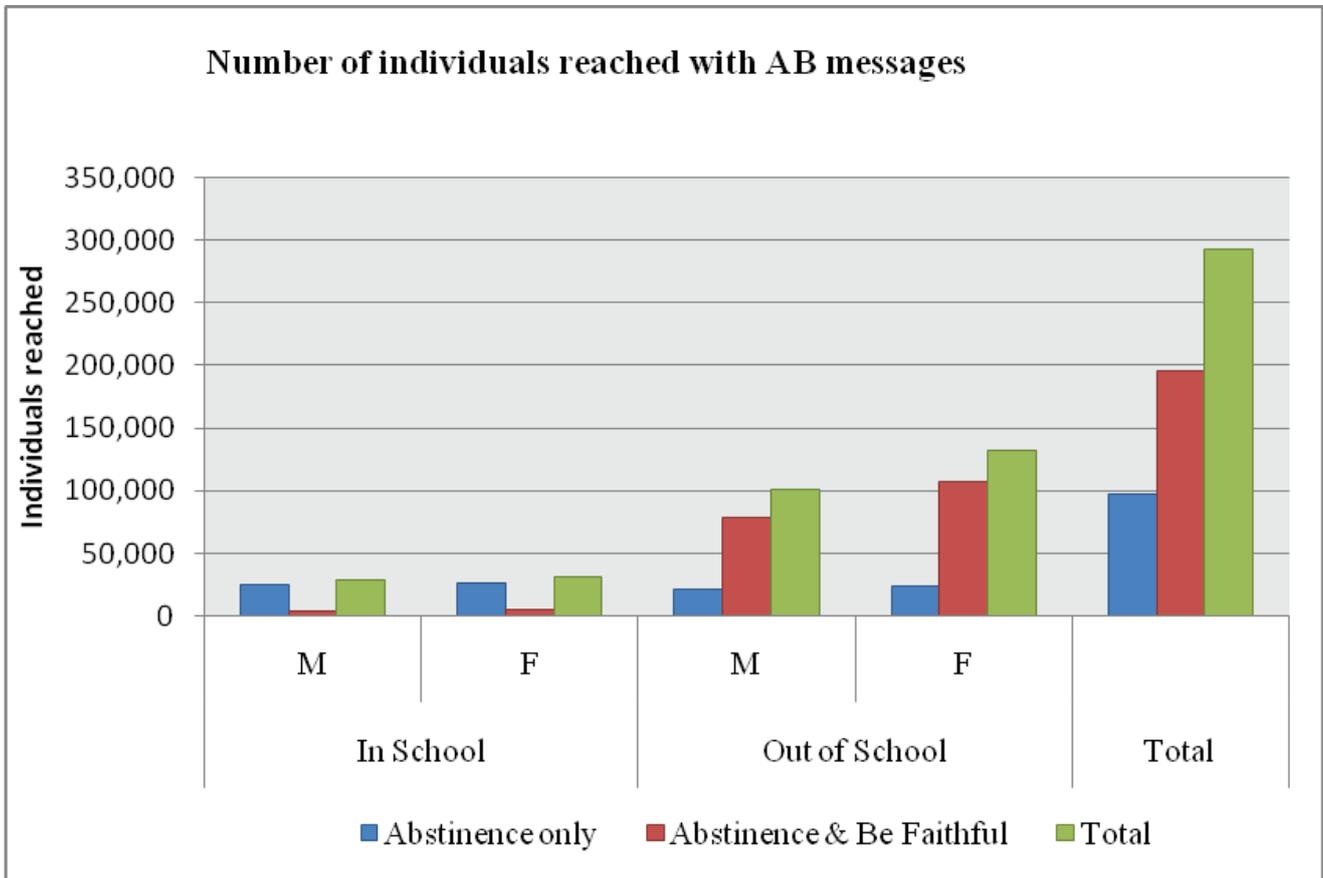
they were able to mobilise couples and some of these initiated and integrated ‘be faithful’ promotion into other development activities. For instance, Kasana TUKO Club members mobilized themselves and formed a savings scheme with a purpose of enhancing both their economic status as well as their ability to sustain the ‘be faithful’ promotion activities.

AIC developed packages to disseminate AB messages that were practical and had examples arising from a wide array of experience in counseling for HIV testing. These packages became popular with a very wide audience including schools. In relation to this the team from AIC was invited to primary, secondary and tertiary institutions to present this information. As a result, AIC was able to register clients from these institutions. This is expected to continue beyond the funding period of UHSP. One of the senior staff of AIC had this to say, *“We acknowledge this development as a positive outcome of this collaboration with UHSP and as capacity that will remain beyond the collaboration.”*

### Key Achievements

- 292,231 Individuals were reached with ‘abstinence’ and ‘be faithful’ messages
- 96,711 youth were reached with abstinence only messages. 53% were in-school and 47% were out-of-school
- 256 individuals were trained to promote HIV&AIDS prevention messages through ‘abstinence’ and/or ‘being faithful’

**Figure 2: Number of in-school and out-of-school individuals reached with abstinence only and abstinence and ‘be faithful’ messages**



## The Youth Corners

AIC utilized its specialised youth corners to target the in-school and out-of-school youth aged 13-24 years with AB messages. The youth met at these centres where well trained staff took them through counselling sessions on HIV prevention that also incorporated abstinence promotion messages. At the youth corners, the youth were also encouraged to join post test clubs so as to continue benefiting from regular information on ‘abstinence’ and ‘being faithful’. One of the members of a post test club who is practicing secondary abstinence had this to say, “I owe a lot to the AIC family and I feel the best way to pay back is by sharing my experiences with the youth through the post test club.” The youth corners utilised music, dance and drama presentations and community outreaches to deliver abstinence promotion messages. The messages



Male Youth Group discussion during the Holiday Seminar

also included information on cross generational sex, alcohol and substance abuse, and transactional sex in relation to HIV&AIDS. The messages were also shared to youth in small and large gatherings through youth seminars, community dialogues, debates, focus group discussions and peer-to- peer talks by the CSOs. To

achieve greater results, UHSP procured equipment such as furniture and recreational materials that were used to set up youth corners at seven AIC branches. These attracted more youth for specialized counselling and guidance in HIV prevention.

## Use of couple clubs

AIC's couple counseling approach went beyond counseling for testing; it included formation and support for couple clubs which ensured continuous peer counseling and support. All couples in general and the discordant couples in particular were encouraged to join couple clubs. Through this initiative, AIC targeted couples with 'be faithful' messages through couple dialogue sessions conducted during couple club meetings. Through these couple clubs, couples continued to receive messages on faithfulness, among other services. The HIV positive and HIV negative

persons for instance shared experiences and messages on how to remain faithful; how to handle stigma and discrimination; benefits of disclosure; prevention of gender based violence; and other HIV related messages. These couple initiatives were further supported by AIC counsellors who responded to technical questions that would arise during the couple dialogue sessions. Referral to HCT and other related services would also be done for members who express interest, and these yielded positive results.

## ABSTINENCE AND BEING FAITHFUL THROUGH YOUTH WINGS AT AIC - SUCCESS STORY



Mugabe recounting his experience with HIV&AIDS

Mugabe is a member of the AIC Mbarara branch post test club. He was introduced to AIC after his friend referred him there to seek care for a sexually transmitted infection (STI). That is when his journey with AIC Mbarara family began. Mugabe moved to Mbarara from the village to work as a matooke (plantain) purchasing officer. His job was well paying and he moved from village to village purchasing matooke that he finally sold in different towns.

However his job came with some negative aspects, *'I discovered women'* says Mugabe. With a stable financial base, Mugabe was able to go to different nightspots and he engaged in unprotected sex with a number of girls he met he had multiple partners in a short period of time. *'I always joked with my friends that I was the only man in the country who had wives in different regions and able to attend to their sexual desires consistently'* Mugabe now recalls. When Mugabe arrived at the AIC youth wing, he was having problems passing urine and pus was oozing from his private parts. The weekly educational talk to the youth clients was on 'abstinence', being faithful and the need to know one's status and that of the partner.

Mugabe tested for HIV, syphilis and gonorrhoea, he tested HIV negative but was found to have gonorrhoea another STI. Mugabe received treatment and ongoing counseling at the AIC Mbarara branch and he also joined the post test club giving him the opportunity to share his challenges and experiences with his peers.

*'My life before AIC was heading for disaster, I lacked guidance, purpose and direction. Now, I am able to continue with my duties not only with pride, but also with dignity. I owe a lot to the AIC family, and I feel the best way to pay back is by sharing my experiences with the hundreds of youth through the post test club,'* he says

This professional and social support network played a big role in influencing behavioral change in his life. Currently, Mugabe is an active member of the post test club despite his hectic work schedule, and he has chosen to abstain from any sexual practices until marriage.

*'Many times I have counseled youths in the youth corner and I have helped them identify their risks, so most of them have resorted to secondary abstinence till marriage and they have promised to live responsibly even in marriage,'* says Mugabe.

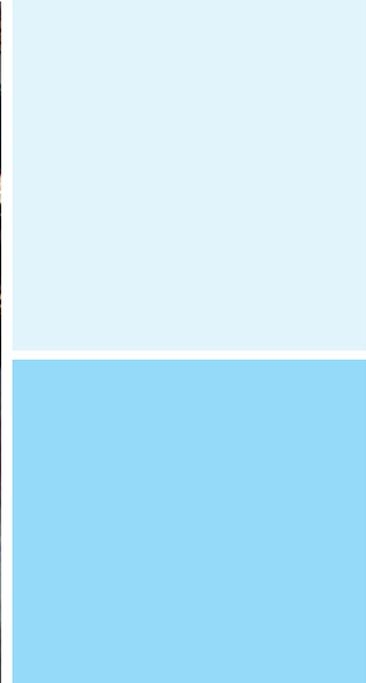
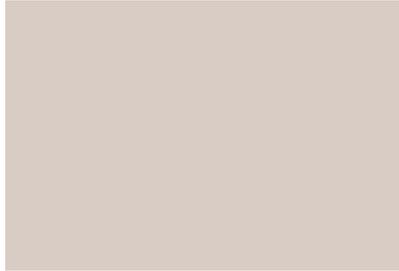
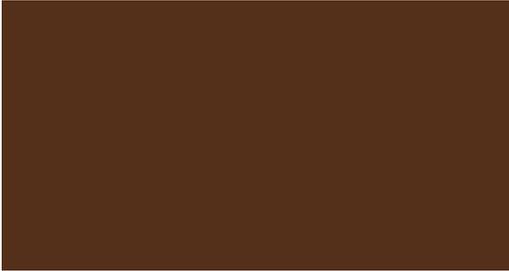
## Lessons learned

- In order to effectively reach the youth with messages, innovative approaches like debates, focus group discussions, games and recreation activities such as music and drama were found to be very effective. In depth dialogues were also necessary to address the questions that the youth had
- Training of health workers in adolescent friendly communication and utilizing peer educators improved the quality of services provided to youth hence the increase in the number of youth who sought services at static sites
- Bringing groups of people with similar experiences together such as couples enhanced peer learning on faithfulness
- There is a need to continuously share messages on AB in order to realize sustained behavior change
- In-school and out-of-school girls between the ages of 16-25 years were identified as very high risk due to their life style and their reluctance to change due to their economic dependency on multiple partners. It is therefore necessary to provide some income generating activities for the girls in this age bracket

## Challenges and Recommendations

- Gender-based violence (GBV), transactional and cross generational sex are still a big impediment to the practices of 'abstinence' and 'being faithful'. There should be facilitation of dialogue in communities especially through model couples, drama troupes and a peer-to-peer approach to GBV prevention should be integrated into AB promotional activities
- There should be continued support for activities that attract teenagers to youth centres and build their life skills. This will empower them to make correct decisions about their lives. Activities that will enable a reduction on the youth's economic dependency on multiple partners especially out-of-school and in-school girls between the age of 16-25 years should be encouraged. This is because this age group were identified as very high risk due to this life style
- There was a constant need for IEC materials and job aids to be used by the peer educators to pass on the messages. The communities still need reading materials to take home. Although UHSP provided some materials that were in English and a few translated into some of the local languages, there is still need to establish the scope of need for such materials, develop them and translate them into the relevant local languages for better communication

## PROMOTION OF HIV PREVENTION THROUGH 'OTHER PREVENTION' METHODS



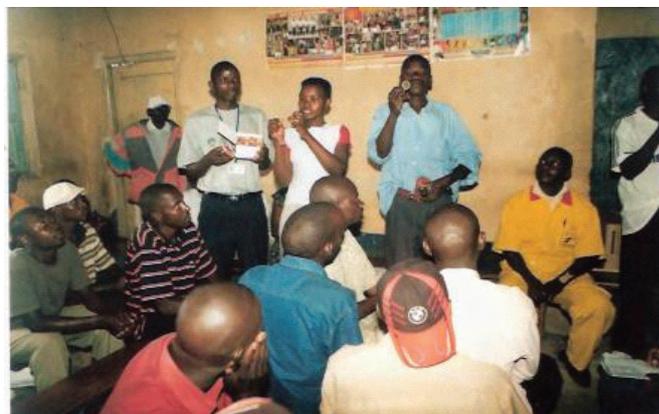
## 5.0 Promotion of HIV prevention through 'other prevention' methods



In an effort to provide a comprehensive HIV prevention strategy UHSP supported implementation of 'other prevention' interventions focused mainly on the most-at-risk populations (MARPs) who include such persons as commercial sex workers, long-distance truck drivers, 'boda boda' motorcyclists, discordant couples, students at higher institutions of learning, fishermen and the communities living near the landing sites, bar and lodge owners, internally displaced persons and other mobile populations. This was important because MARPs remain major pockets of high HIV prevalence even within the generalized epidemic in Uganda.

Six CSOs (see Table 10) were supported during the project to deliver 'other prevention' messages.

Out-of-school youth were reached through outreaches and through static sites that had specialized youth friendly services at 'youth corners'. A peer-to-peer model was also employed to provide accurate information on prevention beyond 'abstinence' and 'being faithful'.



Peer Educators from IDEAH demonstrating condom use in Mbarara district.

UHSP achieved very good results because of the wide network of trained peer educators and community volunteers that served as condom distribution outlets and disseminated 'other prevention' messages at the same time. Those trained included, bar and lodge owners, waiters and waitresses, PLHIV, commercial sex workers and other volunteer condom distributors.

**Table 10: Performance against set targets by implementing partner for individuals reached with 'OP' messages**

Organization	Target	Actual	Male	Female	% Achievement
AIC	365,000	254,164	116,015	138,149	70
UPMA	50,250	226,295	113,812	112,483	451
BUCADEF	50,000	66,341	33,947	32,394	133
IDEAH	70,000	92,538	52,826	39,712	132
URHB	15,000	9,712	7,503	2,209	65
YA	10,000	19,783	9,519	10,264	198
<b>Total</b>	<b>560,250</b>	<b>668,833</b>	<b>333,622</b>	<b>335,211</b>	<b>119</b>

Source: UHSP records

## Key Achievements

- 668,833 individuals were reached with 'other prevention' messages.
- 849 individuals mainly peer educators were trained to give prevention messages beyond 'abstinence' and 'being faithful'
- 205 condom service outlets were established and supported

Messages were conveyed through music dance and drama outreaches, community dialogues, counsellor led educational talks, and couple led sessions in communities to couples and widows emphasizing disclosure and prevention of gender-based violence (GBV). 'Other prevention' seminars including such topics as the relationship between HIV and STIs were conducted by Youth Alive for youth out-of-school and MARPs. Peer educators working with UPMA and URHB were also equipped with games for youth meetings and entertainment.

In AIC, monthly dialogue sessions on 'other prevention' messages were conducted within targeted MARP communities for example out-of-school youth at the market video halls. These sessions were facilitated by AIC staff at all the seven branches. Issues discussed included targeting of behaviours that increase risk for HIV transmission such as: engaging in casual sexual

encounters; engaging in sex in exchange for money or favours; having sex with an HIV-positive partner or one whose status is unknown; using drugs or abusing alcohol in the context of sexual interactions; and using addictive intravenous drugs. The Philly Lutaya Initiative members and other people living with HIV&AIDS (PLHIV) were facilitated through monthly fellowships to provide peer counselling and deliver messages related to 'other prevention' methods. UHSP supported drama outreaches conducted by AIC drama group members to convey 'other prevention' messages.

IDEAH, a UHSP partner CSO that disseminated 'other prevention' messages, supported fellowship meetings of anti AIDS peer support clubs for high risk groups. Seventy five peer educators (40 males and 35 females) from six anti-AIDS peer support clubs in the project target area participated in these fellowship meetings. The following were achieved;

- Together with the project staff, achievements, lessons learned and challenges met by peer educators in the process of reaching out to fellow peers with 'other prevention' messages were discussed. This helped to establish rapport between peer educators and project staff
- Peer educators were supported with IEC materials in order to ease their work

The anti-AIDS clubs also conducted drama performances and poems in their communities to convey the 'other prevention' messages. The peer educators also referred people to access other services like treatment of STIs, HIV testing thus complementing efforts of other service providers.

## PEER-TO-PEER APPROACH, A SUCCESSFUL AVENUE FOR OTHER PREVENTION MESSAGING - SUCCESS STORY



One-on-one discussion with a peer educator

Janet, a 45-year old female resident of Katiko landing site in Mityana district is one of the beneficiaries of 'other prevention' services supported by UHSP. Katiko landing site is a meeting point for boat owners, fishermen and commercial sex workers. *'It is a norm here that whenever the fishermen sell their stocks, they will flock the trading center and look for women for casual sex'* explains one of the peer educators

Janet attended a community dialogue meeting that was to discuss among other HIV related topics 'other prevention'. After the meeting, Janet confided in one of the peer educators and requested for assistance. It was found that Janet had symptoms of STIs which included a vaginal discharge and lower abdominal pain, of which she

didn't know the cause. The peer educator met Janet at her home where further discussions of these signs and symptoms and the implications of STIs in relation to HIV&AIDS were held.

During the discussion, Janet realized how exposed to acquiring HIV she was. She was given a referral note describing her condition to Katiko Health Centre II.

On a follow-up visit to Janet's home, the peer educator was interested in knowing what happened after the referral. During the ensuing discussion, the peer educator reports she looked to be very happy. In her words Janet said *'Musawo (common lay term for health related service providers), you are so helpful because where you referred me I was examined, treated for my condition and I also accepted to take an HIV test since I was at risk of acquiring it. This was done at no cost but I could not believe myself when the HIV results were negative.'* She had never used condoms prior to the first meeting with the peer educator. Janet became a peer educator and after being trained and with continuous interaction with other peer educators she realized the importance of consistent and correct condom use.

During one of the fellowship meetings for the peer educators, Janet later reported she was feeling better and that all STIs had cleared. She was consistently using condoms and had reduced the number of sexual partners to one. She was also ready to go for another HIV test since the counselor had educated her about the need for a follow-up test.

She thanked peer educators and the program and promised to use the training and skills acquired to keep herself and the rest of the community members healthy.

In conclusion, Janet had this to say: *'I cannot express my appreciation to the importance of this project in my life... I had decided to live with my STIs till death and I also thought that I was already HIV positive. My life is new now thank you indeed.'*

## Lessons learned

- Empowering peer educators to pass on ‘other prevention’ messages and conduct community condom education and distribution using the peer-to-peer approach was a very effective way of reaching the high risk groups of people. It opened up boundaries that would have otherwise been difficult to break
- There was a need for orientation of lodge and bar operators on ‘other prevention’ and mobilize them to be important allies in educating and availing condoms to most-at risk populations
- Much as there was a great demand for condoms in the community especially after receiving the messages on ‘other prevention’; condom related stigma still existed. This led to fewer people picking condoms from condom distributors especially in public places. Therefore there was need to continue promoting the use of condoms, both to HIV positive and negative people
- The work done by the peer educators in reaching out to fellow peers with ‘other prevention’ messages including condom education was highly recommended by community members. If such messages are seriously adhered to by the community, a lot of impact was likely to be realized in terms of prevention of HIV infection
- Formation of anti-AIDS peer support clubs brought peer educators together as a team. It was because of such team work that the activities of the peer educators were recognized by local authorities like local council leaders especially reaching out to the communities with HIV&AIDS prevention messages including condom education

## Challenges and Recommendations

- Most-at-risk populations for example fishermen did not have time to sit and listen to the messages that preceded condom distribution. It was necessary to have innovative ways of delivering the messages to them. One of the CSOs, URHB, trained the boat riders to disseminate messages to the fishermen while they were in contact with them at most times
- The peer educators were faced with situations where they had limited knowledge to explain complex issues related to HIV&AIDS to communities. There was therefore a need to provide peer educators additional support to address their knowledge gaps for example asking a health worker to go out to the community with them
- The supply of condoms to communities is still erratic and stigma existed concerning the use of condoms, especially in long term extra-marital relationships. There is need to develop messages that address condoms as a way of preventing HIV infection and dispel the myth that they are related to promiscuity
- There was limited appreciation for data collection and documentation by communities, for example youth were reluctant to sign attendance registers and peer educators did not consistently collect data and success stories. This was tackled through continuous technical and M&E support to the peer educators

## STRATEGIC INFORMATION



## 6.0 Strategic Information



Due to the important role of strategic information to broader program issues like monitoring and evaluation, program management and leadership, accountability and reporting, advocacy and resource mobilization; UHSP supported the CSOs in this area. Emphasis was placed on ensuring that implementing CSOs and their community-based partners appreciated the need to collect and report information on their activities in an accurate and timely manner according to the set guidelines.

During the project period, 215 people from twelve organizations received training on strategic information issues ranging from; data collection, entry, cleaning, analysis, to quality assurance, validation, utilization and

report writing. Through such training, CSOs were able to strengthen the monitoring, evaluation and reporting systems of their organizations. Data quality assessments were also conducted with all the CSOs. UHSP acquired and distributed 125,000 HCT client cards, 38 copies of HCT registers, and 22 copies of guidelines on Logistics Management for HIV commodities.

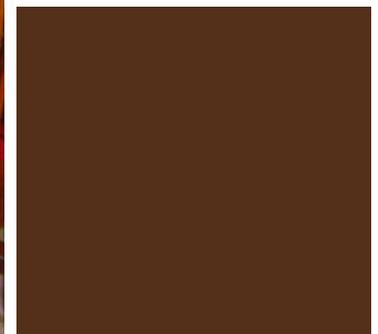
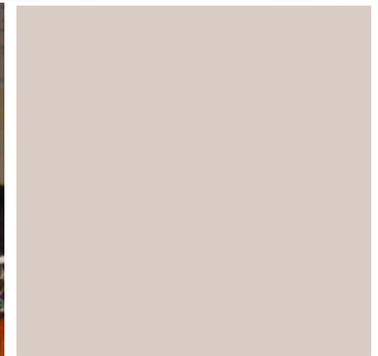
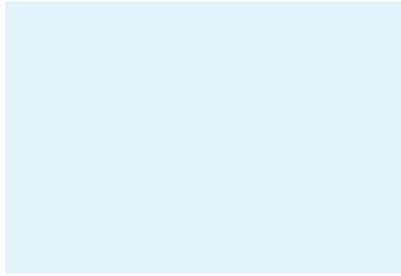
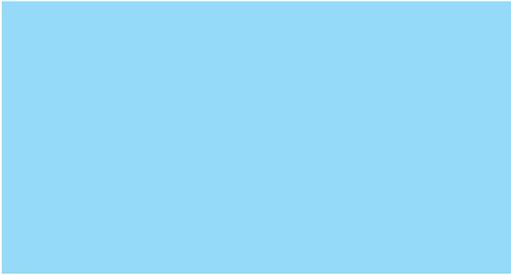
Through further M&E technical support, eleven implementing partners received assistance on how to formulate and strengthen their own M&E plans. The technical support involved M&E systems including planning, data collection, analysis and utilization.

**Table 11: Summary results for Strategic Information**

Indicator	Overall target	Achieved (%)
Number of local organizations provided with technical assistance for strategic information activities	12	12 (100)
Number of individuals trained in strategic information (including M&E, surveillance and/or HMIS)	185	237 (128)

Source: UHSP records

## POLICY ANALYSIS AND SYSTEMS STRENGTHENING



## 7.0 Policy Analysis and Systems Strengthening



UHSP realised that a supportive policy environment is critical to the implementation of HIV&AIDS related activities. UHSP complemented the efforts of the Ministry of Health towards ensuring that policies and guidelines relevant to the activities that UHSP partners were implementing were well known to them. A total of 2,488 health service providers were retrained and oriented on policies and guidelines related to HIV&AIDS activities. Those oriented included CSO personnel and health workers from different

health facilities around the country. Specifically policy orientation was on the HCT policy and the HIV rapid testing protocols.

HIV counselling cue cards were distributed to eight UHSP partner CSOs implementing HCT activities and these include: AIC, FLEP, ICOBI, KICA, MMHF, STF, URHB and YA. The distributed cards comprised of counselling cue cards for adults, HIV rapid testing cue cards and child counselling cue cards.

**Table 12: Summary of results for Policy Analysis and Systems Strengthening**

Indicator	Overall target	Achieved (%)
Number of individuals oriented/trained on the new and revised HIV&AIDS related policies and guidelines	1,230	2,488 (203)

*Source: UHSP records*

## INSTITUTIONAL CAPACITY DEVELOPMENT



## 8.0 Institutional Capacity Development



### 8.1 Technical capacity building

UHSP provided the twelve CSO partners with ongoing technical support in planning, monitoring and evaluation, finance, and integration of HIV&AIDS services through regular support visits made by the UHSP staff from the various departments. Additionally, UHSP provided AIC with technical and financial support in the drafting and finalizing of the Board of Trustees Operations Manual. This manual which was developed with active participation of the AIC Board members is now providing practical guidelines to the Board of Trustees and Senior Management of AIC on Board operational roles and responsibilities, Board of Trustees and Senior Management relationships and other key guidelines that ensure smooth and effective corporate governance of AIC. It is important to note that this manual was the first of its kind in AIC, and was tailored to the needs of AIC as an institution, and that it was a key resource material for guiding Board of Trustees operations at AIC. The launching of this manual also provided a timely opportunity to orient the new Board of Trustees into their expected roles and responsibilities. Related to this, UHSP funded the Annual General Meeting at which the new members of the Board of Trustees were oriented on the Board of Trustees Operations manual. A Finance Director was hired for AIC to help build capacity in their finance department.

### 8.2 Organizational Development Capacity Assessment

During the course of the project, UHSP engaged its partners in capacity building initiatives. In order to establish the capacity needs of its partners, UHSP conducted a participatory organizational development (OD) capacity assessment in which eleven CSO partners participated. The objectives of the assessment were to:

- Inform UHSP on the organizational capacity development level of its partners;

- inform the development of CSO-specific capacity development interventions; and
- facilitate more effective collaboration among UHSP and partners based on the identified needs.

The assessment was administered through group discussions with CSO staff and Directors, and it utilized a CSO capacity assessment tool (see Appendix 4) to collect and analyze information on various capacity needs. The seven focus areas that were assessed included: governance, management systems and practices, financial management, sustainability, information systems, performance management and service delivery. The assessment rated CSO capacity on twenty two components categorized under the major seven focus areas mentioned above.

#### 8.2.1 Outcome of the OD capacity assessment

Analysis indicated that the eleven UHSP partner CSOs were at varied stages of organizational capacity development. Overall all the CSOs were strong in the areas of service delivery, governance and management practices. The challenges that CSOs faced included: limitations in maintaining standards of service delivery; inadequate performance management; poor information systems; and lack of sustainability strategies. Financial management was a cross cutting challenge to most CSOs. Overall eleven components of the assessment that scored 3.5 or less (average score) were identified as capacity building areas (see Table 13).

Eight of these components were identified as top priority capacity building areas under UHSP. These included planning, service delivery, control over assets, standards and supervision, reporting, financial management, information systems and audits.

The results indicated that more than half of the CSOs acknowledged that their capacity to plan, deliver services

**Table 13: Capacity components below the average score of 3.5**

Capacity Component	Average Relevance Score
Planning	2.0
Service Delivery	3.0
Decision Making	3.1
Financial Sustainability	3.1
Income Generating Activities	3.1
Control over Assets	3.3
Standards and Supervision	3.3
Reporting	3.4
Financial Management	3.4
Information Systems	3.4
Audits	3.5

Source: UHSP Organizational Development Capacity Assessment Study

### UHSP priority areas for capacity building

#### Planning

- Service delivery
- Control over assets
- Standards and supervision
- Reporting
- Financial management
- Information systems
- Audits

on a regular and sustained basis, generate income for their organizations and financial sustainability for their organizations were major challenges. The other significant capacity building components included; decision making, standards of service delivery and supervision, control over assets and stocks, information systems, financial management, reporting and audit management. The findings of this assessment were shared and discussed with the partner CSOs during the UHSP midterm review.

Utilizing the findings of the CSO capacity assessment, UHSP took note of the variations in capacity needs across partners and used this information to tailor its technical support to each grantee. A capacity mapping exercise was done and tailored technical assistance was provided to individual CSOs. This was in the areas of strategic planning, monitoring and evaluation and financial systems strengthening.

While all the CSO partners were provided with different forms of technical support, five of them registered significant achievements in strengthening their planning, management and institutional systems strengthening resulting from UHSP support.

BUCADEF, STF, UPMA, and TUKO staff were oriented and equipped with skills in developing comprehensive M&E plans including target setting. Key among the achievement realized was that BUCADEF, UPMA and STF were supported to set up simple but effective electronic databases. The new databases captured information by district, sub-county, intervention area and gender. These databases were also electronically linked to formulas that

to automatically assist in deriving relevant information that could be used to generate reports and develop work plans.

In addition, MMHF, IDEA, and TUKO were supported to review their respective financial systems. While each of these organizations was at different levels in financial management, they all had gaps in maintaining petty cash systems as well as planning internal audits. UHSP worked with these CSO partners to identify strategies for planning and operationalising these systems as a way of strengthening their financial management systems

### 8.3 AIC Organizational and HCT reviews

UHSP supported AIC to review its technical and organizational competencies with a view of establishing workable organizational strategies that would enable it to realize greater organizational performance. The outcome of these reviews are summarized below

#### 8.3.1 The HCT review

UHSP worked with AIC to design and implement an HCT review. The main purpose was to facilitate AIC learn from its own successes and from those of other HCT providers so as to improve and expand its HCT service reach in an efficient and effective way. Data was collected from AIC branches in Kampala, Jinja, Lira and Mbarara taking into consideration the geographical location, duration of existence (new-Lira, old-Jinja and Mbarara) and conflict areas (Lira). In addition the opinion of AIC clients on its services was secured through client exit interviews. For comparative purposes the study team collected data from other HCT providers namely; MMHF in Mbarara, Mulago-Mbarara Teaching Hospitals Joint AIDS Programme (MJAP), Inter Religious Council of Uganda (IRCU) and the Program for Accessible health, Communication and Education (PACE) - formerly known as Population Services International, focusing on among others the following service parameters;

- Access and affordability of services especially for the hard to reach populations
- Coverage of HCT services vis-à-vis organizational mandate
- Adhering to national policy and technical guidelines for delivery of HCT services
- Cost effectiveness of delivery of services
- Level of client satisfaction

### Findings of the review

AIC has over the years registered a lot of achievements, as a pioneer HCT provider in the country. It has particularly been able to reach out to many self-selected clients. However, AIC's new ventures in the non-traditional HCT approaches such as mobile and home-to-home HCT that are more cost effective and have greater opportunity to reach out to people in underserved, hard-to-reach areas as well as MARPs and couples has not been systematically planned for, documented, nor scaled up for greater results.

The findings indicated that AIC's potential in strengthening its HCT delivery lay in:

- Consolidating its branch-based clinics to target and improve on the care and support for the self selected clients
- Consolidating the good will of the Ministry of Health and other service providers to improve the quality of referrals for its clients
- Developing the capacity of its regional branches to become centres of excellence capable of becoming hubs of information on HCT, and avenues for pilot-testing new interventions and approaches that would then be replicated and scaled-up
- Embracing more of the non-traditional HCT approaches to increase the number of new testers
- Diversifying its funding sources to increase its capacity for research, innovation and HCT delivery
- Exploiting its niche in training and capacity building function by mapping out a clear plan on how to establish a fully fledged training centre for HCT laboratory and counseling specialists and providing input when national curricula are being revised

#### 8.3.2 AIC Organizational review

UHSP supported AIC to undergo an organizational review. This organizational review utilized the appreciative inquiry (AI) approach and focused on enabling AIC to reassess its strength weaknesses opportunities and threats (SWOT) and to establish workable organizational strategies that would enhance greater organizational performance. The

review also utilised a trends analysis to enable AIC draw insights and lessons from its past successes, and utilising the McKinsey 7S's which are, strategy, structure, systems, style, staffing, skills and shared values.

### Findings of the organizational review

The findings on the organizational review showed that AIC had consistently provided quality services and had by December 2008 reached over 2.2 m people with HCT service through its direct and indirect sites. It also showed that despite the various management and leadership challenges, AIC's main stakeholders (Ministry of Health and Development Partners) have maintained a sustained interest in the survival and growth of AIC. However, the same findings indicated that AIC had had an up and down growth curve characterized by success and management challenges over the years, leading to negative impacts on its staff motivation and ability to deliver services effectively. The main reasons behind the challenges included limited clarity on the sense of direction of AIC as an organization, inability to widen its resource base to match the growing needs of this institution and a limited ability to document, learn and apply lessons from its past experiences among others.

In light of the above, the organizational review made a number of recommendations. Some of the key recommendations indicated that AIC should:

- Undertake a strategic repositioning exercise that will enable it to examine and forecast its strategic direction with more clarity and review its strategies and specific actions that will place it in a more strategic and competitive position
- Define its clientele groups and design appropriate packages for them
- Decide on an appropriate mix between its facility based service delivery strategies with a community based approach
- Enhance its advocacy function to include public relations and marketing for its services
- Budget and secure resources for facilitating the board committees to function effectively
- Review and update its systems, policies and procedures that support its implementation strategy

- Support, inspire, nurture and develop the skills of its staff through coaching, mentoring, increased delegation of responsibilities and decision making where appropriate
- Regularly carry out operational research on new developments in the HIV arena and come up with areas that can be tailored to the needs of staff and consolidated into a continuous professional development strategy

As a result of these reviews, AIC with support from UHSP started implementing some of the key recommendations.

### 8.3.3 Strategic repositioning and research, documentation and communication strategy

UHSP, in response to the recommendations of the two reviews, further supported AIC to undergo a strategic repositioning exercise whose main purpose was to enable it clarify its future direction. A research, documentation and communication strategy was also developed.

### Strategic repositioning

#### Objectives of the strategic repositioning:

- Facilitate AIC to clarify its vision, mission, values, and ideology;
- support AIC to undertake a detailed situation analysis of its internal and external environments and develop clear strategic directions for the future;
- update the current strategic plan with the new strategic insights drawn from the situation analysis; and to
- support AIC to develop a comprehensive logical framework to guide implementation for the next five years including a one-year plan and budget

As a result of this exercise, AIC clarified its vision, mission and strategic future for the next five years. The exercise enabled AIC to find ways of exploiting its niche in HCT at both service delivery and training levels. AIC



*AIC staff during the strategic positioning workshop*

is also repositioning to build and utilize the different capacities of its close partners and clients to enhance efficiency, effectiveness and exploit varying areas of comparative advantages to enable wider access and utilisation of HCT services.

## Development of a research, documentation and communication strategy

The main purpose of this strategy development was to provide AIC with a framework that would enable it to meet the information needs of its internal and external stakeholders and to equip AIC's staff with the basic skills for implementing this strategy.

### Other objectives were to:

- Identify priority audiences and their appropriate documentation product;
- identify documentation, research and communication, needs and develop key strategies for meeting those needs; and
- develop a documentation, research and communication strategy.

As a result of the above intervention, AIC developed a very comprehensive research, documentation and communication strategy that defined its information needs in respect to its wide clientele and stakeholders, defined the key targeted audiences, and highlighted the various goals for research, documentation and communication with their subsequent intermediate

results. The strategy also defined implementation modalities and a one-year plan and budget to start its implementation. AIC plans to invest in research and documentation as well as in improving its information and technology function to enable better information management and use.

## Lessons learned

- OD interventions are more effective when client organizations played an active role in the design and implementation of those interventions. This active participation evolved and sometimes took quite some time before the need for change was understood and appreciated
- Enthusiasm and positive attitude of leaders and managers of organizations was key to successful implementation of OD interventions. OD activities should therefore prioritize securing ownership of the OD process before it begins

## Challenges and Recommendations

- OD interventions by design need to be participatory so as to allow the organization being supported to appreciate, rediscover themselves and own up to the change process. While the change process requires a lot of time, most projects do not last long enough to create the desired long-term impact. While efforts should be focused on the short term milestones that will translate into impacts in the long-term, projects should design OD interventions in such a way that the organizations being supported own the process and take responsibility for bringing about positive change within their respective organizations
- Many organizations do quite a lot of commendable work that is never known and appreciated due to lack of adequate documentation skills. Technical on-job support is an effective way of building organizational capacity to document and disseminate achievements and lessons learned

## MONITORING AND EVALUATION



## 9.0 Monitoring and Evaluation



**M**onitoring and Evaluation is an important aspect contributing to the success of any project. UHSP therefore had a Monitoring and Evaluation department which was responsible for informing the project managers on the progress of implementation and to what extent the project objectives were being met.

### Activities

At inception of the project the department assisted the CSOs to develop work plans that enabled them achieve the project outputs. UHSP identified early the need to strengthen the information systems it relied on for monitoring program achievements and plans to address these needs were embedded into the CSO work plans with each dedicating at least 10% of their overall budget to monitoring and evaluation. This resulted into accurate data being received from most CSOs.

Monthly data was collected on the indicators UHSP was reporting on as shown in the performance monitoring plan (PMP) Appendix 1. This data was used to generate project reports and USAID and other partner reports. UHSP worked with the Monitoring and Evaluation of the Emergency Plan Progress (MEEPP) project to ensure that indicators to be reported on meet PEPFAR guidelines in terms of disaggregation and appropriate reporting format.

Specific efforts were made to conduct quality assurance during implementation for all the CSOs. To avoid double reporting of results, CSOs were encouraged to implement in geographical areas that did not overlap with other USAID supported partners or any other major implementers in the focus area(s) of interest. UHSP realized that the Health Information Management System (HMIS) in its current form would not pick information on home and community based activities. In light of this, UHSP supported the CSOs to develop appropriate data collection tools and trained their personnel to accurately collect required data at the community level.

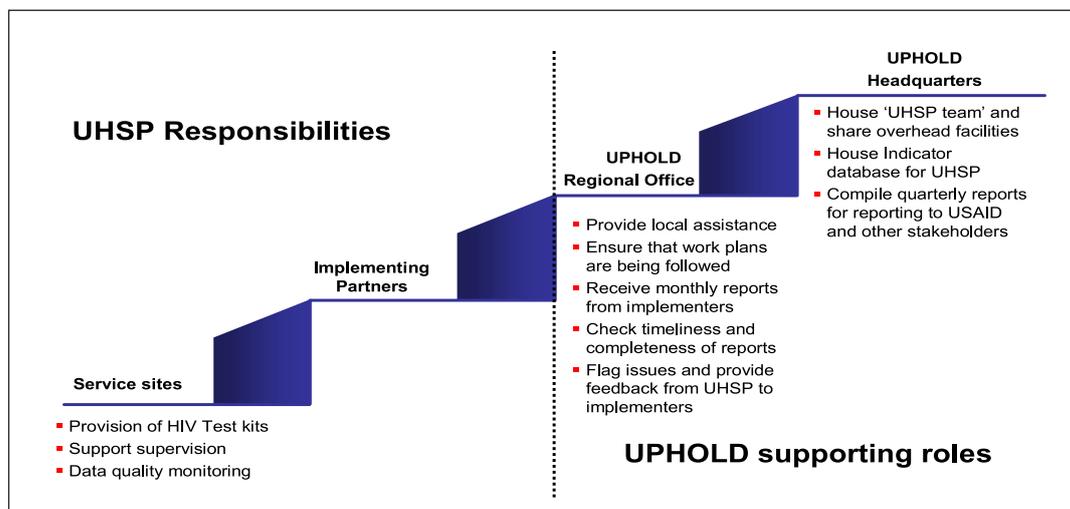
### Performance Monitoring Plan

Strategic planning was carried out at the beginning of the project and the performance monitoring plan (PMP) was developed in a participatory manner. Detailed definitions of the indicators monitored are shown the PMP (see Appendix 1). Indicators were monitored in the areas of HIV counseling and testing, palliative care, 'abstinence only', 'abstinence' and 'being faithful', 'other prevention', strategic information, policy analysis and systems strengthening and institutional capacity building. The PMP accommodated the required PEPFAR indicators.

### UHSP reporting mechanism

Standardized reporting tools were developed; (see Appendix 5) and the data collection flow process was outlined as illustrated in Figure 3. Monthly and quarterly reports were submitted and these were reviewed by Grants, M&E and the Technical departments. From January 2008 to June 2008 while UPHOLD was still existent, the CSOs reported through the UPHOLD regional offices. Reporting responsibilities were shared as shown in Figure 3. From July 2008 to the end of the project, UHSP implementing partners reported directly to the UHSP office in Kampala. The CSOs benefited from on-site support supervision that was given throughout the period of the project.

Figure 3: UPHOLD-UHSP collaboration



## Documentation and dissemination of program results

UHSP wrote and disseminated quarterly reports, an annual report and the bi-annual PEPFAR reports; these reports detailed achievements, challenges and lessons learned by the project throughout its lifetime.

In September 2008, UHSP successfully conducted a mid-term review (MTR) of the implementation progress by partner CSOs. The MTR provided an opportunity to both UHSP and the partners to receive feedback on grant implementation, establish the progress made by individual partners towards achieving end of project results, and identified the constraints hindering implementation and opportunities for improving performance in the remaining period. AIC was noted as unlikely to achieve all the targeted palliative care and 'OP' results. As a result of this six CSOs namely, BUCADEF, IDEAH, UPMA, YA, MMHF and KICA, were provided with additional funds (see Table 14) to implement activities that were initially beyond their scope of work.

An End of Project conference was held in December 2008 and it was a celebration of the promising innovations that enabled UHSP to achieve remarkable results in HIV

counseling and testing, palliative care and HIV awareness and prevention. At the same time, the conference was used to share experiences and challenges in program implementation as well as to identify ways of sustaining promising innovations. The conference brought together civil society organizations that had partnered with UHSP since January 2008.

While the focus of the conference was on promising innovations, implementing partners needed to know how to repackage their services so as to remain relevant to the emerging needs in the HIV&AIDS arena as the project came to a close. To this end USAID and MoH representatives gave remarks regarding the strategic direction for HIV&AIDS partnerships in Uganda.

As part of close-out activities, UHSP produced a documentary showcasing its approaches to reach most-at-risk and hard-to-reach populations. It showed the scope of activities, achievements, successes and challenges encountered during the project period.

## Lessons learned

- Monitoring and Evaluation tools and processes should be developed and integrated into project right at the planning stage of the project
- Data quality audits and on job support and training to CSOs improved on accuracy and completeness of data recording and reporting
- Integrating M&E and support supervision in CSO work plans helped the CSO develop a routine for M&E that would otherwise be missing in their project implementation

## Challenges and Recommendations

- Data capture and reporting from some of the CSOs was inadequate especially at the beginning of the project. Continuous support supervision and tailored M&E technical assistance was provided to the CSOs and great improvement in reporting was noted from all of them
- Stringent reporting requirements sometimes led to late requisition of funds by the CSOs and this subsequently affected timely implementation of some activities
- There was limited appreciation for data collection and documentation by communities, for example youth were reluctant to sign attendance registers and this made it difficult for the peer educators to verify the number and gender of individuals reached with messages especially for AB and OP
- Some of the CSOs used the MoH data capture tools for example HCT and Pre-ART registers to capture primary data. However some of the health facilities were found to have run out of these making it very difficult for the CSOs to collect and verify some of the data. UHSP had to reprint and circulate some of these MoH data capture tools to the CSOs to improve reporting
- Since care for PLHIV is structured in such a way that clients are seen on at least a monthly basis it was difficult to capture unique individuals especially in the area of palliative care. Many of the CSOs had difficulty identifying repeat HIV testers during implementation. They were therefore advised to attempt to use unique identification numbers for all their clients
- Regular on job monitoring and evaluation support supervision should be provided to the CSOs in order to ensure improvement in the monitoring and evaluation function of the CSOs
- Data quality assessments and audits should be conducted on a regular basis to ensure that data collected is a true reflection of activities that are being implemented
- Geographical mapping of areas of implementation should be done at the beginning of the project and periodically during the course of the project to avoid overlapping between implementing partners
- Various implementing partners should be encouraged to meet on a regular basis especially those that carry out activities in the same focus areas and within close geographical areas. This will avoid duplication of services and ultimately ensure that a larger number of unique individuals are provided with the different services

## GRANTS AND SUB-CONTRACTS



## 10.0

## Grants and Sub-contracts



During the period 14 January 2008 to 13 July 2009, a total of Uganda Shillings (UGX) 1,036,575,408 was disbursed to eleven CSO partners that included FLEP, KIC, IDEA, MMHF, ICOBI, STF, YA, URHB, UPMA, BUCADEF and TUKO Club to enable them achieve set targets. Separate grants were awarded for Year 1 and the six months extension period.

During Year 1 of UHSP, UGX 732,458,605 was disbursed to eleven CSO partners to implement activities. Additional funding amounting to UGX 99,799,000 was given to six CSOs namely KICA, YA, UPMA, IDEAH, BUCADEF and MMHF, as shown in Table 14. This was to enable them achieve additional targets beyond what had initially been agreed upon as a result of their good

performance. The total grants fund disbursed to the CSOs during Year 1 of UHSP was UGX 828,095,564.

By the end of Year 1, an average of 99% of the total grant funds had been disbursed to the CSOs. Some of the CSOs such as KICA, STF, FLEP and TUKO utilized less funds for some activities than was originally requested and had some residual funds totaling to UGX 4,162,142. All CSOs refunded the remaining monies. The progress of each grantee was continuously monitored to ensure that timely support was offered whenever this was needed.

**Table 14: Grant summary for UHSP support, Jan – Dec 2008**

Grantee	Initial Grant (UGX)	2 <sup>nd</sup> Grant (UGX)	Total release (UGX)	% release	Grant Balance (UGX)
ICOBI	56,263,000	-	56,263,000	100	-
KICA	56,533,000	25,150,000	79,306,450	97	2,376,550
STF	84,903,900	-	84,147,875	99	756,025
YA	67,657,500	18,268,000	85,885,991	99	39,509
UPMA	25,677,500	11,292,000	36,969,500	100	-
URHB	56,047,500	-	56,047,500	100	-
FLEP	65,872,050	-	65,240,750	99	631,300
IDEAH	38,858,100	15,874,000	54,732,100	100	-
BUCADEF	31,117,700	7,795,000	38,759,980	99	152,720
MMHF	190,958,358	21,420,000	212,378,358	100	-
TUKO	58,570,000	-	58,364,060	99	205,940
<b>TOTAL</b>	<b>732,458,608</b>	<b>99,799,000</b>	<b>828,095,564</b>	<b>100</b>	<b>4,162,044</b>

Source: UHSP records

During the six months extension period of January – July 2009, four implementing partners that is FLEP, IDEAH, KICA and MMHF continued implementing activities. Initial grants totaling to UGX 158,725,300 were given to them and an additional UGX 45,592,500 was given to three of

the four partners to enable them achieve the required targets. The additional funds were realized from exchange rate gains over the UHSP extension period. Table 15 below summarizes grants given out to CSOs during the extension period.

**Table 15: Grant summary for UHSP support, Feb 2009 – July 2009**

Grantee	Initial Grants (UGX)	Additional funds / Modifications	Total release	% release	Grant Balance (UGX)	Comments
IDEAH	30,261,000	0	30,261,000	100%	Nil	
FLEP	23,954,300	11,513,500	35,467,800	100%	Nil	Additional funds to accelerate HBCT during extension period
KICA	34,332,000	13,890,000	48,222,000	100%	Nil	Received additional funds to achieve required targets
MMHF	70,178,000	20,189,000	83,689,800	100%	Nil	Received additional funds to achieve required targets
<b>TOTAL</b>	<b>158,725,300</b>	<b>45,592,500</b>	<b>197,640,600</b>	<b>100%</b>		

Source: UHSP records

In summary, a total of UGX 891,183,908 was awarded in initial grants and UGX 145,391,500 as additional grants to the CSOs over the entire project period. By the end of the project, an average of 100% had been disbursed to the grantees. The source of the additional funds given to grantees during the extension period was realized from gains arising from an increase in USD: UGX exchange rates over the period.

Table 16 shows a summary of funds disbursed to all CSOs that received grants over the entire period of UHSP.

**Table 16: Grant summary for UHSP support, Jan 2008 – July 2009**

Grantee	Initial Grants (UGX)	Additional funds / Modifications	Total release	% release	Grant Balance (UGX)	Comments
FLEP	89,826,350	11,513,500	101,339,850	100%	Nil	Additional funds to accelerate HBCT during extension period
KICA	90,865,000	39,040,000	129,905,000	100%	Nil	Received additional funds for additional targets both in Year 1 and in project extension period
IDEAH	69,119,100	15,874,000	84,993,100	100%	Nil	Received additional funds for additional targets in Year 1
MMHF	261,136,358	41,609,000	302,745,358	100%	Nil	Received additional funds for additional targets both in Year 1 and during the extension period
ICOB	56,263,000	0	56,263,000	100%	Nil	
STF	84,903,900	0	84,903,900	100%	Nil	
YA	67,657,500	18,268,000	85,925,500	100%	Nil	Received additional funds for additional targets in Year 1
URHB	56,047,500	0	56,047,500	100%	Nil	
UPMA	25,677,500	11,292,000	36,969,500	100%	Nil	Received additional funds for additional targets in Year 1
BUCADEF	31,117,700	7,795,000	38,912,700	100%	Nil	Received additional funds for additional targets in Year 1
TUKO	58,570,000	0	58,570,000	100%	Nil	
<b>TOTAL</b>	<b>891,183,908</b>	<b>145,391,500</b>	<b>1,036,575,408</b>	<b>100%</b>		

Source: UHSP records

## Sub-contracts to the AIDS Information Centre

The Uganda AIDS Information Centre (AIC) received funding through a fixed price sub-contracting mechanism. A total of UGX 4,654,636,182 was given to AIC to implement activities; UGX 3,111,610,300 for Year 1 and UGX 1,543,025,882 during the six-month extension period.

## Procurement

HIV test kits, related consumables and condoms, were centrally procured and distributed to grantees. An initial procurement based on the procurement plan was competitively done and items distributed to the partners to facilitate implementation.

Due to the substantial appreciation of the US Dollar against the Uganda Shilling over the project extension period, additional funds were gainfully utilized to procure more HIV test kits and consumables, laboratory reagents, home based care kits, registers and stationery used by the implementing partners. This resulted into increased and accelerated implementation hence an over achievement on most of the UHSP targets.

## Appendix 1: Uganda HIV/AIDS Services Project (UHSP) Performance Monitoring Plan

Intervention	Indicator code	Indicator	Indicator Definition and Unit of Measure		
				Target	Actual
1. HIV Counselling and Testing	1.1	Number of individuals who received counselling and testing for HIV and received their results	Definition: Number of individuals who received counselling and testing for HIV and received their results in UHSP-supported HCT sites Disaggregated by gender, type of facility Unit of measure: Number	512,000	575,243
	1.2	Percent of general population aged 15-49 years receiving HIV test results in last 12 months in the catchment area of UHSP implementing partners (to be evaluated at end of UHSP)	Definition: Number of women and men aged 15-49 who have been tested for HIV in last 12 months and who received their test results the last time they were tested * 100/total number of women aged 15-49 years in the UHSP catchment area Unit of measure: Percent	10	18
	1.3	Number of individuals trained in HIV counselling and testing according to national and international standards	Definition: Number of individuals trained or re-trained to provide HCT services at all levels Disaggregated by gender, type of facility (Hospital, HC IV, HC III etc.) Unit of measure: Number	1,380	1,319
	1.41	Number of service delivery outlets providing HIV counselling and testing services according to national and international standards	Definition: A service outlet refers to units such as a hospital, health centre, stand-alone site or mobile clinic that provides HCT services Disaggregated by Static and Outreach Sites Unit of measure: Number	S:25 O: 178	S:157 O:336
2. Palliative Care: Basic Health Care and Support	2.1	Number of individuals provided with facility-based, community-based and home-based HIV-related palliative care (excluding TB)	Definition: Number of individuals receiving any or a combination of clinical, psychological, spiritual and or support care services Disaggregated by gender Unit: Number	28,200	34,202
	2.2	Number of individuals trained to provide HIV-related palliative care (excluding TB)	Definition: Number of health workers trained or retrained on HIV-related palliative care service provision including clinical, psychological, spiritual and support care services Disaggregated by gender, facility type (Hospital, HCIV, HC III, FSG, PSG etc.) Unit of measure: Number	328	328

<sup>1</sup> S refers to static sites and O to outreaches. Some implementing partners utilize home-to-home counseling. Targets indicated are for a cumulative total of 10 static sites and 70 outreach sites in Q2. Individual homesteads in home-to-home counseling are not identified as separate sites

Intervention	Indicator code	Indicator	Indicator Definition and Unit of Measure		
				Target	Actual
	2.32	Number of service outlets providing HIV-related palliative care services (excluding TB)	Definition: Number of service outlets that provide patient and family-centred care services including any one or a combination of the following: Clinical; psychological; spiritual and support care services Disaggregated by: type of facility (hospital, health centre, dispensary, public, private and community-based service outlets etc.) Unit of measure: Number	7	9
3. Abstinence and Faithfulness	3.1	Number of individuals reached through community outreach that promotes HIV&AIDS prevention through abstinence and/or being faithful	Definition: Number of individuals who have received prevention education through any effort to effect change that might include peer education, classroom teaching, small group, one-on-one information and IEC and BCC to promote abstinence and being faithful Disaggregated by gender Unit of measure: Number	190,250	292,231
	3.2	Number of individuals reached through community outreaches that promote HIV&AIDS prevention through abstinence only	Definition: Number of individuals who have received prevention education through any effort to effect change that might include peer education, classroom teaching, small group, one-on-one information and IEC and BCC all meant at primarily promoting abstinence Disaggregated by gender Unit of measure: Number	70,000	96,711
	3.3	Number of individuals trained to promote HIV&AIDS prevention through abstinence and being faithful	Definition: Number of individuals trained or retrained with the purpose of enhancing their knowledge of or ability to deliver messages and to conduct program activities aimed at promoting abstinence and being faithful Disaggregated by gender Unit of measure: Number	253	265
4. Other HIV&AIDS prevention activities	4.1	Number of individuals reached through community outreach programs that promote HIV&AIDS prevention through other behaviour change beyond abstinence and being faithful	Definition: Number of individuals who attended community outreach activities that focused on behaviour change beyond abstinence and being faithful. Other behaviour change beyond abstinence and being faithful includes targeting those behaviours that increase the risk for HIV transmission such as engaging in casual sexual encounters, engaging in transactional sex etc. Disaggregated by gender Unit of measure: Number	560,250	688,833

<sup>2</sup> This figure is non-cumulative and consists of the number of static sites expected to provide basic health care and support palliative care services

Intervention	Indicator code	Indicator	Indicator Definition and Unit of Measure	Target	Actual
	4.2	Number of individuals trained to promote HIV&AIDS prevention through other behaviour change beyond abstinence and being faithful	Definition: Number of individuals trained or retrained with the purpose of enhancing their knowledge of or ability to deliver messages and conduct activities promoting other behaviour change beyond abstinence and being faithful Disaggregated by gender Unit of measure: Number	440	849
	4.3	Number of condom service outlets	Definition: A condom service outlet refers to a fixed distribution point or mobile unit with a set schedule that provides condoms for free or for sale Unit of measure: Number	215	205
	4.4	Number of condoms distributed	Definition: Number of condoms distributed by UHSP supported implementing partners Unit of measure: Number	1,500,000	2,010,000
5. Strategic Information	5.1	Number of local organizations provided with technical assistance for strategic information (e.g., M&E, surveillance and HMIS)	Definition: Number of local organizations that received technical assistance for strategic information Disaggregated by organizational type: e.g., public, private, CBOs, FBOs Unit of measure: Number	12	12
	5.2	Number of individuals trained in strategic information (e.g., M&E, surveillance and HMIS)	Definition: Number of individuals who are trained or retrained in strategic information (e.g., M&E, surveillance and HMIS) according to national and international guidelines Disaggregated by gender Unit of measure: Number	185	237
6. Policy Analysis and Systems Strengthening	6.1	Number of individuals oriented and trained on the new and revised HIV&AIDS-related policies and guidelines	Definition: Number of individuals who are oriented and trained on the new and revised HIV&AIDS-related policies and guidelines according to national and international guidelines Disaggregated by gender	1,230	2,488
7. Institutional Capacity Building	7.1	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Definition: Number of local organizations provided with technical assistance for HIV-related institutional capacity building in order to enable them better implement PEPFAR supported interventions Disaggregated by organizational type Unit of measure: Number	12	12
	7.2	Number of individuals trained in HIV-related institutional capacity building	Definition: Number of individuals oriented and trained in HIV-related institutional capacity building. Institutional capacity building will be aimed at strengthening organizations in areas such as budgeting, financial and technical reporting, and accountability. Disaggregated by gender	35	175

Intervention	Indicator code	Indicator	Indicator Definition and Unit of Measure		
				Target	Actual
			Unit of measure: Number		
	7.3	Number of local organizations provided with technical assistance to develop exit strategies after UHSP	Definition: Number of local organizations with documented exit strategies after UHSP Disaggregated by organizational type Unit of measure: Number	12	12
	7.4	Organizational Assessment	An assessment of capacity building indicators specific to organizational and technical development including the ability to effectively compete for alternative sources	Completed	Done for 11 CSOs
8. HCT Organizational Review	8.0	An organizational assessment of AIC	An organizational assessment of AIC that includes recommendations for addressing identified issues and a work plan on how to address these recommendations	Completed	Completed

Appendix 2: Table detailing CSO scores per focus area

Capacity Focus Area	Capacity Component	UPMA	FLEP	IDEAH	ICOB	YA	MMHF	KICA	BUCADEF	STF	TUKO	URHB	Total
Governance	Mission and goals	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	1.0	4.0	41.0
	Policies	4.0	4.0	3.0	4.0	4.0	3.0	4.0	4.0	4.0	4.0	4.0	42.0
	Structure, roles and responsibilities	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	42.0
	Stakeholder involvement	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	2.0	2.0	40.0
	Overall score	4.0	3.0	3.8	4.0	4.0	3.5	4.0	3.8	4.0	2.8	3.5	40.3
Management systems and practices	Administrative procedures	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	2.0	4.0	42.0
	Human resource management	4.0	4.0	4.0	4.0	4.0	3.0	4.0	4.0	4.0	3.0	4.0	42.0
	Reporting	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0	1.0	1.0	4.0	37.0
	Decision making	3.0	3.0	3.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	37.5
		3.8	3.8	3.8	4.0	3.8	3.5	3.8	3.5	3.0	2.3	3.8	39.1
Financial management	Financial management	4.0	4.0	2.0	4.0	4.0	2.0	2.0	3.0	4.0	3.0	4.0	37.0
	Financial controls	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	1.0	4.0	41.0
	Control over assets	4.0	4.0	2.0	4.0	4.0	4.0	3.0	2.0	4.0	1.0	4.0	36.0
	Audits	4.0	4.0	2.0	4.0	4.0	4.0	4.0	2.0	4.0	2.0	4.0	38.0
	Overall	4.0	4.0	2.5	4.0	4.0	3.5	3.3	2.8	4.0	2.0	4.0	38.1
Sustainability	Financial sustainability	4.0	3.0	4.0	3.0	3.0	4.0	3.0	3.0	2.0	1.0	4.0	34.0
	Income generating activities	3.0	1.0	4.0	3.0	3.0	4.0	3.0	3.0	2.0	4.0	4.0	34.0
	Community leader support	4.0	4.0	4.0	4.0	3.0	4.0	4.0	4.0	4.0	4.0	4.0	43.0
	Technical linkages	4.0	4.0	4.0	4.0	4.0	4.0	4.0	2.0	4.0	4.0	4.0	42.0
	overall	3.8	3.0	4.0	3.5	3.3	4.0	3.5	3.0	3.0	3.3	4.0	38.3

Capacity Focus Area	Capacity Component	UPMA	FLEP	IDEAH	ICOB	YA	MMHF	KICA	BUCADEF	STF	TUKO	URHB	Total
Information systems	Information systems	4.0	4.0	4.0	4.0	4.0	4.0	2.0	4.0	3.0	2.0	2.0	37.0
	Overall	4.0	4.0	4.0	4.0	4.0	4.0	2.0	4.0	3.0	2.0	2.0	37.0
Performance management	Standards and supervision	4.0	3.0	3.0	3.0	3.0	3.0	4.0	4.0	4.0	1.0	4.0	36.0
	Indicators and targets	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0	2.0	4.0	41.0
	Monitoring and evaluation	4.0	4.0	4.0	4.0	3.0	4.0	4.0	4.0	4.0	3.0	4.0	42.0
	Planning	3.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	4.0	4.0	1.0	22.0
	overall	3.8	3.0	3.0	3.0	2.8	3.0	3.3	4.0	3.8	2.5	3.3	35.3
Service delivery	Service delivery	4.0	2.0	4.0	2.0	2.0	2.0	4.0	4.0	4.0	3.0	2.0	33.0
	overall	4.0	2.0	4.0	2.0	2.0	2.0	4.0	4.0	4.0	3.0	2.0	33.0

Source: UHSP Organizational Development Capacity Assessment Study, 2008

Appendix 3: CSO Capacity Assessment Tools

**Name of CSO:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Districts of Implementation:** \_\_\_\_\_

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Component	Stages of Capacity Development and Characteristics				Evidence Attached
	1	2	3	4	
<b>GOVERNANCE</b>					
1. Mission and Goals	The organization does not have clearly defined mission and goals.	The organization has clearly defined mission & goals but they do not reflect the organization's current structure and context & they may or may not be written & posted.	The organization has clearly defined mission & goals that reflect the organization's structure & context, but they are not written and posted.	The organization has clearly defined mission and goals that reflect the organization's structure and context, are written, and are clearly posted	
2. Policies	The organization has no written constitution, by-laws or operational policies to guide work, human resources mgmt. practices, or financial management	The organization has basic written constitution and bylaws but no written policies that guide work, human resource management practices or financial management	The organization has constitution, bylaws and some written policy but policies are incomplete	The organization has well conceived constitution and bylaws and thoroughly developed operational policies to guide work, human resources management practices & financial management	
3. Structure, Roles and Responsibilities	The organization has no formal structure and member roles and responsibilities are not clear.	The organization has a basic organizational structure with clearly defined lines of authority and responsibilities.	The NGO has an organizational structure which is well designed and relevant to the NGO's mission/goals; and roles and responsibilities are clearly defined and appropriate, but some positions are not filled.	The NGO has an organizational structure which is well designed and relevant to the mission/goals, roles and responsibilities are clearly defined and appropriate, and all positions are filled.	
4. Stake holder Involvement	The organization does not have complete information about key stakeholders and service providers in the area (geographic and technical) in which it operates	The organization has some information about stakeholders and service providers in the area (geographic and technical) in which it operates, but this is incomplete and out of date.	The organization has complete & up-to-date information on all key stakeholders in the same geographic & technical area, has identified where they are, what they are doing and their expectations, but does not hold regular meetings with them.	The organization has complete & up to date information about all key stakeholders working in same geographic & technical area & stakeholders participate in at least yearly reviews of the HIV/AIDS activities & their impact on the organization's area of operation.	
<b>MANAGEMENT SYSTEMS AND PRACTICES</b>					
5. Administrative Procedures	The organization has no documented administrative procedures to guide the use of resources (use of transport, drawing of supplies, & retirements).	The organization has documented administrative procedures but these are not well known or understood by members.	The organization has documented administrative procedures which are known to members but these are not consistently adhered to.	The organization has documented administrative procedures, updated as necessary, which are known and understood by members and which are consistently adhered to.	

Component	Stages of Capacity Development and Characteristics				Evidence Attached
	1	2	3	4	
<b>MANAGEMENT SYSTEMS AND PRACTICES continued</b>					
6. Human Resources Management	The organization has no personnel policies or job/task descriptions for staff or volunteers.	The organization has no personnel policies, has job/task descriptions, but staff and volunteers are not aware of or do not have copies of their job/task descriptions.	The organization has personnel policies and clear job/task descriptions (which staff & volunteers have copies of), but policies & job/task descriptions are not respected/adhered to.	The organization has comprehensive personnel policies and job/task descriptions that are known to staff & volunteers and respected/adhered to.	
7. Decision Making	Information is not freely shared with all staff & partners & decisions are taken by the manager and his/her closest colleagues.	There are systems in place to share information, but decision-making is still carried out by the top leaders without involvement of all the staff and partners.	There are systems in place to share information and some decisions are made jointly by staff members and partners, but others are made by the top leaders.	Information is regularly shared with staff members and partners, who all participate in planning, progress reviews and decision-making.	
8. Reporting	The organization does not regularly submit quarterly program or financial reports to supporting institutions.	The organization submits quarterly program reports to supporting institutions, but does not submit financial reports regularly.	The organization submits quarterly program & financial reports to supporting institutions, but these are not reviewed by the relevant managers & staff before submission.	The organization submits quarterly program & financial reports to supporting institutions & these are reviewed by the appropriate managers and staff before submission.	
<b>FINANCIAL MANAGEMENT</b>					
9. Financial Management	The organization has no documented financial procedures (i.e. procedures manual).	The organization has documented financial procedures, but these are not routinely adhered to.	The organization has documented financial procedures and these are adhered to, but there are long delays in compiling the supporting documentation for all expenses.	The organization consistently complies with its documented financial procedures and is able to compile all supporting documentation for expenses within one month of the expense being incurred.	
10. Financial Controls	The organization has no systems in place to ensure effective financial control over its budget and expenditures.	The organization has systems in place for financial control but does not separate funds from different sources or for different projects.	The organization separately monitors funds from different sources and projects and regularly monitors expenditure against budgets.	The organization separately monitors funds from different sources & projects, regularly monitors expenditure against budgets & produces quarterly financial reports which are disseminated to all members & stakeholders.	

Component	Stages of Capacity Development and Characteristics				Evidence Attached
	1	2	3	4	
<b>FINANCIAL MANAGEMENT CONTINUED</b>					
11. Control over Assets	The organization has no inventory of assets and no systems in place for stock control.	The organization has an inventory of assets, but this is not periodically updated or inventory checked.	The organization has an inventory of assets and this is periodically updated and inventory checked, but there are no systems in place for stock control.	The organization has an inventory of assets and this is periodically updated and inventory checked and there systems for stock control are in operation.	
12. Audits	No external (if large organization) or internal (if small community-based organization) audits of the organization's finances are conducted	Either external (if large organization) or internal (if small community-based organization) audits are periodically conducted, but audit recommendations are not always implemented or the organization does not have adequate technical capacity to make recommendations.	Either external (if large organization) or internal (if small community-based organization) audits are conducted annually and recommendations are made and usually implemented by qualified personnel.	Either external (if large NGOs or internal (if small CBOs) audits are conducted annually & recommendations are always made & implemented by qualified staff. The audit reports and actions taken are reported to the financial committee or board of the organization & to stakeholders.	
<b>SUSTAINABILITY</b>					
13. Financial Sustainability	The organization has taken no steps to identify potential local, national or inter-national resource providers to support its programs and activities.	The organization has identified potential resource providers & has learned about their interests & potential support, but has not yet managed to attract resources from anyone.	The organization knows the resources that it needs, has identified resource providers and has managed to gain support from at least one source.	The organization has a business development plan, has success-fully bid for resources from one or more sources and has sufficient funds to support activities over the next 12 months.	
14. Income Generating Activities	The organization has no long-term plan for supporting activities and no income generating activities to fund programs	The organization has a long-term plan for supporting activities, but has not yet acted on this plan and has no income generating activities to fund programs	The organization has a long-term plan for supporting activities and is acting on this plan; income generating activities are functioning, but are insufficient or too weak to sustain programs	The organization has a long-term plan for supporting activities, the plan is being implemented effectively; solid income generating activities are in place & functioning in a way that will sustain activities for 3 or more years.	
15. Community Leader Support	Community Leaders are not aware of or involved in the organizations' programs and activities.	The organization has made efforts to inform community and business leaders about their programs and activities, but there is little involvement in practice.	The organization keeps community & business leaders informed about their programs and activities and these occasionally participate.	The organization regularly keeps community & business leaders informed about their programs and activities & they regularly participate in these.	

Component	Stages of Capacity Development and Characteristics				Evidence Attached
	1	2	3	4	
<b>SUSTAINABILITY continued</b>					
16. Technical Linkages	The organization has no technical linkages with government, national or international organizations to share best practices or program experiences.	The organization has made linkages with government, national or international organizations to learn about best practices but has not applied these to programs and has made little effort to share these with stakeholders.	The organization has linked with government, national or international bodies to share technical expertise & experiences, has plans to apply best practices to its programs but has not yet implemented any changes or improvements or shared its technical knowledge with stakeholders.	The organization has actively linked with government, national or international organizations to share technical expertise & experiences, has applied best practices to its program and shared this information with stakeholders.	
<b>INFORMATION SYSTEMS</b>					
17. Information Systems	The organization has no systems for collecting, storing, analysing or reporting data of project activities	The organization has a system for collecting, storing, analysing and reporting data of project activities, but staff are not trained to apply the system and all or part of the system is not functional	The organization has a system for collecting, storing, analysing and reporting data of project activities and staff are trained to apply the system, but data is not being collected at regular intervals and is not compared to baseline and target information and is not disseminated to program staff, partners and funding agencies	The organization has a system for collecting, storing, analysing & reporting data, staff are trained to apply the system & data is collected at regular intervals, is entered into a register/database, is analysed against baseline information & targets and is regularly reported on and disseminated to program staff, partners and funding agencies	
<b>PERFORMANCE MANAGEMENT</b>					
18. Standards and Supervision	The organization has no standards for service delivery in its programs, any supervision that takes place does not follow established standards	Standards are developed for service delivery, but staff are not aware of these standards, are not trained to apply them and service delivery according to standards is not supervised.	Standards are developed for service delivery, staff are aware of these standards and appropriately trained to apply them, but service delivery according to standards is not consistently supervised nor standards met	Standards are developed for service delivery, staff are aware of these standards, appropriately trained to apply them, and service delivery according to standards is consistently supervised and met	

Component	Stages of Capacity Development and Characteristics				Evidence Attached
	1	2	3	4	
<b>SUSTAINABILITY continued</b>					
<b>PERFORMANCE MANAGEMENT</b>					
19. Indicators and Targets	The organization has no indicators or targets for project interventions	The organization has indicators and targets, but there is no baseline information for these indicators and progress toward targets is not measured	Organization has clearly defined indicators and targets, baseline information is available, but progress toward targets is not measured	Organization has indicators & targets, baseline information is available & progress toward targets is routinely measured & documents/reports about progress are available	
20. Monitoring and Evaluation	The organization has no systems to collect, analyze and report on its programs, activities and impact.	Systems & trained individuals are in place to collect & analyze information on programs, activities & impact but information is not regularly collected reported.	Data on programs & activities is available and is up to date and reports are drafted but data/findings are not used for follow-up monitoring or planning.	Data on program activities are available, are up to date and the data are regularly used for program follow-up monitoring, program adjustments and planning.	
21. Planning	The organization has no annual work plan.	The organization has an annual work plan & associated budget, with specific actions, persons responsible & deadlines for achievement developed with participation of stakeholders, but these are not updated to include findings of supervision and M & E & are not consistently used to guide implementation and resource allocation.	The organization has an annual work plan & associated budget with specific actions, persons responsible & deadlines for achievement developed with participation of stakeholders These are used to guide implementation & resource allocation. However, these are not regularly updated include findings of supervision & M & E.	The organisation has an annual work plan & associated budget with specific actions, persons responsible & deadlines for achievement developed with participation of stakeholders. These are regularly updated based on findings of supervision & M & E, used to guide activities & resource allocation. Progress against the plan is regularly reviewed with stake-holders and necessary adjustments made.	
<b>SERVICE DELIVERY</b>					
22. Services Offered	The organization is not currently providing services	The organization is providing services in some project activity areas but some project activity area services remain non-functional, or the services being provided are very irregular.	The organization has established a service delivery system and services are being provided for all project activity areas on a regular and sustained basis.	The organization has established a service delivery system & services are being provided for all project activity areas on a regular & sustained basis. These services are supervised regularly (no less than quarterly) by trained supervisors, the quality of services being provided is assessed, weaknesses in service delivery are identified and actions to improve services are developed, implemented and monitored.	

### Worksheet 1 CSO CA

## Evidence Data Worksheet

District \_\_\_\_\_ Name of CSO \_\_\_\_\_

Date \_\_\_\_\_ Assessment: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

**Guidance:** This worksheet is to be completed for 1<sup>st</sup> and 2<sup>nd</sup> assessments. Compare results in one assessment to the previous assessment. In the table below, note any areas in which there was a significant improvement in performance. In the column labelled “Evidence of/Reason for Change in Performance” describe what changes took place that justify or explain this improvement. (The final column of the CSO CA tool should be marked when there is an important piece of evidence to be entered in the Table below).

Focus Area		Component	Performance at 1 <sup>st</sup> Assessment
Governance	1	Mission and Goals	
	2	Policies	
	3	Structure, Roles and Responsibilities	
	4	Stakeholder Involvement	
Management Systems and Practices	5	Administrative Procedures	
	6	Human Resources Management	
	7	Decision Making	
	8	Reporting	
Financial Management	9	Financial Management	
	10	Financial Controls	
	11	Control over Assets	
	12	Audits	
Sustainability	13	Financial Sustainability	
	14	Income Generating Activities	
	15	Community Leader Support	
	16	Technical Linkages	
Information Systems	17	Information Systems	
Performance Management	18	Standards and Supervision	
	19	Indicators and Targets	
	20	Monitoring and Evaluation	
	21	Planning	
Service Delivery	22	Service Delivery	
Total Organizational Capacity	23	Add together the cumulative scores for each focus area	
Average Score	24	Divide by 7 and enter the result in far right column	

### Worksheet 1: CSO CAPACITY ASSESSMENT Score Sheet

Date \_\_\_\_\_

Name of CSO \_\_\_\_\_

**Guidance:**

1. Enter scores for each component in the score column.
2. Add the scores for each component together and enter the result in the Cumulative Score for Focus Area column.
3. Divide the cumulative score by the total number of components (follow guidance in the Calculation column).
4. Enter the result of the calculation in the Average Score for Focus Area Column.

Focus Area		Component	Score	Cumulative Score for Focus Area	Calculation	Av. Score for Focus Area/ NGO
Governance	1	Mission and Goals			/4	
	2	Policies				
	3	Structure, Roles and Responsibilities				
	4	Stakeholder Involvement				
Management Systems and Practices	5	Administrative Procedures			/4	
	6	Human Resources Management				
	7	Decision Making				
	8	Reporting				
Financial Management	9	Financial Management			/4	
	10	Financial Controls				
	11	Control over Assets				
	12	Audits				
Sustainability	13	Financial Sustainability			/4	
	14	Income Generating Activities				
	15	Community Leader Support				
	16	Technical Linkages				
Information Systems	17	Information Systems			None	
Performance Management	18	Standards and Supervision			/4	
	19	Indicators and Targets				
	20	Monitoring and Evaluation				
	21	Planning				
Service Delivery	22	Service Delivery			None	
Total Organizational Capacity	23	Add together the cumulative scores for each focus area				
Average Score	24	Divide by 7 and enter the result in far right column				

**Worksheet 2: Action Planning**

Date \_\_\_\_\_

Name of CSO \_\_\_\_\_

ACTION PLAN AIMED AT IMPROVING MAIN WEAKNESSES IDENTIFIED					
NO.	WEAKNESS IDENTIFIED	ACTION	TIME FRAME	RESPONSIBLE PERSON	INDICATOR





UGANDA HIV/AIDS SERVICES PROJECT (UHSP)

Monthly Summary Form

Technical Area: Palliative Care - Basic Health Care and Support

Month/Year:

Name of Implementing Partner:

District:

Indicator	Sub-county 1		Sub-county 2		Sub-county 3		Sub-county 4		Totals	Comments
	M	F	M	F	M	F	M	F		
Name of sub-County										
1 Number of villages served in each sub-County										
2 Number of new Palliative Care givers trained in each sub-County										
3 Total number of new clients receiving Palliative Care										
4 Number of new clients served by category										
a Medical care (Including provision of drugs to treat/prevent opportunistic infections)										
b Nursing Care (includes promotion of infection control, hygiene and sanitation practices as well as the proper usage of drugs)										
c Psychosocial care (please include spiritual care and counseling)										
d Material support (includes provision of supplies e.g., food clothes etc.)										
e Number receiving any other intervention under home based care (please specify intervention)										
f Number receiving any combination of the above (please specify)										

Instructions:

- In the electronic version of this form, please add rows or columns as necessary
- Please report on only the **HIV+ Clients** and not their care givers or other family members
- In column 3, please report on the **total number of new clients** receiving palliative care each month
- In columns a-f, please report on the number of **new** clients (divided into male and female) who are receiving each type of palliative care





John Snow, Inc.

UGANDA HIV/AIDS SERVICES PROJECT (UHSP)  
MONTHLY REPORTING FORMAT

Technical Area: Other Prevention

Month/Year:

Name of Implementing Partner:

District:

Service Outlet	Sub-county	Number of Individuals reached		Number of service providers trained		Comments
1	2	3		4		5
		F	M	F	M	
<b>Other Behaviour Change - Community Outreach Programs</b>						
<b>Totals</b>						
<b>Other Behaviour Change - Condom Distribution</b>						
		No. of Condom Outlets	No. of Condoms Distributed	No. of individuals receiving condoms		
				F	M	
<b>Totals</b>						

**Instructions:**

- a. Please indicate the name of the service outlet and sub-country as appropriate.
- b. In column 3, please indicate the number of individuals reached with messages from Community outreach programs. **(Community out reach programs include, Drama sessions, Peer education sessions, School sessions, Games or any Community gatherings used to pass on messages provided the number of attendees can be accurately estimated)**
- c. In column 4, please indicate the total number of individuals trained per service area disaggregated by sex
- d. Other Behaviour Change includes Condom distribution - In column 3, please indicate for each month the total number of condom outlets and total number of condoms distributed



