|  |
| --- |
| **Name of organization: UNITED HANDS OF TRANSFORMATION-UGANDA (UNIHOT-UGANDA)****Address: Kabarole District Fort Portal Municipality** **South Division** **Kabarole District, Western Uganda****Organization’s Email:**  unitedhandsont@yahoo.com  |
| **Project title:** Strengthening Community Engagement for Prevention of HIV/AIDS among Vulnerable Population Groups  |
| **Name of the project area: 8 Sub counties in Kabarole District.** |
| **Names of Sub counties to be covered** | **Number of parishes to be covered per sub county mentioned** | **Number of target villages** |
| 1. Buheesi
 | 4 | 20 |
| 1. Kibiito
 | 4 | 20 |
| 1. Bukuku
 | 4 | 20 |
| 1. Rwimi
 | 4 | 20 |
| 1. Karambi
 | 4 | 20 |
| 1. Mugusu
 | 4 | 20 |
| 1. Fort Portal
 | 3 | 5 |
| 1. Kicwamba
 | 4 | 20 |
| **Project time frame:**Start date: January 2014End date: November 2016 | **Total amount requested:** **UGX: 638,414,500 /=****Amount in Uganda shillings** **1$=shs2,600/=** |
| **Targeted direct project beneficiaries by Age** (stipulate number and denominator for each group) |
|  | **Female** | **Male** | **Total** |  |
| Age category  | Target | Denominator | Target | Denominator | Target | Denominator |
| 10-14 | 8,905 | **9,540** | 7,830  | **8,440** | 16,735 | **17,980** |
| 15-24 | 9,538 | **10,772** | 8,399 | **10,532** | 17,937 | **21,304** |
| 25+ years | 9,715 | **10,462** | 9,670 | **10,496** | 19,385 | **20,958** |
| **Total 1** | **28,158** | **30,774** | **25,899** | **29,468** | **54,057** | **60,242** |
|  |
| Target population by Category e.g. Fisher folk, CSWs, etc (only indicate numbers and denominators for each targeted population) |
| **Category of Target population** | **Female** | **Male** | **Total** |
| Target  | Denominator | Target  | Denominator | Target  | Denominator |
| 1. Hunter  | 300 | 300 | 200 | 200 | 500 | 500 |
| 2. CSWs  | 500 | 500 | - | - | 500 | 500 |
| 3. *Boda boda* riders | 5 | 5 | 575 | 575 | 580 | 580 |
| 4. Couples including pregnant women | 6,536 | 7,984 | 6,536 | 7,984 | 13,073 | 14,968 |
| 5. Youth out of school | 2,908 | 3,068 | 3,846 | 4,995 | 5,754 | 7,063 |
| 1. PLHIV
 | 3,380 | 4,624 | 2,285 | 3,512 | 5,666 | 7,136 |
| 1. Other population
 | 14,248 | 14,998 | 14,082 | 14,802 | 28,330 | 29,800 |
| **Total 2** | **27,072** | **30,674** | **27,324** | **31,868** | **54,398** | **60,542** |
| **Note: Total 1 is expected to be the same as Total 2**

|  |
| --- |
| **Service providers to be trained –peer educators** |
| **Category** | **Number** |
| Volunteer Peer educators | 43 |
| Village Health Teams | 30 |
| Community resource corps/volunteers | 16 |
| **TOTAL** | **89** |

**Intervention Areas**

|  |  |  |  |
| --- | --- | --- | --- |
| **Targets by Intervention Areas** | **Male** | **Female**  | **Total Target**  |
| 1. Behavior change communication (BCC)
 | 32,158 | 28,899 | 61,057 |
| 1. HIV Counseling & Testing (HCT)
 | 17200 | 14800 | 32,000 |
| 1. Prevention of mother to child transmission of HIV (PMTCT)
 |  | 2639 | 2639 |
| 1. Safe Male Circumcision
 | 4500 |  | 4500 |
| 1. Structural HIV prevention
 | 39,158 | 38,899 | 78,057 |
| 1. Condoms distribution
 | 1,560,000  | 840,000 | 2,400,000  |

 |
| **Key Contact person** **Name:** Mwebembezi Jostas**Position:** Executive Director**Email :** Mwebembezijs@yahoo.com**Telephone:+256774553595/+256701670709** |  |

1. **ORGANIZATIONAL BACKGROUND AND QUALIFICATIONS**

Founded in 2013 by a group of social workers and youth of Kabarole District, who decided to build a new rural society in Uganda, a society in which each of us has a chance to grow, achieve, create dignity not for ourselves but also for the future generation, and contribute to the improvement of women, children and men in health, education, agriculture, environment, governance and sector innovations.

Officially registered in 2013 as NGO/CSO with the NGO Board of Uganda (Registration number: CD/NGO/159) with domain **“UNITED HANDS OF TRANSFORMATION- UGANDA” (UNIHOT-UGANDA)** and after being convinced that through human rights advocacy, environmental protection, HIV/AIDs sensitization and prevention, improved water and sanitation, education innovation, agriculture value chain and food security we shall contribute fully to the benefit of our communities.

**UNIHOT-UGANDA** is a charitable, nonpartisan, non-religious and non-profit organization.

**UNIHOT-UGANDA** isconvinced that the educated people alone cannot solve the burden of rural poor women, men, orphans and vulnerable children alone, but it is united effort of all people to come up and promote meaningful cultural norms and fight away poverty, end hunger, improve health and live a good life.

**UNIHOT-UGANDA** is dedicated to give time and resources in all forms and efforts to facilitate development initiatives by providing assistance and working together with people to discuss and develop ideas which will meet the true needs of the community.

Grounded in a rights-based approach, UNIHOT-UGANDA will work with professionals to mobilise communities to be health rights advocates, promoting equity and social justice for all, with a particular focus on marginalized and vulnerable populations.  The organisation is guided by values of honesty, team work, equality, voluntarism, confidentiality and service above self.

The project will be implemented in 8 sub counties in Kabarole district i.e. Buheesi, Bukuku, Karambi, Mugusu, Kicwamba, Fort Portal, Kibiito and Rwimi. Out of 8 sub counties 31 parishes will be selected and from those parishes 145 villages are targeted. This arrangement is critical because of the vastness of Kabarole district with its poor infrastructure, high rate of HIV/AIDS, early marriages, limited care for expectant mothers among other related health issues.

**2.0 PROJECT DESCRIPTION**

**2.1 Problem Statement**

Kabarole District is located in the central-western part of the Western Region of Uganda. The district has 2 counties and a municipal council, 14 sub-counties and 3 town councils. Kabarole has a population of 403,200

In Kabarole District, just in reflection of national trends, HIV prevalence rates have stagnated and the number of new infections is increasing. Majority of the population (60% under 18 years, 51% female) live in rural areas and only 20% have a secure income[[1]](#endnote-2). A predominance of high risk populations and poor access to basic services, particularly for marginalized groups, presents challenges for HIV prevention in Kabarole and necessitates a combination prevention strategy.[[2]](#endnote-3)

HIV/AIDS awareness campaigns in Kabarole district are being hindered by lack of funds, causing an increase in the rate of HIV infections. Last year, a research carried out by the Rwenzori Think Tank also indicated that the HIV infection rate had increased from 15% to 20%, partly because of lack of awareness.

The Kabarole district secretary for health and education Joshua Kagaba has said that the HIV prevalence among secondary schools in Kabarole district currently stands at 30%.

Kagaba told the New Vision on Thursday morning that a study by the district with the help of other Non-Governmental Organization shows that of every 1000 students at least over 250 are HIV positive.

<http://www.newvision.co.ug/news/632269-hiv-aids-high-in-kabarole-district-secondary-schools.html>

Nearly 80% of those infected with HIV are between the ages of 15 and 45 - the breadwinners and parents of families which have on average more than seven children. AIDS orphans are estimated to be in the vicinity of 115,000 and rising, and some experts fear that this figure could increase five-fold in the next five years. War, an increase in children born out of wedlock and the collapse of health services account for the overall rising number of orphans, estimated at between 400,000 and 1,100,000. About 69% of all orphans in Uganda are between 10 and 19 years of age. According to one estimate reported by UNICEF, half the children in Uganda under 15 years will be orphans by the year 2,010.

The geographical and service coverage of the HIV/AIDS response by government and nongovernmental organisations in Kabarole district also remains limited. The current HIV/AIDS interventions are not evenly distributed across the district, resulting in some sub-counties being left out by services. Most programs do not sufficiently reach rural areas because they cover only a few sub-counties within the district, and there is often a higher concentration of interventions around urban centres than in the rural area[[3]](#footnote-2). Furthermore it has been noted that some of the main drivers and risk factors of the epidemic such as intact foreskin and discordance among monogamous sexual relationships are not adequately addressed.

Complex behavioral and structural drivers underpin the epidemic and a lack of comprehensive sexual reproductive health information is contributing to both risky behavior (e.g. drug/substance abuse and unprotected sex with multiple partners) and low demand for and access to HIV prevention, care and treatment services. Presently, less than 50% of the population can refute all HIV and AIDS myths and misconceptions and only 69% recognize being faithful as a major prevention strategy. The knowledge that individuals do have about generalized epidemic is not being translated into practice.

Harmful socio-cultural norms such as gender inequality, early and polygamous marriages, and prostitution further exacerbate the epidemic in Kabarole. Combined with stigma and discrimination faced by people living with HIV (PLHIV) and disabled youth contributes to the HIV epidemic and hinders effective response. Lack of community-led responses to address culturally ingrained beliefs jeopardizes positive behavior change. Compounding this is a lack of appropriate services, particularly for marginalized groups. Only 15% of Kabarole’s health centers implement outreach to most at risk populations and only 13% have functional Post-Test Clubs[[4]](#footnote-3).

A study by PANOS Eastern Africa indicates that “Kabarole health centre, like many others in the district and across the country, seems to offer more despair than hope to her patients, mostly women and children”[[5]](#footnote-4). The laboratory facilities at the only health centre IV are inadequate and at times not functioning to capacity. This means that diagnosis and monitoring of treatment are less than optimal leading to low quantity and quality of health services delivery. This creates a significant barrier for referrals and linkages to biomedical interventions.

The HIV prevention programming in the District has been poorly aligned to the above behavioral and structural drivers, new infections continue to rise. The individuals and particularly those from high risk groups have been negatively affected. This is straining limited resources and preventing the achievement of District and National development objectives.

**2.2 Solution to the Problem**

In order to address the HIV epidemic in Kabarole District, it is critical to target the structural and behavioral drivers with a focus on the identified most at risk populations. Prevention efforts need to provide these individuals with information, support and services as well as address the problems that heighten their risk, including lack of opportunity, gender inequality, and poverty.

This proposed project therefore will build on UNIHOT-UGANDA’s successful community engagement model of social and behavioral change communication, focusing on individuals from high risk populations (fisher folk, commercial sex workers, *Boda Boda riders,* youth living with HIV, and transport workers). Peer education and training as an awareness-raising strategy for sexual and reproductive health (including HIV) will be complemented by capacity building for service providers and government, including supporting increased collaboration on community-led HIV prevention efforts.

**2.3 Geographical Coverage**

UNIHOT-UGANDA proposes to implement this project in 8 sub counties in Kabarole district i.e Buheesi, Bukuku, Karambi, Mugusu, Kicwamba, Fort Portal, Kibiito and Rwimi. Out of 8 sub counties 34 parishes will be selected on from those parishes 180 villages are targeted

This project will engage youth, community, and government and service providers in these communities over the three years to achieve maximum and sustained results from behavior and social change communication. Also planned are Sub-County and District-wide activities, and outreach to key most at risk populations. These activities will extend programme reach beyond the focal Parishes, ensuring the sharing of learning and good practices in targeting at risk populations.

|  |  |  |
| --- | --- | --- |
| Sub County  | Denominator (by sub county) | Target (by sub county) |
| Male  | Female | Total | Male  | Female | Total |
| 1. Rwimi Sub-County
 | 11,900 | 13,100 | 25,000 | 10,675 | 10,841 | 21,516 |
| 1. Kicwamba Sub-County
 | 7,000 | 7,200 | 14,200 | 5,224 | 5,317 | 10,541 |
| TOTAL | 18,900 | 20,300 | 39,200 | 15,899 | 16,158 | 32,057 |

**2.4 Target Population**

This 3 year project will directly reach60,242Individualcommunity members who reside in Kabarole District with behaviour and socio-structural HIV prevention interventions, including:

To ensure a comprehensive combination HIV prevention strategy, the programme will also engage **89 service providers** (i.e. Volunteer Peer Educators, CORPS and Village Health Teams) in order to increase supply of appropriate biomedical services in support of reducing new HIV infections.

1. **OBJECTIVES**

3.1 Project Goal: Contributing to the reduction of new HIV infections in Kabarole district by 40% by 2015.

3.2 Project Purpose: Increasing coverage, demand and utilization of comprehensive and community-led HIV prevention services.

3.3 Project Objectives:

1. To empower over 32,057 individuals and communities to effectively demand for quality HIV/AIDS services and to demand for inclusive delivery of these services in Kabarole district by August 2016.
2. To increase adoption of safer sexual behaviors and practices among 18,057 target populations and community members in Kabarole district by August 2016.
3. To create a sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic in Kabarole district by August 2016.
4. To achieve a well coordinated HIV prevention response in Kabarole district by August 2016.
5. To strengthen the monitoring and evaluation systems of the project by then end of August 2016.
6. **AREAS OF FOCUS AND APPROACHES TO BE USED**

UNIHOT-UGANDA selected the eight target sub-counties/town councils through a participatory and consultative process involving; Kabarole District Health Officer, Community Development Officer, the HIV/AIDS Focal Person, Senior Health Educator and three sub-county People Living with HIV (PLHIV) associations. This process ensured: greater involvement of PLHIV (GIPA) and more meaningful involvement of PLHIV (MIPA); as well as minimising duplication of efforts; and greater engagement of key stakeholders.

In order to achieve the project goal, purpose and objectives, the proposed programme will use targeted behavioral and social change communication strategies delivered through UNIHOT-UGANDA’S integrated and cost-effective approach. These are evidence based innovative approaches to addressing drivers of the HIV/AIDS epidemic while improving the quality and efficiency of service delivery.

Regular engagement with all stakeholders will guide programme development and implementation, including the sharing of monitoring and evaluation data. Key programmes strategies are summarised in the table and outlined in further detail below.

|  |
| --- |
| **Programme strategies and approaches to be used**  |
| **Objective** | **Strategies to target behavioural and structural drivers** |
| 1 | * Youth-led peer education model that engages community volunteers, including those from targeted most at risk populations
* Targeted behaviour change communication with a focus on at risk populations
 |
| 2 | * Youth-led peer education model that engages community volunteers, including those from targeted most at risk populations
* Activities delivered in collaboration with others and to support service providers to increase delivery and access of HIV prevention services.
 |
| 3 | * Community-led model for social change communication
* Integrated livelihoods and life skills to promote HIV prevention protective factors
 |
| 4 | * Capacity-building of service providers
* Sharing and learning amongst those involved in combination HIV prevention from grass-roots through to District level (extending beyond through established Western region network)
 |

In a bid to increase knowledge and awareness of high risk populations of safe sexual behavior and increase demand for and access to services, the project will utilize a peer education model engaging community volunteers, including those from targeted most at risk populations. UNIHOT-UGANDA will recruit, train and support Volunteer Peer Educators (VPEs) and in order to have greater impact in the project area, eight VPEs will be selected from each of the targeted parish. These will be individuals living and working to deliver weekly, targeted behavior change communications through awareness-raising and advocacy activities to a range of community stakeholders, with a particular focus on the identified most at risk populations in Kabarole district. These sessions will address sexual and reproductive health and life skills (including human rights, gender equity and issues of stigma and discrimination). Engaging young people from at risk populations as VPEs to support the design and delivery of these activities will ensure targeted and effective programming.

Supporting community members to be empowered, especially those from most at risk populations, with the knowledge to make informed decisions regarding their sexual and reproductive behaviour will ensure that they can live healthy, productive lives. Activities which support this objective and the overall goal focus on the ABC+ approach to HIV prevention, aligning with the National HIV Prevention Strategy and targeting those most at risk of new infections, using a community-driven approach.

It is essential to address the stigma and discrimination faced by young adults from most at risk populations thereby ensuring sustained behaviour change. For the most at risk communities to improve their sexual and reproductive behaviour and reduce HIV infection, community members, service providers and district and sub-county officials must be aware of the harmful socio-structural norms and provide support to these groups for positive behaviour change. To increase the number of community members, service providers and government actors that are aware of the socio-structural norms jeopardizing HIV prevention strategies, the programme will use targeted social change communication with a particular focus on the issues faced by most at risk populations. The VPE-led model ensures ongoing interaction between community members, supporting collective HIV prevention efforts with a focus on promotion of the ABC+ strategy, regular VCT and access to appropriate health services. Practices that have been proven to significantly reduce chances of HIV infection such as safe male circumcision will be vigorously promoted.

In order to strengthen the coordination amongst state and non-state actors delivering combination HIV prevention strategies to have more effective referral systems, UNIHOT-UGANDA will strengthen existing relationships with previously trained service providers and Civil Society Organisations (CSOs) to ensure increased access to information on HIV prevention services and support structures in targeted communities. VPEs and staff will provide referrals to and follow up on prevention, treatment and care services. In this way, the project will support linkage with providers of biomedical HIV prevention services such as PMTCT, HCT, SMC and ART. The PLHIV networks and associations as well as community stakeholders will be supported to engage with district and sub-county officials on local policy, planning and resource allocation processes on combination HIV prevention strategies. Increased collaboration will also be supported through linking to UNIHOT-UGANDA’s experience sharing network through quarterly meeting to share best practices and coordinate programming and advocacy efforts.

UNIHOT-UGANDA will support networking and/or collaboration between a range of partners over the three years in order to achieve the project objectives and goal as seen hereunder.

|  |
| --- |
| **Partnerships & role** |
| **Partner** | **Role** |
| * Kabarole District PLHIV Network
* PLHIV Networks in the four targeted sub-counties
* Community groups and networks of most at risk populations
* District & sub-county local government
* UNICEF, World Vision and other NGOs, networks and coalitions operating in the area
* District and sub-county health centres
* Faith based institutions
* Private clinics and drug shops
* Cultural institutions
 | * Support programme design and delivery to best meet the needs of most at risk populations
* Engaged through VPE activities in support of community-led response to HIV prevention and management of AIDS
* Support mobilisation of service providers and government stakeholders for capacity-building, support effective referral systems
* Support shared learning of good practice and advocacy efforts
 |

UNIHOT-UGANDA will work very closely with these identified partners, ensuring that all project activities adhere to the principles of gender equity, including incorporating sessions into the social and behaviour change communication sessions that address issues of girl’s rights and gender equity. We will also ensure that gender imbalances are addressed throughout project design, implementation and evaluation phases. These measures should ensure that our interventions address the concerns of women, girls, boys and other marginalized groups.

Significant to effective programme delivery and sustainability will be alignment to district, national and international HIV and AIDS strategies. At district level, UNIHOT-UGANDA has complimented Kabarole’s District Development Plan, the Ministry of Education and Sports’ PIASCY programme, the Ministry of Health’s National Strategic Plan for HIV/AIDS 2007/8–2010/12 (specifically Prevention Objective 1 – Accelerate prevention of sexual transmission of HIV including targeting of vulnerable and high risk groups), National HIV Prevention Action Plan for Uganda 2011-13, and the National HIV Prevention Strategy 2011-2015. Internationally, our efforts contribute to the attainment of MDG 6 target 7; to halt and begin to reverse the spread of HIV/AIDS by 2015.

1. **ACTIVITIES**

**Objective 1:** To empower over 18,057 individuals and communities to effectively demand for quality HIV/AIDS services and to demand for inclusive delivery of these services in Kabarole district by August 2016.

This will be supporting community members, especially targeted beneficiaries to be empowered with knowledge, behaviours and practices necessary to demand for quality HIV/AIDS services and to demand for inclusive delivery of these services, so they can live healthy and productive lives.

**Key activities include:**

**Activity 1.1.1: Project Launch at the district targeting 30 key stakeholders:** UNIHOT-UGANDA will hold a project launch at the district targeting the key stakeholders in order to gain their support for effective project delivery and sustainability.

**Activity 1.1.2: Conduct 180 monthly HCT Outreaches (1 outreach/month/sub-countyX3 years) for target beneficiaries (9,158 females and 8,899 males)**

UNIHOT-UGANDA will work with government health facilities Rwimi Health Centre IV and other service providers like Marie Stoppes and Reproductive Health Uganda to provide HCT services to target beneficiaries using daytime HCT, moonlight HCT for 100 CSWs and youth friendly service delivery approaches. CSWs will be targeted at their places of work especially in Kicwamba and Rwimi town councils. 2 Health workers in each of these facilities will be facilitated to carry out HCT, while the testing kits will be provided freely by the District Health Office. 10 VHTs, 10 CORPs & 25 PEs will mobilise beneficiaries within their areas including out-of-school youth, boda-boda riders, CSWs, married couples, pregnant women and other community members to undertake HCT and immediately know their results. The outreach team shall be facilitated with meals, refreshments and facilitation fees will be provided for the health centre staff. BCC messaging, SRH, STI screening & treatment and condom distribution shall be integrated in the HCT & all other outreaches by the project. After undertaking HCT, those found positive will be referred to access HIV care, support & treatment services at accredited government health facilities and the negative ones will be encouraged to participate in fidelity clubs. All those tested will be provided risk reduction counselling to enable them lead healthy, safe & productive lives.

**Activity 1.1.3: Conduct 96 quarterly PMTCT outreaches (1 outreach/quarter/sub county (08) x 3 years) for 639 pregnant women & lactating mothers**

PMTCT will be promoted as a means of ensuring that all born babies are free from HIV as well as enabling PLHIV to have HIV free babies. These outreaches will be conducted by UNIHOT-UGANDA in partnership with the district HC IV & reproductive health Uganda and these will be integrated with HCT outreaches. PMTCT messages and information on EID, male involvement in PMTCT activities, community referrals for ANC, PMTCT, delivery, PNC, immunization, etc. to health facilities will also be conducted. The project VPEs and staff will also follow-up mother-baby pairs in the community and refer beneficiaries for PNC services and further follow-up at the health facilities.

**Activity 1.1.4: Conduct 96 quarterly SMC outreaches (1 outreach/quarter/sub county (08) x 3 years) for 3500 males**

UNIHOT-UGANDA will promote safe medical male circumcision and will work with the VHTs, PEs, CORPs, local council leaders, boda boda associations, community leaders (religious, cultural & political) to mobilise males to benefit from this activity across the project area. UNIHOT-UGANDA will align her project activity planning with that of the District health facilities to provide quality SMC services to target beneficiaries. SMC services & consumables will be provided by target sub county HC staff. UNIHOT-UGANDA will provide transport & facilitation fee to the government HC/hospital staff. SMC services will be provided in line with the MoH standard policies and procedures for SMC service delivery.

**Objective 2:** To increase adoption of safer sexual behaviors and practices among60,242 target populations and community members in Kabarole district by August 2016.

Community members will be empowered, most especially the target populations, on how to access HCT, PMTCT, SMC, condom use and HIV prevention services so that they can live healthy and productive lives. Activities which support this objective and the overall goal focus align with the National HIV Prevention Strategy, targeting those identified as target populations, and a community-driven approach. The activities which support this objective are in line with the National HIV Prevention Strategy and overall goal focus on the ABC+ approach to HIV prevention – Abstinence, Being faithful to one uninfected partner, and correct and consistent Condom use.

**Key activities under this objective include:**

**Activity 2.1.1: Recruit and Conduct training sessions for 30 VHTs, 16 CORPs and 43 PEs (59 males, 40 females) in HIV combination prevention approach and effective communication skills.**

UNIHOT-UGANDA staff in collaboration with DHT, LC chairpersons and boda-boda associations will recruit project VHTs and PEs. Thereafter UNIHOT-UGANDA together with DHO, DHE and CDO will conduct 1 training session to last 5 days for max. 89 participants each on HIV combination prevention approaches to a group of 89 participants including; (30 VHTs of which 15 will be PLHIV, 16 CORPs of which 8 will be PLHIV and 43 peer educators). Peer educators will include (**20** boda-boda riders, **15** youth out of school and **8** CSWs. Participants will be oriented on the current HIV/AIDS prevalence in the area, HIV epidemic (behavioural, biomedical & socio-structural) drivers in Kabarole district, HCT, SMC, PMTCT, SRH, STIs, alcohol & substance abuse, SGBV, gender and power relations in HIV&AIDS, myths & misconceptions about HIV&AIDS, condom programming, socio-structural HIV prevention, behavioral HIV prevention, community dialogues, community mobilisation, IEC/BCC, M&E tools, data collection, etc. and roles as community resource persons for effective implementation of the project.

The trainees will be given skills in community mobilization and HIV and AIDS education to enable them mobilize and guide communities on available services, how and where to access the services including making referrals. It will also focus on communication skills, combination HIV prevention and rights to access HIV preventions services.

After the training, participants will be given materials and job aides to guide them conduct small group, peer to peer interpersonal community interactive sessions. The VHT & PEs will be provided with resource packs, training certificates and staff support visits over the course of the project as well as a monthly token to motivate them to work harder.

**Activity 2.1.2: Establish 40 condom outlets:** Condom outlets will be established at designated sites in bars, hotels, lodges, video & disco halls, etc to ensure easy access of the condoms for target beneficiaries in the target sub- counties. VPEs will be responsible for managing the condom outlets to ensure proper storage of the condoms & avoid condom stock outs. Monthly reports will be written by the VPEs & submitted to UNIHOT-UGANDA project officer for this activity.

**Activity 2.1.3: Procure 34 male dildos (1 per parish):** the project will procure 34 male models that will help VPEs to demonstrate condom use.

**Activity 2.1.4: Procure 34 condom storage wooden boxes (1 per parish):** In order to ensure safe storage of condoms, the project will put in place wooden boxes at the selected outlets. These will be conveniently located and in consideration of privacy and confidentiality.

**Activity 2.1.5: Conduct condom demonstrations and distribution of 2,400,000 condoms (1,560,000 male and 840,000 female):** the Project team and VPEs will deliver condom demonstrations to equip especially target populations to use condoms correctly and consistently during sexual encounters. The demonstrations and distribution will be done by the VPEs. VPEs will offer condom education and demonstrate on correct condom use with the aid of 34 male to target beneficiaries before the condoms are distributed.

**Activity 2.1.6: Conduct 12 bi-annual (4 per year) drama shows for 7,000 people (3,550 females and 3,450 males)**

Music, dance and drama will be used to mobilise youth and adults, especially those in harder to reach youth and adults and target populations, to introduce them to the project objectives and to disseminate targeted behavioral and social change communication messages. Messages will focus on topics such as HCT, CHCT, PMTCT, correct & consistent Condom use, SMC, EID, SGBV, stigma & discrimination, structural & behavioral HIV & AIDS drivers. Edutainment is a means of targeting large groups of people and will help to enhance interest n the activities but at the same time ensuring that those that are participating and watching also benefit from the discussions that take place during the events themselves.

**Activity 2.1.7: Conduct 576 bi-monthly BCC educational sessions targeting60,242 beneficiaries (25,899 males, 28,158 females) (4 sessions/month/sub-county (08) x 3 years):**

BCC sessions will be conducted for the following thematic areas including; HCT, PMTCT, SMC, SRH, condom usegender & power relations, stigma & discrimination, alcohol & substance abuse and other socio-structural and behavioural drivers of the HIV epidemic in Kabarole district. The VPEs will deliver sessions on the subjects highlighted above as well as making appropriate referrals within the target project area. This will aim at disseminating comprehensive, correct knowledge about HIV, and encouraging safer sexual behaviors and practices necessary to make informed decisions regarding their SRH and to increase understanding on SRH rights. Volunteers will use a variety of methods that include resources such as picture codes among others to disseminate information. BCC sessions will be conducted using peer-to-peer approach, small group (25-30 people) discussions/approach and interpersonal sessions.

**Activity 2.1.8: Reproduce and distribute 61,057 IEC/BCC Materials:** The project will reproduce the existing materials on posters and calendars with key messages on HCT, PMTCT, SMC, condom use HIV sero-discordance, ART, CHCT, EID, SGBV, Stigma & discrimination, etc for wider access to the masses. UNIHOT-UGANDA will obtain these materials for reproduction from Uganda Aids Commission, DHO and DHE’s offices. These materials will be distributed during outreaches and they will include 3,000 posters, 9,000 charts, 2 banners, 3,000 fliers, 9,000 brochures, 3,500 calendars and 1000 T-shirt.

Objective 3: To create a sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic in Kabarole district by August 2016.

A critical gap in combination HIV prevention strategies is the need to address underlying social cultural gender and other social drivers. To bridge this gap, **key activities to be done will include:**

**Activity 3.1.1: Conduct 90 community dialogue sessions (1 dialogue/every two months /sub-county x 3 years) for 60 target beneficiaries (15 elders, 20Political, 15 cultural and 10 Religious leaders**

The project will conduct 90 quarterly community dialogue sessions targeting community cultural, political and religious leaders from various parishes and villages (depending on influence) to discuss the socio- cultural, gender, other structural and behavioural drivers of the HIV epidemic in Kabarole district. Some of these include early/childhood marriages, polygamy, alcohol and drug abuse, sexual and gender based violence, forced/negotiated marriages among young girls, widow inheritance, cross generational sex, stigma and discrimination of PLHIV, etc. The dialogues will result in action plans and UNIHOT-UGANDA together with relevant stakeholders will guide implementation of agreed upon actions. Through the dialogue sessions, the community leaders are expected to make and enforce community by-laws where necessary to address structural and behavioural drivers of the HIV epidemic in their communities and areas of jurisdiction. UNIHOT-UGANDA project staff, DHT, CDO and police will facilitate these community dialogue meetings. UNIHOT-UGANDA will provide transport refund and SDA to the local government facilitators.

**Activity 3.1.2: Conduct 90 (1 dialogue/ every two months /sub county(05) x 3 years) community dialogues to engage60,242 people (25,899 males and 28,158 females) to address sexual gender based violence, childhood/ forced marriages and other socio- cultural structural drivers of HIV in Kabarole.**

To address norms about masculinity related to HIV/AIDS, gender-based violence and coercion related to HIV/AIDS, legal rights and protection of women and girls impacted by HIV/AIDS, childhood/forced marriages, polygamy, widow inheritance, alcohol abuse, etc., increased male involvement in HIV prevention activities and uptake of HIV prevention services, increased access to income and productive resources of women and girls impacted by HIV/AIDS the project will engage both men and women in dialogue meetings. The dialogues will result in action plans and UNIHOT-UGANDA together with relevant stakeholders will guide implementation of agreed upon actions by community members. The dialogue meetings will be facilitated by UNIHOT-UGANDA project staff, DHT, CDO and police in the target sub counties. UNIHOT-UGANDA will provide transport refund and SDA to the local government facilitators. About 40-45 people will be targeted per meeting.

Objective 4: To achieve a well coordinated HIV prevention response in Kabarole district by August 2016.

This will create a coordinated and supportive environment within the project area which is essential for sustained behaviour change. UNIHOT-UGANDA therefore recognizes the critical role that community-driven responses play in development.

**Key activities will include:**

**Activity 4.1.1: Organize 6 bi-annual & participate in 12 Quarterly stakeholder DAC review meetings at the district for 30 key stakeholders:**

UNIHOT-UGANDA will organise 6 bi-annual & participate in 12 quarterly stakeholder review meetings targeting key stakeholders including local government (DHO, CDO, GLOBAL HAND & HIV& AIDS partners, DHE) to ensure a co-ordinated HIV & AIDS response in Kabarole district and advocate for stronger combination HIV prevention strategies, programmes and budgets. Participants will be provided lunch, refreshments and transport refund. The staff will also identify planning meetings that are held at sub-county as well as district level which they will attend to advocate with the stakeholders for improved support on HIV prevention strategies and increases financial support on activities targeting MARPS as well as youth. This is meant to influence the strategies.

**Activity 4.1.2: Participate in 30 annual sub county AIDS coordination meetings (two meeting per Sub County per annum) in 3 years.**

UNIHOT-UGANDA will participate in SAC meetings in each of the target 8 sub counties. SAC members and sub county Local Council leaders will be facilitated with refreshments and transport refund to seek their support and ownership of project activities, review coordination of HIV & AIDS implementation and service delivery and share experiences in their respective areas. All this shall work to improve coordination and HIV service delivery in their constituencies.

UNIHOT-UGANDA will also identify planning meetings that are held at sub-county as well as district level which they will attend to advocate with the stakeholders for improved support on HIV prevention strategies and increased financial support on activities targeting key population as well as youth.

**Activity 4.1.3: Develop the UNIHOT-UGANDA advocacy agenda and Participate in Annual HIV/AIDS Advocacy/ commemoration days**

UNIHOT-UGANDA will participate in the HIV national advocacy/commemoration days specifically World AIDS day, international candle light day and Philly Lutaaya day to contribute the national agenda for the year and the success of the day. The activities shall include dissemination of HIV prevention messages, distribution of IEC material and condoms, sharing of advocacy materials, health education through games and quiz.

UNIHOT-UGANDA will develop an advocacy agenda that will guide its advocacy over the three year period of this grant. The Advocacy agenda will be developed based on issues identified in the initial quarter of the project after better understanding of the challenges contributing to poor HIV and AIDS services in the district and needs of the target population. UNIHOT-UGANDA will also identify the key decision-maker(s) who have the power and influence to cause the desired change as the key target for the advocacy messages. UNIHOT-UGANDA will also identify other stakeholders and persons who have a similar interest in addressing the problem for networking and then identify joint advocacy activities and messages. This agenda will aim at contributing to improvement in HIV and AIDS services in KABAROLE district. This will be used as a guide during various HIV and AIDS advocacy events and days in the districts.

UNIHOT-UGANDA will document the key advocacy success stories which will be widely distributed to stakeholders. This will help in ensuring scalability and replication in other areas.

The project team, VHTS, CORPs & PEs and all stakeholders will be mobilised for the hosting of the candle light memorial on the eve of World Aids Day as well as commemoration of the district organised World Aids Day. This will further support awareness rising about HIV and to assist coordination between government and non-governmental actors in HIV prevention. The prayers will include delivering messages on HIV prevention and elimination of Mother Child HIV transmission campaign, Youth meetings sessions with youth leaders, giving testimonies by PLHIV, HCT deliverance and contributing help to the victims of HIV/AIDS.

**Objective 5**: To strengthen the monitoring and evaluation systems for the effective project implementation.

To ensure full implementation and greatest impact of the proposed project, the following activities will be completed:

**Activity 5.1.1: Conduct 12 Quarterly Review meetings and Support Supervision visits for project Volunteers, CORPs and Peer Educators:** the project teamwill visit the VPE placements on a quarterly basis to meet with VPEs and community stakeholders to assess programme progress, to obtain feedback, strengthen relationships with local government and to ensure VPE welfare. This is helpful for ensuring that project VHTs & PEs implement BCC messaging and other project activities including data collection, condom education, etc. effectively and efficiently in order to achieve project goal and outcomes. It will be held for one day at the project head office and will be facilitated by the project coordinator.

**Activity 5.1.2: Submit 12 Quarterly Reports to GLOBAL HAND Head Office:** These will be delivered to the Kampala Head Office to document project progress.

**Activity 5.1.3: Conduct 1 Midterm Review (Evaluation):** The MTR will enable the project to make comparisons of performance of indicators against baseline values and enable an opportunity for program adjustments.

**Activity 5.1.4: Conduct 6 Semesterly Board Field Visits-Monitoring visits:** UNIHOT-UGANDA’s Board on a bi-annual basis will visit the project area for monitoring purposes and for quality assurance checks and ensuring value for money. These visits are essential to monitor operations of the field team in line with expected deliverables and quality standards. It is also an opportunity to build capacity of staff in key areas to ensure effective implementation and management of programme interventions.

**Activity 5.1.5: Conduct 12 quarterly project review meetings for staff:** UNIHOT-UGANDA will hold 12 quarterly project team meetings to review the project implementation process and trouble shoot any challenges. Quality improvement in program activities and review of the implementation plan shall be carried out in the meeting.

**Activity 5.1.6: Facilitate 12 quarterly capacity building for the project staff:** UNIHOT-UGANDA will facilitate her project Staff that includes Project Coordinator, M&E officer, field officer and Finance Officers attend quarterly capacity building trainings in Kampala.

**Activity 5.1.7:** **Reproduce M&E Data collection tools:**

Data will be a prerequisite at every stage of project implementation for proper monitoring and indication of project progress from the project and activity start to the end. The data collection tools will be developed both in a simplified format for the beneficiaries and other monitoring officer and standard data tools will be used by the M&E officer at program level. UNIHOT-UGANDA will reprint the standard GLOBAL HAND tools to be used during data collection.

1. **LOGICAL FRAMEWORK MATRIX**

| **Hierarchy of results** | **Objectively Verifiable Indicators** | **Means of Verification** | **Assumptions/ Envisaged Risks** |
| --- | --- | --- | --- |
| **Goal:** To contribute to the reduction of new HIV infections in Kabarole district by 40% by 2015.  | * Kabarole district HIV incidence rate
* Kabarole district HIV prevalence rate
 | * AIDs Indicator Survey
* District Sentinel Survey
 |  |
| **Outcome 1:**60,242 individuals and communities empowered to effectively demand for quality HIV/AIDS services and to demand for inclusive delivery of these services in Kabarole district by August 2016 | * % of women and men (10-59 years) that tested for HIV in the last 12 months and know their results
* % of HIV-positive mothers and their infants receiving a minimum package of PMTCT
* % of males that are circumcised
* % and number of people that know the nearest place where they can be tested for HIV
 | District LQAS reports, Annual project reports | HIV/AIDS services will be available and accessible by the targeted community |
| **Output 1.1:60,242** individuals accessing HCT services | * Number of individuals who received testing and counseling services for HIV and received their test results
* Number of individuals testing for HIV as couples
 | * Testing forms
* Activity reports
* HCT registers
 | * Test kits available at the health centre
 |
| **Output 1.2:** 800 expectant and lactating mothers accessing community PMTCT services through integrated HCT outreaches. | * Number of pregnant women and lactating mothers reached with PMTCT messages
* Number of pregnant mothers referred from the communities to health facilities for ANC/PMTCT and received services
* Number of referrals for PNC services and infants referred for EID services
* Number of women who received HCT services
* Condoms distributed to pregnant women/lactating mothers
 | * ANC registers
* Referral forms
* Activity reports
 | Expectant and lactating mothers willing to undertake PMTCT |
| **Output 1.3:** 4500 males circumcised through SMC outreaches. | * Number of males circumcised as part of the minimum package of SMC for HIV prevention
 | * SMC registers
* Activity reports
* Referral forms
 | Males will appreciate the usefulness of circumcision |
| **Output 1.4:** 3000 people reached through fidelity clubs activities | * Number people reached by members of fidelity clubs.
 | * List of fidelity clubs
* Activity reports
 | Community members will embrace the project |
| **Activities (per objective)** | **Inputs** |  |
| **Activity 1.1.1:** Launch the project at the district level 30 stakeholders | Staff, Stationery, Venue, Training manuals, Tents, Public address system, testing materials, circumcision materials, sanitization materials | Requisite resources available |
| **Activity 1.1.2:**Conduct 100 monthly HCT Outreaches to communities  | Requisite resources available |
| **Activity 1.1.3**: Conduct 96 quarterly PMTCT outreaches  | Requisite resources available |
| **Activity1.1.4** Conduct 60 quarterly outreaches for SMC  | Requisite resources available |
| **Outcome 2:** Safer sexual behaviors and practices adopted among60,242 target populations and community members in Kabarole district by August 2016. | * % of females (15-49 and males 15-54) years reporting consistent condom use in the last 12 months with a non-marital sexual partner
* % of men and women that have disclosed their HIV results to their sexual partners in the last 12 months
* % of MARPS females (15-49) and males (15-54) years reporting consistent condom use with a non-marital sexual partner
 | * LQAS survey
* Impact assessment
* Evaluation report
 |  |
| **Outputs 2.1:** 89 peer educators, corps and VHTs trained in HIV & AIDS information dissemination and mobilization skills | * Number of VPEs trained and able to mobilize & disseminate HIV/AIDS information
 | * VPE training reports
* Attendance lists
 | VPES will attend and fully participate in the organized training |
| **Output 2.2: 2,4**00,000 condoms distributed. | * Number of condom service outlets providing condoms to end users (disaggregated by female and male)
* Number of condoms distributed to end users
 | * Outlet registers
* Condom distribution log sheets
* Activity reports
 | The district will ensure timely and adequate condom supplies. |
| **Output 2.3:** 10,000 people reached with messages through drama shows. | * Number of drama shows conducted
 | * Activity reports
 | Existing drama groups able to compose and present relevant messages  |
| **Output 2.4:**60,242 people reached with BCC educational sessions at sub-county/town council level | * Number of BCC educations sessions conducted.
 | * BCC education reports
* Activity reports
 | Community members will be receptive and supportive of the project objectives |
| **Output 2.5:**60,242 of the targeted populations reached with IEC/BCC materials. | * Number of IEC/BCC materials reproduced and distributed
 | * Invoices
* IEC/BCC distribution log sheets
 | The Uganda Aids Commission will provide relevant IEC information. |
|  | * Number of radio talk shows held
 | * Partnership agreements with the radio station
* Recordings
* Activity reports
* photos
 | Radio is one of the most preferred source of information for majority of the targeted population.  |
| **Activities (per objective)** | **Inputs** |  |
| **Activity 2.1.1:** Recruitment and training of 89 peer educators, corps and VHTs | Staff, Demonstration materials, condoms, training materials, drama groups, Facilitator/ Trainer, IEC/BCC materials, Seed capital | Requisite resources available |
| **Activity 2.1.2:** Establish 34 condom outlets | Requisite resources available  |
| **Activity 2.1.3:** Procure 34 male dildos | Requisite resources available  |
| **Activity 2.1.4:** Procure 34 condom storage wooden boxes | Requisite resources available  |
| **Activity 2.1.5:** Conduct condom demonstrations and distribute 2,400,000 condoms (1560,000 male & 840,000 female) | Requisite resources available  |
| **Activity 2.1.6**: Conduct 6 bi-annual drama shows for 10,000 people | Requisite resources available  |
| **Activity 2.1.7:** Conduct 576 bi-monthly BCC educational sessions targeting key populations at sub-county/t/council level | Requisite resources available |
| **Activity 2.1.8:** Reproduce and Distribute 30,000 IEC/BCC Materials across the project area | Requisite resources available |
| **Outcome 3:** A sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic in Kabarole district by August 2016.  | * % of women and men who experience sexual and gender based violence (SGBV)
* Average age of first marriage
* % of target population that vies SGBV as NOT acceptable
* % of men and women who are able to negotiate safer sex with their sexual partners
* % of population with accepting attitudes towards PLHIV
 | * District LQAS report
* Annual report
 | The targeted rights and duty bearers will translate the acquired knowledge into practice. |
| **Output 3.1:** 60 community leaders (15 elders, 20 political, 15 cultural & 10 religious) engaged and participated in community dialogue sessions. | * Number of community dialogues conducted
* Number of by laws enacted
* Number of community leaders participated & engaged in dialogue sessions
* Number of discouraged cultural and religious norms that perpetuate HIV epidemic
 | * Attendance lists
* Activity reports
 | The religious and cultural and political institutions will embrace and support the project intervention |
| **Output 3.2:60,242** people participate in community dialogues to address gender sexual based violence | * Number of community based dialogue sessions on social-cultural, gender based and other structural drivers of the HIV epidemic
* Number of people attending community based dialogue sessions on social-cultural, gender based and other structural drivers of the HIV epidemic
 | * Attendance lists
* Dialogue reports
 | The political, religious and cultural leaders will mobilize the communities to participate in the project  |
| **Activities (per objective)** | **Inputs** |  |
| **Activity 3.1.1:** Conduct 90 community dialogue sessions (1 dialogue/ every two months per sub county x 3 years) for 60 target beneficiaries (15 elders, 20 politicians, 15 cultural and 10 religious leaders) | Staff, training manual, stationery, sports materials | Requisite resources available |
| **Activity 3.1.2:** Conduct 90 community dialogues (1 dialogue / every two months per sub county x 3 years) to engage60,242 people to address SGBV and socio-structural drivers of the HIV epidemic. | Requisite resources available |
| **Outcome 4:** Well-coordinated HIV prevention response in Kabarole district by August 2016. | Requisite resources available |
| **Output 4.1:** 6 bi-annual & 12 quarterly stakeholder review meetings at the District for 30 key stakeholders  | * Stakeholders’ challenges solved and best practices scaled
 | Minutes of meetings | Targeted populations willing to benefit from the project. |
| **Output 4.2:** CSO with an advocacy agenda in place | * Advocacy agenda in place
 | Advocacy reports  | CSO willing to develop an advocacy agenda  |
| **Output 4.3:** 3 documented advocacy success stories in place | * Number of advocacy success stories documented
 | * Organization periodic reports
* Recordings from beneficiaries
 | Requisite resources availableOrganizational periodic reports available  |
| **Output 4.4.** Participated in atleast six HIV/AIDS commemorative and advocacy day’s events organised by the district  | * Number of HIV/AIDS commemorative and advocacy events held and participated in.
 | * Attendance lists
* Activity reports
* Photos
 | CSOs and other stakeholders willing to participate in these meeting. |

|  |  |  |
| --- | --- | --- |
| **Activities (per objective)** | Inputs |  |
| **Activity 4.1.1:** Organize 6 bi-annual & participate in 12 Quarterly stakeholder review meetings at the district | Staff, stationery, sensitization material, Referral forms, refreshments, fuel. |  |
| **Activity 4.1.2:** Participate in 30 annual Sub County AIDS coordination meetings  | Staff, stationery, sensitization material, Referral forms, refreshments, fuel. | Requisite resources available |
| **Activity 4.1.3:** Develop the UNIHOT-UGANDA advocacy agenda and participate in HIV/AIDS advocacy / commemoration days’ events organised by the district. | Requisite resources available |
| **Outcome 5:** monitoring and evaluation systems for the effective project implementation**.** | Requisite resources available |
| **Output 5.1**12 quarterly field visits & review meetings held with project volunteers , CORPs and Peer Educators | Numbers of Volunteers, CORPs and Peer Educator participate in the reviews.  |  Quarterly activity reports  Attendance list  Photos  | Volunteers, CORPs and Peer Educator willingness to participate in the review meetings |
| **Output 5.2** 12 quarterly trips to submit reports to GLOBAL HAND | Number of trips done  |  Report submitted to GLOBAL HAND  Photos  | Responsible staff submitting reports on time |
| **Activities (per objective)** | Inputs  |  |
| **Activity 5.1.1:** Conduct 12 Quarterly reviews meetings and support supervision visits for project volunteer, CORPs and Peer Educator  | Staff, stationery, sensitization material, activity reports, data collection tools, refreshments, fuel. | Volunteers, CORPs and Peer Educators willing to participate in the review meetings  |
| **Activity 5.1.2:** Submit 12 Quarterly reports to GLOBAL HAND Head Office | Responsible staff submitting reports on time  |
| **Activity 5.1.3:** Conduct midterm Review. | Target beneficiaries willing to participate in the midterm review  |
| **Activity 5.1.4:** Conduct 6 bi-annual Board Field Visits-Monitoring visits. | Board members willing to participate in monitoring visit.  |
| **Activity 5.1.5:**Conduct 12 quarterly review & planning meetings for project staff  |  Targeted project staff available to attend project review & planning meetings. |
| **Activity 5.1.6:** Facilitate 12 quarterly capacity building for the project staff. | Targeted staff willing to attend the capacity building trainings. |
| **Activity 5.1.7:**Reproduce Monitoring and evaluation Data collection tools | Requisite resources available |

**7.0 MONITORING AND EVALUATION NARRATIVE**

1. **M&E Framework and Plan**

| **Hierarchy of Results**  | **OVI** | **B** | **T** | **MOVI** | **F** | **L** | **F** | **L**  | **R** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Goal:** Contribute to the reduction of new HIV infections in Kabarole district by 40% by 2015. |
| **Outcome 1:**60,242 individuals and communities empowered to effectively demand for quality HIV/AIDS services and to demand for inclusive delivery of these services in Kabarole district by August 2016 | * % of women and men (10-59 years) that tested for HIV in the last 12 months and know their results
* % of HIV-positive mothers and their infants receiving a minimum package of PMTCT
* % of males that are circumcised
* % & number of people that know the nearest place where they can be tested for HIV
 | TBD | 25% | Baseline and Endline Secondary Data  | Annual | Project staff and M&E  | Annual | M& E Officer | VPE, Staff; stationary, Secondary data |
| **Output 1.1:**60,242 individuals accessing HCT services | # of individuals who received Testing and Counseling services for HIV and their test results | TBD | 25,800 |  HCT registers  | Monthly | Project staff and M&E  | Quarterly | M& E Officer | VPE, Funding for services |
| **Output 1.2:** 150 CSWs accessed HCT through 18 bi-monthly moonlight outreached activities. | # of CSWs accessing the HCT services | N/A | 150 | * Outreach reports
* HCT records
 | Monthly  | Project staff and M&E  | Annual | M& E Officer | VPE, Funding for services |
| **Output 1.3:** 800 expectant and lactating mothers undertake PMTCT through outreaches. | **#** of pregnant women & lactating mothers referred from the community to health centres for ANC/PMTCT and receive services | N/A | 800 | Copy of referral forms | Monthly | Project staff and M&E  | Monthly | M& E Officer | VPE, stationary, Training materials |
| **Output 1.4:** 4,500 males circumcised through outreaches. | # of individuals who received Safe Male Circumcision services  | TBD | 4,500 | Health Centre & Clinic registers | Monthly | Project staff and M&E  | Quarterly | M&E | VPE, funding for services |
| **Outcome 2:** Safer sexual behaviours and practices adopted among60,242 target populations and community members in Kabarole district by August 2016. | % of targeted population reporting consistent condom use with casual sexual partner | TBD | 15% | Baseline and Endline evaluation | Annual | Project staff and M&E  | Annual | M&E | VPE, Project Team |
| **Outputs 2.1.1:** 30VHTs,16 CORPS and 43 volunteer peer educators trained in HIV & AIDS information dissemination and mobilization skills | # VPEs trained on HIV prevention peer education, including data collection | N/A | 89 | VPE training report, Participant lists | Monthly | Project staff and M&E  | Quarterly | M& E Officer | Staff, stationary |
| **Output 2.1.2:** 2,400,000 condoms distributed. | # of condom service outlets providing condoms to the end users | N/A | 34 | Condom distribution log sheet | Monthly | Project staff and M&E  | Quarterly | M&E Officer | VPE, stationary &Training |
| # of condoms distributed to end users | N/A | 2,400,000 | Condom distribution log sheet | Monthly | Project staff and M&E  | Quarterly | M& E Officer | VPE, stationary &Training |
| **Output 2.1.3:** 8,000 people reached with messages through drama shows | # of people reached with drama messages | N/A | 8,000 | Photographs | Annual | Project staff and M&E  | Annual | M& E Officer | VPE, Funding for services |
| **Output 2.1.4:**60,242 people reached with BCC educational sessions at sub-county/town council level | # of targeted populations attending the BCC educational sessions | N/A | 25,800 | Activity reportsAttendance registers | Annual  | Project staff and M&E  | Annual | M& E Officer | VPE, Funding for services |
| **Output 2.1.5:** 60,262 of the targeted populations reached with IEC/BCC materials. | # of people accessing the IEC/BCC messages | N/A | 25,800 | Distribution records | Monthly  | Project staff and M&E  | Quarterly | M& E Officer | VPE, Funding for services |
| **Outcome 3:** A sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic in Kabarole district by August 2016.  | % of target population that views SGBV as NOT acceptable.  | TBD | 30% | Baseline and Endline Secondary Data from UN and World Bank; | Annual | Project staff and M&E  | Annual | M&E | VPE, Staff, survey team; stationary, Secondary data |
| % of men & women who are able to negotiate for safer sex with their sexual partners | TBD | 20% | Baseline and End line  | Annual | Project staff and M&E  | Annual | M&E | VPE, Staff,  |
| % of young people engaged in transactional or cross-generational sex | TBD | 20% | Annual Project Reports | Annual | Project staff and M&E  | Annual | M&E | VPE, Staff, stationary, Sec. data |
| **Output 3.1.1:** 60 Cultural, Elders, Political and Religious leaders develop by-laws to address structural and behavioral drivers of the HIV epidemic in their communities. | # of cultural and religious undergoing the training | N/A | 60 | * Dialogue reports
* Attendance lists
 | Monthly | Project staff and M&E  | Quarterly | M&E | VPE, Staff, stationary |
| **Output 3.1.2:60,242** community members participate in dialogues to promote HCT, PMTCT, SMC and Condom Use | # of individuals attending community dialogues sessions  | N/A | 25,800 | * Activity reports
* Attendance lists
 | Monthly | Project staff and M&E  | Quarterly | M&E Officer | VPE, stationary &Training |
| **Outcome: 4:** Well coordinated HIV prevention response in Kabarole district by August 2016 | # of government and non-government partners delivering strengthened combined HIV prevention strategies | N/A | 30 | Feedback on strengthened HIV prevention strategy interventions | Annual | Project staff and M&E  | Annual | M& E Officer | Staff, stationary |
| **Output 4.1.1:** 12 Quarterly stakeholder stakeholders meetings held involving the District AIDS Committee, District Health Office, and District PLHIV Network leadership. | # of quarterly stakeholder meetings conducted | N/A | 12 | Staff activity log sheets, meeting minutes | Quarterly | Project staff and M&E  | Quarterly | M&E Officer | Staff, stationary |
| **Output 4.1.2:** 30 bi-annual sub county AIDS coordination meetings held in each of the 5 sub counties | # of clients referred for other services and followed up  | N/A | 30 | Referral forms  | Monthly | Project staff and M&E  | Quarterly | M&E Officer | VPE, stationary &Health personnel  |
| **Output 4.1.3:** 3 documented advocacy success stories in place and HIV/AIDS commemorative and advocacy days held | # of success stories documented | N/A | 3 | * Copies of documented stories
* Activity reports
 | monthly | Project staff and M&E | Quarterly | M&E Officer | StaffVHTs, VPEs and CORPs |
| Outcome 5: strengthened monitoring and evaluation systems at UNIHOT-UGANDA | # of M&E packs produced for data collectors to use | N/A | N/A | M&E packs distribution record form | Monthly | Project staff and M&E  | Quarterly | M&E Officer | Staff, stationary |
| **Output: 5.2.1.** 12 quarterlyM&E related support visits | # of M&E related support visits | N/A | 12 | M&E field monitoring reports,  | Quarterly | M&E Officer | Quarterly | M&E Officer | Staff, stationary |
| **Output: 5.2.4**. Midterm Review (Evaluation) | Midterm review report  | N/A | 1 | Evaluation report | Once; midway | M&E Officer | Once; midway | Project Coord. | Staff, stationary |
| **Output: 5.2.5.** Semesterly Board Field Visits-Monitoring visits | # of monitoring field visits made by the Board members | N/A | 12 | Reports  | Semesterly  | M&E Officer | Quarterly  | M&E Officer | Stationary, fuel, funds. |

**(b) Monitoring & Evaluation Narrative**

1. **Data Collection**

UNIHOT-UGANDA has competent and qualified staff who will track the project progress by collecting data from the following sources:

* **Quantitative and qualitative data from the targeted populations:** focus group discussions and in-depth interviews will be utilised to assess knowledge acquisition, attitudinal shift, behaviour change and replication of techniques.
* **Qualitative data from key adult stakeholders** assessing the development of a supportive environment for the MARPs to adopt positive behaviour change.
* **Quantitative data from secondary sources** (i.e. health clinic data, sub-county and district offices etc.) to correlate with self-reported data. This data will then be used in (1) tracking monthly outputs (as described in the M&E framework above), (2) measuring progress toward outcomes and (3) evaluating impact.
1. **Data Storage**

All data collected by the Volunteer Peer Educators and staff will immediately be filed in both hard and soft form by the Monitoring and Evaluation Unit. All hard data will then be kept in files, well ordered and clearly labelled (per community) for easy referral. All soft/electronic data is entered into Excel and is then saved in the correct file (only once, with all previous versions being deleted) within a soft filing system.

1. **Data Analysis, Reporting, and Utilization**

Once received, data will be cleaned and spot-checked. It will then be entered into an Excel and/or EpiInfo, according to the type of data. Impact data from annual experience sharing and pre and post-tests will be analyzed by EpiInfo. Following analysis, qualitative and quantitative reports which summarize progress/challenges by placement community and overall programme will be written by the VPEs, the programme team and the M&E unit in line with UNIHOT-UGANDA’s Reporting Framework.

1. **Monitoring Process**

UNIHOT-UGANDA possesses a comprehensive and robust participatory monitoring and evaluation system in place. The M&E unit is managed by the M&E Officer and is supported by the Programme Coordinator and the Management Committee. The following is the general procedure for M&E.

* VPEs record all field data for activities, events and lessons learnt in line with all required reporting frameworks, compiling data monthly. Training in these M&E procedures features prominently in VPE initial training.
* Through monthly support and supervision visits and quarterly M&E unit field visits, UNIHOT-UGANDA staff monitor and verify the field activities conducted by the VPEs.
* At each stage in the reporting framework, data is assessed to guide decision-making by all staff members ensuring effective utilization of the M&E data to inform programming and organizational decisions.
* Trends, progress and data are fed back regularly to community and district stakeholders as well as VPEs to ensure participatory collaboration in the use of data for planning.
1. **Quality Assurance**

UNIHOT-UGANDA trains staff on quality assurance and staffs are expected play a central role in quality assurance by conducting data quality checks. This entails (a) staff verifying and investigating the validity of the data and case studies collected by the VPEs in the field through monthly field visits, (b) the project staff and M&E unit conduct spot-checks on all data collected and (c) inputting, reliably and completely, data into Excel. UNIHOT-UGANDA also carries out routine monitoring checks.

1. **Monitoring & Evaluation Capacity Building**

Professional development and skill building of programme staff and M&E unit staff is a priority for UNIHOT-UGANDA. As such, an internal program for capacity building of relevant staff in M&E functions takes place on a monthly basis for each programme unit. These monthly Staff M&E Support Meetings have the objective of increasing the knowledge, skills and practice of staff who manage different parts of UNIHOT-UGANDA’s M&E systems and tools.

1. **Monitoring & Evaluation Budget**

The total M&E costs over the three year project period is UGX 186,122,000 which accounts for 14% of the proposed budget.

1. **Monitoring External, Uncontrollable Factors**

Key potential areas of risk and mitigating strategies are:

* Resistance by communities to UNIHOT-UGANDA’s MARP-led approach: it’ll engagement of community stakeholders throughout the programme cycle and monthly monitoring and advocacy meetings
* VPE disease/injury: VPEs trained in health & safety measures, incident prevention and emergency response procedures.

**III C. CROSS CUTTING ISSUES**

**III. C 1. Coordination and District Participation**

This project recognizes that existing structures in public, private, civil society and community which are essential for ensuring effective coordination, participation and delivery of services for people infected or affected by the HIV/AIDS epidemic in Kabarole district. This includes the local government, district AIDS coordination structures, CSO forums and networks, PHA forums and networks, and community-based organisations.

By facilitating partnerships among district departments, CSOs, PHA networks and CBOs, it is expected that duplication of activities will be minimized while referrals within the health and social support system will improve. Training district and sub-county leaders of government departments, CSOs, CBOs, PHA networks, PWD groups in HIV/AIDS action planning, resource allocation, fiduciary management, actual service provision and M&E is also expected to facilitate mobilisation of communities to form groups/networks, prepare proposals and manage activities in their localities. Strengthening community management information system is expected to facilitate proper identification and targeting of vulnerable groups.

**III.C.2. Gender**

The prevalence of SGBV is high in Kabarole and the institutional and community response has been weak due mainly to cultural norms that promote male superiority and the submissiveness of females. Yet, the Modes of Transmission study has shown that SGBV is one of the key drivers and gender determinants of HIV/AIDS. Prevention of SGBV and responding to address the effect of SGBV is seen to contribute to reduction of HIV infections. The project will therefore strengthen capacities of medical, social and community institutions and technical staffs to prevent and respond to SGBV.

**III.C.3. Community engagement**

The project appreciates the complementarily of government programmes with those of civil society and local communities in order to achieve greater results. In the bid of eliminating any possibility of duplication of activities, the project design has been set to build synergy and engage with all stakeholders involved in HIV/AIDS in Kabarole district through periodic consultative meetings, project progress review meetings, presentation and incorporation project work plans and budgets into the district overall priorities, strategic plans, goals and objectives.

**III.C.4. Meaningful and Greater Involvement of Persons Living with HIV (MIPA/GIPA)**

The only active social infrastructure is of the PLHIV but there is absence of networks of youth clubs, post-test clubs, faith based clubs and women groups that provide psychosocial support to infected and affected persons. These are important because they represent a ready pool of volunteers to provide HIV and AIDS services at community levels such as HIV prevention, care and social support through Behavioural change communication (BCC), condom distribution, home based care (HBC), ART adherence, referrals, emotional rehabilitation, school attendance, child protection and socialization. The project will strengthen the social infrastructure of PLVHIV who are strategically positioned close to the targeted populations and empower them to implement and manage HIV/AIDS services.

**III. C.5. Sustainability and Project Closeout plans**

UNIHOT-UGANDA will deliberately integrate the project activities within the existing local government structures and other community groups and networks for sustainability. The project will be phased out taking into consideration the need to nurture and support the systems and structures that will have to be sustained after the project, and this is a core ingredient of the project.

1. **MANAGEMENT SYSTEMS AND HUMAN RESOURCES**

**8.1 Governance and Management Structure** (refer to the organizational chart)

UNIHOT-UGANDA is a nationally registered nongovernmental organisation. See attached the organisational structure. The Secretariat is led by the Executive and composed of 10 full-time employees and two volunteers.

**8.2 Project Management Staff for this Project**

The key personnel to be supported by this project and their qualifications and experiences are noted below. (CVs and signed commitment letters were attached with the concept paper).

|  |
| --- |
| **Key Project Management Personnel and % Effort** |
| **Name**  |  **Position**  | **Qualifications/ Experience**  | **% Effort**  |
| Miss Mukabera Annette | Project Coordinator  |  | 100% |
| Kayongo Alex | Field Officer (Biomedical) | * Bsc. Medicine and surgery (Makerere University).

Over five years of delivering public health programs in Northern Uganda. | 100% |
| Miss. Birungi Mary | Project Administrator |  |  |
| MwebembeziJostas | Monitoring & Evaluation Officer | Bachelors of Science in Business in Statistics | 100% |
| Ninsiima Barbra | Finance & Administration Officer  | Bachelors in Business Admin. (Accounting) with over five years experience in accounting. | 40% |
| Nyaika Robert | Executive Director | Bachelors Degree in Law with vast experience in project planning and management and general organisational management  | 20% |
| To be recruited | Volunteer Peer Educators | Preferably individuals with atleast a Uganda Advanced Certificate in Education and having previously participated in HIV/AIDS or other health programmes. | 50% |

**9.0 IMPLEMENTATION PLAN**

| **Work Plan** | **Year 1** | **Year 2** | **Year 3** | **Expected outputs** | **Quantified targets** | **Responsible person** |
| --- | --- | --- | --- | --- | --- | --- |
| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
| S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A |
| **OBJECTIVE 1:** To empower over60,242 individuals and communities to effectively demand for quality HIV/AIDS services and to demand for inclusive delivery of these services in Kabarole district by August 2016. |
| Activity 1.1.1: Project Launch at the district targeting 30 key stakeholders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 30 key partners prepared to work with the project | One launch at the district level | UNIHOT-UGANDA Project team |
| Activity 1.1.2: Conduct 180 monthly HCT outreaches (1 outreach/month/sub-county x 3 years) for target beneficiaries (21628 females and 20639 males) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 42,267 people accessing HCT services | 108 monthly outreaches | UNIHOT-UGANDA |
| Activity 1.1.3: Conduct 60 quarterly PMTCT outreaches (1 outreach/quarter/sub county x 3 years) for 800 pregnant women & lactating mothers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 800 expectant & lactating mothers reached | 800 | UNIHOT-UGANDA Project Team |
| Activity 1.1.4: Conduct 60 quarterly SMC outreaches (1 outreach/quarter/sub county x 3 years) for 4500 males  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4500 males circumcised  | 4500 | UNIHOT-UGANDA& Project Team |
| OBJECTIVE 2: To increase adoption of safer sexual behaviors and practices among60,242 target populations and community members in Kabarole district by August 2016. |
| Activity 2.1.1: Recruit and Conduct training sessions for 30 VHTs, 16 CORPs and 43 PEs (23 males, 20 females) in HIV combination prevention approach and effective communication skills. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 70 VPEs recruited | 70 VPEs | UNIHOT-UGANDA Project team |
| Activity 2.1.2: Establish 34 condom outlets |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 34 outlets in every targeted parish | 34 | CONCER-EM Project team |
| Activity 2.1.3: Procure 34 male dildos |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 34 male dildos procured  | 34  male dildos | UNIHOT-UGANDA Project team |
| Activity 2.1.4: Procure 34 condom storage wooden boxes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 20 condom storage | 20 | UNIHOT-UGANDA Project team |
| Activity 2.1.5: Conduct condom demonstrations and distribution of 700,000 condoms (560,000 male and 140,000 female) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2,400,000 condoms distributed  | 2,400,000 condoms | UNIHOT-UGANDA Project team |
| Activity 2.1.6: Conduct 6 bi-annual (2 per year) drama shows for 8,000 people (3,550 females and 4,450 males)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8,000 people reached | 8,000 | UNIHOT-UGANDA Project team |
| Activity 2.1.7: Conduct 576 bi-annual BCC educational sessions targeting60,242 beneficiaries (25,899 males, 28,158 females) (2 sessions/month/sub county x 3 years) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25,800 | 25,800 | UNIHOT-UGANDA Project team |
| Activity 2.1.8: Reproduce and distribute 61,0242 IEC/BCC Materials |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | # IEC materials reproduced and distributed | 3,000 posters, 9,000 charts, 2 banners, 9,000 fliers, 9,000 brochures, 10,000 calendars and 1000 T-shirt. | UNIHOT-UGANDA Project team |
| OBJECTIVE 3: To create a sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic in Kabarole district by August 2016. |
| Activity 3.1.1: Conduct 90 community dialogue sessions (1 quarter/sub county\* 3 years) for 60 target beneficiaries (15 elders, 20Political, 15 cultural and 10 Religious leaders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 3600 people participating in the dialogue meetings  | 3600 | UNIHOT-UGANDA Project team |
| Activity 3.1.2: Conduct 90 (1 dialogue/quarter/sub county x 3 years) community dialogues to engage60,242 people (28,158 females) to address sexual gender based violence, childhood/ forced marriages and other socio- cultural structural drivers of HIV in Kabarole.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 18,057 people participating in the dialogue meetings  | 18,057 | UNIHOT-UGANDA Project team |
| Objective 4: To achieve a well coordinated HIV prevention response in Kabarole district by August 2016. |
| Activity 4.1.1: Organize 6 bi-annual & participate in 12 Quarterly stakeholder DAC review meetings at the district for 30 key stakeholders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 stakeholder review meetings  | 12 stakeholder review meetings  | UNIHOT-UGANDA Project team |
| Activity 4.1.2: Participate in 30 sub county AIDS coordination meetings (two meeting per Sub County per annum) in 3 years. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | # 30 DAC & SAC meetings involved in | 30 DAC& SAC meetings | UNIHOT-UGANDA Project team |
| Activity 4.1.3: Develop the UNIHOT-UGANDA advocacy agenda & Participate in HIV/AIDS Advocacy/ commemoration days |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Advocacy agenda in place and HIV/AIDS days commemorated | 6 days (world AIDS Day on December 1st and Philly Lutaaya Day on December 17th. | UNIHOT-UGANDA Project Team |
| OBJECTIVE 5: To strengthen the monitoring and evaluation systems for the effective project implementation |
| Activity 5.1.1: Conduct 12 Quarterly Review meetings and Support Supervision visits for project Volunteers, CORPs and Peer Educators |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 Quarterly Review meeting | 12 | UNIHOT-UGANDA Project Team |
| Activity 5.1.2: Submit Quarterly Reports to GLOBAL HAND Head Office: These will be delivered to the Kampala Head Office to document project progress. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 quarterly reports submitted to GLOBAL HAND Head Office | 12 (quarterly) reports  | UNIHOT-UGANDA M & E Officers |
| Activity 5.1.3: Conduct Midterm Review (Evaluation) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Project midterm review conducted | One project review  | UNIHOT-UGANDA Project Team |
| Activity 5.1.4: Conduct 6 bi-annual Board Field Visits-Monitoring visits |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 6 field visits | 6 | UNIHOT-UGANDA M & E Officers |
| Activity 5.1.5: Conduct 12 quarterly project review meetings for staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 project team review meetings  | 12 | UNIHOT-UGANDA M & E Officers |
| Activity 5.1.6: Facilitate 12 quarterly capacity building for the project staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 capacity building activities | 12 | UNIHOT-UGANDA M & E Officers |
| Activity 5.1.7: Reproduce M&E Data collection tools |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | M&E Data collection tools | 1 | M & E Officer |

1. **Cost Proposal - Financial Management and Budget**

Kindly see the additional Excel document.

1. Kabarole District Local Government 3-Year Development Plan 2010/2011-2012/13 (June 2010) [↑](#endnote-ref-2)
2. Uganda HIV Modes Of Transmission and Prevention Response Analysis (March 2009) [↑](#endnote-ref-3)
3. Kabarole District Health Department Report, 2011 [↑](#footnote-ref-2)
4. Kabarole District Health Report (August 2011) [↑](#footnote-ref-3)
5. [↑](#footnote-ref-4)