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AIM PROJECT EVALUATION

FINAL REPORT

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CONTENTS

PREFACE ..... **III**

ACKNOWLEDGEMENTS ..... **IV**

ACRONYMS ..... **V**

EXECUTIVE SUMMARY ..... **VII**

BACKGROUND **1**

SCOPE OF WORK, EVALUATION DESIGN AND DATA METHODOLOGY **3**

FINDINGS **6**

UNINTENDED CONSEQUENCES **53**

CONCLUSIONS **54**

LESSONS FOR SCALING UP **58**

TABLES:

Table 1: AIM and Comparison Districts selected for Field Work and Survey 5
Table 2: Program Structure and Components covered during evaluation 7
Table 3: AIM districts compared to all other districts: Selected SES Indicators – 2001-2005 18
Table 4: AIM district results compared to all other districts – 2001 and 2005 (or latest) 18
Table 5: Effect of PEPFAR on AIM Core Program Areas 20
Table 6: DAC Performance and Management Ratings in AIM and Comparison districts 21
Table 7: AIM District DAC Assessment 22
Table 8: DAT Empowerment Measures (AIM Districts Only) 25
Table 9: Assessment of Clinical Services in Health Units Visited in AIM and Comparison Districts 27
Table 10: Assessment of HCT and PMTCT sites withTrained Personnel in AIM and Comparison Districts 30
Table 11: General Assessment of Laboratory Services in AIM Districts 33
Table 12: CBHC Grantees covered by the evaluation team in the 3 AIM program districts 39
Table 13: Constraints faced by PHAs to access and utilize health services in AIM and comparison districts 46
Table 14: Percentage Households with OVC in AIM and Comparison districts 49
Table 15: Assessment of Information Systems' Functionality in AIM and Comparison Districts 50

FIGURES:

Figure 1: AIM Program Annual Grant and Direct Program Expenditures 14
Figure 2: Some PMTCT Indicators Based on 2004 Data 32
Figure 3: Source of HIV/TB Testing in AIM and Comparison Districts 34
Figure 4: TB Detection and Treatment Services: AIM, Comparison and National Comparison 35
Figure 5: Some TB Indicators in AIM and Comparison Districts 36
Figure 6: Proportion of TB patients running out of drugs in AIM and Comparison districts (AIM N=147, Comparison N = 91) 37
Figure 7: PHA Households Receiving Material Support in the last 12 months in AIM and Comparison Districts (AIM N=147, Comparison N = 91) 41
Figure 8: Psycho social support received by PHAs in the past 12 month in AIM and Comparison districts (AIM N=146, Comparison N=91) 42
Figure 9: Practical support received by PHAs in the past 12 month in AIM and Comparison districts (AIM N=147, Comparison N=91) 43
Figure 10: Medical support received by PHAs in the past 12 month in AIM and Comparison Districts (AIM N=147, Comparison=91) 44
Figure 11: Percentage of respondents who considered the problem to be "too big to overcome" for AIM and Comparison DISTRICTS (AIM N=147, Comparison N=91) 46

PREFACE

Any project evaluation is a risky enterprise for both the evaluator and for the people responsible for the design and implementation of the project under scrutiny. The commitment of resources to the evaluation process is rarely proportional to the size and level of effort made to implement the project. Implementers always know more about the history of the project, and frequently have formed their own conclusions. Evaluators must rely on the facts available, conduct their analysis and reach appropriate conclusions which "assess the value" of the project. Inevitably, there will be disagreements about what the facts are and what they mean.

This report has gone through nine revisions, since the first draft was submitted in March 2006. The report is longer than normal, in part because the Scope of Work required us to evaluate the project within the framework of a complex Performance Monitoring Plan, which contained thirty four separate elements organized under five major objectives. We have made every effort to respond to comments and to correct the factual record as presented. In doing so, we have also revised some of our analysis and conclusions. What is presented represents the best effort and consensus judgment of the evaluation team.

ACKNOWLEDGEMENTS

There are many persons who provided necessary support and guidance to this evaluation effort. Elise Ayers, the Cognizant Technical Officer for USAID Uganda, provided advice, guidance, and extensive comments on early drafts of the report. We are aware that this was a burden at times, and hope the results are, nevertheless, useful to her and to the USAID Mission. We received outstanding support from the AIM staff as well. We single out Helene Rippey, the Quality Assurance Manager, whose support was constant, timely and substantively very useful. Lillian Nakitende did a wonderful of job of making appointments and providing daily schedules. Programme Director Med Makumbi was always available to answer questions and give his perspective on the AIM project.

On the Uganda government side, we are grateful to the cooperation of many leaders in government at the national and district levels who took time from their busy schedules to meet with us and provide both information and views. We have done our best to accurately reflect their assessment of various aspects of the AIM project. Civil Society leaders at the national and local level were equally forthcoming and remarkably candid in their appraisals, both of their own organizations and of the support received from AIM. Finally, we appreciate the willingness of many ordinary Ugandans, and particularly those with HIV/AIDS and their families for meeting with us and answering questions. They have given this report an added dimension that could not be achieved by talking with officials and activists alone.

The Management Systems International team in Uganda, MEMS, provided daily logistical and administrative support to the team, without which the team could not have been assembled and deployed as expeditiously as it was. Augustine Wandera MEMS' staff, served on the team and was the primary point of contact and information for the many revisions of this report deserves special mention, as does Rosern Rwampororo, the Chief of Party of MEMS, who worked hard to assemble the best possible team with very little lead time.

Finally, the study team would like to recognize the extraordinary skill and commitment of the Ugandan members of the evaluation team. The team leader arrived in Kampala on Thursday, the team was assembled by Saturday, and by Monday we were working together to review documents and select sample districts followed by field work. None of them had worked together before, but they quickly exhibited the kind of skill and commitment to independent inquiry and thoughtful analysis that marks an experienced professional. All contributed to the findings, analysis and conclusions in this report, and have reviewed the several revisions.

Together we have made every effort to be responsive to the Scope of Work, and to provide USAID as well as Ugandan leaders with fresh insights, useful conclusions and lessons learned from the AIM experience. We are comfortable with our analysis and conclusions, but we recognize the possibility of errors of fact and interpretation, for which we are responsible.

ACRONYMS

ACCF	Africa Child Care Foundation
AIC	AIDS Information Center
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS/HIV Integrated Model District Program
AMREF	African Medical and Research Foundation
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASED	Advocacy for Social Development and Environment Uganda
BCC	Behavioral Change Communication
BUDNET+	Bushenyi District Network of People Living with HIV/AIDS
CB DOT	Community – Based Directly Observed Treatment
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHBC	Community Home Based Care
CSO	Civil Society Organization
DAC	District AIDS Committee
DAT	District AIDS Team
DDHS	District Director of Health Services
DDP	District Development Plan
FBO	Faith Based Organization
FINCA	Foundation International Community Assistance
FY	Fiscal Year
GOU	Government of Uganda
HBC	Home Based Care
HC	Health Center
HCT	HIV Counseling and Testing
HIV	Human Immune – Deficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-District
ICOBI	Integrated Community Based Initiatives
IEC	Information, Education Communication
IMAU	Islamic Medical Association of Uganda
JCRC	Joint Clinical Research Center
JIA	Joint Institutional Assessment
JSI	John Snow International
Lab	Laboratory
LIFE	Leadership and Investment in Fighting the Epidemic
M&E	Monitoring and Evaluation
MAHA	Moyo AIDS Heroes' Association
MEMS	Monitoring, Evaluation Management Services
MIS	Management Information System
MOGLSD	Ministry of Gender, Labor and Social Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MSI	Management System International

MTR	Mid Term Review
NACWOLA	National Community of Women Living with AIDS
NAYODEP	Nagongera Youth Development Program
NGO	Non Governmental Organization
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PADA	People with AIDS Development Association
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	Persons Having AIDS
PMP	Performance Monitoring Plan/Performance Management Plan
PMTCT	Prevention of Mother to Child Transmission
PSSG	Peer Social Support Group
PTC	Post Test Clubs
RCT	Routine Counseling and Testing
RNA	Referral Network Association
SOW	Scope of Work
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organization
TB	Tuberculosis
THETA	Traditional and Modern Health Practitioners Together Against AIDS
TOT	Trainers Of Trainers
TPC	Technical Planning Committee
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UNASO	Uganda Network of AIDS Service Organizations
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
UWESO	Uganda Women Efforts to Save Orphans
VC	Village Committee
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

This report presents the findings, conclusions and lessons learned of a team commissioned by USAID Uganda to evaluate the USAID funded AIM (AIDS Integrated Model District) Project. The Project was a multi-faceted effort implemented in 16 Ugandan districts from 2001 to 2006 at a final cost of approximately $38 million dollars. The project provided support to many Ugandan entities, including national and local level NGOs active in the HIV/AIDS prevention, care and support efforts, and to Ugandan government ministries and agencies at the national and district levels. The primary focus of the project was, through an integrated program coordinated by district committees, to improve local health posts capacity to diagnose and treat HIV/AIDS and related diseases, as well as to expand prevention education and care services by making grants to local civil society organizations. The project also sought to improve the quality and breadth of health management information systems from the local to the national level.

Evaluation Design:

The evaluation began in Kampala March 7, 2006. The evaluation research design employed a comparative mixed method design structured as a rapid appraisal to fit within the eighteen days of field research time available to the team. Data collection focused on three of the sixteen AIM districts, with three 'control' districts paired with each of the three experimental districts. A small sample survey from PHA registered families was conducted in all six districts yielding data on utilization of AIM type services. Data was analyzed and initial conclusions were presented in preliminary Briefing Note to USAID Uganda and to AIM staff on March 31, 2006.

The report contains eleven conclusions and seven 'lessons learned', of which the most significant are presented here in summary form.

Findings and Conclusions:

1. AIM achieved PMP Targets

With regard to specific improvements in DAC planning, development of better testing, treatment and institutional referral systems, AIM districts outperformed comparison districts by a substantial margin.

AIM was able to demonstrate the efficacy of integrated planning, implementation and monitoring of multiple HIV/AIDS inputs at the local level with varying success. Through the extraordinary efforts of the JSI staff, which provided training, budget support, and JSI management of equipment purchases, grant financial and program management, and technical assistance to the DAC and various CSOs, the AIM districts over the life of the Program did achieve or exceed predicted results as measured by selected PMP indicators. **In general all AIM districts performed better than comparison districts on most PMP dimensions.**

2. Access to services expanded

AIM reports impressive gains in VCT and PMTCT intake over the five year life of the project, but available data from non-AIM district show equally strong numbers, reflecting an improving national level effort to promote and engage people in VCT and PMTCT counseling. As stated previously in the Mid-Term Review, AIM succeeded in meeting its PMP targets. However, the data available to the team from the Government of Uganda show that AIM districts performance on specific indicators such as VCT and PMTCT intake are not appreciably different than other districts. As USAID has noted, there are

essentially two national programs providing support to PMTCT and, through the AIC, to VCT. We conclude that the additional input from the AIM project with regard to these important services had little differentiating impact as compared with the effect of the other national programs.

3. Utilization of Services

Based on responses to a small sample survey of PHA families in AIM and Comparison districts, the Comparison districts respondents were able to utilize medical, psycho-social and practical support at the same or a greater level than those in AIM districts. Despite the considerable increase in accessibility of services in AIM districts, this does not appear to have translated into greater utilization as reported by PHA respondents.

This finding is limited to PHA respondents, and does not affect the utilization of services by the wider population, such as use of Voluntary Counseling and Testing. Nor does the data reflect any differences in the quality of services rendered.

When asked about constraints to utilization of services, AIM district respondents generally were better able to overcome problems of distance, lack of money for transport, as well as reporting that facilities in the AIM districts were more reliable with respect to being open, respectful, and able to provide needed services. This suggests that AIM's investments in the quality of services have had a positive impact.

4. Testing a Model

One of the original goals of this project was to "test a model" of integrated service delivery coordinated and managed by a district level decision and oversight structure made up of local government officials and representatives of various civil society organizations.

This goal was not attained.

For a model to be tested, there must be a base line established and some form of comparisons districts established at the beginning, the original design must be substantially carried out, and the external environment for implementation must remain relatively stable over the life of the "test". None of these criteria was met in the AIM experience. No base line was established against which changes over time might be measured, and no comparison cases were set up against which to assess results in the project districts.

Another major requirement for 'testing a model' is that the intervention remains stable. This was not possible with AIM. Over the five year life of the project, AIM went through several revisions and strategic redirections, the last as late as September 2004, with less than 18 months left in the five year period, following a highly critical mid term review in June 2004. Changes in the external environment also affected the "test", including the withdrawal of CDC, the arrival of PEPFAR, and the subsequent doubling of project funding.

Nevertheless, AIM did succeed in influencing important elements of national HIV/AIDS policy and field guidance, and did succeed in demonstrating that local government and CBOs, including PHA networks, could work together to be effective providers of services for the purpose of prevention, care and support for HIV/AIDS victims.

5. A poorly grounded project design:

The original project design as expressed in the JSI proposal expressed an innovative strategy for linking national and local entities, and for pairing 'advanced' model districts as mentors with less advanced districts. Unfortunately, the optimistic assumptions of this strategy had little grounding in the realities of

the Ugandan social and political structure, including a weak governmental structure and an under-staffed and under budgeted government health system. The original project design was too complex and overly ambitious for the existing capacities of local government and health facilities, and for the five year time frame allowed for the 'test'

6. Changes and Delays in Implementation Strategy

Delays in implementing the strategy affected the implementation of the district and local level capacity building and empowerment objectives, including local government and local civil society organizations enlisted to provide a variety of HIV/AIDS related services.

7. Political Leadership not consistently engaged

Although AIM leadership did succeed in building capacity in the DACs, the DAT was essentially ignored, eliminating the important connection between local political leadership and the technical implementation bodies at the local level. This meant that local politicians, in a number of cases, turned to forming or supporting CSOs as a means of exercising influence over the allocation process. Moreover, true 'ownership' of the project's decision making process remained in the AIM project office, or in the project's field offices. Neither the DAT nor the DAC were, by the end of the project, truly empowered, increasing capacity notwithstanding.

8. Local Government has limited capacity to sustain program

Grafting substantial new responsibilities for HIV/AIDS prevention, care and support along with new information and data collection systems, onto a weak governmental structure, (Local Government, Ministry of Health, and the Ministry of Gender, Labor and Social Development), may not be sustainable. AIM, as with many foreign assistance projects, was able to overcome structural weaknesses and constraints through the skill, authority and budget resources available to it. Unless there is structural change in the management and funding of the Ugandan health system, it is likely that budget and staff shortages, staff turn-over, stock-outs, inadequate transport, and poor equipment maintenance, will emerge once again to constrain access and utilization of services of the health clinics.

9. Civil society grant program had limited impact

AIM's incorporation of Civil Society Organizations into the HIV/AIDS treatment and support services system was laudable and did produce a level of engagement and involvement, as well as increasing district level awareness of the HIV/AIDS condition. The team's limited evidence on this suggests that PHA networks, among all the local CSOs involved, were the most effective in responding to AIM's support, especially in expanding informal networks of information and referral.

However, many CSOs engaged by AIM were not primarily HIV/AIDS organizations, and, although they may have successfully completed their grants, whether they will continue as part of the HIV/AIDS alliance is open for question. The reasons for the limited impact of the NGO/CSO mobilization are, first, many of these organizations were not initially committed to the HIV/AIDS effort, second, the grant period was too short and the budget too limited to realize significant gains in service impact, and third, the inability of the project to define service targets against the potential needy population meant that achievements could not be assessed in any meaningful way.

10. OVCs May Need Separate Program

The strategy for dealing with Orphans and Vulnerable Children in the AIM program was to rely on the Ministry for Gender, Labor and Social Services in collaboration with many grant funded CSOs to provide a variety of services to families and to the children. We conclude that this was not a very effective

strategy, in part because the Ministry is understaffed and under budgeted, and the CSO grants were only for one year, making it difficult to develop a sustainable partnership. Complicating the problem is the combination of orphans with vulnerable children, the latter being a much larger and somewhat different category. In some real sense, all children in a poor country afflicted with disease and poor nutrition are vulnerable. The team concluded that a program de-linked from HIV/AIDS treatment and care might achieve greater focus, attract more funding, and be more effectively organized. This is a very tentative conclusion, needing much more analysis and debate before a final policy strategy is reached.

11. Data collection and management

As previously found in the Mid-Term Review, most of the performance indicators and relevant data collection and management processes were designed to serve the accountability needs of the AIM project, USAID, and PEPFAR. The evaluation found at the local level a lack of ownership of these data systems. While capacity to manage the data requirements was increased, the data systems also imposed considerable burden for data collection and aggregation on the districts, especially at the lower levels (HC IV), which were found to be the least reliable parts of the health delivery system.

Lessons for Scaling Up

The Problem Restated

Recent data from the National Sero-survey portray a more nuanced situation than was true in 1999 when the basic thinking for AIM was done. Several striking features of the disease have been illuminated:

- Knowledge levels remain high, though not as ‘sophisticated’ as desired.
- Behavioral change has occurred, especially among the 15-19 age group.
- Regional differences in the prevalence rate are striking, with a number of districts in the north and east showing prevalence rates of around 3 %. Other districts show rates higher than the national average.
- Higher than average prevalence rates appear in sub-regions that are somewhat better educated, somewhat more affluent, and more urbanized. On these three variables, the prevalence ratio may be curvilinear. Less educated, less affluent (more poverty), and less densely settled populations show lower prevalence, the same would be true for the higher rates of education, income and urbanization. This suggests that peri-urban areas attracting rural to urban migrants, some school leavers, and more predominantly male than female, are the areas where conditions are more favorable to higher levels of HIV/AIDS prevalence.
- Women continue to show higher prevalence levels.
- Discordant couples may be a ‘sleeper’ category, requiring special attention.

As the problem becomes more nuanced, and specific by social class, category and region, so should the strategy and level of effort become more targeted and specific.

Lessons

1. The HIV/AIDS campaign must be tailored to the nature of the problem at the local level.

The AIM program, as part of the original concept, had the idea that if strategies, plans and matching resource allocations were determined at the district level, the HIV/AIDS campaign would be responsive to the unique characteristics of the disease in THAT DISTRICT. The project did not assert that 'one size would fit all.' Although this individualization was not realized as much as hoped in the project, it is today an even stronger requirement.

2. Disaggregated information is essential.

If the national campaign is to rely on district governments and CBOs to plan and implement an effective program, the officials responsible for the district planning process must have access to information on the state of the problem they are trying to deal with***…information must be local, timely, relevant, and limited to what is needed to make decisions.***

3. The political and the technical must be joined.

For whatever reasons, AIM largely marginalized the local level political process, considering the campaign against HIV/AIDS a technical issue. As with any threat that affects large numbers of people, HIV/AIDS is a political issue, and what to do about it is even more so. The United States is committed to advancing democratic practices and institutions as well as fighting disease. The two are linked. Engaging the Ugandan political process in this fight, however difficult, is critical to its success, and will benefit the democratization process as well.

4. The government's system is part of the problem, and must be part of the solution.

Any new effort must approach the weaknesses of the rural and small town health delivery system in a systematic way. USAID is funding other programs, such as DELIVER, to address the important issue of supply management, but other issues also affect the system's efficiency and effectiveness, most notably technical staffing and related incentives, insufficient capital budgets, and limited operational budgets for outreach and networking programs.

5. Complex programs cannot be sustained without structural management and resource changes.

AIM's effort to integrate services through multiple modalities would have been difficult in the most advanced post industrial countries. By force of its expertise and control over resources, AIM was able to accomplish many things, but this evaluation is skeptical of the long term sustainability of these accomplishments. The experience of the Comparison districts, many of which have had donor assistance in various forms, is instructive. For the most part, the Comparison districts were 'living within the means' of the Government of Uganda, and the resulting poor performance is testimony to what that means. Local Government does not have control over a sufficient portion of its revenue base to be responsive to local conditions. The national line ministries continue to operate within their own program priorities and budget resources. The Ministry for Gender, Labor and Social Development is particularly understaffed and under budgeted. If SUSTAINABILITY is to become an OPERATIONAL issue, consideration must be given to it at the very beginning of the project.[1]

[1] USAID does not fund what is often called 'parallel programs'. However, the fact that foreign aid resources are 'off budget' does mean that monies are available for priorities and activities that could not otherwise be funded by the government. The issue is not whether such programs are desirable or produce useful development related changes,

6. Multi-year contracts with CSOs and CBOs will produce effective services or adequate coverage.

AIM's grant program combined with various capacity building efforts may have helped create a pool of organizations with the potential for delivering services on an extensive and continuous basis. However, the one year grant process is an inadequate funding modality for this purpose. A scaled up national program would do well to include CSOs that have demonstrated their commitment and capacity to deliver relevant services. The modality for engaging these CSOs should be a competitive contract, funded over a three to five year period, with specific service and coverage targets included in the contract. The role of the DAC/DAT should be to monitor, and evaluate the achievements of the CSO contractor on a periodic basis. A small grant program should be continued to stimulate the development of other organizations, and to keep the process open and competitive. CSO small grants of one year duration, however well executed, will not produce the kind of reliable, competent, and consistent services needed for PHAs and their families.

7. OVC programs deserve a separate identity and a more nuanced approach.

The evaluation found that OVC programs were not as effective as expected, both in terms of coverage and in impact. OVC was, to paraphrase, an orphan child of the HIV/AIDS campaign, although AIM made great efforts to mainstream the program. The evaluation team is aware of the debate in Uganda about how best to provide support to orphans, vulnerable children and the families. On balance, the evaluation team believes that 'stand alone' programs from a funding and organizational point of view, would provide more focused and effective services than attempting to integrate these programs into HIV/AIDS campaigns. The reasons for this have to do with the wide range of characteristics and factors that define and determine the OVC problem. Not all orphans are victims of HIV/AIDS. Not all the problems of pre-adolescent VCs are related to HIV/AIDS. There is a bundle of issues with this group, many of which tend to get submerged by the effort to integrate them into an HIV/AIDS program.

but whether the changes introduced have a reasonable chance of being funded by government budgets after foreign donor assistance is completed or withdrawn.

BACKGROUND

The Problem

The seriousness of the HIV/AIDS epidemic in Uganda in the late 1990s is incontrovertible. In 1999, the Government of Uganda estimated that 1.4 million people were living with HIV/AIDS, of which 112,000 were newly diagnosed that year. Women were disproportionately affected at 55% of the adults living with HIV/AIDS. By 1999, an estimated 838,000 people had died from AIDS, leaving about 1.7 million orphans (loss of one parent or both) and life expectancy had dropped form 54 to 42. Although down from much higher rate of nearly 20%, HIV/AIDS prevalence in 1999 stood at 8.3% of the adult population. Massive educational and informational campaigns had succeeded in both increasing knowledge about HIV/AIDS, and producing behavioral change towards safer sexual practices, including condom use, and a reduction in non-regular sexual partners.

The challenge, as identified in the technical proposal submitted by the winning implementing partner, John Snow International (JSI) was to sustain these changes over time, especially in a population with youth and adolescents making up over 50% of the population.[2]

The Program[3]

The AIDS/HIV Integrated Model District Program (AIM) was funded through a Cooperative Agreement with the United States Agency for International Development (USAID) for the period May 2001 through May 2006. It was implemented by JSI Research and Training Institute, Inc., and included World Education and World Learning as consortium members. Key Government of Uganda (GOU) partner institutions included the Ministry of Health (MOH), Ministry of Local Government (MOLG), Ministry of Gender, Labor and Social Development (MOGLD), and the Uganda AIDS Commission (UAC). Civil society organizations at the national and district level were also critical partners. AIM was designed by MOH, UAC, USAID and the Centers for Disease Control and Prevention (CDC) and other members of the LIFE Initiative.[4]

In support of the National Strategic Framework for HIV/AIDS in Uganda, the AIM program was designed to assist with increasing the provision of quality **integrated** HIV/AIDS services at district and sub-district level. AIM was designed to work closely with local government, NGOs, CBOs, FBOs, the private sector and other partners to increase availability and access to a range of core comprehensive HIV/AIDS services in selected districts. The mission of the AIM program was to establish ***effective replicable models that would successfully contribute to the decrease in HIV prevalence and incidence in Ugandan adults and children,*** and that play a significant role in increasing the level of care and support to all those in Uganda affected by AIDS.

The overall goal of the AIM program, when fully implemented, was for men, women and children in sixteen selected districts in Uganda[5], to access and utilize appropriate, affordable and quality integrated HIV/AIDS prevention, care and support services. Key program objectives included:

[2] USAID – JSI Cooperative Agreement Number 617-A-00-00002-00, "Epidemiology" p. 10.

[3] This program description is taken directly from the USAID Scope of Work, prepared for the evaluation.

[4] The Leadership and Investment in Fighting the Epidemic (LIFE) Initiative brought with it the first of many substantial increases in U.S. Government financial support to Uganda for HIV/AIDS.

[5] The 16 AIM districts were selected at the same time, but were rolled out in a two phased approach. Phase I districts were: Lira, Pader, Apac, Rukugiri, Bushenyi, Ntungamo, Katakwi, Soroti, Kumi and Tororo. Phase II districts were

- To strengthen and support the capacity of government, non-governmental organizations (NGOs), community based organizations (CBOs), faith-based organizations (FBOs) and the private sector to plan, implement, manage and provide quality services at the national, district and sub-district level.

- To increase integration and quality of comprehensive HIV/AIDS prevention, care and support services in selected districts.

- To increase access to and utilization of quality HIV prevention services in selected districts and sub districts.

- To increase access to and utilization of quality HIV/AIDS clinical, community and home-based care in selected districts and sub-districts.

- To increase access to and utilization of quality social support services for people infected and affected by HIV/AIDS including orphans, vulnerable children and adolescents in selected districts and sub districts.

Throughout the past five years, AIM has operated within a dynamic environment of evolving donor priorities, funding mechanisms, system constraints (see attachment 1 on the SOW for further details). Initially, funding for this program came through USAID and CDC. In November 2002, the ceiling for the cooperative agreement was increased from $19 million to $38 million through funding from the LIFE Initiative and USAID infectious disease resources for tuberculosis. CDC funding ended in program year three, and since January 2004, AIM has been funded directly by USAID through the President's Emergency Plan for AIDS Relief (PEPFAR) initiative. A Mid-Term Review (MTR) took place in June 2004. [6]

brought on in early 2003 after JSI received an increase in their funding. Phase II districts were: Mubende, Kibaale, Pallisa, Nebbi, Arua, and Yumbe.

[6] After the Mid Term Review, World Learning dropped out of the implementing consortium. Since this was a management, rather than an impact related event, the evaluation team did not attempt to develop a thorough explanation as to why this happened.

SCOPE OF WORK, EVALUATION DESIGN AND DATA METHODOLOGY

A. Scope of Work[7]

Although USAID does not intend to replicate AIM, it continues to provide substantial funding for the fight against HIV/AIDS in Uganda. In order to learn from the experience of AIM, USAID commissioned this final, results oriented evaluation in early 2006. An evaluation team was assembled in March 2006 through the efforts of the Monitoring and Evaluation Management Services (MEMS) office which supports USAID Mission analytic work in Kampala. The team organized and began field data collection March 14th, concluding 12 days of field work on March 25th.

USAID prepared Scope of Work (SOW) for this evaluation focused on assessing results, unintended consequences and lessons learned relevant to "scaling up" to a national level program. The Scope's key questions are:

Program Results

a) Did AIM achieve its overall goal and results ***as outlined in the performance monitoring plan?*** [8] *What factors facilitated or hindered its achievement of planned results?*

b) Did the Program yield any unintended positive/negative results?

Lessons learned

a) What are the lessons learned from AIM program relative to scaling up HIV/AIDS services nationwide disaggregated for the Government of Uganda, the United States Government's support to the national response, and USAID project management?

b) Is there evidence to suggest that activities would produce the same results if [9] *scaled-up throughout the country?*

B. Evaluation Team

The AIM evaluation was undertaken by a seven person team made up of one US based senior evaluator, and six Ugandan researchers. The evaluation was "participatory" in that of the Ugandan team members, one was from USAID, one from the Ministry of Local Government, and one, a medical doctor, had been a member of the AIM regional staff. One team member was a staff member from the USAID funded Monitoring and Evaluation Management Services (MEMS) office, and two were independent consultants with medical and public health research backgrounds.

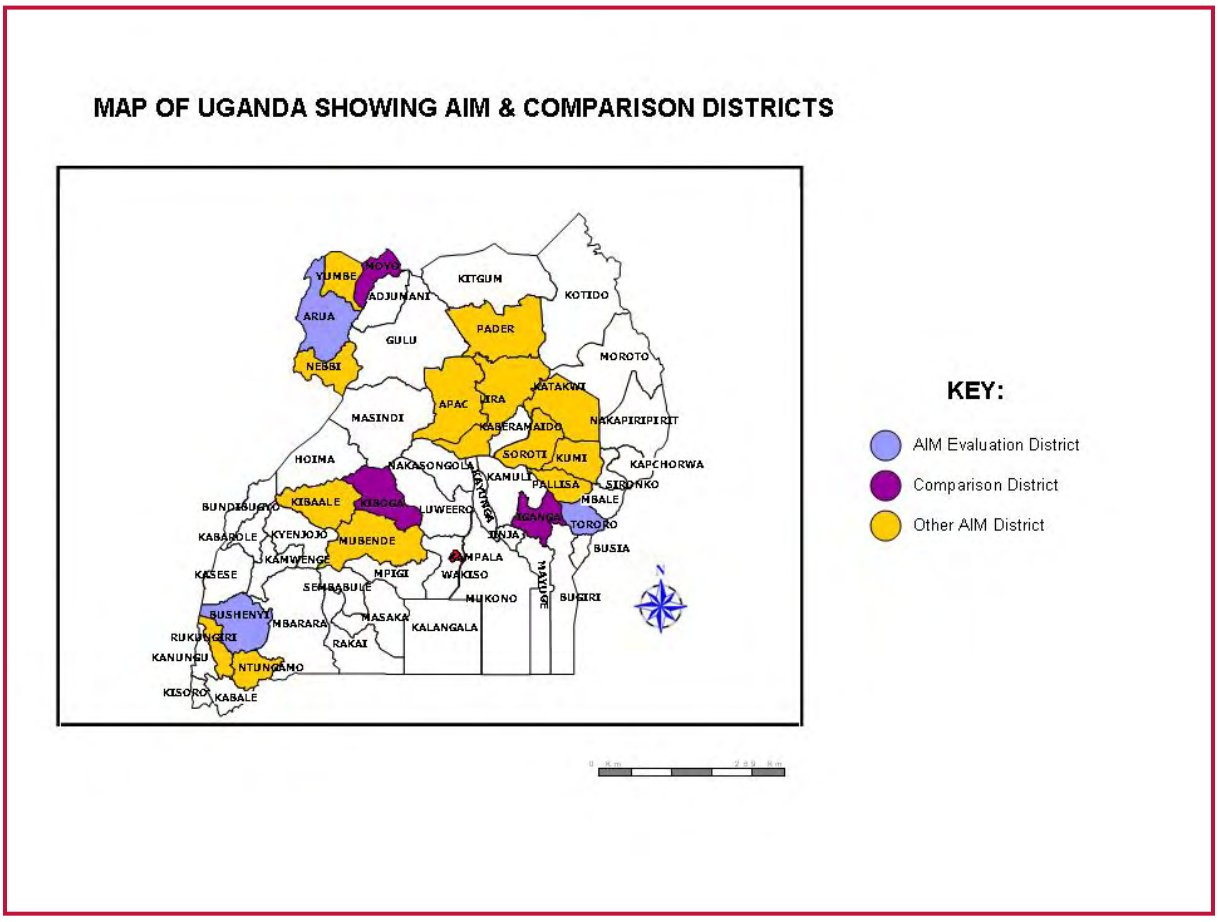
[7] The evaluation SOW is attached in Appendix A

[8] Emphasis added. The SOW focused the team's work on the most recent Performance Monitoring Plan Goal and Objectives. USAID advised the team that the Mid Term Review had covered management and other historical issues up through June 2004. In order to explain why certain results were achieved or not, the team did examine the original project design and subsequent changes in strategy.

[9] USAID Uganda Draft Scope of Work November 2005, dated February 26, 2006.

C. Evaluation Design

The evaluation research design employed a comparative mixed method design structured as a rapid appraisal to fit within the eighteen days of field research time available to the team. Conceptually, the team chose to focus on both the provision of services, the "supply side" or referred to in the AIM Performance Monitoring Plan (PMP) as "Access", as well as the "demand side", mainly the utilization of those services by Ugandan beneficiaries.[10] Three main units of analysis were selected: first, national level leaders who had received training and other inputs from AIM, second, the district level, including the Uganda unit of local government and local level civil society organizations, and third, HIV/AIDS affected Households, as identified from People with HIV/AIDS (PHA) registration lists. The primary comparisons were between three AIM districts and three matching Comparison districts, each set located in a different part of the country. The AIM – Comparison sets were: Tororo-Iganga (East), Arua-Moyo (West Nile), and Bushenyi-Kiboga (West and Central). The AIM districts selected each had an AIM regional office which provided the evaluation team with transport, communications and logistic support. Comparison districts were selected on the basis of similar demographic and HIV/AIDS characteristics, and for proximity.



[10] The USAID approved Performance Monitoring Plan referenced in the SOW and used by the team is found in Appendix I

D. Data Collection

The data collection methods included extensive and intensive review of AIM documents, open ended and structured interviews with key actors at the national, district and local level, observation of health post outpatient and laboratory functioning, and macro-level aggregate data comparisons. These methods focused mainly on the "supply" side provision of AIM sponsored services and other inputs organized around coordination, planning and expansion of "access" to services available to Ugandans in the 16 AIM districts.

The six Ugandan team members divided into three sub-teams, each responsible for field work in two districts; one district was an AIM district, the other a "Comparison" district selected for similar demographic characteristics. Each sub-team was provided a 'field study and key informant question guide'[11] and charged with gathering interview and observational data on each of the five objectives contained in the 2005 AIM Performance Monitoring Plan, as requested by the SOW.

To assess the "demand" or utilization results, a weakness noted by the Mid-Term Review, a small sample survey was undertaken, using a modified version of a household questionnaire that had been widely used in Uganda by the National Behavioral and Sero-Survey of 2004/5. Respondents were randomly selected from membership lists of organizations of people living with HIV/AIDS in each of the six districts selected for evaluation research. For each AIM district, a minimum of 40 households was identified, and for each comparison district, a minimum of 20. The final survey results were higher, with an N = 143 for AIM districts, and N = 99 for comparison districts. Table 1 shows the districts and the final numbers of households interviewed in the AIM and the Comparison districts.

TABLE 1: AIM AND COMPARISON DISTRICTS SELECTED FOR FIELD WORK AND SURVEY

District	**AIM Sample** *(N)*	**Comparison Sample** *(N)*
Tororo	49	
Iganga		20
Arua	46	
Moyo		48
Bushenyi	49	
Kiboga		26
Total	**144**	**94**

E. Data Analysis and Presentation

To facilitate comparative analysis, on return from field investigations, each team member was assigned primary responsibility for preparing the written field assessment for one major element from the list of five program objectives. Each field team was asked to rate the performance of the districts they visited on a scale of 0 – 3, with 0 meaning not functional or available, 1 minimal functioning, 2 meaning functional but with problems and 3 meaning the district was fully functional according to PMP results standards as of March 2006 when the field work was done. From this, a comparative nominal ranking score was given to both the AIM and the Comparison districts for most of the Objectives. All team members then shared data from their field notes with the primary reporter for that objective in order to provide qualitative evidence to support the numerical rankings, and to provide additional findings with respect to unintended

[11] Field Study Guide and Survey Questionnaire may be found in Appendix C & D

consequences and lessons learned. Two presentations of the team's preliminary analysis and findings were given to AIM and USAID leaders and in a separate session, to AIM staff March 30th and 31st. The final draft report was submitted November 6th, 2006.

FINDINGS

A. Introduction to findings

The evaluation research presented here examines, first, the evolution of the program strategy starting from the original design as developed by CDC and USAID as well as the JSI technical proposal, second, the underlying "program theory" for the Program, third, the role of national level organizational development, and last, the team's assessment of selected elements of each of the five Program Objectives as stated in the Performance Monitoring Plan of 2005. With only 12 days available for field data collection, it was necessary to limit the team's focus to what was considered to be key elements of each PMP Objective as indicated in table 2 below[12]: The findings and analysis provide information relevant to answering Scope of Work question: *a) Did AIM achieve its overall goal and results* ***as outlined in the performance monitoring plan?*** [13] *What factors facilitated or hindered its achievement of planned results?*

[12] By choosing not to assess these elements, the report does not imply that the elements were not important, or that the AIM intervention was not successful. This applies to IEC/BCC effort by the AIM project, as well as to other elements not examined. Most analysts stress the need for continuing a high level of information, education, communication and behavioral change activities, especially when there is a high birth rate and half the population is fifteen years or younger.

[13] Emphasis added. The SOW focused the team's work on the most recent Performance Monitoring Plan Goal and Objectives. USAID advised the team that the Mid Term Review had covered management and other historical issues up through June 2004. In order to explain why certain results were achieved or not, the team did examine the original project design and subsequent changes in strategy.

TABLE 2: PROGRAM STRUCTURE AND COMPONENTS COVERED DURING EVALUATION

PMP Objective	Program Structure	Components covered in the Evaluation
1. Capacity of (all partners) to plan, implement and manage services at (all levels)	District capacity building	✓
	Conflict district HIV capacity	(Not accessible to evaluation team – security)
	District level IEC/BCC capacity	(See explanation)
2. Integration and Quality of intervention	Referral Network	✓
	Integrated IEC/BCC	
	Quality Assurance	
3. Access and Use of Prevention Services	PMTCT	✓
	IEC/BCC for prevention	
	Medical transmission	✓
4. Access and use of CARE and SUPPORT services	Palliative Care	✓
	OI/STI	
	TB	✓
	HCT	✓
	Lab	✓
	OVC	✓
5. Improved use of Strategic Information	District and grantee collection, analysis and use of data	✓
	M&E and reporting on results	✓
	Access to and use of data	✓

As noted above, one of the AIM efforts was the combined Information, Education and Behavioural Change (IEC/BCC) element that cut across three of the five objectives.

AIM had a Quality Assurance Program (QAP) that developed, printed and disseminated standard operating procedures for different HIV/AIDS program areas. For example AIM assisted the Ministry of Health (MOH) and the Ministry of Gender, Labor and Social Development (MOGLSD) to develop the HIV/AIDS/TB and OVC services operating procedures (toolkits). Interviews with key users of some of the toolkits that AIM produced indicated that the materials were of good standards and for that reason they were adopted by line ministries as indicated below.

A Senior Medical Officer, AIDS Control Program, MOH indicated that *"the VCT toolkit produced by AIM was good at that time and the Ministry of Health adopted and used it, however after using it for a while, as a Ministry we are planning to have it revised due to recent developments"*

An officer from a USAID Project that is supporting the OVC Secretariat in the MOGLSD indicated that *"the OVC care service guidelines that are in use were developed by assistance from AIM Project and adopted by the MOSLSD"*

The evaluation team was confident that to the extent that these two ministries adopted operating procedures developed by AIM, there is some evidence to support the reasoning that AIM's QAP did good things, at least from the two ministries point of view.

The team also did not assess AIM efforts in Conflict Districts for reasons of a continued security threat in those areas.

B. Changes in the Program strategy and key delivery systems[14]

The USAID SOW for this evaluation does not direct the evaluation toward an assessment of management and strategic program issues. These issues were covered by the AIM Midterm Review, conducted in 2004. However, for purposes of explaining some of the findings and conclusions reached by the evaluation team, it is necessary to know that while the broad program goals of the AIM program remained constant, e.g., supporting selected districts to "plan, implement and monitor decentralized core and ancillary services" and "strengthen the capacity of NGOs and CBOs to manage, plan and provide essential services at the national, district and sub-district level", the strategies, tactics and focus of the program shifted substantially over the 5 year life of program, resulting in a rather different program than that envisioned in 2001 implementation proposal submitted by John Snow International. Some of the "innovations" outlined in the Cooperative Agreement that were not realized are:

AIM program Proposed Innovations

- **Twinning Districts**

The original concept was to match up "ready to go" districts, i.e., those with strong local governments and basic HIV/AIDS services in place, with "underserved" districts. The purpose of this twinning was to facilitate transfer of skills and capabilities from one to the other. Originally, ten 'ready to go' districts would be selected through an assessment process and matched up with similarly assessed 'underserved' districts. By the end of the program, sixteen districts had been selected, all receiving more or less the same kind of technical and capacity building support.

The "twinning" innovation could not be implemented. The explanation for the failure to do so, according to JSI, was that when districts were "finally selected in the second year of the program, there simply weren't any that were ready to go"[15] After discussions with the project's Advisory Group, "the idea of twinning was replaced with the idea of CLUSTERS supported by an AIM team." In effect, AIM's regional staff would provide technical support and oversight to several "clustered" districts, a rather different concept. The discovery that the 'twinning' innovation would not work to build capacity in less developed districts forced AIM to adopt a different approach. In effect, the district clusters facilitated AIM project management, while still providing a means for building local capacity in the AIM districts.

- **Phasing Districts**

The technical proposal rejected the phased approach after consultations with Ugandan stakeholders, and chose a 'simultaneous rollout' with the basic idea of quickly creating a 'critical mass' of public, civil society and commercial private sector actors all essentially engaged in cooperation and coordination in implementing various aspects of a complex set of prevention, care and support interventions. As noted in the proposal "success….relies on three strong arms; district health officials, private sector members[16]

[14] All quotes and summaries in Section III. B are found in or interpolated from Attachment 2, the USAID-JSI Cooperative Agreement, op. cit. pp 10- 35.

[15] Memorandum prepared in response to the first draft of this report by AIM staff, 3 May 2006, p.2

[16] USAID commented that it understood "private sector members" to include both commercial and civil society. This may well have been the proposal drafter's intent, although in the literature, the phrase 'private sector' is not generally used to include the NGO community.

(commercial and civil society), and the District AIDS Committee (DAC). District support from health officials as well as other local political leaders is mandatory." [17]

By the end of the Program in 2006, there was little evidence of engagement of the commercial sector and district level political leadership engagement was more ad hoc than systematic.[18] AIM did provide training to DAT members and attempted to improve the institutional capacity of this element of the program. While DAT was intended to provide political leadership and coordination, in all the three AIM districts visited, there was no functional DAT in place. However, in Bushenyi district, the District Chairperson and the Secretary for Health were active as individuals in HIV/AIDS related activities but the leadership and coordination role of the DAT was less pronounced.

The proposal emphasized the critical role of the DAC stating "We view the establishment of a properly functioning DACs as the **cornerstone** of long-term sustainability of HIV/AIDS services in selected districts," and that DACs and private sector partners would have transition plans in place to ensure continuation of the various program elements as well as fund-raising capabilities for the civil society participants. As will be demonstrated below, AIM did strengthen DACs, and did secure the engagement of civil society organizations.

- **One Stop Service Centers**

The proposal refers to 'one-stop centers', whereby multiple services would be provided the results of which could be measured by locally determined achievable and measurable results. For reasons advanced below, this concept was dropped early in the project.

Based on explanation by USAID, the idea of 'one stop' services centers was abandoned very soon after the project started as it was unrealistic to expect the lowest level of Ugandan rural Health Center (HC III) to manage the delivery of a complex sophisticated set of services. Instead, selected health centers were designated and supported to provide six clinical services, but other social support services were to be provided by an array of project supported district level [19]civil society organizations. By 2006, 'one-stop' service centers were not visible. Program results data, as reflected in the program's PMP, was made uniform across all AIM districts, and whatever flexibility that remained to the DAC to set priorities and develop local information systems was largely submerged by the need for a standardized approach.

The original strategy provided for substantial flexibility to the DACs to determine, with some national priorities such as PMTCT and VCT, what the local priorities would be, how they would be measured, and how information would be managed. While DAC capabilities were strengthened, whether the

[17] In its comments on an earlier draft of this report, USAID wondered whether the team conducted any analysis to determine what commercial sector is available at a district level. Given the limited time available for field work, systematic data gathering and analysis on these questions was not feasible. However, the team did note the existence of private clinics in district towns, and was advised that even public health system doctors frequently managed a private practice in addition to their health post duties.

[18] AIM leadership asserts that of the three AIM districts examined by the evaluation team, only in Tororo was there serious problems of lack of coordination with the political leadership. "In both Arua and Bushenyi – DAC and DAT work harmoniously and DATs fulfill their coordination role fairly effectively." Memorandum prepared by AIM. Op cit, p2.

[19] However, after a debate, it was agreed that selected sites (i.e. district level facilities) would have a minimum of 6 services – as noted later in document. This replaced the notion of one-stop shop. It was decided because the reality is that it is not practical to have the majority of rural Uganda's reach all services in 1 facility at a district level – particularly community-based services, which are not offered through a clinic facility. Debate today even surges on the services need to be focused at sub-county level and catchment area; however, many clinical interventions are too sophisticated for HC III's and therefore a tiered and networked approach is critical".

"community empowerment" and "local need driven" aspirations articulated in the original plan were realized is the subject of subsequent findings, analysis and conclusions.[20]

- **Sub-granting**

Consistent with the core concept of community empowerment as realized through the DAC mechanism, the program intended that the DACs would receive a 'single grant', with which each DAC would establish funding priorities both to local MOH facilities as well as to local civil society organization through a sub-grant program.[21] JSI would be "responsible for oversight of funds provided to NGOs and CBOs. DACs will have a significant role in the identification and selection" of grantees, but would not make the grants directly; this would be JSI's responsibility. The projected schedule for grant disbursements was that grant making would begin in year 1, 'dramatically increase in year 2-4, with year 5 being a transition to 'other funding' year.

The 'single grant' concept did not develop as planned. The proposed schedule of grant making was not followed. It was replaced by a large number of one year grants to local organization made by AIM with input from the DAC. Although DACs did participate in grant reviews and monitoring, the extent to which DACs developed a sense of priority setting and allocation authority and power over budgets will be the subject of more detailed findings presented below.

A key feature of this grant strategy was that national level organizations such as The AIDS Support Organization (TASO) or Traditional and Modern Health Practitioners Together Against AIDS and Other Diseases (THETA) would be eligible for grants primarily by submitting proposals to the local DACs, with the exception of a "Special Fund" that might be accessed for all-Uganda developments.
By 2006, while capacity building for national organizations had occurred, the linkage between national and district "branches" had not developed for the most part. This will be discussed in greater detail below.

- **Strengthening Training and IEC for Capacity Building**

The proposal relied heavily on training at the district level and particularly on the creation of 'Training of Trainers (TOT)' in District 'centers of excellence' with 'twinned' districts working together. The proposal recognized that by 2001, a plethora of good training materials already existed in Uganda, and AIM would build on whatever existed. AIM did provide training to national level NGOS, and subsequently at the district level for government officials as well as NGOs and CBOs. AIM also produced policy guidelines, training manuals and a vast array of information and communications materials.

[20] This is an interesting issue – in reality you want your plans to be standardized. There is a NSF and HSSP and NOP for OVC that all partners follow. Technically, all of these issues should be in all district strategic plans. The flexibility should fall in particular priority areas and funding levels as well as how the districts managed and coordinated the response. This was suppose to be piloted by AIM; however, there was a national push to get the national coordination guidelines ratified, making it more difficult for districts and AIM to feel empowered to pilot what really might work best.

[21] We recognize that the DAC is not the only vehicle for community empowerment, but our reading of the original proposal is that the DAT/DAC structure was to be the primary means by which this would occur. The team's reasoning is that the DAC was, in theory, a public-private priority setting, coordinating and monitoring body the empowerment of which would give substantial voice to the entire local level community with respect to the HIV/AIDS issue. We see local government, elected and appointed, as well as civil society leaders as a critical part of the process.

- **Summary of Changes**[22]

Major elements of these 'four innovations' did not materialize, including district twinning, one stop centers, centers of excellence or the pre-eminent role of the DAT in deciding on District priorities and resource allocations available through AIM. The projected schedule of grant making was not met. Very few grants were made in 2001 or 2002. It was late in FY 2003 and well into 2004 before the grant making process developed real momentum.

C. Theory of the Program assessed

Every project has a more or less explicit theory of change that underlies the activities and interventions which are designed to achieve some observable, hopefully measurable result in terms of expected behaviors, organizational capacities, policies, and revamped institutional structures and processes. As stated in the JSI proposal, the AIM Program's underlying theory of change was not explicit, and many assumptions were made that, in retrospect, were faulty or at best naïve.

A careful reading of the technical proposal, however, permits a plausible reconstruction of the basic theoretical elements of the AIM Program. It is important to understand these, for very often projects that do not do as well as expected are not a function of weak management or sloppy implementation, but are rooted in inappropriate theoretical propositions and assumptions. When this happens, even the best, most efficient and energetic management team may be unable to overcome some of the structural constraints that were assumed away during the project design phase.

AIM Program Theory

Listed below are what appear to be some of the key elements of the AIM program theory:

- The *integration* of services and support would provide for more effective and efficient delivery of quality HIV/AID services to local populations.
- A comprehensive approach to increasing access and utilization would result in substantially expanded coverage and, ultimately in reduction in HIV incidence, as well as improving medical and life support systems to PHAs and their families.
- The district level was the key point in the Uganda government and social structure where effective integration and management of services could be done.
- A wide array of relatively short training programs would be a key ingredient in raising capacity and producing 'empowerment'.
- A combination of funding streams, including AIM direct expenditures, grants to local government, and proposal based competitive grants to a variety of CSOs would, with training, produce the expanded capacities necessary for increased access and utilization of HIV/AIDS services.

[22] USAID's comment on this summary is that USAID "discovered that this was not a viable idea – didn't really have many indigenous organizations at each district to serve this role – was not researched before trying to implement," The team concurs with this observation. Indeed, one of the principle conclusions of the evaluation is that the original design as set out in the official proposal submitted by JSI and accepted by USAID is that there was very little prior 'ground proofing' of the concepts and innovations that AIM was to introduce. As noted throughout this section, changes had to be made to restructure the project to better fit with the realities of the Ugandan health system environment. On the one hand, the recognition that change was necessary is laudable and reflects considerable thought and discussion. On the other hand, it is difficult to sustain the idea that AIM was a 'pilot' program designed to test a certain approach to delivering services when the project was undergoing almost constant revision, as will be seen in subsequent sections of this report. A more difficult question which we do not attempt to answer is why this original design was accepted in the first place.

- It was possible to 'test' a model of integrated, comprehensive HIV/AIDS services in a five year program in 16 districts in Uganda.
- By the end of the program, there would be enough empirical knowledge about what worked, what did not and why to inform a scaling up of the model, or effective activities to all Ugandan districts.

This theory depended on several assumptions.

- That there would be sufficient stability in Uganda and in the donor community to permit a "model" to be tested over a five year period.
- That there was sufficient consensus among all stakeholders as to what the "model" actually entailed.
- That existing government and non-governmental organizations at the national and particularly at the district level were sufficiently well developed to be an adequate platform for mounting a highly complex, integrated activity.
- That the process of implementing (testing) the model was essentially a technical and management challenge,
- That political leadership and governmental structures would fully commit to and support the district integrated delivery model
- That building capacity is the same as empowerment, or will lead to empowerment.
- That other funding would become available at the end of the five years to sustain the heightened level of activity and capacity promoted by the program.

As will be further explained, many of these assumptions turned out to be weak given the time frame of the program, and the pressure to ramp up both disbursements and coverage in the last two years of the program's life further undermined the capacity building and empowerment strategy in the original program design.

D. Managing Complexity

The JSI technical proposal, depending on how one categorizes the various activities, projected AIM development and technical support and training for some thirty six different core and ancillary services and interventions under five different objectives. These included addressing micro-finance and income generating activities, home based care, an array of general and education system interventions, as well as five different testing and treatment regimes. AIM also was active in condom delivery, and, late in the Program, distribution of prophylactic drug Co-trimoxazole (Septrin).

To manage this range of interventions without any effort to 'do development' would require enormous discipline, stability, leadership and skill on the part of the implementing partner, John Snow International. But to manage and be accountable while at the same time attempting to build capacity and empower national ministries, NGOs, as well as 16 district DACs, and local NGOs, CBOs, FBOs, in a coordinated, comprehensive prevention, care and support system was, in hindsight, a Herculean task that could not be successfully mastered within the time frame allowed.

By the mid-term review (MTR) in June 2004, AIM had not been able to make many grants at the local level and was slow in dispersing funds. The program of capacity building seemed to be stuck at the national level. There was a substantial backlog of grant applications, and, according to the MTR, the program lacked vision and coherence. Elements of the original design had already disappeared, and the

assumptions about moving quickly with 'ready to go' districts turned out to be wrong. A careful reading of the MTR would suggest a Program on the verge of collapse.[23]

Impact of PEPFAR

Some of the factors contributing to this difficult situation could have been foreseen, some not. Originally funded by USAID and CDC, the $19,992.239 million dollar agreement was doubled in 2002 with resources from the LIFE Initiative. Although the JSI proposal contemplated operations in 16 districts, the concept of district twinning no longer applied. Basically, the additional resources were to be applied to building educational outreach, diagnostic and testing services, and HIV/AIDS care and support to the 16 selected by the Government of Uganda.

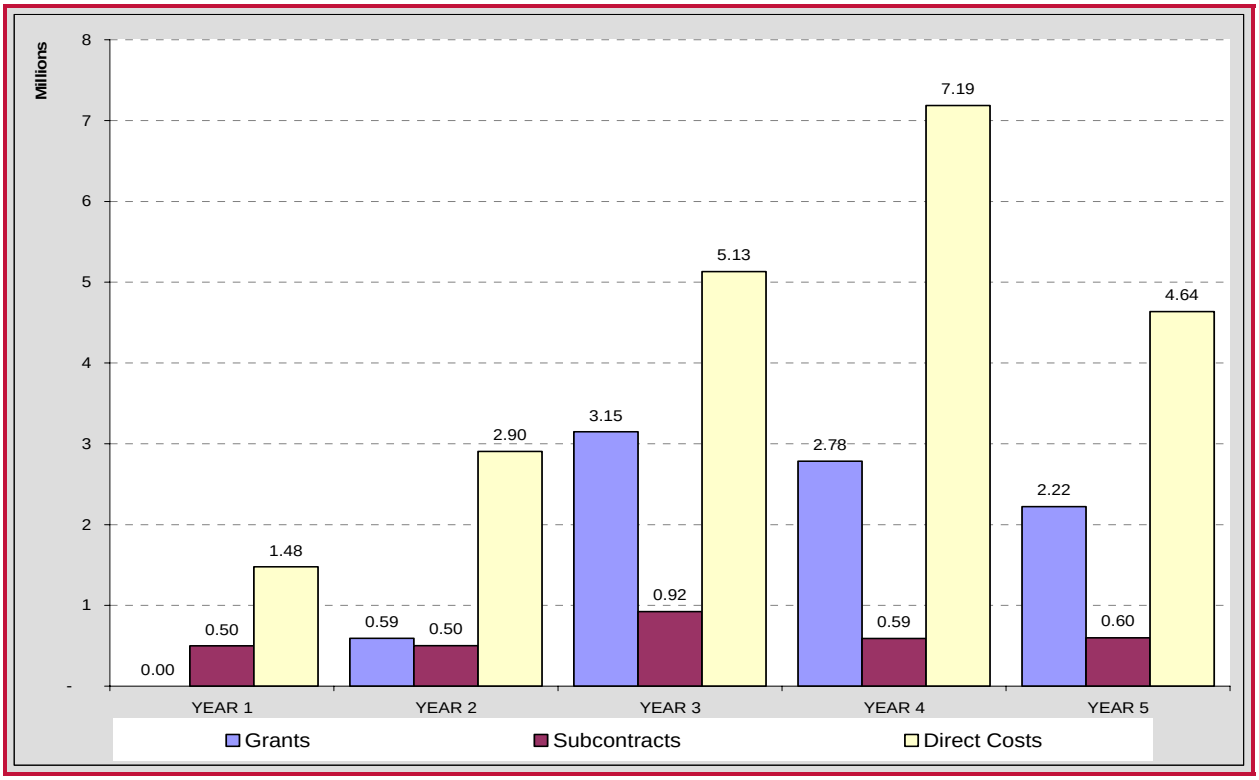
PEPFAR imposed a number of changes 1) the PMP under went changes a number of times to reflect PEPFAR program areas and results reporting requirements. 2) Program area focus changed to reflect PEPFAR program areas. For example a lot of prevention and community work that did not directly feed into PEPFAR was scaled down. AIM focused more on identifying HIV positive people and providing them with support than doing preventive work. Grantees involved in these areas were either dropped or asked to focus on PEPFAR areas" 3) when CDC funding stopped, AIM had to drop the CDC indicators that were more research oriented. The implementing partners in John Snow International asserted that these types of changes affecting program areas, indicators, reporting cycles and formats can in no way be considered minimal [24]

The difficulties outlined above, including responding to PEPFAR reporting, disagreements over program emphasis, the continual evolution of the Performance Monitoring Plan, and the 'discovery' that some of the original assumptions of the program did not conform to Ugandan realities made adjustments difficult and time consuming. This contributed to additional delays in the implementation of the program, while pressure continued to mount to accelerate spending with roughly two years, 2004 and 2005, left in the program.

[23]For example, the MTR states: "The programme lacks clear vision and has found it difficult to strike the right balance between building capacity and expanding service coverage. These problems reflect a failure to implement the original programme design….there is a significant gap between this and actual implementation, and the program failed to put into practice many of its original ideas. The programme also lacks clear conceptual thinking. AIM is not able to articulate clearly what it means by a model district' or how achievement of this will be measured." MTR, p 13.

[24] According to USAID, PEPFAR requires very basic reporting that all projects/activities should be capturing regardless including numbers reached, number of sites supported and the number trained. Some definitions required modification and this needed to be filtered down to the grantees, but overall, the PMP did not require substantive changes. The PMP was an ongoing evolution. The biggest challenge with PEPFAR was the changes in reporting times, i.e., AIM was working with the GOU planning cycle, USAID's fiscal and annual cycles, and then PEPFAR, which did not align with either of these – thus providing multiple sets of targets depending on the reporting period. It took existing USG funded projects under PEPFAR some time to figure out how to project targets across different periods, and how to draw upon different reports, i.e., USAID, PEPFAR.

FIGURE 1: AIM PROGRAM ANNUAL GRANT AND DIRECT PROGRAM EXPENDITURES



Note: The figure indicates substantial grant making activity in FY 2003. The Mid-Term Review report states that there was a backlog of grant requests which was not cleared until the end of FY 2003. Many grantees did not receive funding until calendar year 2004.

When the MTR report was released in June, the third Chief of Party was brought in by JSI, a retreat was held in September 2004, and a new, or some would say, return to the key parts of the old, strategy was put in place. But with 18 months remaining, the effort to build DAC and local civil society organization capacity was attenuated, while the pressure to make grants had the unintended effect, according to DAC interviews, of sidelining the goal of empowerment and substantial DAC authority in deciding on resource allocations.

E. Stability in building core services

Although the idea of integrating a hierarchy of activities and services provided by one-stop centers and satellite sites did not work out, the array of services that were supported did remain constant, sometimes with changes in name. Organized into two broad categories of Prevention and Care and Support, these were:

- Education and information program focused on awareness and prevention.
- HIV information and education programs by CBOs at the district level
- Voluntary Counseling and Testing (VCT) and routine Counseling and Testing (C & T)
- Pregnant Mothers Testing, Counseling and Treatment (PMTCT)
- Laboratory Upgrading

- Opportunistic Infection Management
- Tuberculosis Detection and Case Management
- Orphans and Vulnerable Children support (OVC)
- Community Home Based Care (CHBC)
- People Living with AIDS (PHA) support

Technical support, acquisition of equipment, as well as policy and guidance development, training and most of the responsibility for grant making and financial management for the Program was lodged in the AIM Program office in Kampala. AIM developed a standard set of inputs in each service area, including training, technical assistance, policy and guidelines development, infrastructure support, procurement and logistics, materials development, operational support and information/education/communication activities to promote behavioral change (IEC/BCC) After 2004, the AIM regional centers staffed by Ugandan experts played an increasingly important role, and in some cases an essential role in moving the Program forward toward measurable results for each of the key services envisioned by the original Program design.

F. National Level Organization Role

Whether national level organizations would have an actionable role in the implementation of the model, or whether they would be coordinating partners in some way was not made clear in the original JSI proposal. The primary emphasis was on the DACs. As stated: "The goal is to strengthen the capacity of DACs to be effective players in the management of decentralized health service delivery." AIM was to build "…skills of committee members in problem analysis, prioritization, planning, coordination and accountability by having them …develop a district health action plan." AIM would support HIV/AIDS core and ancillary services, the "range and type of (such), as well as the process of expanding services …to the sub-district, county, parish and village level will be determined by individual DACs".

For many of these activities, the JSI technical proposal listed, without much strategic discussion as to just what these organizations' role was to be, a number of Ugandan national level NGOs, including AIDS Information Centre (AIC), TASO, THETA, Islamic Medical Association of Uganda (IMAU), National Community of Women Living with AIDS (NACWOLA), Uganda Women Efforts to Save Orphans (UWESO), and Foundation International Community Assistance (FINCA). These were identified as 'partners'. Much of the first year of the Program was focused on capacity assessments, capacity building and management consulting with these and others.[25] Through a program called the Joint Institutional Assessment (JIA),[26] AIM provided capacity building training, key materials, and organizational development consultations with twelve national organizations which were stakeholders in the HIV/AIDS effort. . In addition to five weeks of training on such issues as strategic planning, financial management, and human resources, each organization received specialized help in key areas of concern. For example, the National Community of Women Living with HIV received help in developing a strategic plan and a financial management policy. As the umbrella organization for HIV/AIDS service organizations, UNASO received both Trainers and Participant Manual/Guides in Strategic Management, Human Resource Management, and the like, as well as a Generic Training of Trainers Manual.

[25] See Appendix E for a list of Ugandan national level organizations that received organizational development support from AIM.

[26] In reviewing the working draft, USAID observed that "the entire basis of the AIM program evolved from the need to expand proven activities mostly from the following national NGOs to other regions and in a comprehensive manner…" This may be so, but this 'entire basis' was not set out as a well developed strategy in the JSI proposal, nor was it realized in the subsequent district level grant program.

The key purpose of the JIA effort was to build strong national organizations which would, in turn, strengthen their respective branches at the district and community level.[27]

Evaluation interviews with seven of the AIM national level grantees produced several findings:

1. All but one of the grantees valued the organizational development support they received from AIM, while one stated that it was redundant and too elementary for their already well structured organization.

2. One grantee said that AIM intervention saved their organization from collapsing altogether. Others found most of the efforts useful, but not critical to their survival. UNASO especially valued the development of the various training manuals and guidelines.

3. All of the organization leaders expressed frustration and puzzlement about why AIM did not continue to work with these organizations after a year or so of intensive interaction during the early stages of the AIM Program. They expected to become implementing partners. Instead, according to one, "our district branches began to receive grants directly from AIM, and we didn't even know about it." Another said that they had reserved four district networks, loosely affiliated with the national organization, for AIM support in 2002, but it wasn't until 2004 that any grants were actually made. "We almost lost our local affiliates" said the Director. Many NGO leaders interviewed were disappointed that there was no real AIM follow-on program after the capacity building phase.[28]

4. Not specific to AIM alone, all voiced concerns about the parallel and special reporting requirements imposed by various donors. One organization, not an AIM grantee, but a very major actor in the HIV/AIDS arena, stated that they no longer prepared individualized reports to all donors…putting in place a 'basket of funds' approach with one report to all funders. Other informants said they would like to do this, but some major donors would not accept this approach.

In addition, AIM did see the need for and did work closely with several ministries, especially the Ministry of Health.

1. Interviews with Ministry of Health, Ministry of Local Government, and the Ministry of Gender, Labor and Social Development, valued the assistance of AIM, especially in the realm of providing technical assistance, in some cases direct participation in the writing of national guidance policies, related manuals and field guides, and in engaging national and district level linkages in working out problems of coordination and management of the complex array of interventions in the "model" districts.[29]

2. MOH officials raised some concern whether there was too much emphasis placed on developing Civil Society Organization (CSO) capacities, especially for even low level services, i.e., prophylactic distribution, HIV/AIDS and related OI care. One even suggested that some national NGOs, as advocates for priority treatment of the HIV/AIDS epidemic, had developed a vested interest in the epidemic, and the high levels of foreign donor support it

[27] Memorandum prepared by AIM staff for the Evaluation Team, March 2006, "JIA in a nutshell".

[28] USAID comments that UWESO and THETA, two prominent national level organizations, did receive additional support from AIM. This was acknowledged by one, who also said that the follow up grant making was so slow in coming that the linkage between the national and the local organizations suffered.

[29] See Appendix F for a complete list of Policies, Guidance and Manuals produced with the assistance of the AIM Program. In several cases, these were authored by AIM staff, and approved by the relevant Ministry.

had attracted.[30] If these views are widespread in the Ministry, it suggests that there may be tension between the Ministry's view of how resources should be used to manage the HIV/AIDS issue. As health professionals, some Ministry officials may have been reluctant partners in an integrated and comprehensive scheme that assigns a significant role to CSOs beyond education and social services.

In a statement echoed by several other doctors in the health system, HIV/AIDS was described today as a serious 'chronic' issue, but not the highest Uganda health priority. The reasoning behind this statement, according to interviews, is that Uganda's information and education campaigns had worked, along with better diagnostic and clinical treatment. Now, it is possible to maintain reasonable health levels for Persons Having AIDS (PHAs), and, among many areas of the country, the HIV/AIDS prevalence rate had declined to below 5%, while some were above the national average of 6.4%, which meant that 'one approach' no longer fit all situations or regions.

This reasoning was found at the national as well as at the local level. Whether factually correct or not, it does suggest a disconnect between the priorities of MOH officials and working doctors, and the priorities of the international donor community. The next point in this argument, outlined below, provides a possible insight into MOH priorities.

1. All Ministries voiced concern about the relative weakness of their District and sub-district health and social services sector capacity, staffing and budget. High turnover, difficulties in keeping highly trained doctors and technical staff in remote areas, lack of budget for all but the essentials, and other factors contributed to government structures that were limited in their ability to take on many new functions or reporting tasks. Yet this is exactly what AIM and other foreign donor programs require. As one official put it, "how can you expect under staffed and under budgeted organizations to take on all these requirements? There must be structural reform and basic capacity building if the system is work up to standard."

G. Macro Level Comparisons between AIM and All Other Uganda districts

The AIM Program covered sixteen Ugandan districts representing more than thirty percent of the population. AIM districts differed somewhat from "All Other[31]" districts in that they were less densely populated, less urban and somewhat less literate A striking difference was that the male/female ratio for AIM districts was substantially lower than All Other or the national average. This suggests that male out-migration was occurring in AIM districts.

[30] In many countries lacking a long tradition of self help through CBOs and NGOs, tension does develop between the private non-governmental organization sector and government service organizations when NGOs, often with foreign help, develop advocacy programs as well as government or foreign donor funded service delivery programs for needy sections of the population. Ministry officials see themselves as the 'professionals' and NGOs as 'amateurs' not really competent to deliver complex care. Moreover, the NGOs and CBOs attract donor funding which might otherwise go to strengthening Ministry structures and programs. See, for example, USAID Armenia reports, The Armenian NGO sector, MSI 2001-2003.

[31] For purposes of this comparison Kampala district was excluded from "All Other" districts since it was considered to be an outlier.

TABLE 3: AIM DISTRICTS COMPARED TO ALL OTHER DISTRICTS: SELECTED SES INDICATORS – 2001–2005

	AIM districts	All other Districts	National
Population Size[32]	7,939,232	17,781,300	27,207,600
Population Density	154	170	126[33] (303)
Literacy	10.5	9.8	10.8
Urbanization[34]	7.3	7.8	8.9
Gender ratio m/f[35]	90.9	98.7	97.5

Using available data from the Ministry of Health, an attempt was made to compare AIM districts to All Other Districts on some key indicators used by the AIM Program to measure progress towards results. Indicators included HIV/VCT Intake, HIV/AIM Prevalence levels and OVC data. This attempt was only partially successful. As seen in Table 4 below, data was available at the district level for only four indicators: PMTCT intake, TB detection, TB treatment and Timely Health Management Information System (HMIS) Report submittal. These data were configured as a percent of the population to make them comparable.

TABLE 4: AIM DISTRICT RESULTS COMPARED TO ALL OTHER DISTRICTS – 2001 AND 2005 (OR LATEST)

	AIM districts N=16 Total	All other Districts N = 40[36] Total
PMTCT Intake[37]	41,548 (0.52%)*	91,561 (0.51%)
TB detection rate[38]	41.3%	44.4%
TB success rate	78.3%	70.2%
Health units submitting HMIS returns timely[39]	85.3%.	83.8%

* As a population percentage

From this data, AIM districts perform about the same as All Others on PMTCT intake, less well on TB detection, but better on treatment of TB. AIM district health units were somewhat better in submitting HMIS reports on time. Unlike palliative care, CT and PMTCT and now ART more recently actually have strong national programs supported by UNICEF and other donors. The data in Table 4 may reflect these programs.

Given the Government of Uganda's emphasis on promoting local government planning and implementation capacities, and the AIM Program's major emphasis on developing district level capacity for planning and managing an integrated HIV/AIDS programs, it is surprising that critical results indicators are not disaggregated at the district level. The Mid-term review made the same observation,

[32] Based 2005 mid year projections (Statistical Abstract 2004, UBOS)
[33] National population density is given as 126 persons per square km, however taking district average results into 303. It is possible that area under water/swamps may not be included in the district areas thus pushing up the computed national level density using district densities.
[34] Percentage of population living in the urban centers
[35] Number of males per 100 females
[36] This is based on 2004 District list
[37] Based on 2004 data MOH (Number of pregnant mothers tested)
[38] Based on 2005 data
[39] Based on 2005 HMIS MOH

stating that 'without improvements in the availability of district data, it will be difficult for AIM or districts to set appropriate coverage targets or monitor progress." [40] The most credible recent prevalence survey, the National HIV/AIDS Behavioral Sero-Survey conducted in 2004/5, does provide some data at an artificial sub-regional level, but does not report data disaggregated to the district level.

H. Performance Monitoring Plan Objectives: Findings from the districts

These findings are presented below according to the order of the objectives presented in the AIM Performance Monitoring Plan as approved by USAID. Because the PMP is such an important tool for monitoring progress, the team first presents findings about the PMP. Next we present each PMP Objective, selected AIM Measures, and the AIM Results figures as reported in the FY 2005 Annual Report. An evaluation team composite ratings table is presented, showing the consensus ratings provided to each AIM and comparison district visited for that Objective and PMP Results Measure, for those Measures where it was possible for the team to make observations and collect data. For many results, such as VCT intake, the PMP aggregates data from all districts into a single program level figure. The team was unable to confirm these data at the district level and accepts them at face value. Following the composite ratings tables, the team presents findings about achievements as well as identifying issues and concerns.

Performance Monitoring Plan: Findings

USAID places great emphasis on Performance Monitoring Plans. The PMP is the principal formal tool for managers to monitor progress and to make adjustments if needed. USAID, its implementing partners, and consulting experts devote significant amount of time and thought to developing a PMP that, where possible, can produce good quantitative data on the activities progress toward achieving expected Intermediate Results and the main Objectives of the project. With PEPFAR funding, AIM realigned its PMP measures and indicators to integrate additional PEPFAR measures. Although the majority of the PMP indicators were already in place, according to USAID, JSI respondents indicated that PMP indicator guidance changed six times from 2002 to 2005, requiring constant adjustments to the data collection and reporting process. More important, according to JSI respondents, is the impact these changes had on three areas of the program many considered critical to achieving impact as illustrated in Table 5.

The AIM approved Performance Monitoring Plan

AIM met or exceeded most of the Intermediate Results targets as approved in the PMP of 2005/2006. Each of the five IR Objectives states the necessary qualitative improvements necessary to achieve the goal, including strengthening capacity, increasing integration and quality of services, and access and utilization of services and care, and, last, access to and utilization of strategic information. For these five objectives there are thirty two indicators and corresponding measures. Many of the indicators/measures focus on quantitative outcomes. For example, for Objective 2, Increased Integration and Quality of Comprehensive HIV/AIDS intervention at District and Sub-District level, the first measures is the number of Hospitals and Health Center IVs that *provide* 6 clinical services. The AIM Performance claim is that 100 percent of these units '*will have capacity* to provide a combination of 6 clinical services.' Another Performance Measure for this Objective states that all Health Sub-Districts will have a 'functional referral network'. The AIM claim is that by the end of the project, 52 networks will be functioning.

[40] Mid Term Review, p 8 and *passim*

TABLE 5: EFFECT OF PEPFAR ON AIM CORE PROGRAM AREAS

Original AIM Core Areas	Part of PEPFAR Program Areas	Program Area scaled down/ re-focussed
1.Voluntary counselling and testing (VCT)	✓	
2.Targeted prevention efforts for populations that are at risk		✓
3.Clinical care including prevention and treatment of Opportunistic Infections (OI's)	✓	
4.Clinical care including prevention and treatment of Tuberculosis (TB)	✓	
5.Community and home-based care of HIV/AIDS	✓	
6.Mother to Child Transmission of HIV prevention (PMTCT)	✓	
7.Orphans and Vulnerable Children (OVC) interventions	✓	
8.Adolescent friendly/appropriate services		✓
9.Sexually Transmitted Illnesses (STIs) management		✓
10.Laboratory capacity	✓	

The team found that the PMP indicators, measures and claims, although largely met in quantitative terms, did not capture the qualitative dimensions of 'functionality or improvements in quality of services' as might be measured, for example, by systematic client exit surveys. Most of the results indicators have measures such as number of personnel with enhanced skills, or number of labs refurbished. For Objectives 3 and 4, where utilization is stressed, of the 30 separate PMP measures, a generous assessment yielded eleven indicators that measured utilization in quantitative terms, and of those, perhaps four could be accepted as measuring results defined as something close to **impact**. A good example of an indicator that actually assesses results as **impact** is PMP measure 9 for Objective 3: Percent of HIV+ women completing course of ARV for PMTCT. Here the PMP claim is 36 percent against a target of 60 percent in 2005.

The introduction of PEPFAR funding in the middle of the AIM project added an additional set of global PEPFAR indicators that were not easily integrated into the existing PMP. The result is a very complex PMP with thirty two separate indicators organized under seven Intermediate Results and Five Objectives.[41] The team was unable to estimate the time and effort that went into developing the PMP, developing data collection formats, training people to use them, collecting, assembling and organizing the data, as well as presenting the data to USAID and other readers in a format that would be useful to managers and planners.

Assessment of Selected PMP Measures

In this section, we evaluate the results of the AIM project against the PMP Objectives and selected measures as explained above. These results are compared with the performance of comparison districts, using the same measures.

[41] According to one Ugandan source familiar with the AIM project, the original AIM PMP had 46 indicators derived from USAID, CDC and to some extent, JSI.

PMP OBJECTIVE 1: Strengthening the Capacity of Government, NGOs, CBOs, FBOs and Private Sector to Plan, Implement and Manage Integrated Services at the National District and Sub-district levels

***Intermediate Result**: Strengthening the Capacity of Government, NGOs, CBOs, FBOs and Private Sector to Plan, Implement and Manage Integrated Services the National District and Sub- district levels.*
Performance Measures Examined by Evaluation 1. *Number of AIM supported Districts with a functional official District level HIV/AIDS coordinating body in place.* 2. *Number of AIM supported Districts that have developed comprehensive and multi-sectoral HIV/AIDS strategic and annual work plan as part of the District development plans*
***PMP Claim**:* *By Sept 2005, 16 Districts had DAC and 16 had Multi-sectoral Strategic HIV/AIDS Plans*

Table 6 presents the evaluation team's consensus ratings for each major dimension of DAC performance by AIM and Comparison districts.

TABLE 6: DAC PERFORMANCE AND MANAGEMENT RATINGS IN AIM AND COMPARISON DISTRICTS

Area rated	AIM DISTRICTS				COMPARISON DISTRICTS			
	Tororo	Arua	Bushenyi	**Total**	Iganga	Moyo	Kiboga	**Total**
Capacity to plan	2	3	3	**8**	3	1	0	**4**
Integration of DAC Plan in DDP	1	2	3	**6**	1	1	0	**2**
HIV plan implemented	3	3	2	**8**	3	1	0	**4**
Monitoring being done	2	3	2	**7**	2	1	0	**3**
Score	**8**	**11**	**10**	**29**	**9**	**4**	**0**	**13**

Score Key:

0: Not functional or not available
1: Minimally operational with many problems
2: Moderately operational with a few problems
3: Fully functional

The consensus rating clearly demonstrate that the DACs in AIM districts had developed planning and monitoring skills and processes to a much greater degree than in comparison districts. The possible exception to this is the integration of the DAC plan into the more general District Development Plan (DDP) which is the primary framework document for all district level government activity planning, although AIM districts performed better here than did the comparison districts. The difficulty with integrating the two plans derives from the fact that the DDP is on a three year cycle, while the HIV/AIDS plan is based on a five year cycle, which does not align well with either end of the DDP. Regardless of the AIM intervention, it was not possible to integrate the two documents. The evaluation team compared the two documents and found that the HIV/AIDS plans were not integrated into the district plans. This finding raises questions about the longer term sustainability of a separate HIV/AIDS planning process.

DAC Capacity strengthened

The relatively higher performance of AIM districts appears to be a function of AIM training and technical assistance inputs. The district evaluation teams found that AIM provided training to DAC members in each district regarding their roles and responsibilities. AIM managed to transfer skills to the DAC in the five key roles as stipulated by the UAC guidelines.[42]

AIM contributed to capacity building in Districts by placing emphasis on collaboration with CSO service providers. Most AIM supported Districts developed closer working relationships with CSOs and District authorities. Specific capacity building interventions included: training DAC and grantees on roles and responsibilities, Monitoring and Evaluation, Planning, Training Of Trainers (TOT) and supported training in the Program core areas. In addition to training, AIM provided technical support to DACs and AIM regional staffs were involved in supporting DAC activities. The level of monitoring and supervision by the DAC in AIM supported districts was more frequent with wider coverage than in the comparison Districts. Quarterly meetings were held and this enabled stakeholders to share information, lessons and to improve on their subsequent interventions as observed by some district key informants.[43]

Districts had different levels of engagement in the roles and responsibilities as seen in Table 7 below:

TABLE 7: AIM DISTRICT DAC ASSESSMENT

Role	Arua	Bushenyi	Tororo
1. Planning	3	3	3
2. Monitoring	3	3	2
3. Evaluation	0	0	0
4. Information sharing	2	2	1
5. Tracking resource use	3	3	3

0: No engagement *1: Minimal engagement*
2: Moderate engagement *3: Full engagement*

Planning

Through AIM grants and training, the DAC participated well in drawing up strategic, annual, quarterly and monthly planning in all districts. The DAC benefited from the close support and collaboration provided by AIM regional office staff, many of whom were public health professionals.

AIM supported the Districts to conduct a situational analysis which enabled the DAC to focus on HIV/AIDS service needs. AIM worked with the DAC (to coordinate members) and to redefine critical interventions after the midterm review. DACs ensured that services reached underserved areas in their respective Districts, reduced duplication and provided monitoring to partners implementing HIV/AIDS programs in their respective areas. This made smooth adjustments in implementation possible. DACs did monitor implementation of programmes by CSO and government grantees. AIM supported partner districts to develop directories of service providers that will be useful in harmonization and partnerships.

[42] In this section, we do not assess Comparison districts. It is likely that Comparison districts would score much lower on most of these factors.

[43] The personalities and the degree of efficiency and probity by which business is conducted by local officials varies a good deal. A small sample of three districts may distort generalizations to the universe of 16 districts with which AIM worked.

All AIM supported Districts developed five year comprehensive HIV/AIDS strategic plans and they were current with involvement of key stakeholders and almost all sectors. The DAC was initially trained on HIV/AIDS strategic planning and District HIV/AIDS five year plans were developed in workshops with input from key stakeholders.

> *DAC for example, reviews the proposals submitted and recommends to AIM program which ones should be supported, monitors how the grantees are using the grants to ensure the money is used for the purposes for which they had been given and draws HIV/AIDS plans and reviews them often to ensure that priority areas of HIV/AIDS are addressed by the plan.* **DDHS Bushenyi.**

Monitoring

In all the AIM districts visited, the grantees had been supervised by the DAC at least once. The DAC members also confirmed that they carried out support supervision. The grantees regularly submitted activity reports to the DAC and AIM regional offices although in some cases DAC was not provided with the reports, which was the responsibility of the CSOs. Capacity was built in the DAC and CSO's to monitor HIV/AIDS interventions. Due to the wide range of activities, the DAC formed working committees to supervise and cover the technical areas. This initiative was not seen in the Comparison districts.

AIM provided grants to DAC to carry out monitoring field visits to grantees. On the HMIS, AIM trained staff and provided grants to improve HMIS data handling, through fuel for supervision, allowances, computers, software etc.

In Tororo district, monitoring visits were made but the information collected was not very useful, according to interviews with DAC members. The 'monitoring visits' were described as perfunctory; serving the purpose of making sure the CSO was actually functioning.[44]

Evaluation

All districts reported that they had just received the new National Strategic Framework for M&E –and had not yet started implementation. However, at the time of this evaluation, there was no indication that any evaluations of any of the programs instigated and supported by AIM were planned by the local DACs.[45]

Information sharing

Representation of the various district departments in the DAC was good and there was good information sharing between the different DAC members. Most of the DAC members were delegated by their heads of Department. Vibrant district level CSO Association/Networks (supported by AIM) provided a forum for dissemination of the information from DAC to the represented CSOs.

[44] The process of monitoring, usually conducted by some official body with oversight responsibilities for a program, can be quite productive for mutual learning. It can also be done simply to meet a formal requirement, and in some cases, as a punitive exercise. CSO respondents in Tororo could not provide the team with evidence that DAC monitoring had been helpful.

[45] USAID comments on the first draft noted: "however, there are no guidelines for implementing at district level. The National Monitoring and Evaluation Framework has not been operationalized."

Tracking Resource Use

AIM trained the DAC/T members in monitoring the use of resources by grantees. This also applied to the MAP project grantees, although these were addressed in separate meetings. DAC monitoring however was limited to the grants provide by the projects.

DAC Empowerment

The team views empowerment to mean a combination of improvements in the following characteristics for the DAC: i) access to information, ii) inclusion and participation, iii) implementing institutions accountable to DAC and iv) DAC organization capacity. The question therefore is, to what extent did AIM influence the change in these characteristics as far as DAC is concerned?

Through the support to HMIS AIM improved the range and quality of information generated/accessed regarding HIV/AIDS activities in the districts, which was reported as being used by the DAC especially in planning.

DAC participated in reviewing AIM supported proposals and the core five responsibilities indicated in the UAC guidelines. Though there was some improvement in DAC's actual influence over many of the activities, the team did not get a sense of the DAC having more than an initial screening and advisory authority. Inclusion of most CSOs was achieved through representation.

Most of the implementing institutions were not under the DAC control nor accountable to it. Only the CSO and Government departmental activities which had given grants through DAC were actually accountable. DAC control was limited to those activities funded by AIM or MAP. There was little indication that accountability will remain after cessation of the grants through DAC.

DAC organizational capacity was improved especially in the technical aspects (assessing grantees, supervision and technical planning). However, the team was unanimous in the view that leadership capacity was not very well built. Most DACs were comprised of mainly delegated members; linkages with the lower level coordination structures were not developed. In some cases, extra structures were developed at HSD level because the sub-counties had not been formed. For example, Ad Hoc committees of service providers were formed and funded by AIM. The mandate of these committees was to ensure improvement in services delivery at levels lower than the HSD. This weakens the multi-sector interface between district and sub-counties which is recommended by UAC, and used by all sectors other than health.

The recording and reporting system used was directly linked to the AIM specifications of indicators and this may not continue when the project ceases.

DAT engagement and empowerment

The evaluation team found that AIM provided training of DAT members in each district regarding their roles and responsibilities. However, the DAT did not become fully operational and the members were simply involved in routine DAC activities. Table 8 shows the five standards by which the evaluation team assessed the functioning of the DAT in each of the AIM districts visited.

TABLE 8: DAT EMPOWERMENT MEASURES (AIM DISTRICTS ONLY)

Role	Arua	Bushenyi	Tororo
1. Advocacy	I	I	0
2. Political guidance	0	0	0
3. Strategic planning	0	0	0
4. Partnership development	0	0	0
5. Social mobilization	I	I	0

The team was informed by AIM, that empowerment of the DAT was difficult under the roles assigned to them in the UAC guidelines. There is consensus among the evaluation team that the DAT was not functioning in the 3 AIM districts visited. Individuals DAT members like the Chairman of LC V and Secretaries of Health carried out some advocacy and social mobilization work but this was not a systematic plan by the DAT. This could not be considered as engagement of DAT.

Issues and Concerns

> *"Integrating HIV/AIDS in the District programs has been very slow. People talk about it sentimentally but on the ground things are very slow"*
>
> **District Chairperson, Tororo**

Coordination between National and District levels

There did not appear to be strong linkages between national NGOs, and to a lesser extent, national ministries and the various entities charged with carrying out different elements of an integrated program at the district level. For example, Umbrella PHAs and other national organizations are not representative of those at lower levels. Interviews with national level NGOs in Kampala indicated that apart from their own efforts, AIM did not facilitate strong linkages after the second year of the project.

Capacity

Field visits revealed that DAC capacity was still lacking in planning, coordination and monitoring and support supervision. Because of financial support (and requirement) from AIM, there were more monitoring activities/programmes in the AIM Districts than in comparison districts, with most of the emphasis on monitoring visits. However, the cessation of active grants as well as the lack of "facilitation" money in local budgets, as reported by DAC members, meant that monitoring has ceased with the end of the project.

Information sharing and use

CSO activity reports were sent directly to the AIM office, according to local official DAC members. This undercut the flow of information to the district planning and monitoring process. DAC members said they were not able to analyze and compile the reports for district use.

However, there were gaps in sharing information within the government departments as seen in the Tororo Gender and community development department. For example although this department had representation on the DAC, the officers in the department said they had limited or no information on DAC deliberations.

Lack of integrated planning and implementation beyond AIM.

AIM's interventions did not appear to be reflected in district activities outside AIM funded activities. For example the activities of other partners/donors in the district were not analyzed and reflected in the plans, budget and reports of the District.

The AIM District HIV/AIDS plans appear to be 'stand alone' documents, and are not sequenced and or harmonized[46] with the District Development Plans and budgets. Although most DAC members are also members of the Technical Planning Committee (TPC), there was no reflection of HIV/AIDS/DAC activities and programs in the TPC. This lack of 'mainstreaming' of the HIV/AIDS effort into the regular functions of the district may threaten the sustainability of the heightened level of effort stimulated by the AIM project.

Functionality of structures at lower levels

Lack of operational structures at levels below the district weakened the participatory planning/inclusion and impact in non-clinical programmes.

AIM engaged DATs (and DACs) in their partner districts until 2002 through training and capacity building in their roles as described in the UAC coordination guidelines. However, for the last 4 years of the program, AIM in all subsequent activities (in most districts) worked with a combined group of DAC and DAT. Combining the DAC and DAT in a way affected the independence and professionalism of the DAC. Secondly this arrangement in a way shadowed DAT's role as to provide political leadership and coordination. The success in the fight against HIV/AIDS in Uganda has been attributed to political leadership and commitment, therefore this mix of roles of political leadership and technocrats could have impacted on the AIM's results.

PMP OBJECTIVE 2: Increased integration and quality of comprehensive HIV/AIDS interventions at district and HSD levels

Intermediate Result: *Increased integration and quality of comprehensive HIV/AIDS interventions at district and HSD levels.*
PMP Measures *1. Number of Hospitals and HC IV's providing 6 HIV clinical services* *2. Number of HC IIIs providing 3 HIV clinical services* ***3.*** *Number of HSDs with RN committees meeting regularly and utilizing referral directory*
PMP Claim *78 Hospitals and HC IV's providing 6 HIV clinical services* *28 HC IIIs providing 3 HIV clinical services* *48 HSDs with RN committees meeting regularly and utilizing referral directory*

The evaluation team visited 19 facilities in AIM districts, and eight in comparison districts. The capacity of district hospitals to provide the 6 HIV services was determined by site visits. Attention focused on HC IVs and, where they were found open, on HC IIIs to a lesser extant. The consensus ratings are presented in Table 9 below.

[46] District Development Plans are 3 years while the HIV/AIDS plans are 5 year plans

TABLE 9: ASSESSMENT OF CLINICAL SERVICES IN HEALTH UNITS VISITED IN AIM AND COMPARISON DISTRICTS

Services Points	AIM DISTRICTS				COMPARISON DISTRICTS			
	Tororo	Arua	Bushenyi	**Total**	Iganga	Moyo	Kiboga	**Total**
HOSPITAL	3 (1)	3 (1)	3 (2)	**9**	X (0)	3 (1)	2 (1)	**5**
HC IV	3 (2)	3 (3)	3 (2)	**9**	0 (1)	2 (1)	2 (2)	**4**
HC III	2 (3)	2 (1)	2 (4)	**6**	X (0)	X (0)	2 (2)	**2**
Functioning of HIV/AIDS Referral Network	2	1	2	**5**	0	0	1	**1**
Score	**10**	**9**	**10**	**29**	**x**	**5**	**7**	**12**

The numbers in the parenthesis indicate the number of facilities visited.

Score Key:

0: Not functional or not available
1: Minimally operational with many problems
2: Moderately operational with a few problems
3: Fully functional
X: No opportunity to assess

Achievements: HC IVs and HC IIIs

The team's consensus ratings clearly show that based on what the team could assess, the AIM districts had performed as expected in the PMP reporting, with the exception of the HC IIIs. In all three AIM districts, HC IIIs were the weaker part of the interface between the health system and the citizen. Nevertheless, the situation in the Comparison districts was far more serious.

Health Units provide Testing Services

Technical support supervision was provided by the regional AIM teams to the implementing sites. All facilities use national HIV protocol both in static and outreach. All facilities provided test results on the same day. Technical support was provided on quarterly basis and involved district focal persons and Ministry of Health program officers. The support provided by the AIM regional teams was considered a critical part of the functioning of the DAC by most district respondents.

The HC IIIs were functioning in terms of provision of TB, STI and OI services, but all reported that they encountered personnel and stock out problems which reduced their ability to remain open and functional on a continuous basis.

AIM supported interventions

All HC IVs visited were providing 6 core services (TB, STI, VCT, PMTCT, LAB and OI) in all districts visited. These services were offered daily by the facility though client attendance was concentrated on particular days. The AIM contribution was to refurbish the labs to fill the structural (Building, furniture and Equipment) gap at Health Centre IVs for counseling and Laboratory work, as well as to support to facilitate health outreach programs conducted by HC IV staff.

AIM's support to the health facilities enhanced the facility capacities to reach the Ministry of Health accreditation requirement to start Anti-Retro-Viral treatment regimes for HIV/AIDS patients. This was

because AIM refurbished/ and or built labs and provided equipment which were a key factor in the accreditation of a health facility to start ARV treatment regimes. Also, AIM supported the districts in ensuring that logistics and consumables for HIV clinical services were provided through linking them with Ministry of Health and delivering HIV testing kits, TB reagents and TB drugs.

It is clear that AIM investments in improving testing, counseling and outreach was successful in expanding the capacity of HC IVs, but somewhat less successful at the HC III level.

Comparison districts: HC IVs and HC IIIs

As presented in Table 9 above, Comparison district health facilities were substantially less well equipped or active in providing testing and outreach programs for HIV/AIDS and related infections. This was especially true at the HC IV level, generally the most utilized health post for rural Ugandans.

Issues and concerns

Human resource shortages were a major constraint in reliable service delivery in all districts. Lower level health facilities (HC III) lacked trained personnel especially in the labs which rendered them non-functional. High staff turnover was reported by most health center heads.

Achievements: Health Sub-Districts (HSD) with Referral Network (RN) Committees

Referral Networks existed in all the HSDs but were at different levels of functioning across districts. In Tororo where they had been formed earlier, the RN committees regularly met with support from AIM grants. These referral networks worked well where referral directories had been updated like in Tororo District. It was also found that referral between facilities had better compliance. In Arua it was indicated some RN committees had not met for a while since the beginning of 2006, this mainly due to lack of transport facilitation. This facilitation money previously had been provided through the AIM Program.

The consensus findings are that AIM intervened successfully to

- Increase referral between government facilities and Private/Community Based Organizations
- Promote regular update of referral register
- Increase interaction between the various service providers through HSD stakeholders meetings

Issues and concerns

There was no feedback about treatments for referred patients from the referral intake centers especially the Hospitals. Respondents reported that there was no time to fill in the referral action form by the health workers who were “busy and committed”. This was compounded by the late availability of referral directories in Bushenyi and Arua. In these two AIM districts, the directories arrived in March 2006. The evaluation team learned that the use of the new referral notes was not popular mainly because of time spent and cost of production of the notes once the initial supply was exhausted. Many respondents said the AIM forms are duplicative of forms issued by the MOH and widely used. There was difficulty in appreciating the AIM referral form as a necessary tool in the Health service delivery points compared to the MOH referral form from Ministry of Health.

Follow up was a problem especially at HSD level. Respondents reported that they often had little knowledge of what happened after a referral was made.[47]

[47] This same finding was documented in an earlier AIM funded study in two AIM districts.

Formal networks not withstanding, informants asserted that referral services closer to the people work better. Even without the referral directories, most providers especially in the HC III knew of the services available at different points and referrals were occurring.

Comparison districts

The evaluation team did not find evidence of the referrals networks in the comparison district like those observed in the AIM districts. All that was evident was the traditional referrals system in the health facilities. For the CBOs, referrals were carried by the patient either verbally or physically with no documentation, not even from referring facility.

OBJECTIVE 3: Increase Access to and utilization of quality HIV/AIDS prevention services

Intermediate Result: *Increase Access to and utilization of quality HIV/AIDS prevention services*
Performance Measures 1. *Number of functional HCT sites delivering Counseling and testing services according to national guidelines* 2. *Number of personnel with enhanced skills to provide HCT services* 3. *Number of functional sites providing PMTCT according to national guidelines* 4. *Number of personnel with enhanced skills to provide PMTCT services according to national guidelines*
PMP Claims: *117 functional HCT sites delivering Counseling and testing services according to national guidelines* *330 personnel with enhanced skills to provide HCT services* *90 functional sites providing PMTCT according to national guidelines* *1447 personnel with enhanced skills to provide PMTCT services according to national guidelines*

The table 10 below represents the assessment and number of sites visited in both AIM supported and Comparison districts[48]

[48] Hospitals have been excluded in this analysis because they generally seemed to be fully functional according to the national guidelines and they had adequate capacity, equipment, resources.

TABLE 10: ASSESSMENT OF HCT AND PMTCT SITES WITHTRAINED PERSONNEL IN AIM AND COMPARISON DISTRICTS

Area rated	AIM DISTRICTS				COMPARISON DISTRICTS			
	Tororo	Arua	Bushenyi	**Total**	Iganga	Moyo	Kiboga	**Total**
HCT Service provision	2 (3)	2 (3)	2 (2)	**6**	1 (1)	1 (1)	2 (2)	**4**
Staff trained in HCT	3 (3)	2 (3)	3 (2)	**8**	1 (1)	2 (1)	2 (2)	**5**
PMTCT Service Provision	3 (3)	3 (3)	3 (2)	**9**	1 (1)	x (0)	1 (2)	**x**
Staff trained in PMTCT	3 (3)	2 (3)	3 (2)	**8**	1 (1)	x (0)	3 (2)	**x**
Score	**11**	**9**	**11**	**31**	**4**	**x**	**8**	**9**

The numbers in the parenthesis indicates the number of facilities visited.

Score Key:

0:Not functional or not available
1: Minimally operational with many problems
2: Moderately operational with a few problems
3: Fully functional
X: No opportunity to assess

Objective three introduces the terms "access and utilization". Various AIM reports sometimes used the term access to suggest utilization. In this report, "access" means availability of a service. "Utilization" means actual client/patient/beneficiary use of the service. For example, VCT uptake data measures utilization of available VCT sites. Similarly the term "site" suggests a physically distinct location. It fact, a 'site' is simply the place where, inter alia, a particular service is made available. A VCT site is where there is actual counseling and testing service provision, trained personnel, and some regularity and continuity of location and time the service is provided. A VCT site could be located at an HC IV, or elsewhere. PMTCT site definition is one offering VCT, ANC, Maternity, ART for mother and baby, malaria prophylaxis and follow up of mother's condition.

Achievements

AIM was able to train health workers in PMTCT, VCT, Routine Counseling and Testing (RCT) from all the Health Sub-Districts and health facilities visited. The program was able to train trainers at the district level to support implementation and supervision of HCT and PMTCT services.

The three AIM districts examined were able to conduct integrated VCT outreach to HC III, II, secondary schools and trading centers at least once in a fortnight.

AIM provided support to scaling up and or strengthening HCT/PMTCT services in some HSD by establishing the infrastructure. The AIM program provided direct support to refurbish HIV counseling and testing rooms and PMTCT counseling rooms. These were also furnished with chairs and tables.

The program provided support in linking up with various developing partners providing complimentary HIV services in the districts through joint planning, referral networks and partnership forum meetings. E.g. TASO, JCRC ART centers, Plan International, AIC and MOH. This enhanced access and utilization of comprehensive care for PHAs.

Through the grants mechanism, AIM supported formation of social groups like Post Test Clubs. The program was also able to provide technical and financial support for Peer Social Support Groups (PSSG) meeting for HIV+ mothers for follow up. This has resulted in a number of babies receiving Nevirapine and followed up to 18 months for an HIV test to monitor the effectiveness of the PMTCT interventions.

AIM also helped in developing and disseminating IEC/BCC materials in the form of print, radio spots, drama groups for mobilizing communities to access and utilize HCT and PMTCT services.

AIM provided technical support supervision to the implementing sites in conjunction with Ministry of Health program officers, AIM technical officers and district officials. As a result, technical teams for HCT and PMTCT have been established and are functional in the districts.

Issues and Concerns

Despite the created high demand for HIV testing, some of the HCT sites reported regular stock out of testing kits, for example in Tororo at HC IV (Nagongera). This has hindered continuity and hence utilization of HIV services.

There is instability in Health Worker staffing due to high staff turnover and this has led to loss of trained and skilled personnel. Reasons associated with high turnover were mainly frequent staff transfer and study leave. In Bushenyi, outreaches that were being supported through the AIM grant support had stalled due to lack of funds following the completion of the AIM Program.

Although the Program increased capacity of PMTCT service provision in the facilities of AIM supported districts, utilization of these services remained low. Low service utilization was mainly attributed to low staff levels and social cultural issues that in some districts like Arua hindered mothers from delivering in health facilities. Low staffing level for example could not permit a pregnant mother, coming to an anti-natal clinic to receive PMTCT services on the same day on top of having to spend long hours waiting in the queue.

The problem of low utilization of PMTCT services was not only observed in AIM districts, but also in the comparison districts and at national level.

Comparison Districts

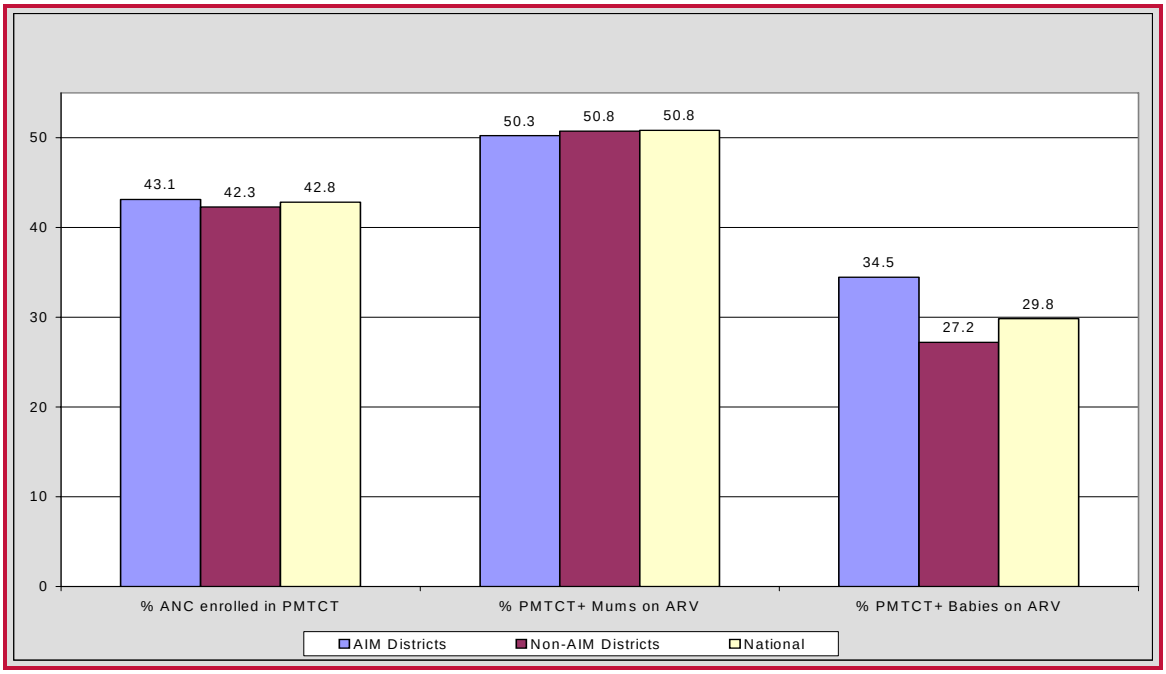
There were HCT services in all the 3 districts at the sites visited at Hospital and HC IV level. Follow up of mothers is done through appointment dates with the health workers and done at the Health facility level.

In Iganga and Moyo, the various sites suffered from serious constraints. The HC IV had shortage of staff, especially Lab personnel. Stock outs of were reported at HC IV's in Iganga and Kiboga for Nevirapine (Tablets and syrup) with frequent stock out of HIV testing kits and septrin. There was lack of infrastructure for counseling and testing services especially in Kiboga in the 2 HC IV's. Staff in these centers resorted to counseling under trees and in the general waiting rooms.

Service Utilization: PMTCT Indicators for AIM and Comparison districts

Many of the indicators used in the AIM PMP have measures reporting how AIM has expanded availability of HIV/AIDS relevant services in the AIM districts. Utilization data is more difficult to find. The evaluation team found aggregate quantitative data on PMTCT utilization relevant to Objective 3, which is presented in Figure 2 below.

FIGURE 2: SOME PMTCT INDICATORS BASED ON 2004 DATA



Source: Ministry of Health PMTCT

The graph shows that the AIM program has almost similar trend of service utilization in relation to comparison districts and nationally for ANC and PMTCT (mothers on ARV). However there is a significantly higher percentage in the AIM districts with regard to the number of babies born to HIV+ mothers receiving Nevirapine. This may reflect the positive impact of national programs supported by USAID. It also demonstrates the difficulty in attributing significant impact of this intervention to the AIM project alone.

OBJECTIVE 4: Increased access to and utilization of HIV/AIDS care and psychosocial support services (Objective 4: Part 1 Laboratory)

Intermediate Results: *Increased access to and utilization of HIV/AIDS care and psychosocial support services (Objective 4 Part 1 Laboratory)*
Performance Measures 1. *Number of laboratories conducting diagnostic tests for HIV, syphilis, Malaria and TB* 2. *Number of Laboratory facilities refurbished by AIM* 3. *Number of Laboratory facilities supplied with equipment* 4. *Number of staff with enhanced skills in laboratory safety procedures and laboratory tests*
PMP Claim: *125 Laboratories conducting diagnostic tests for HIV, syphilis, Malaria and TB* *82 Laboratory facilities refurbished by AIM* *113 Laboratory facilities supplied with equipment* *136 staff with enhanced skills in laboratory safety procedures and laboratory tests*

Objective 4 is about **access** and **utilization** of laboratory services, but the PMP measures focus exclusively on access or the improvements in the availability and quality of services. To balance this, the evaluation presents data on utilization of services provided by the facilities, and identifies some important issues that need to be addressed in any scaling up of the program. First, we examine **access** as measured by the PMP.

TABLE 11: GENERAL ASSESSMENT OF LABORATORY SERVICES IN AIM DISTRICTS

Services Points	AIM DISTRICTS				COMPARISON DISTRICTS			
	Tororo	Arua	Bushenyi	**Total**	Iganga	Moyo	Kiboga	**Total**
(Number of HC IV labs visited)	*(3)*	*(3)*	*(2)*		*(1)*	*(1)*	*(3)*	
Performing the 6 tests	3	3	3	**9**	1	1	1	**3**
Refurbished Laboratories	3	3	3	**9**	1	1	0	**2**
Functional Equipment	3	3	2	**8**	1	1	2	**4**
Trained Staff	3	3	3	**9**	1	x	3	**4**
Score	**12**	**12**	**11**	**35**	**4**	**3**	**6**	**13**

The criteria for scoring was based on HC IVs visited per district. The HC IIIs did not have much lab equipment or lab staff for functionality except in Bushenyi.

Score Key:

0: Not functional or not available
1: Minimally operational with many problems
2: Moderately operational with a few problems
3: Fully functional
X: No opportunity to assess

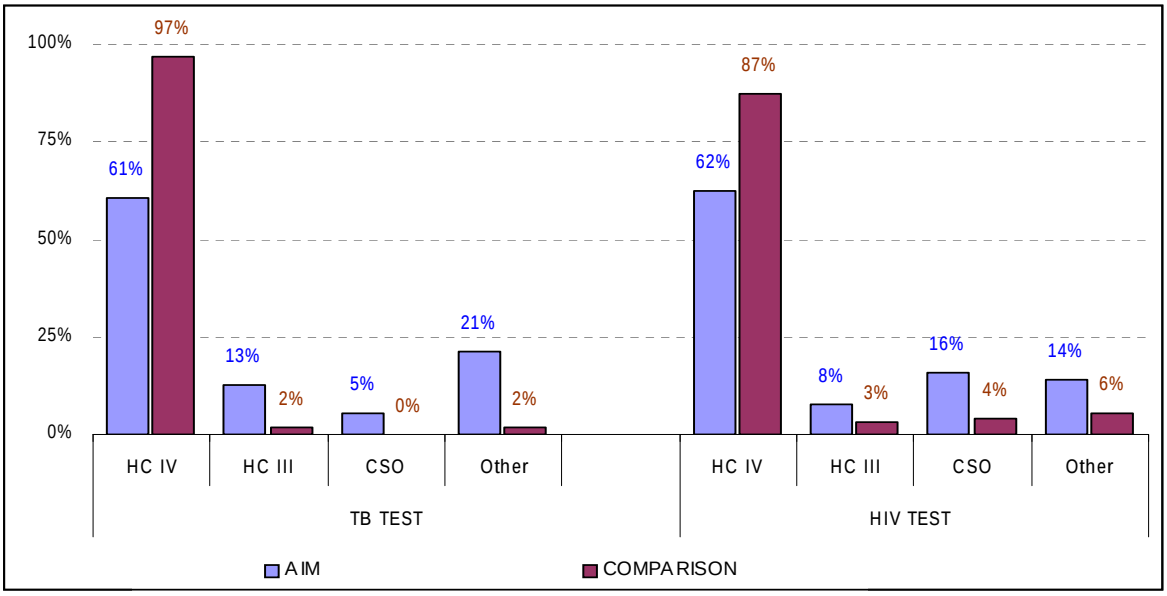
Achievements: Access to testing

The AIM supported districts had health facilities with better Laboratory facilities than the comparison districts in all areas. The AIM program provided support to refurbish the labs, provided furniture and Laboratory equipment and trained staff on laboratory testing. The program also supported quality assurance by providing quality control kits for support supervision of the Laboratory services. In addition, AIM contracted African Medical and Research Foundation (AMREF) to provide technical support supervision.

Utilization of Services by PHA Families

Objective 4 identifies "utilization" of services as part of the objective statement. The evaluation used small sample surveys of PHA families to develop data on utilization. Respondents in both AIM and comparison districts provided information on what types of services they had used in the last year. In this section we examine these responses comparing AIM with Comparison districts.

FIGURE 3: SOURCE OF HIV/TB TESTING IN AIM AND COMPARISON DISTRICTS



Laboratory Service Utilization as reported by survey respondents is presented in Figure 3 above. Most of the laboratory tests are carried out at HC IVs in both AIM and Comparison districts. The AIM supported districts are conducting more tests at HC IIIs and Hospitals than the Comparison districts. There seems to be an increased use of lower level labs in AIM districts which could be linked to AIM capacity building activities, including more active outreaches from HC IV's to HC IIIs and provision of equipment. This would suggest that in spite of staffing and stock out problems at the lower levels, these can become part of a functioning system. Functional HC IIIs would reduce the travel and transaction times for rural Ugandans who now travel to the HC IVs and to the hospitals for routine care.

It is also relevant to note the pre-eminence of the HC IV in providing services to patients in Comparison districts, while in AIM districts, respondents used a greater array of service locations, including CSOs trained by AIM.

Issues and Concerns

Some of the equipment provided by AIM was faulty and not functioning properly, including some microscopes. Some water distillers could not work due to low water pressure levels in Tororo.

External factors

Although the program was able to provide logistical and technical support, it was difficult for the districts to continue providing fuel for transport to support supervision activities for the Lab- focal person. The inadequacy of district funding for these purposes has been noted in other areas as well.

There was a general shortage of Laboratory staff and this has limited the availability especially at HC IIIs. Also, the quality of laboratory testing was not adequate and this was attributed to low staff cadres, especially the Microscopists who received 3 months lab orientation and were sent to the lower facilities.

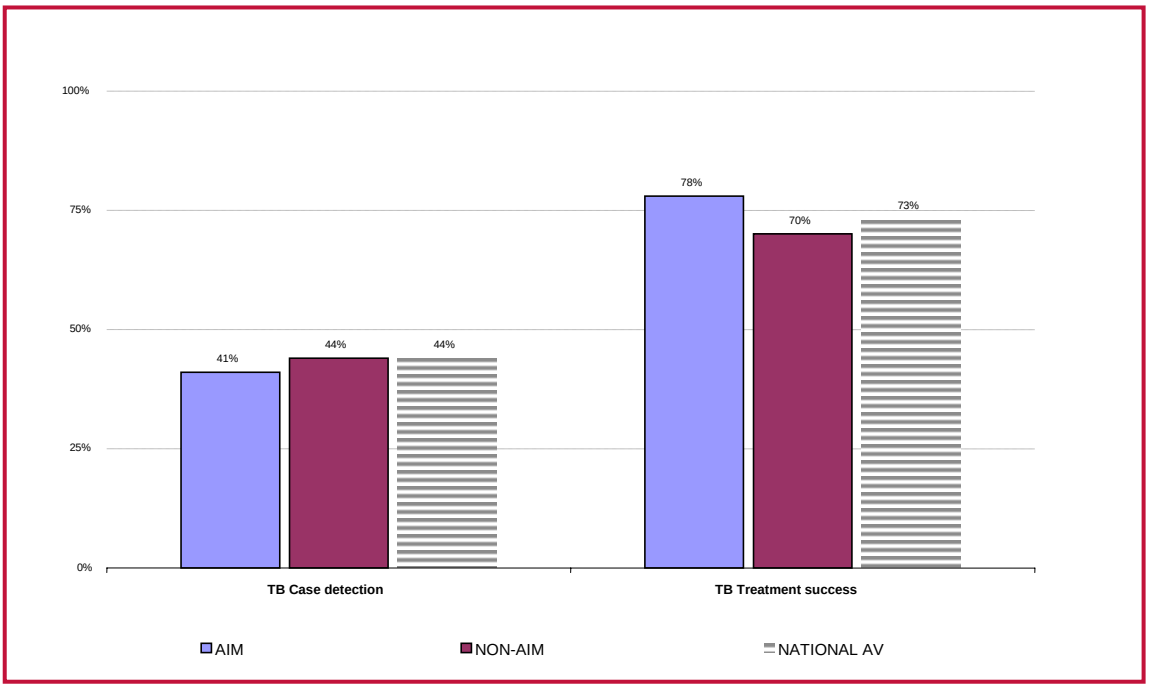
There is high client load generally for the Laboratory staff compounded by multiple formats in which they have to summarize their data (registers and donor partner programs).

OBJECTIVE 4: UTILIZATION OF TUBERCULOSIS (TB) SERVICES (Objective 4 part 2)

Intermediate Result: *Utilization of Tuberculosis (TB) Services (Objective 4 Part 2)*
Performance Measures 1. *Number of sites providing TB care and treatment according to national standards* 2. *Percentage of TB detection case* 3. *Percentage of TB cases who successfully complete treatment*
PMP Claim *373 sites providing TB care and treatment according to national standards* *70% case TB detection* *77% TB cases who successfully complete treatment*

For this part of Objective 4, the PMP does present utilization data with regard to TB patients who successfully complete the treatment regime. To assess the utilization of TB services, the evaluation team was able to compare the performance of AIM districts with district level data reported to the Ministry of Health. These data are presented in Figure 4 below.

FIGURE 4: TB DETECTION AND TREATMENT SERVICES: AIM, COMPARISON AND NATIONAL COMPARISON



Data Source: Annual TB Report 2004, National TB/Leprosy Program, MOH 2004

Detection of TB cases

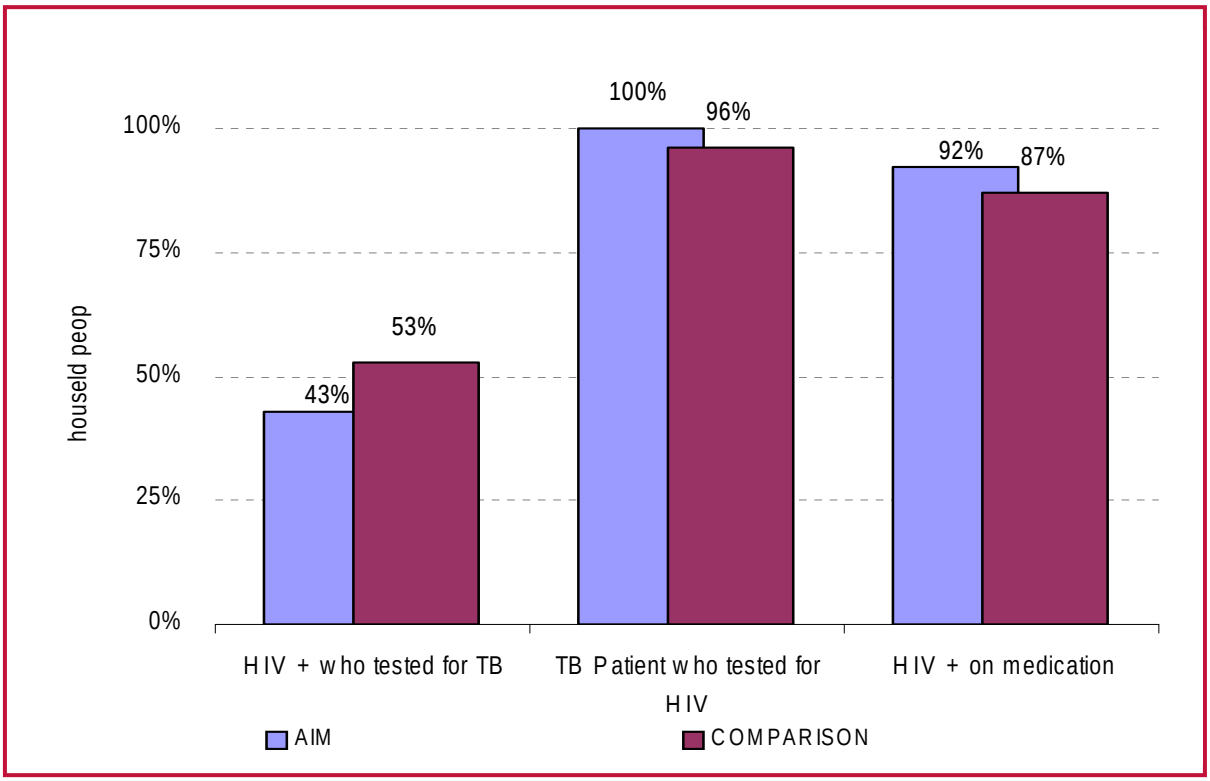
Generally there is low TB case detection in the country as of 2004 although this picture may have changed with increased surveillance by AIM and other district health facilities. There was minimal difference in case detection rate between the AIM and comparison districts and nationally although AIM districts seem to show lower case detection rate. The effectiveness of the efforts for increasing case detection seems to have minimal impact by 2004. This may be a result of lack of health worker awareness to screen TB patients despite training and lack of community awareness.

Treatment of TB

The PMP claim of treatment success was achieved in AIM districts with better rates compared to both national and Comparison districts. This could be attributed to AIM capacity building and facilitation of sub-county health workers as well as CB-DOTS activities.

Turning to the evaluation's Household Survey data, we examine those families whose members were HIV + and had been tested for TB

FIGURE 5: SOME TB INDICATORS IN AIM AND COMPARISON DISTRICTS



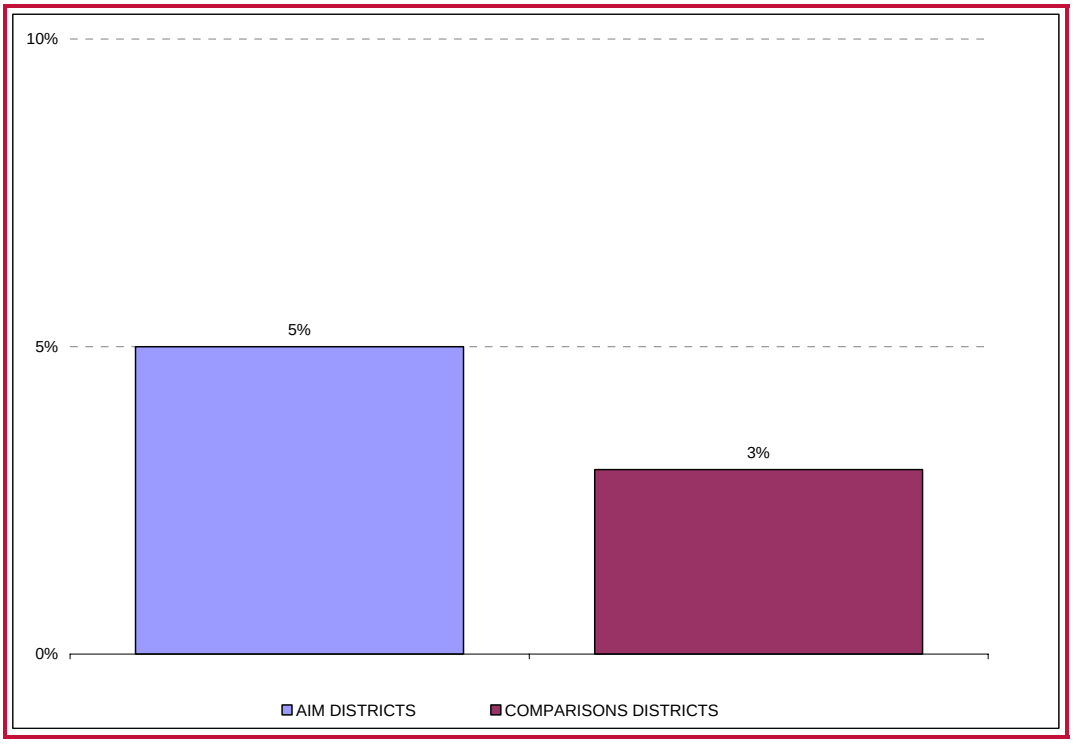
Source: Household survey data

From the household survey, a substantially higher percentage of TB patients reported testing for HIV than HIV patients reported testing for TB in both AIM and comparison districts. This is indicative that there is routine counseling and testing for HIV among TB clients. On the other hand, there are fewer PHAs screened for TB in both AIM and comparison districts, though the percentage is somewhat higher in comparison districts.. This is indicative that health providers examining HIV patients may not be sensitive to signs of TB, and hence there is less screening for TB among PHAs in the health facilities. However, once detected, there are more HIV patients receiving treatment in the AIM districts than the comparison districts.

As we have noted elsewhere, maintaining a steady supply of medications is critical for HIV and TB treatment regimes. Unfortunately, interruptions in the supply chain were frequent, according to local health post officials, and patients were unable to maintain their treatments. However, the data from the evaluation Household Survey indicate that no more than five percent of the respondents reported that they had run out of TB drugs in either the AIM or the Comparison districts. If there is a fall off in the

completion of the TB treatment regime, then there may be other factors at play besides supply chain problems.

FIGURE 6: PROPORTION OF TB PATIENTS RUNNING OUT OF DRUGS IN AIM AND COMPARISON DISTRICTS (AIM N=147, COMPARISON N = 91)



Source: Household survey data

There is small variance in the proportion of TB patients who run out of drugs in both AIM and Comparison districts, with slightly higher percentage of AIM district respondents reporting problems. Since AIM districts have a somewhat higher percent of PHAs on TB-DOTS, this may also be driving the somewhat higher percentage reporting interruptions in their treatment. Both figures could be linked to the national drug shortages which occurred early in 2005 and 2006. These drug supply interruptions support the more general observation made by Ugandan health officials that the health system has structural weaknesses that must be addressed nationally; weaknesses that cannot be effectively addressed by sub-national projects such as AIM.

OBJECTIVE 4: Increased assess to and utilization of community, Home Based Care and PHA Networks (Objective 4 part 3)

Intermediate Result: *Increased assess to and utilization of quality HIV/AIDS clinical, community and Home Based Care*
Performance Measures *(1) Number of service outlets/sites providing general HIV related palliative care (non- ART care) excluding TB/HIV.* ***(****2) Number of persons with enhanced skills to provide general HIV- related palliative care.* ***(****3) Number of individuals provided with general HIV – related palliative care, disaggregated by sex.* *(4) All AIM supported districts with functional PHA network at HSD level linked to the existing RN network.* *(5) Number of PHAs registered in a PHA network.* ***(6)*** *Percentage of identified PHAs accessing care and support services through the referral network of HIV/AIDS services.*
PMP Claims: *547 service outlets/sites established.* *4,635 persons with enhanced skills to provide general HIV- related palliative.* *25,607 individuals provided with general HIV – related palliative care, disaggregated by sex.* *65 functional PHA networks established at HSD level and linked to the existing RN network.* *61,264 PHAs registered in a PHA network* *44% of identified PHAs accessing care and support services through the referral network of HIV/AIDS services.*

One of the principle findings of the Mid Term Review was that the PEPFAR measures and indicators focused mainly on 'access' indicators, such as number of improved laboratories, and number of clinics that could provide six or three HIV/AIDS related tests. As noted in this report, only a few of the PMP indicators approach actual utilization, even though the PMP language brackets access and utilization in two of the five objectives. The Mid Term Review noted that efforts to develop "user" surveys did not materialize. With limited time, this evaluation did survey PHA families randomly selected from PHA registration lists in both AIM and comparison districts.

Community and Home Based Care (CBHC)

The evaluation team lacked sufficient time to verify the numbers used to report results for PMP Objective 4 part 3. Instead, the team focused on spot checks of AIM grantees who had received capacity building and grants for the purpose of providing home based care. The AIM Program supported some of grantees, mainly Community Based Organizations (CBOs) to offer CHBC targeting particularly PHAs.[49] Table 12 below, presents the grantees visited during evaluation in the 3 AIM program districts.

[49] See Appendix G for a complete list of all AIM grantees.

TABLE 12: CBHC GRANTEES COVERED BY THE EVALUATION TEAM IN THE 3 AIM PROGRAM DISTRICTS

District	Grantees
Bushenyi	BUDNET+
Tororo	Community Alert
Arua	Ediofe HC III Caritas Arua African Child Care Foundation (ACCF) ASED

Because of the breadth of the AIM Program's grant and capacity building program to community organizations, and the limited number of providers the team was able to interview and observe, no consensus rating was attempted for this element of Objective 4.

AIM Program interventions

AIM program supported and strengthened CBOs to provide CHBC in a number of ways.

- Capacity building to enhance their knowledge and skills in Home Based Care.
- Technical support through support supervision visits to the implementing CBOS. This was done in collaboration with the district HBC trainers and DAC members that are in-charge of community services.
- Logistics in the form of bicycles to support community counseling aides involved in HBC.

AIM Achievements

The AIM grantees visited revealed that they provided the following CHBC services to PHAs;

- Psycho-social support – home visits, counseling and encouragement of PHAs to join Post Test Clubs (PTCs).
- Material support that included mainly provision of HBC kits to PHAs. In Tororo and Bushenyi districts, for example, 100 and 200 kits were reported to have been provided to PHAs respectively
- Basic medical care and referrals of Opportunistic Infections for treatment and septrin prophylaxis.
- Nutritional improvement through training and provision of piglets, goats etc
- **CBOs** which received grants from AIM were able to provide HBC when properly supported. This enabled some PHAs to receive support and care at home which was noted to have improved their quality of life

CBOs also were harnessed to promote treatment of OIs through referrals and Septrin prophylaxis. PHAs who might otherwise have difficulty in acquiring low level treatment could be reached by CBOs, again with proper support and engagement from the local health facilities.

Issues and Concerns

The PMP did not measure and the evaluation team could not estimate coverage, or the ratio of people actually served to the population needing such service at the district level.[50] The team's tentative finding is that there are still many PHAs who need to be reached with support. CBOs that were active reported that they could have reached more PHAs, but did not have enough kits for their clients. The availability of material support that can be provided is a key factor in gaining access to families, whereby other, less tangible services, may be provided.

Another appropriate standard that might be used to assess the effectiveness of CBO outreach is whether they can provide more or less continuous service rather than 'one off' visits and provisions of kits. With some exceptions, most of the CBOs could not provide continuous services without external support.

Comparison Districts

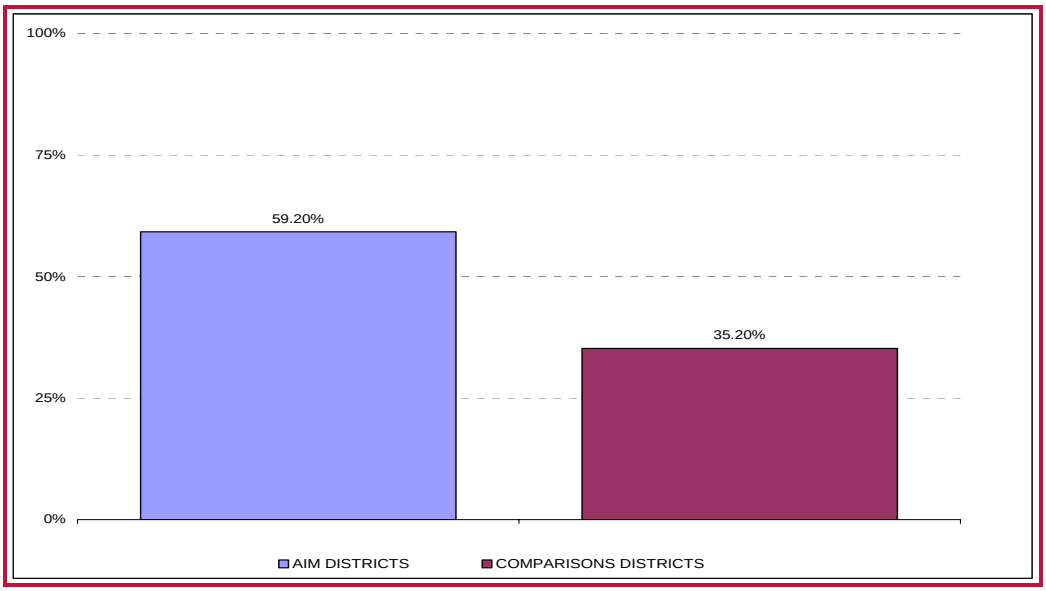
Whereas there was also provision of HBC to PHAs in the comparison districts, it was mainly in a form of psycho-social support – home visits and counseling by PHAs and community volunteers. The groups included; PADA in Bulamogi sub-county and a group of community volunteers in Busiki HSD trained under WHO & Italian Initiative for Iganga, MAHA in Moyo district. Compared to AIM program districts, the HBC scale was smaller and limited in service provision due to constraints related to lack of transport and HBC kits, except in the case of MAHA which received training in HBC with UNICEF support.

Utilization of Services by PHA Families: AIM and comparison districts

Below we present in quantitative terms the extent to which PHA families utilized HBC services. These tables are based on the findings of the household survey with PHA families in AIM and comparison districts. Using the categories established by the National Behavioral Sero-Survey, we asked PHA Households whether they had received support in four areas: Material support (money/goods), Psycho-social support (Counseling/Group Sharing), Practical Support (assistance with home care/children/household tasks) and Medical Support (drugs, treatment regimes, preliminary referrals.) The responses are presented below.

[50] This was a major conclusion of the Mid-Term Review as well. The finding applies to all other PMP Objectives and related measures. There is no district population denominator used that would facilitate setting of realistic coverage targets.

FIGURE 7: PHA HOUSEHOLDS RECEIVING MATERIAL SUPPORT IN THE LAST 12 MONTHS IN AIM AND COMPARISON DISTRICTS (AIM N=147, COMPARISON N = 91)



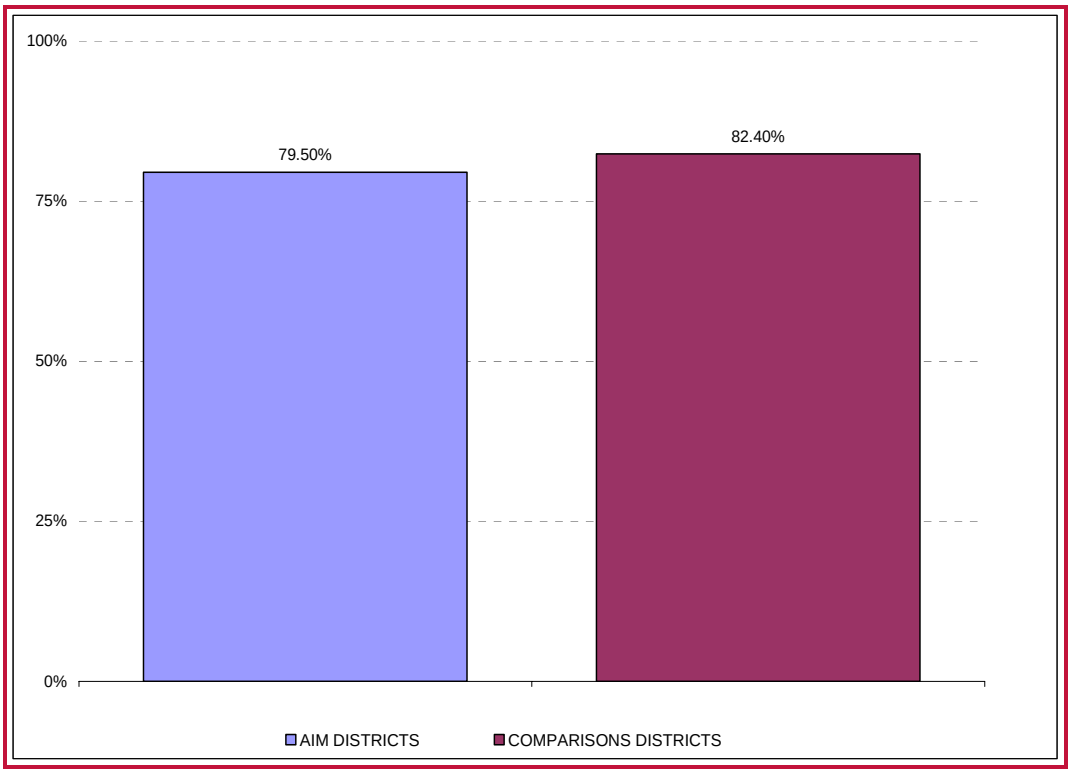
Source: Household survey data

The figure above indicates that in the AIM program districts, PHAs received more material support than in the comparison districts. This could be partly attributed to AIM support. The AIM grantees (CBOs) provided HBC kits to PHAs as earlier noted. For example, 31% of CBOs in AIM districts provided material support to PHAs as compared to 13.9% for the comparison districts.

Turning to the remaining three types of support, psycho-social, practical and medical support, the survey found that Comparison district families reported about the same or higher levels of services on all three types compared to AIM program districts. The team is uncertain about why this is so. We suggest some hypotheses, but cannot be certain and suggest further comparative study.

One explanation is that the World Bank's MAP project was affecting the Comparison district results. However, all the AIM districts in the evaluation were benefiting from the MAP, while 2 of the 3 Non AIM districts were also benefiting from the MAP program. Therefore the higher or same levels of services on all three types can not be explained by the presence of MAP

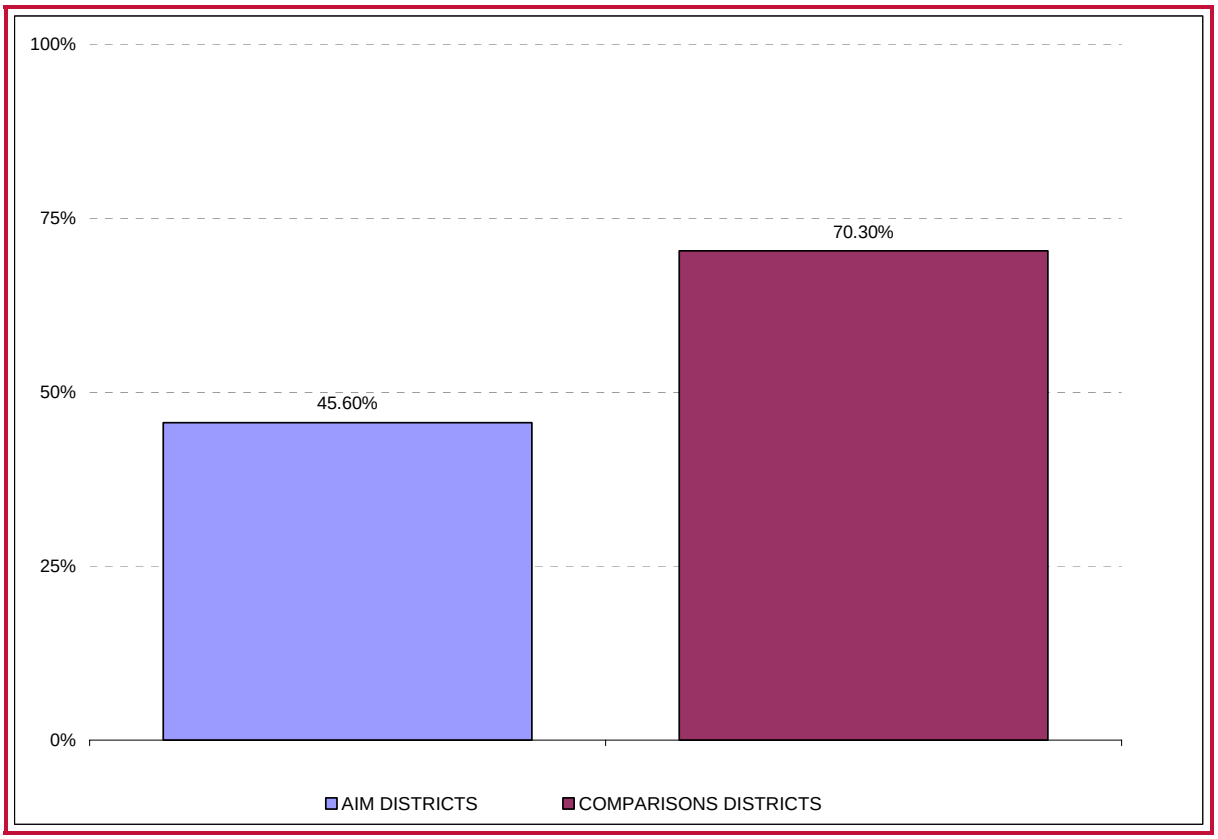
FIGURE 8: PSYCHO SOCIAL SUPPORT RECEIVED BY PHAS IN THE PAST 12 MONTH IN AIM AND COMPARISON DISTRICTS (AIM N=146, COMPARISON N=91)



Source: Household survey data

AIM district respondents reported receiving psycho-social support at about the same level as PHAs in the comparison districts.

FIGURE 9: PRACTICAL SUPPORT RECEIVED BY PHAS IN THE PAST 12 MONTH IN AIM AND COMPARISON DISTRICTS (AIM N=147, COMPARISON N=91)

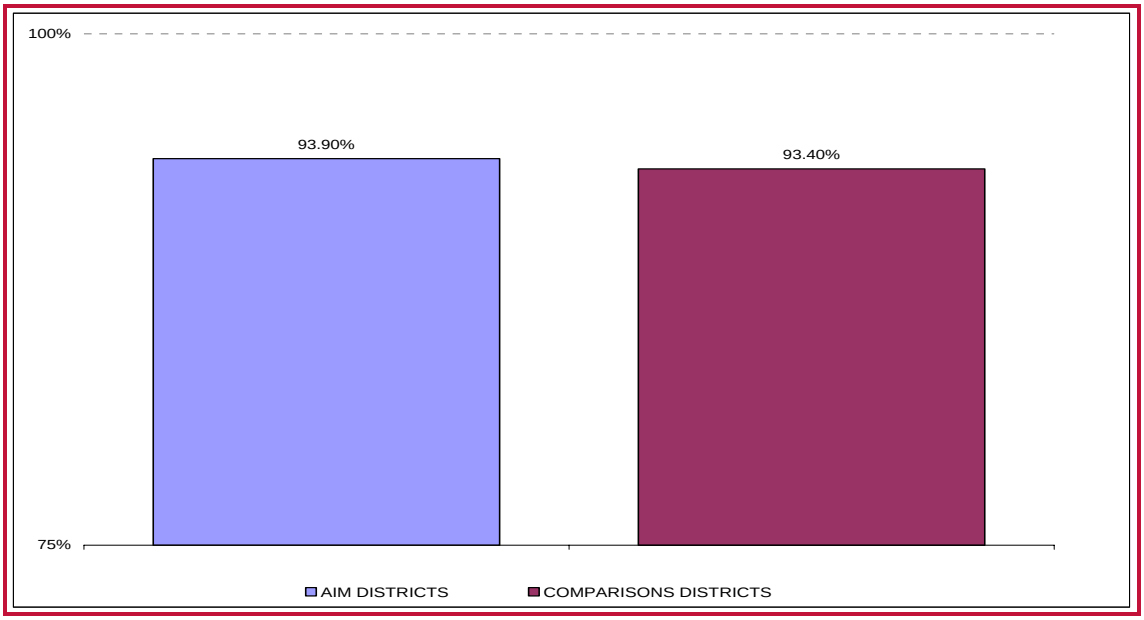


Source: Household survey data

PHA families in comparison districts reported much higher receipt of practical support, defined as assistance in housekeeping, patient care, cooking, etc., than PHA respondents in AIM districts.

The next question asked respondents to report on receipt of medical support from all sources over the previous twelve months.

FIGURE 10: MEDICAL SUPPORT RECEIVED BY PHAS IN THE PAST 12 MONTH IN AIM AND COMPARISON DISTRICTS (AIM N=147, COMPARISON=91)



Source: Household survey data

With regard to receipt of medical support (drugs, treatment), there was almost no difference in the responses from comparison districts and AIM districts. A high percentage of PHAs in both groups found ways to secure medical support.

Issues and Concerns: Utilization of Services

A surprising finding from the survey responses is that Comparison districts PHA families report utilization of medical, practical and psycho-social support equal to or more than families in AIM districts. The AIM districts superior supply of material goods was noted by PHA families, but on the other three utilization measures, AIM districts respondents reported utilization levels no better than, and in the area of 'practical support', much lower utilization levels. Whether this indicates that AIM supported CBOs were neglecting psycho-social and practical support services is difficult to answer, and would require additional research. It would also be useful to examine the 'quality' of services received in AIM districts versus Comparison districts.

This evaluation noted a possible increased tendency of PHA family members to rely on the CBOs in AIM districts for support and care of their PHA member. This may indicate that AIM trained CBOs were providing superior service. It may also be that families welcomed the CBO services related to the burden of care and support, rather than having to rely on relatives and neighbors. The approaches for HBC should therefore also focus on the role of the family support to the PHA in that particular community. One area where family support could be strengthened is in providing good nutrition for PHAs, a dimensions not adequately addressed by CBOs in the HBC, according to interviews.

PHA Networks

The AIM program gave special attention to the role of PHA Networks as both part of a robust referral system but also as providers of HBC. The reasons for this are straightforward. PHAs understand the disease and the social stigma many still attach to it. Many have learned to live with it, have 'come out' as

HIV positive persons, and for all these reasons may be more committed to helping others facing the same problem. PHA Networks have been organized in many districts and are not an AIM creation. However, the AIM program did recognize the potential of such networks and, towards the end of the Program, paid increasing attention to harnessing their commitment and energy.

While the PHAs Networks were present in both AIM and comparison districts surveyed, networks in the former were found to be more active and organized than in the latter. This could be perhaps due to the AIM grants they received. The grants supported not only refurbishment of their district offices but also facilitated PHA registration and formation of lower level PHA groups at HSDs and Sub County level.

AIM Achievements: Mobilization of PHA Networks

Although both comparison and AIM districts have PHA organizations, AIM has accorded PHAs an opportunity to share experiences and support for each other.

> *It has made us one family and we are able to counsel each other and we have come to learn and appreciate that HIV/AIDS is like any disease.* **PHA member (Bushenyi).**

Other AIM achievements include mobilizing PHAs to utilize available HIV/AIDS care and support services (HCT, PMTCT, ART and HBC programs). PHA Networks have established linkages and help to identify patients from the community, referring patients to other support organizations (TASO, JCRC, CDC, AIC for care and treatment of OIs and follow ups.) They have been active in the informal referral process.

Through their networks, members have been sensitized on the importance of Septrin prophylaxis and many PHAs reported enrolled on Septrin prophylaxis. AIM accorded PHAs an opportunity for continued psycho-social support which enhances positive living. Districts leaders have come out to recognize the plight PHAs and their concerns are taken care of in DDP, as was noted especially in Bushenyi.

> *Through our network, we now have a voice. Recently, the district has even given us free office space at the district.* Coordinator BUDNET+ (Bushenyi).

Lastly, AIM support for the PHA networks, by increasing their capacity and 'legitimacy', as led to greater involvement of PHAs in planning and decision making (e.g. PHAs represented on DAC and participated in the development of the HIV/AIDS plans for the districts.

Issues and Concerns:

Logistical and financial resource constraints have implications on the continuity of the networks. For example, following the completion of the AIM Program, there was noted reduced activity of the networks due to lack of financial support.

Constraints to utilization of services for PHA families are many, and many families find it difficult to overcome them. The sample survey asked PHA families in AIM and comparison districts to identify the major problems/constraints they faced in gaining access to and utilizing health services in their HSD. The responses are summarized in Table 13 below.

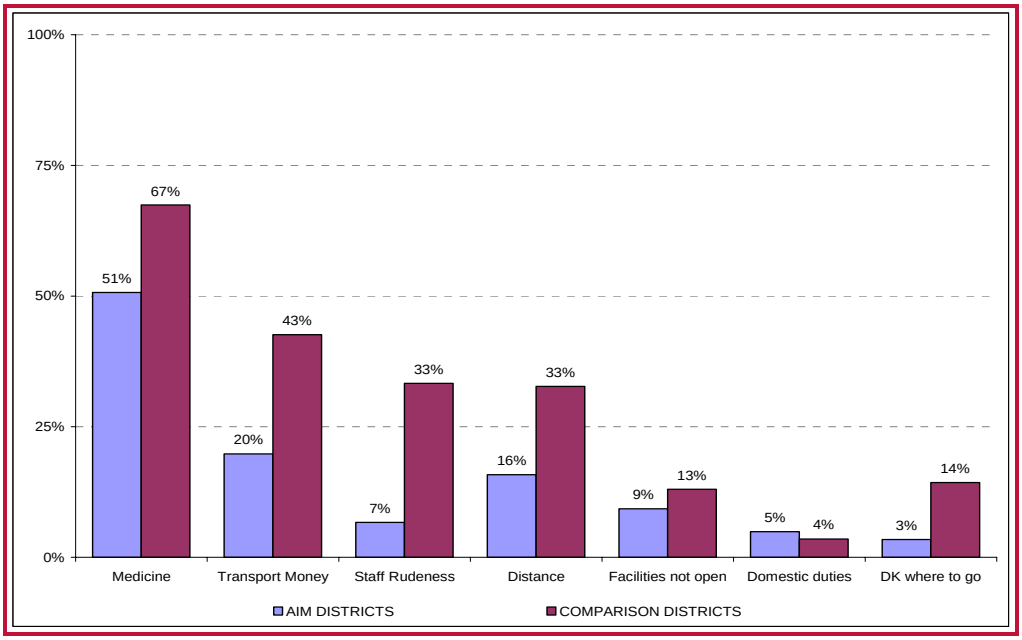
TABLE 13: CONSTRAINTS FACED BY PHAS TO ACCESS AND UTILIZE HEALTH SERVICES IN AIM AND COMPARISON DISTRICTS

	Minor problem		Major problem but can manage		Too big to Overcome	
	Comparison	AIM	Comparison	AIM	Comparison	AIM
Distance too great	20.0%	24.5%	42.9%	64.2%	32.7%	15.8%
No money for transport	14.7%	10.6%	46.8%	65.5%	42.6%	19.8%
Can't leave home, duties	80.5%	84.2%	12.3%	14.6%	3.5%	4.9%
Facilities often not open	81.4%	77.8%	9.3%	9.3%	13.0%	9.3%
Medicines often not available	46.4%	18.6%	14.0%	2.9%	67.4%	50.7%
Don't like going when other people men / women are there	90.0%	88.9%	11.1%	10.0%	0.0%	0.0%
Staff do not treat us with respect	76.7%	16.7%	50.0%	16.7%	33.3%	6.7%
Don't know who / where to go	86.2%	71.4%	14.3%	10.3%	14.3%	3.4%

Source: Household survey data

The responses in the "too big to overcome" column are perhaps the most revealing and are presented in bar graph form below for more impact.

FIGURE 11: PERCENTAGE OF RESPONDENTS WHO CONSIDERED THE PROBLEM TO BE "TOO BIG TO OVERCOME" FOR AIM AND COMPARISON DISTRICTS (AIM N=147, COMPARISON N=91)



Whereas the PHAs in AIM and Comparison districts encountered a number of constraints while seeking medical care, on all but one of the constraint dimensions, PHAs living in Comparison districts reported that the problems they faced were considered "*too big to overcome"* compared to responses from PHA families in AIM districts. AIM districts excelled in 'treating with respect', informing people 'where to go', and providing more accessible services. This could partly be attributed to AIM support (grants) that were reported to have improved the services in AIM districts.

PMP Objective 4: Increased access to and utilization of quality HIV/AIDS care and psycho social support services for Orphans and Vulnerable Children (OVC) (Objective 4 part 4)

Intermediate Result: *Increased access to and utilization of interventions for Orphans and Vulnerable Children (OVC)*
Performance Measure • *No of OVC programs supported by AIM in its districts* • *No. of providers-caretakers trained by AIM in caring for OVCs* • *No. of OVCs served by OVC program supported by AIM*
PMP Claim *87 OVC programs supported by AIM in its districts* *FY05 8590 providers-caretakers trained by AIM in caring for OVCs* *FY05 16,031 OVCs served by OVC program supported by AIM*

Note: PMP data is annual data, not cumulative.

AIM'S OVC strategy

AIM's strategy to increase access and utilization of OVC services in AIM supported districts was to strengthen the capacity of OVC programs in districts to reach orphans and their care givers. Key interventions included strengthening capacity of CBOs, FBOs, NGOs and district officials and supporting development and dissemination of the National OVC policy and implementation guidelines. AIM sought to support OVC programs to provide holistic and integrated OVC services consisting of a package of components that are part of the ten core program areas prescribed under the Uganda National OVC policy[51]. The package components including health, food security and nutrition, legal, psycho-social support and socioeconomic security for OVCs and their households would be provided through direct support and/or referral. OVC grantees were expected to benefit from organizational development training[52] offered to CSO grantees and from sensitization on OVC policy and its recommended package of services.

Achievements

In the AIM and the comparison districts, the evaluation team held discussions with selected District officials including District Community Services Based and Probation officers and with CSOs providing OVC services. In the Arua district the Team visited 3 out of 9 AIM supported CSO grantees, 3 out of 7 in Tororo and 2 out of 5 in Bushenyi district.

OVC Services

[51] The policy was enacted in November 2004

[52] strategic planning, financial and human resource management and resource mobilization

CSOs supported by AIM were mostly providing education support including scholastic material support (books, uniforms, pens and school fees), food security and nutrition support (training and in some cases food supplies were provided) and socio- economic security support (mainly vocational training including tailoring , brick laying and carpentry for out of school OVCs). There was much less focus on HIV /AIDS related services with some CSO grantees not providing any such support at all. HIV/ AIDS activities supported by AIM CSO grantees in Tororo, Bushenyi and Arua were mostly on sensitization and testing of OVCs their caregivers and communities. There was little evidence of CSOs linking their clients to providers of OVC services that they did not offer.

The Evaluation's PHA household survey findings showed that OVC support desired most by households caring for OVCs in the AIM districts was catered for under AIM interventions: in AIM districts, the OVC households reported school fees and adequate food and other basic household needs as the most pressing problems encountered in caring for OVCs.

Comparison Districts

The situation in comparison districts was not much different. OVC households reported school fees, adequate food and basic needs as the most pressing problems.

Capacity Building

The AIM CSO grantees reported to have received training in resource mobilization (proposal writing), AIM financial and program reporting. All except the Tororo CSOs reported they had received training on the OVC policy and core OVC program components. Some OVCs carried out their operations reasonably well while others lacked capacity to do so for example, one of the OVC grantees in Tororo offering vocational training had no trained technical instructors. As mentioned above, few AIM grantees implemented comprehensive and reasonably well integrated OVC services. In comparison OVC grantees in the in AIM districts were more aware of the OVC policy.

AIM strengthened the capacity of AIM districts to coordinate and supervise OVC programs. This is linked to AIM's support to DAC to supervise projects and to ensure that services reached underserved areas. Mainstreaming of OVC into district plans and supervision was stronger in the AIM districts.

Comparison Districts

CSO groups in comparison districts were less aware of national OVC policies and there was little effort to integrate HIV/AIDS with other services, usually focused on needs related to schooling.

Issues and Concerns

<u>Capacity and Grant Size</u>

OVC grantees were not able to adequately address the demand for OVC services due to relatively small grants size and in some cases low capacity of grantees. Gap analyses conducted by AIM and UBOS 2002 Census Report for example indicate that there that there are far more OVCs than the grantees were able to serve. Some respondents expressed fear that OVC numbers were growing.

> *Out of 1345 orphans registered in Budumba, Busaba and Busolwe Sub Counties, only 100 orphans were served*
>
> *Mr. Mutono Hiire, Community Alert, Butalegya District formerly part of Tororo (A CBO providing OVC services).*

So many people are dying and leaving relatives to look after the orphans. Last week, some one died and left 7 orphans to look after

Chairperson Butalegya District (formerly part of Tororo District)

The PHA household survey also revealed that most of the PHA households in both AIM and Comparison districts had OVCs as shown in the table below.

TABLE 14: PERCENTAGE HOUSEHOLDS WITH OVC IN AIM AND COMPARISON DISTRICTS

District	Percentage of households with OVCs
AIM districts (N=147)	93.9%
Comparison districts (N=91)	97.8%

Most of the grantees visited by the Evaluation Team had stopped their operations after AIM closed due to lack of funds. Many did not seem to have capacity to easily obtain funding from other sources.

Time constraints and commitment

One year grants are not sufficient in length to develop serious remedial, training, or systematic care programs. Many Civil Society grantees demonstrated increased capacity through training and supervision by AIM, especially by AIM regional staff, but the one year grant period, according to almost all respondents, was simply too short to develop systematic programs and the capacity to mount longer term programs. AIM staffs were convinced that many grantees could provide consistent services, but without longer term support, this will not happen. Some more entrepreneurial grantees have already moved on to other donor funded programs.

As discussed above in the PHA section, CSOs that have already demonstrated commitment and an interest in being involved in HIV/AIDS support programs are the best candidates for providing services over time. Many CSO grantees did not see themselves as primarily HIV/AIDS related organizations, although they did bring in HIV/AIDS clients into their programs with AIM grant support. It is unlikely that they will retain a commitment to the HIV/AIDS effort.

PMP Objective 5: Improved use of strategic program information

***Intermediate Result**: Increased access to and utilization of strategic information*
Performance Measure 1. *No of AIM-supported districts that track HIV/AIDS indicators* *Definition: AIM districts that have an HIV/AIDS district-based MIS* 2. *Total number of individuals in AIM districts trained and or/retrained in strategic information for HIV/AIDS*
PMP claim: *All 16 districts will have an HMIS system for tracking HIV/AIDS up and running*

Accurate, relevant, and usable information is a key ingredient in any program. Information systems must produce usable information that matches up with the various levels of decision making if decisions about program policy, progress, and achievements are to be well grounded and rational. One of the major challenges of any information system is to find a balance between comprehensiveness on the one hand, and the needs of local, national and international decision makers. The AIM project devoted much attention to the problem of designing an information system that would serve AIM, Ugandan decision makers at the district and national level, as well as providing the PEPFAR Coordinator's office in Washington with information needed to be accountable to the President and to the US Congress. Objective 5 of the PMP measures the development of a Health Management Information System for tracking HIV/AIDS. Many of the findings cited below are consistent with the findings of the Mid Term Review.

TABLE 15: ASSESSMENT OF INFORMATION SYSTEMS' FUNCTIONALITY IN AIM AND COMPARISON DISTRICTS

Services Points	AIM DISTRICTS				COMPARISON DISTRICTS			
	Tororo	Arua	Bushenyi	**Total**	Iganga	Moyo	Kiboga	**Total**
District records /HIV data	2	3	2	**7**	1	2	3	**6**
District organs have trained staff in MIS and M&E	3	3	3	**9**	1	x	3	**4**
Persons in place in MIS/M&E using the skills	2	2	2	**6**	1	2	2	**5**
Score	**7**	**8**	**7**	**22**	**3**	**4**	**8**	**15**

Score Key:

0: Not functional or not available
1: Minimally operational with many problems
2: Moderately operational with a few problems
3: Fully functional
X: No opportunity to assess

Achievements

Computer support

AIM *strengthened the capacity* of the district HIV/AIDS focal person, records assistants and some grantees to capture and manage HIV/AIDS performance data through training and provision of computers and software. Specifically in the AIM supported districts, substantial improvements in the provision of hardware, software and personnel skills relevant to a functioning HMIS system were achieved. The team found the following:

- Provision of computers and printers at district level for the HMIS focal persons
- HMIS focal person at district level trained.
- Provision of computers and printers for some HSD level e.g. Koboko Health Centre IV
- Provision of computers and printers to some CSOs to strengthen information and data management, for example ICOBI in Bushenyi and ASED in Arua also benefited from computers and printers for capture and management of HIV/AIDS performance data.
- Motorcycles and bicycles or/fuel allowances to facilitate routine data collection were given.
- AIM contributed to the development and distribution of HMIS data collection form and HIV/AIDS service referral form especially for the community service providers.

Materials

AIM supported development and distribution of handbooks and guidance manuals for different HIV/AIDS services areas. Handbooks and manuals developed and/or distributed included:

- HIV/AIDS Referral Directories (in districts like Arua and Bushenyi, these came out at Program close out, while for Tororo the directory was about four months old)
- OVC Policy
- A Resource Trainer's Manual for Community Volunteers
- Training Manual for OVC Service Providers

Formats prepared

At the national level the Program championed the inclusion of HIV/AIDS indicators in the HMIS form. Revised HMIS forms were even found in both AIM and comparison districts.

Through the above interventions the Program created sensitivity/ or awareness for use of strategic information at both HSD and district level, but none at the lower levels where the data originates. The use of data and strategic information for planning purposes varied across districts, for example in Arua and Bushenyi districts, there was observed significant use of monitoring data for both planning and implementation of HIV/AIDS services.

Comparison Districts

In districts like Moyo and Kiboga with externally HIV/AIDS supported programs, like Uganda AIDS Control Program, HIV/AIDS data was being collected. Reports from facilities and CSOs were reported to be aggregated at the district by the DDHS office (HIV/AIDS focal person). The reporting formats depended on the program(s) and these were different from the HMIS report. Some of the projects in the comparison districts had trained the DAC in use of monitoring information. There is no evidence for use of the information rather than reporting to the projects.

In districts without any program like Iganga, the MOH HMIS form is the main reporting tool. The records assistants were trained by MOH in 1998. The data is aggregated manually, i.e. due to lack of computers or

old computers that have broken down. The district HMIS focal person mainly relies on returns from the HC III. As we have seen in previous sections, the HC III and lower health facilities may be the weakest link in the information chain.

Issues and concerns

AIM districts

Work load

At HSD level, AIM supported interventions have created extra workload which has not been matched by staff increases. The records assistants are also generally overloaded. The AIM data collection tool was generally reported as very demanding – a lot of information was required. .The AIM Program created more reporting forms (resulting into multiple/parallel reporting formats) there was no effort to address this problem.

Data Quality

It was indicated that low level facilities did not have capacity created to support the HMIS data collection system. One records assistant at HC IV indicated that "the quality of data from the health facility (HC III) is very poor. There is a need to train people who collect and enter data at health facility" One respondent at a HC IV reported that that the records assistant recorded data inaccurately.

HMIS Management

Supervision and performance monitoring feedback to grantees was not provided in written form and the team saw no evidence of systems to track utilization of the supervision team recommendations i.e. information showing whether the recommendations were adopted by the grantees.

There is lack of tracking data on CSOs/CBOs and the services areas they are involved in at district level.

Comparison Districts

The HMIS situation in comparison districts was still worse than in the AIM districts. This appears to be attributable to the residue of other foreign assistance projects, all of which have, of course, focused to one degree or the other on how to collect relevant data. The findings in comparison districts were:

- Multiple/parallel reporting formats exist in all districts that have foreign donor projects.
- Low completion rate of returns from the lower health facilities (estimated at about 65%).
- Late submission of HMIS returns due to low completion rates and lack of computers. Computers supplied under earlier donor projects no longer function, so data has to be hand processed.

UNINTENDED CONSEQUENCES

The evaluation team was alert to unintended consequences of the AIM Program, as requested in the SOW. However, these must be considered impressionistic and requiring further research and analysis. We are able to identify both positive and negative unintended consequences, as presented below.

Advocacy

By focusing its effort at the District level, the AIM Program served to increase local governments sensitivity to the issue of HIV/AIDS, especially in so far as PHA and other CBO networks became energized to 'advocate' at the local level for more support as well as to provide services. Whether the AIM grant program succeeded in significant expansion of HIV/AIDS services through CBOs or not, the Program certainly contributed to creating more organizational capacity and awareness among local CBOs.[53]

Decentralized Government

Uganda has followed a program of decentralization to the district of most government planning, development, infrastructure and social service programs. This process is by no means complete; the revenue base for local government has been annihilated by recent tax reduction decisions of the national government. The AIM Program, by requiring that local government be heavily involved in planning, monitoring and implementing HIV/AIDS programs, served also to expose many of the weaknesses of local government offices at the district level, especially the lack of operational budgets to facilitate program implementation and monitoring.

Displacement

There is some evidence from the Household Survey that may suggest that as AIM improved systems of prevention, care and support by both government facilities and organized CBOs, families with PHA or OVCs or both became more dependent on these programs and less reliant on other family members, neighbors or local communities. This outcome suggests the emergence of a 'welfare' mentality which may erode community self reliance. The evaluation is very wary of this conclusion, but puts it forward as an issue to consider in designing future programs.

Raised Expectations

The AIM Program was multi-faceted and, because of the array of interventions taking place in sixteen districts, was also very management intensive. The interface between AIM and local government, health providers and CBOs was constant and significant during the life of the Program. This high level of management attention, as with many foreign donor projects, can produce raised expectations and a kind of "Hawthorne Effect", by which the performance of the health and CBO personnel in the AIM districts continues to improve in part because of the amount of attention that is being given by the Program.

[53] USAID Democracy and Governance programs around the world emphasize the importance to democratic governance of a robust and diverse array of civil society organizations. USAID has promoted civil society development through a variety of programs, almost all involving training and grants to improve the legal standing of independent civil society, the capacity of these organizations to represent interests and provide services, and to participate actively in the social and political life of the countries. In the AIM project, the explicit purpose was to develop capacity to deliver services, but the unintended consequence might have been to promote a process by which civil society organizations can participate in and contribute to local government and democratic decision making.

Unfortunately, when AIM is no longer, and no new funding source becomes available to sustain the effort, the natural human tendency is to revert back to a lower level. CBOs wait for the next grant program. Microscopes malfunction but are not reported or replaced. Data collection instruments introduced by the Program become disused.

CONCLUSIONS

1. AIM achieved PMP Targets

With regard to specific improvements in DAC planning, development of better testing, treatment and institutional referral systems, AIM districts outperformed comparison districts by a substantial margin.

AIM was able to demonstrate the efficacy of integrated planning, implementation and monitoring of multiple HIV/AIDS inputs at the local level with varying success. Some districts, such as Bushenyi achieved a level of ownership and competence not matched by other AIM districts visited. Through the extraordinary efforts of the JSI staff, which provided training, budget support, and JSI management of equipment purchases, grant financial and program management, and technical assistance to the DAC and various CSOs, the AIM districts over the life of the Program did achieve or exceed predicted results as measured by selected PMP indicators. **In general all AIM districts performed better than comparison districts on most PMP dimensions.**

2. Access to services expanded

AIM reports impressive gains in VCT and PMTCT intake over the five year life of the project, but available data from non-AIM district show equally strong numbers, reflecting an improving national level effort to promote utilization of VCT and PMTCT services. As also stated previously in the Mid-Term Review, AIM succeeded in meeting its PMP targets. The data available to the team from the Government of Uganda show that AIM districts performance on specific indicator such as PMTCT intake is not appreciably different than non-AIM districts. It is worthy to note the national VCT and PMTCT programs are the only two clinical HIV/AIDS interventions that were coordinated geographically and technically at the district and service delivery level. As USAID has noted, district focused PMTCT activities supported by AIM, UPHOLD, EGPAF, UNICEF and other international NGOs were coordinated through the MOH. MOH also coordinated VCT support by AIM, UPHOLD, AIC and other partners at the district and facility level. We conclude that the additional input from the AIM project with regard to these important services had little differentiating impact as compared with the effect of the other national programs.

3. Utilization of Services

Based on responses to a small sample survey of PHA families in AIM and comparison districts, the Comparison districts respondents were able to utilize medical, psycho-social and practical support at the same or a greater level than those in AIM districts. Despite the considerable increase in accessibility of services in AIM districts, this does not appear to have translated into greater utilization as reported by PHA respondents.

This finding is limited to PHA respondents, and does not affect the utilization of services by the wider population, such as use of Voluntary Counseling and Testing. Not does the data reflect any differences in the quality of services rendered.

When asked about constraints to utilization of services, AIM district respondents generally were better able to overcome problems of distance, lack of money for transport, as well as reporting that facilities in

the AIM districts were more reliable with respect to being open, respectful, and able to provide needed services. This suggests that AIM's investment in the quality of services has had a positive impact.

4. Testing a Model

One of the original goals of this project was to "test a model" of integrated service delivery coordinated and managed by a district level decision and oversight structure made up of local government officials and representatives of various civil society organizations. This goal was not attained.

For a model to be tested, there must be a base line established and some form of comparisons districts established at the beginning, the original design must be substantially carried out, and the external environment for implementation must remain relatively stable over the life of the "test". None of these criteria was met in the AIM experience. No base line was established against which changes over time might be measured, and no comparison cases were set up against which to assess results in the project districts.

Another major requirement for 'testing a model' is that the intervention remains stable. This was not possible with AIM. Over the five year life of the project, AIM went through several revisions and strategic redirections, the last as late as September 2004, with less than 18 months left in the five year period, following a highly critical mid term review in June 2004. Changes in the external environment also affected the "test", including the withdrawal of CDC, the arrival of PEPFAR, and the subsequent doubling of project funding.

Nevertheless, AIM did succeed in influencing important elements of national HIV/AIDS policy and field guidance, and did succeed in demonstrating that local government and CBOs, including PHA networks, could work together to be effective providers of services for the purpose of prevention, care and support for HIV/AIDS victims.

5. A poorly grounded project design:

The original project design as expressed in the JSI proposal expressed an innovative strategy for linking national and local entities, and for pairing 'advanced' model districts as mentors with less advanced districts. Unfortunately, the optimistic assumptions of this strategy had little grounding in the realities of the Ugandan social and political structure, including a weak governmental structure and an under-staffed and under budgeted government health system. The original project design was too complex and overly ambitious for the existing capacities of local government and health facilities, and for the five year time frame allowed for the 'test'. Originally, the thought was that national level organizations would, after some capacity building efforts, play a lead role in supporting, mentoring and monitoring local level activities that the project would foster. As it turned out, for some organizations, building capacity took much longer than expected. Others, already reasonably well developed, waited until 2004 for the district level grant program to kick in

6. Changes and Delays in Implementation Strategy

Delays in implementing the strategy affected the implementation of the district and local level capacity building and empowerment objectives, including local government and local civil society organizations enlisted to provide a variety of HIV/AIDS related services.

For the first two years of the project, few project resources were going to the local level, putting pressure on the project implementing partners to speed up the expenditure rate through grants and direct expenditures managed by the AIM project. At the same time, capacity building efforts were undertaken at the district level with the hope that the District AIDS Committees would soon shoulder the burden of local grant proposal review and performance monitoring.

7. Other Factors

Although AIM leadership did succeed in building capacity in the DACs, the DAT was essentially ignored, eliminating the important connection between local political leadership and the technical implementation bodies at the local level. This meant that local politicians, in a number of cases, turned to forming or supporting CSOs as a means of exercising influence over the allocation process. Moreover, true 'ownership' of the project's decision making process remained in the AIM project office, or in the project's field offices. Neither the DAT nor the DAC were, by the end of the project, truly empowered, increasing capacity notwithstanding.

8. Local Government has limited capacity to sustain program

Grafting substantial new responsibilities for HIV/AIDS prevention, care and support along with new information and data collection systems, onto a weak governmental structure, (Local Government, Ministry of Health, and the Ministry of Gender, Labor and Social Development), may not be sustainable. AIM, as with many foreign assistance projects, was able to overcome structural weaknesses and constraints through the skill, authority and budget resources available to it. Budget and staff shortages, staff turn-over, stock-outs, inadequate transport, and poor equipment maintenance, will emerge once again to constrain access and utilization of services of the health clinics.

9. Civil society grant program had limited impact

AIM's incorporation of Civil Society Organizations into the HIV/AIDS treatment and support services system was laudable and did produce a level of engagement and involvement, as well as increasing district level awareness of the HIV/AIDS condition. The team's limited evidence on this suggests that PHA networks were the most effective in responding to AIM's support, especially in expanding informal networks of information and referral.

However, many CSOs engaged by AIM were not primarily HIV/AIDS organizations, and, although they may have successfully completed their grants, whether they will continue as part of the HIV/AIDS alliance is open for question. The completion of AIM's grant funding means, for some, a return to the status quo ante. Civil Society Organizations that do not win follow on funding from other sources already languish, waiting for some new grant program. Clients, faced with less reliable and predictable services, may lose faith and confidence, turning back toward less dependent coping strategies, or simply fatalistic acceptance of their plight.

The reasons for the limited impact of the NGO/CSO mobilization are, first, many of these organizations were not initially committed to the HIV/AIDS effort, second, the grant period was too short and the budget too limited to realize significant gains in service impact, and third, the inability of the project to define service targets against the potential needy population meant that achievements could not be assessed in any meaningful way.

10. OVCs May Need Separate Program

The strategy for dealing with Orphans and Vulnerable Children in the AIM program was to rely on the Ministry for Gender, Labor and Social Services in collaboration with many grant funded CSOs to provide a variety of services to families and to the children. We conclude that this was not a very effective strategy, in part because the Ministry is understaffed and under budgeted, and the CSO grants were only for one year, making it difficult to develop a sustainable partnership. Complicating the problem is the combination of orphans with vulnerable children, the latter being a much larger and somewhat different category. In some real sense, all children in a poor country afflicted with disease and poor nutrition are vulnerable. The team concluded that a program de-linked from HIV/AIDS treatment and care might

achieve greater focus, attract more funding, and be more effectively organized. This is a very tentative conclusion, needing much more analysis and debate before a final policy strategy is reached.

11. Data collection and management

As previously found in the Mid-Term Review, most of the performance indicators and relevant data collection and management processes were designed to serve the accountability needs of the AIM project, USAID, and PEPFAR. The evaluation found at the local level a lack of ownership of these data systems. While capacity to manage the data requirements was increased, the data systems also imposed considerable burden for data collection and aggregation on the districts, especially at the lower levels (HCIII), which were found to be the least reliable parts of the health delivery system.

The AIM PMP provided managers with an extraordinary array of quantitative data which, for the most part measured output and outcome progress. As a monitoring tool for output and, increasingly, for measuring utilization of AIM supported facilities, the PMP was well constructed and probably useful, but it did not yield much information about the qualitative dimension of expected objective level results. Nor did it produce information about how services were used by clients, or the impact of those services on the health and well being of those families afflicted with HIV/AIDS.

There are a number of problems with the way data is aggregated and reported if the primary planning, implementing and monitoring of HIV/AIDS prevention, care and support programs are to be the district level. These are:

a. Results indicators are not reported at the district level.

It was impossible to obtain HIV/AIDS prevalence levels or incidence rates at the district level. The USAID SOW background document states:

> **The mission of the AIM program was to establish effective replicable models that would successfully contribute to the decrease in HIV prevalence and incidence in Ugandan adults and children.**

The progress towards the achievement of this ‘mission’ cannot now be measured at the district level, only at the national level, and then only for HIV prevalence. Nowhere could one find ‘incidence’ data at any level.

If the AIM Model of District Level Integrated Service Delivery is to be taken seriously by officials and CBO leaders alike, they must be able to avail themselves of a few, straightforward progress measures by which they can assess their efforts, and, if necessary, make appropriate adjustments. Without useful information, there can be no ‘empowerment’.

b. Coverage targets are not set

This is true especially for sub-groups such as OVC or PMTCT populations. It is impossible to know from the PMP or MOH data whether a targeted program is reaching certain coverage objectives defined as a percent of the target population in a given parish, sub-county or district.

LESSONS FOR SCALING UP

The evaluation team assumes that scaling up of the national program for HIV/AIDS, to largely be funded PEPFAR and the Global Fund. At the AIM closing conference in March, 2006, the USAID Mission Director announced a US commitment of $169 million dollars to HIV/AIDS in FY 2006. The overall cost of the AIM program was $38 million for 16 districts expended over five years. At this level, the expenditure per district was about $475,000 per year. This includes project indirect costs, so the actual amount per district was roughly $300,000 per year. It is reported that Uganda will have close to 77 districts by 2007, which would require $23 million per year (not including project management overheads) or about $115 million over five years. As there are numerous other donors that also contribute to the HIV/AIDS campaign, it appears that for the foreseeable future Uganda should have sufficient donor funding to scale up to a national program.

Lessons

1. The HIV/AIDS campaign must be tailored to the nature of the problem at the local level.

The AIM program, as part of the original concept, had the idea that if strategies, plans and matching resource allocations were determined at the district level, the HIV/AIDS campaign would be responsive to the unique characteristics of the disease in THAT DISTRICT. The project did not assert that 'one size would fit all.' Although this individualization was not realized as much as hoped in the project, it is today an even stronger requirement.

2. Disaggregated information is essential.

If the national campaign is to rely on district governments and CBOs to plan and implement an effective program, the officials responsible for the district planning process must have access to information on the state of the problem they are trying to deal with***…information must be local, timely, relevant, and limited to what is needed to make decisions.***

3. The political and the technical must be joined.

In response to the national coordination guidelines, which focused primarily on the DAC, AIM largely did not engage the local level political process. As with any threat that affects large numbers of people, it is a political issue, and what to do about it is even more so. The USG is committed to advancing democratic practices and institutions as well as fighting disease. The two are linked. Engaging the Ugandan political process in this fight, however difficult, is critical to its success, and will benefit the democratization process as well.

4. The government's system is part of the problem, and must be part of the solution.

Any new effort must approach the weaknesses of the rural and small town health delivery system in a systematic way. USAID is funding other programs, such as DELIVER, to address the important issue of supply management, but other issues also affect the system's efficiency and effectiveness, most notably technical staffing and related incentives, insufficient capital budgets, and limited operational budgets for outreach and networking programs.

5. Complex programs cannot be sustained without structural management and resource changes.

AIM's effort to integrate services through multiple modalities would have been difficult in the most advanced post industrial countries. By force of its expertise and control over resources, AIM was able to accomplish many things, but this evaluation is skeptical of the long term sustainability of these accomplishments. The experience of the Comparison districts, many of which have had donor assistance in various forms, is instructive. For the most part, the Comparison districts were 'living within the means' of the Government of Uganda, and the resulting poor performance is testimony to what that means. Local Government does not have control over a sufficient portion of its revenue base to be responsive to local conditions. The national line ministries continue to operate within their own program priorities and budget resources. The Ministry for Gender, Labor and Social Development is particularly understaffed and under budgeted.

6. Multi-year contracts with CSOs and CBOs will produce effective services or adequate coverage.

AIM's grant program combined with various capacity building efforts may have helped create a pool of organizations with the potential for delivering services on an extensive and continuous basis. However, the one year grant process is an inadequate funding modality for this purpose. A scaled up national program would do well to include CSOs that have demonstrated their commitment and capacity to deliver relevant services. The modality for engaging these CSOs should be a competitive contract, funded over a three to five year period, with specific service and coverage targets included in the contract. The role of the DAC/DAT should be to monitor, and evaluate the achievements of the CSO contractor on a periodic basis. A small grant program should be continued to stimulate the development of other organizations, and to keep the process open and competitive. CSO small grants of one year duration, however well executed, will not produce the kind of reliable, competent, and consistent services needed for PHAs and their families.

7. OVC programs deserve a separate identity and a more nuanced approach.

The evaluation found that OVC programs were not as effective as expected, both in terms of coverage and in impact. OVC was, to paraphrase, an orphan child of the HIV/AIDS campaign, although AIM made great efforts to mainstream the program. The evaluation team is aware of the debate in Uganda about how best to provide support to orphans, vulnerable children and the families. On balance, the evaluation team believes that 'stand alone' programs from a funding and organizational point of view, would provide more focused and effective services than attempting to integrate these programs into HIV/AIDS campaigns. The reasons for this have to do with the wide range of characteristics and factors that define and determine the OVC problem. Not all orphans are victims of HIV/AIDS. Not all the problems of pre-adolescent VCs are related to HIV/AIDS. There is a bundle of issues with this group, many of which tend to get submerged by the effort to integrate them into an HIV/AIDS program.

APPENDIX A: SCOPE OF WORK

AIM FINAL PROGRAM EVALUATION

Scope of Work (SOW) - November 2005

1.0 BACKGROUND

The AIDS/HIV Integrated Model Project (AIM) is funded through a Cooperative Agreement with the United States Agency for International Development (USAID) for the period May 2001 through May 2006. It is implemented by JSI Research and Training Institute, Inc., and includes World Education and World Learning as consortium members. Key Government of Uganda (GOU) partner institutions include the Ministry of Health (MOH), Ministry of Local Government, Ministry of Gender, Labor and Social Development, and the Uganda AIDS Commission (UAC). Civil society partners at the national and district level are also critical partners. AIM was designed by MOH, UAC, USAID and the Centers for Disease Control (CDC) and other members of the LIFE Advisory Group in late 2000.

In support of the National Strategic Framework for HIV/AIDS in Uganda, the AIM program was designed to assist with increasing the provision of quality integrated HIV/AIDS services at district and sub-district level. AIM was designed to work closely with local government, NGOs, CBOs, FBOs, the private sector and other partners to increase availability and access to a range of core comprehensive services in selected districts. The mission of the AIM program was to establish effective replicable models that would successfully contribute to the decrease in HIV prevalence and incidence in Ugandan adults and children, and that play a significant role in increasing the level of care and support to all those in Uganda affected by AIDS.

The overall goal of the AIM program was for men, women and children in selected districts in Uganda, to access and utilize appropriate, affordable and quality integrated HIV/AIDS prevention, care and support services. Key program objectives included:

- To strengthen and support the capacity of government, non-governmental organizations (NGOs), community based organizations (CBOs), faith-based organizations (FBOs) and the private sector to plan, implement, manage and provide quality services at the national, district and sub-district level.
- To increase integration and quality of comprehensive HIV/AIDS prevention, care and support services in selected districts.
- To increase access to and utilization of quality HIV prevention services in selected districts and sub districts.
- To increase access to and utilization of quality HIV/AIDS clinical, community and home-based care in selected districts and sub-districts.
- To increase access to and utilization of quality social support services for people infected and affected by HIV/AIDS including orphans, vulnerable children and adolescents in selected districts and sub districts.

Throughout the past four and a half years, AIM has operated within a dynamic environment of evolving donor priorities, funding mechanisms, system constraints (see appendix for further

details). Initially, funding for this program came through USAID and CDC. CDC funding ended in program year 3, and since January 2004, AIM has been funded directly by USAID through the President's Emergency Plan for AIDS Relief (PEPFAR) initiative. A mid-term review (MTR) took place in June 2004 and it is envisaged that the final program review (FPR) will take place in January – February 2006.

2.0 PURPOSE OF EVALUATION

The Automated Directive System (ADS) 203.3.6.1 requires that an evaluation is conducted when there is a distinct and clear management need to address an issue. The purpose of this evaluation is to extract lessons that would benefit the USG/Uganda Team and GOU partner institutions with future programming. Secondly, implementing partners, JSI, World Education and World Learning have interest in this evaluation in terms of knowing what worked and what did not work during the implementation of the project. The evaluation will be able to provide answers both at program and strategic level by addressing the question of whether AIM achieved the intended goals. The evaluation will also distil lessons learned about program implementation that will have a bearing on scaling up HIV/AIDS intervention and replication of similar intervention nationwide.

3. KEY EVALUATION QUESTIONS

This evaluation entails examining a number of questions:

3.1 Project Results

a) Did AIM achieve its overall goal and results as outlined in the performance monitoring plan? What factors facilitated or hindered its achievement of planned results?
b) Did the project yield any unintended positive/negative results?

3.2 Lessons learned

a) What are the lessons learned from AIM project relative to scaling up HIV/AIDS services nationwide disaggregated for the Government of Uganda, the United States Government's support to the national response, and USAID project management?
b) Is there evidence to suggest that activities would produce the same results if scaled-up throughout the country?

4. EXISTING INFORMATION SOURCES

The following information document and sources are available and relevant to the study:

- GOU: National frameworks, policies and implementation guidelines from Uganda AIDS Commission, Ministries of Health, Local Government and Gender, Labour and Social Development, Local Government Development Plans and reports
- USAID: Original Request for Application, Emergency Plan related documentation, and The Role of Evaluation in USAID http://www.dec.org/pdf_docs/PNABY239.pdf
- AIM:

- Cooperative Agreement and amendments
- Annual and quarterly reports
- Annual work plans, results framework and performance monitoring plan
- Mid-term Review of AIM
- AIM Website
- Strategy papers for core services
- Tools, training materials, guidelines, etc.
- Grantee stories, lessons learned, case studies
- Internal assessments and reviews
- Other

5. EVALUATION METHODOLOGY

The evaluation team is expected to employ a variety of complementary methodologies in conducting this evaluation. The team is expected to share their methodologies with USAID and selected GOU counterparts for approval before commencing field work.

Proposed points of contact / interviews:

- Key central government officials from Ministry of Health /AIDS Control Program, Uganda AIDS Commission, Ministries of Gender and Local Government
- Local Government Officials including representatives from the District HIV/AIDS Committee
- National, district and community level partners including non-governmental, faith-based and people living with HIV/AIDS
- USAID representatives and representatives of the USG Emergency Plan Team members
- Others as determined appropriate

6. DELIVERABLES

The evaluation team is expected to deliver the following outputs:

Deliverable	Week Due
1. An inception report to be reviewed by USAID and selected GOU partners. The report will include i) A detailed work plan showing a timeline for each evaluation activity to be undertaken, including field work ii) Methodology detailing sampling/selection procedures for districts, CBOs/NGOs, facilities and any other beneficiaries to be visited. iii) "Ready for pre-test" instrument for data collection	First
2. Oral briefing to USAID and selected GOU partners to present methodology, data collection instruments and analysis plan.	First
3. Oral debriefing of USAID, selected GOU and other partners to present key findings prior to submission of draft report	Fourth
4. Draft evaluation report for review by USAID and selected GOU counterparts.	Fourth
5. Final evaluation report incorporating feedback from USAID and selected GOU counterparts.	Sixth

7. TEAM COMPOSITION

The evaluation team will be comprised of one international and 4-5 national experts. The team leader will have prior HIV/AIDS evaluation experience in Africa. Uganda experience is highly preferred. The Ugandan team members will be senior technical staff from key Government agencies and civil society. The team should collectively cover the following fields or experience.

- HIV/AIDS, tuberculosis and orphans and other vulnerable children service delivery in a multisectoral, decentralized environment
- Public/Private partnerships, with a focus on local government and civil society
- Capacity building of key leadership and service delivery organizations
- Program evaluation

8. ROLES AND RESPONSIBILITIES

Government of Uganda (Uganda AIDS Commission, Ministry of Health, Ministry of Local Government)

- Provide concurrence on final program review scope of work
- Serve as key points of reference and information, including key documents, for final review
- Provide concurrence with inception report and workplan
- Participate in oral debriefing
- Review and comment on final report

USAID's roles and responsibilities (includes MEMS) are to:

- Select and contract the evaluators
- Have a full time USAID staff member or representative to participate in the evaluation
- Manage the evaluation process
- Provide briefing to team
- Review draft report and provide feedback
- Sign off the final report
- Submit evaluation report to USAID/PPC/CDIE

AIM's roles and responsibilities are to:

- Participate in final review scope of work development
- Provide relevant documents as needed
- Provide logistical support for the evaluation team including office space, assistance with setting up meetings, interviews and providing transport (2 vehicles)

Evaluation Team Leader's roles and responsibilities:

- Guide and manage evaluation exercise
- Responsible for all deliverables to USAID

9. SCHEDULE AND LOGISTICS

Team members will be expected to spend approximately four weeks (24 days) in Uganda conducting this evaluation. The evaluation team leader will be expected to provide several days prior to and following the in-country work to prepare and complete the evaluation.

The in-country activity is expected to commence on January 16, 2005 and will be completed by February 10, 2005**.** The team leader is expected to begin work the week of January 9th and to complete the final evaluation no later than February 28, 2005. The Team shall be provided office space at AIM offices for the duration of this evaluation. MEMS, the USAID monitoring and evaluation contractor, will facilitate a one-day, Team Planning Meeting (TPM) for this evaluation study in its Kampala offices. The Team leader is expected to finalize his/her own program of work following the TPM, working within the parameters of the illustrative work plan. The Team leader shall be required to deliver a draft report to MEMS and the AIM Cognizant Technical Officer, who will share it with GOU counterparts. USAID/GOU partners will review and provide comments on the draft evaluation report within a period of about one week of its receipt, and the evaluation team shall be required to submit to USAID/GOU Partners a final version of the report that is responsive to USAID/GOU comments no later than February 28th**.** The final report will be submitted in both hard copy and electronic form. Three bound copies of this report will be provided to USAID for distribution to key partners. Electronic submission to USAID is intended to facilitate compliance with USAID's requirement for the delivery by USAID operating units of an electronic copy of every completed evaluation to USAID/PPC/CDIE at cdie_acq@usaid.gov.

10. BUDGET IN (PERSON DAYS) FOR THE CONSULTANT/FIRM

10.1 Budget in (person days) for Evaluation Team

a) Budget in (person days) for Team Leader

No.	Activity	No. of Days
1.	Preparation /Document review	2
2.	TPM, Initial Meeting with USG/GOU Partners, Study preparation	1
3.	Development of tools	2
4.	Pre-testing and finalizing of tools	2
5.	Field work	13
6.	Data analysis	3
7.	Oral briefing and Prepare draft report	4
8.	Revise draft report based on comments from for USG/GOU Partners	2
	Total	**30**

b) Budget in (person days) for each consultant on the team

No.	Activity	No. of Days
1.	Preparation /Document review	2
2.	TPM, Initial Meeting with USG/GOU Partners, Study preparation	1
3.	Development of tools	2
4.	Pre-testing and finalizing of tools	2
5.	Field work	13
6.	Data analysis	3
7.	Oral briefing and Prepare draft report	4
8.	Revise draft report based on comments from for USG/GOU Partners	2
	Total	**28**

Note: These tables are just illustrative for budgeting for number of man days to accomplish the tasks. The team leader may switch days across activities, but the total numbers of days should not exceed 26 days for team members (2 days for final review and editing of document) and 31 days for the team leader.

ILLUSTRATIVE REPORT OUTLINE

Cover page (Title of the study, the date of the study, recipient's name, name(s) of the evaluation team.

Preface or Acknowledgements (Optional)

Table of Contents

List of Acronyms

Lists of Charts, Tables or Figures [Only required in long reports that use these extensively]

Executive Summary [Stand-Alone, 1-3 pages, summary of report. This section may not contain any material not found in the main part of the report]

Main Part of the Report

1. *Introduction/Background and Purpose:* [Overview of the final evaluation. Covers the purpose and intended audiences for the study and the key questions as identified in the SOW)

2. *Study Approach and Methods:* [Brief summary. Additional information, including instruments should be presented in an Appendix].

3. *Findings:* [This section, organized in whatever way the team wishes, must present the basic answers to the key evaluation questions, i.e., the empirical facts and other types of evidence the study team collected including the assumptions]

4. *Conclusions:* [This section should present the team's interpretations or judgments about its findings]

5. *Recommendations:* [This section should make it clear what actions should be taken as a result of the study]

6. *Lessons Learned:* [In this section the team should present any information that would be useful to people who are designing/manning similar or related new or on-going programs in Uganda or elsewhere. Other lessons the team derives from the study should also be presented here.]

Appendixes
[These may include supplementary information on the evaluation itself; further description of the data collection/analysis methods used; data collection instruments; summaries of interviews; statistical tables, and other relevant documents.]

SOW Attachment 1: External Environment and Context[54]

The RFA for the program that became the AIDS Model Integrated AIDS/HIV program was issued in December 2000 by USAID. In partnership with the Centres for Disease Control and under the guidance of the Uganda Life Advisory Group, consisting of representatives from governmental and nongovernmental organizations, AIM was designed to expand successful HIV/AIDS strategies and to facilitate delivery of comprehensive services.

With a significant increase in U.S. Government HIV/AIDS resources, the scope of the Cooperative Agreement was expanded in program year two to include six new districts and to support the National TB and Leprosy Program to roll-out CB-DOTS in the sixteen districts[55]. The Cooperative Agreement increased from $20 million to $38 million through this modification.

During the life of AIM, many initiatives were taking place at the national and district level, most of which are described in key GOU and AIM documents. Several activities, many of which were supported directly by the U.S. Government and/or AIM, include review and revision of the National Strategic Framework on HIV/AIDS, development of a national HIV/AIDS monitoring and evaluation framework, development of district coordination guidelines, the establishment of the Partnership Committee and self-coordinating entities and adoption of the Three Ones. AIM has worked closely with the UAC on all of these initiatives.

The World Bank supported Multi-country AIDS Program (MAP) also began in 2001. Originally designed to support the entire country, the MAP project works in 30 districts and has significant similarities with the AIM program as relates to supporting decentralized HIV/AIDS service delivery, with a key focus on civil society. Several Global Fund proposals were submitted for HIV/AIDS, ART, OVC and TB. All but TB were significantly supported by USAID. In 2004/2005, the Resource Centre of the MOH began a process of revising the national HMIS with a particular focus on HIV/AIDS indicators. AIM supported this revision process and the training for its roll out, all the while maintaining its support for a parallel MIS designed by AIM precisely because of the HIV/AIDS data gaps in the old national HMIS. AIM has worked closely with the central ministry and district level MOH staff to develop and implement HIV/AIDS services under the mandate of MOH.

GOU continued its emphasis on administrative and fiscal decentralization during this period. Processes advanced unevenly across districts, with manpower and other capacity shortages the rule, rather than the exception. In 2005, the decision was made to expand the number of districts from 56 to more than 76. Five of the AIM districts are directly affected by this decision. Also in 2005, the GOU abolished the graduated tax at local government level. Several initiatives under the auspices if NKG are currently underway including a review of the decentralization, with the goal of strengthening decentralization, and assessing the role of regional tier governments. AIM

[54] The Leadership and Investment in Fighting an Epidemic (LIFE) Initiative was launched by the United States Government in 2000 to increase support to HIV/AIDS in fourteen countries.

[55] AIM expanded from 10 to 16 districts in November 2002 to cover Rukingiri, Ntungamo, Bushenyi, Kibaale, Mubende, Tororo, Pallisa, Kumi, Soroti, Katakwi, Lira, Apac, Pader, Nebbi, Arua and Yumbe.

has worked closely with the Ministry of Local Government, the Uganda Local Government Authority and the Uganda Local Authorities Association.

AIM has also worked closely with other key partners including the Ministry of Gender, Labor and Social Development in support of the National orphans and other vulnerable children (OVC) policy and implementation plan. AIM has been a key technical supporter in the development of an OVC toolkit for community programs. At the district level AIM worked closely with local government, including technical staff across key sectors. Civil society has also been a critical partner to AIM at the national and district level, with 38 national grantees and 393 district based grantees awarded through AIM.

Uganda recently conducted a national sero-prevalence survey to determine HIV prevalence across the country. Whereas previous estimates of prevalence were derived from sentinel surveillance data and small, localized studies, this study, released in 2005, is nationally representative and offers a wealth of useful data. The first sero-survey was conducted in 1987/88.

Several key activities within the USG and AIM should also be noted, including the turnover of two Chief of Parties, changes in funding partners and mechanisms, including the withdrawal of CDC and the introduction of the Emergency Plan, as well as some key internal project management resolves, which have resulted in AIM revisiting its approaches, interventions and expected outcomes at several points in the life of the program.

The team which conducted the mid-term review of AIM included representatives from the Ministries of Health and Local Government and civil society as well as three international team members.

APPENDIX B: EVALUATION ACTIVITY SCHEDULE

	Week Due					
Activity	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**[56]	**Week 6**
Preparation /Document review						
TPM, Initial Meeting with USG/GOU Partners, Study preparation						
Development of tools						
Pre-testing and finalizing of tools						
Field work – data collect						
Data analysis						
Draft Report write-up						
Final report write-up						
Final Report submission						

[56] USG Team reviews draft report

APPENDIX C: EVALUATION KEY INFANT GUIDE

AIM Evaluation, USAID Uganda
March, 2006

Key Informant Question Guide: District and Sub-district Level

Explain the purpose of your visit. Assure your respondent that his/her name will not be identified in the report connected with any information he/she gives you. Please, encourage the respondent to be open. His/her cooperation will benefit the design of the follow-on program.

Instruction to the Interviewer: Complete for each interview. You may use your own notebook to record responses for open-ended dialogue questions but for each key informant interview must have a completed data sheet. The questions are open-ended and require probing and a dialogue with the respondent. Some of the questions may provide answers that are possible to 'code', if so, please use the form to enter responses to those questions.

Whether you take notes on this form or in a separate notebook, be sure to get the following information.

1. Name (optional)----------
2. Position/responsibility----------
3. District/sub-district----------
4 Length of service in position----------
5. Date_____
6. Interviewer_____

PMP Objective 1: ***Strengthening Capacity to plan, implement and manage integrated services.***

Key Informants: CAO, District HIV/AIDS Focal Point Person, Members of DAT and DAC, DDHS, HIV/AIDS program Person(s) in Health Sector, Community Development Officer,.

(1) How does the DAC in this district function? Probe for leadership commitment and authority over other departments, membership, frequency of meetings, reasons why they meet, Agenda, participation of members in discussions, reporting and linkages with other committees/teams/levels, main outputs of the committee?

(2) What is the multisectoral HIV/AIDS planning process like? How the plan was developed, who participated, which groups were left out, were there any problems during planning, how were the priorities of the plan reached? To what extent do you think the plan can be implemented and why?

(3) To what extent is the multisectoral HIV/AIDS plans integrated in the District development plans, how frequently is the HIV/AIDS plan reviewed, do all the key persons participate in the review?

Check for evidence of this integration: (1) Yes….O (2) No…O

(4) How does the DAC influence implementation of the multisectoral plan, or it is done by others? how are implementation resources determined? How does DAC influence the budgeting, who implements what and where? What is the influence of DAC on the various stakeholders (Funding and Implementing partners), How is DAC involved in the monitoring, evaluation and report the processes of HIV/AIDS activities in the district

Would you say the DAC has control over the implementation of the Plan?
(1) Yes….O (2) No…O (3) Some Influence …O

(5) What do think are the major achievements of the AIM program in strengthening capacity of the DAC to plan, implement and manage integrated services?

What are the major weaknesses/problems/challenges DAC has in doing its job *if any?*

(6) Given that grants have ended; will the district be able to continue the level and quality of work that has been achieved by the program? What are strategies in place?

(1) Intake number at VCT and other sites as PERCENTAGE of District Vulnerable Population (15-49). Try to work out extrapolation if necessary.

Financial year 2005

	Target	**Reached /Served**	
VCT			
STI			
Antenatal attendance			
Pregnant women tested			
Pregnant women testing plus			
Pregnant women NVP			
Babies NVP			
OVC			
PHA			

Instruction to the Interviewer: Arrange visits to sites**:** (*Try to select sites on random basis if possible).*

- 2 or 3 HC IVs. (Offering at least 6 core AIM supported services).
- 4 HC IIIs. (Offering at least 3 core AIM supported services).

PMP Objective 2: ***Increased Integration and Quality of Comprehensive HIV/AIDS intervention at District and Sub-District level***

Key Informants: HSD HIV/AIDS program persons, In charges of HSD, Program Committee Members

District…….
Name of Facility …….
Level …….

(1) Does the HC IV provide the following services on a regular basis? Check if yes and you are able to confirm that services are being given when you visit.

about counseling and testing

Location 1.– 2. –3. No

District: HCT_____ Counseling _____ Testing_____

Services	**No**	**Yes**	**Frequency**	**Observation Level and Adherence to guidelines**		**Percent Personnel Trained**
				Yes	**No**	
HCT						
PMTCT						
STI						
TB DOTS						
Lab						
OI						

(2) What contribution has the AIM project made to your HC capacity to provide these services? (Probe for training/technical assistance/equipment/budget/supplies?)

(3) Are there any difficulties or constraints you face in providing these services? (Probe for specifics…list if possible)

(4) Given that grants have ended; will the district be able to continue the level and quality of work that has been achieved by the program? What are strategies in place?

PMP Objective 2: ***Increased Integration and Quality of Comprehensive HIV/AIDS intervention at District and Sub-District level***

Key Informants: In charges of HC IIIs, Committee Members

District…….
Name of Facility …….
Level …….

(1) Does this facility provide the following services on a regular basis? Check if yes and you are able to confirm that services are being given when you visit.

Services	**No**	**Yes**	**Frequency**	**Observation Level and Adherence to guidelines**		**Percent Personnel Trained**
				Yes	**No**	
STI						
TB DOTS						
OI						

(2) What contribution has the AIM project made to your HC capacity to provide these services? (Probe for training/technical assistance/equipment/budget/supplies?)

(3) Are there any difficulties or constraints you face in providing these services? (Probe for specifics…list if possible)

(4) Given that grants have ended; will the district be able to continue the level and quality of work that has been achieved by the program? What are strategies in place?

PMP Objective 3: Referral Networks are operated by the HC. A PMP claim is there are 48 Referral Networks.

Key Informants: (HSD In charges and members of the referral committees, HC IIIs)
Examine referral process by asking person responsible to 'walk you through' the process. Determine whether the HC staff are knowledgeable, have data forms, information to give clients for various forms of treatment or support available.

(1) Is the facility part of a functioning referral process that keeps records, reports and provides accurate information to client?
Yes….O Partially …O Not functional …O

(2) Discuss the functioning of referral process between this facility and providers of HIVAIDS services not available at this facility.

(3) How has the AIM project contributed to the establishment of a referral network here?

(4) Are there any difficulties or constraints you face in offering referral service?

(5) In your experience, do you find that people actually follow up on the referrals you give?
Yes….O Most …O Some …O Few …O

(6) The AIM project has helped to organize PHA networks to help others find assistance. In your experience, is there a PHA network in this area? Does this network help to send people to the HCs referral services? (Probe for relationship good or bad)
PHA network active ….O Some …O Very Few …O Never, DK …O

(7) Given that grants have ended; will the district be able to continue the level and quality of work that has been achieved by the program? What are strategies in place?

Objective 3: Increased access to and utilization of quality HIV/AIDS Prevention Services (Prophylactics and behavior change)

(1) Discuss with health personnel about strengths, problems, and constraints to maintaining high level of service to vulnerable population.

(2) If possible: establish what percent of women received PMTCT against estimated total population of PHA pregnant women in district.

(3) Discuss causal factors for reported lack of follow through using prophylactic regimes by HIV+ Mothers.

(4) Discuss with health service providers and clients the general problem of behavior e; focus on males, females, youth. What factors contribute to difficulty of getting people to do what needs to be done?

(5) (probe: lack of information, distance and inconvenience, social stigma, denial, financial constraints, unhappy with services provided, etc.)

(6) Discuss with health service providers what kinds of programs offered by AIM seem to have the most positive impact on motivating people to take care of themselves?

Objective 4: Increased access to and utilization of quality HIV/AIDS care and psychosocial support.

Interviewer: PMP claims 103 labs can test for HIV, syphilis, malaria, TB. 82 have been refurbished and 113 supplied with new equipment. 68 staff are trained to do these. Visit at least two labs in each district. Confirm status and training of technicians. Assess whether lab technicians believe this quality can be sustained in future.

Intermediate Result 1: Improved Laboratory capacity for testing
II
Objective 4. Intermediate Result 2. Increased access and utilization of QUALITY PREVENTION SERVICES.

Interviewer: This IR has 7 Performance Measures, mostly having to do providing to HPAs prophylaxis and care for TB. See PMP Summary for details P.6/7. Team should visit at least 5 HC IIIs and discuss treatment regimes as described.

1. Assess the general quality of data recording and use of HMIS system at HC level to confirm AIM intake and care figures.

2. Ask Respondent what kinds of problems, constraints, and issues they face in delivering quality care. Probe for training, supply chain, other possible constraints.

3. Ask Respondent whether they believe that the current level of quality care can be sustained after the AIM project.

Objective 4. Intermediate Result 3. Increased access to and utilization of QUALITY CLINICAL AND HOME BASED CARE (NON ART) .

Interviewer Note: PMP claims 528 outlets created including PTCs, CHBCs, OI Sites, and PHA Networks, as well as 4653 persons trained. 65 PHA networks are linked to RNA networks. **HOWEVER, AIM DATA INDICATES THAT NUMBER OF PHAs TREATED IS LESS THAN HALF OF THE TARGET, AND THE PERCENT OF PHAs RECEIVING CARE AND SUPPORT THROUGH THE REFERRAL NETWORKS IS 44 PERCENT AGAINST TARGET OF 70 PERCENT. AS WITH PMTCT, THERE IS A GAP BETWEEN SUPPLY AND EFFECTIVE DEMAND AS UTILIZED.**

SELECT PURPOSIVE SAMPLE OF AT LEAST ONE EACH OF THE VARIETY OF AIM FUNDED OUTLETS MANAGED BY CSOS, INCLUDING PTCS AND PHA NETWORK LEADERS FOR INTERVIEWS.

1. Examine the quality of record keeping on intake and treatment provided by the site and determine that it meets guidelines.

Yes_____ Some deficiencies _____ Not _____

2. Clarify the kind of services provided by this OUTLET. What do they do?

3. If services are provided to families with orphans, what kind and how has the AIM grant helped to meet this need?

4. Does this organization receive funding or support from other sources besides AIM? Is this sufficient to maintain their program?

5. What kind of problems does the Outlet face is providing services to PHAs and families in need?

6. Will the Outlet be able to continue to provide same level of services after AIM grant closes? How will they do this?

7. What does the CSO respondent think are the reasons why it is difficult to get PHAs to access and utilize available treatment and support services?

8. Are there GENDER differences as well as AGE differences which affect whether PHAs seek and use services provided? What are they?

Objective 5 IR: Increased access to and utilization of STRATEGIC INFORMATION

Interviewer Note: PMP says all 16 districts will have HMIS system for tracking HIV/AIDS up and running by end of project with trained personnel for data management as well as Monitoring and Evaluation.

IF YOU HAVE NOT ALREADY DONE SO, CONFIRM THAT HMIS SYSTEM IS FUNCTIONAL.

DETERMINE WHETHER MONITORING AND EVALUATION IS DONE BY EITHER GOVERNMENT OR BY CSOS AND, IF SO, WHAT USE IS MADE OF INFORMATION AND ANALYSIS?

APPENDIX D: EVALUATION PHA QUESTIONNAIRE

USAID Uganda
AIM Project Final Evaluation
Household Access and Utilization of AIM supported services
Questionnaire

Informed Consent Form[57]

I am working for the Monitoring, Evaluation and Management Services (MEMS) Uganda office of Management Systems International, Inc., USA. I am conducting a study of the AIDS/HIV Integrated Model District Programme (AIM) supported by the Government of Uganda and USAID, and implemented by John Snow International. The purpose of the study is to evaluate the effectiveness of the programme, and to learn lessons that might be applied to develop a more effective national AIDS/HIV programme.

You are hereby kindly requested to contribute to the study by answering questions that will be asked of you and members of your family. The questions will be about your knowledge, attitude, belief and practice related to AIDS/HIV prevention and care. You will be asked questions and I will write down the answers.

It is important that you understand the following information about this study:

- Your participation is entirely voluntary. You may refuse to take part. If you agree but wish to withdraw at any time, you may do so. You have a right not to answer any specific question.

- Your participation in this study will not affect you in any way. Your name will remain confidential; it will not appear on this questionnaire.

- Information that identifies you or your household will not be released in any way.

- The findings will be used only for evaluation purposes and future program development.

- You have the right to ask questions at any point in the interview.

Please tell me if you agree to participate by signing or initialing this form.

Respondent Name/Signature:_____ Date:_____
OR (if persons is unwilling to sign or unable to do so)

[57] Consent Form adapted from forms used by Kyambogo University graduate interviewers in study of Mulago TASO Branch and from Makerere University Institute of Public Health baseline survey of Kampala District. No publications dates, circa 2002/3.

I _____will sign here indicating that the information above was read to you, and you agree to participate and that your consent is given voluntarily.
Interviewer Signs_____ Date:_____

AIM Uganda Household Survey Questionnaire[58]

March 2006

Interviewer _____ Sample ID#_____

I. Respondent demographics

101.	Location of household	District	Division
102.	Respondent Gender	M____1 F____ 2	
103.	Respondent Age	_____	
104.	Have you attended school?	No	1
		P1-P4	2
		P5-P7	3
		S1-S4	4
		S5-S6	5
		Tertiary	7
		Other	8 _____
105.	Are you currently working	Yes	1
		No	2
106.	(IF YES) What do you do?	_____	
107.	Do you have other sources of income	Yes	1
		No	2
108.	On Average how much do you Earn per month (Ug. Shs.)	_____	
109.	For how long have you stayed in This area?	_____ Years _____ Months	

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[58] This questionnaire is based on questionnaires used by Kyambogo University TASO Case Study, Makerere University Behavioral Surveillance Program Study Team Baseline Study, 2005 and the Uganda HIV/AIDS Sero-Behavioral Household Questionnaire, Version 9. November, 2003. The evaluation team has made every effort to build on the experience and practice of previous research studies, and in the best tradition of good social science, is appreciative that these reports have included their survey instruments. We have made substantial changes, and any methodological or conceptual errors are the responsibility of the team.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

II. Household Information

201. Total persons in Household _____

Interviewer: Please complete table for all household members. List by # only.

202. Household Family Health Inventory
Table 1

Family Member Number	**Gender**	**Age**	**Respondent Relationship to Head of HH**	**Health Status Tested**	**Health Status Not tested**	**Reside at Home Most of time**
Example 1	**Male**	**35**	**Head**	**HIV+**		**Yes**

(key and relationship to Respondent)

Key:
01 Head
02 Husband
03 Wife
04 Son
05 daughter
06 Son in Law
07 Daughter in Law
08 Brother
09 Paternal Niece/Nephew
10. Maternal Niece/Nephew
11. Parent
12. Other relative
13. Adopted/Foster/Stepchild
14. Not Related
15. Don't Know

203. Are there any others who usually live here?_
(LIST)_____
_____

III. Access to and Use of Services

You told me that in your household, _____ (number) person/people have HIV+ and some have other diseases.

~~~~~~

I would like some information about the help or support that your household may have received from anyone besides your close relatives.

~~~~~~

301. Number of Persons in Household with Tested HIV+_____ TB_____
Not Tested HIV+_____ TB_____

302. Level of illness in family:_____(**enter appropriate number**)

Key: # _____ (enter) HIV+ but not ill
#_____(enter) Intermittent illness but still functioning
#_____(enter) Some Very Ill, cannot function or move around

Interviewer: Respondent answers:___ Sick Person(s) Answers___ Check one or both.

303. In the last 12 months, besides help from family, has this person and your household received:

a) Any material support for _____(number), such as monetary support, clothes or food for which you did not have to pay? _____Yes 1
_____ No 2

b) Any practical support for _____ (number), such as training for caregivers, help in household work, legal services or help in finding practical support?

_____ Yes 1
_____ No 2

c.) Any kind of medical support for _____(number), such as medical testing, treatment, medicines, for which you did not have to pay?

_____ Yes 1
_____ No 2

d.) Any kind of social, spiritual, or emotional support for ____(number), such a companionship or advice from a counselor which you received AT HOME, for which you did not have to pay.

_____ Yes 1
_____ No 2

(Interviewer: please ask for each kind of support, name of organization giving it, frequency, and level of satisfaction. Enter data in correct space below

304. Family Support Source/Frequency and Satisfaction Table

Type Support	Source Type	Name of Organization…..	Frequency Support	Satisfaction
Material				
Practical				
Medical				
Psychosocial				

Key:

Source of Support		Frequency		Satisfaction	
None	**0**	**None**	**0**	**None**	**0**
Government	**1**	**One time**	**1**	**Not Satisfied**	**1**
Church	**2**	**Several**	**2**	**Somewhat**	**2**
Faith Based Org.	**3**	**Frequent**	**3**	**Mostly**	**3**
CBO	**4**				
Local NGO	**4**	**Regular**	**4**	**Very**	**4**
National NGO	**5**				
Post Test Club	**6**				
PHA Network	**7**				
Other	**8**				
DK/DR	**9**				

305. If there are OVCs (orphans and vulnerable children) in your family, have they all been registered with the Community Development Office/Community Services/Local Counsel.

Yes_____1
Some_____ 2
None_____ 3
DK/DR___ 4

306. Are there any special problems related to caring for OVCs that you have had to deal with in your family? (PROBE FOR OPEN RESPOSE)

_____
_____
_____

_____
_____

307. Of all the services you have been able to use to help with this illness, which one was the most helpful and useful to you?

Interviewer: This is an open ended question. Probe for name and reason why the respondent likes this service provider. If more than one is mentioned, record all.

Response:_____
_____
_____
_____
_____

~~~~~~~~~~~~~~~~~~

Now we would like to ask you a few questions about your use (utilization) of the medical services provided for treatment of HIV/AIDS, TB, STI, or OI for the sick people in your household.

308. Have you or members of the family been tested and/or received treatment in the last 12 months?

Interviewer: Please complete for each sick person in the household.

308 a. Medical Treatment Utilization: Sick Person #_____ (page 4)

Type Test	Tested	Where Done	Results	On Medication Now	Treatment completed
HIV					
TB					
STI					
OI					
Malaria					

Key:

Tested:	**Where Done**	**Results**	**Medication Now**	**Completed**
Yes – 1	HC IV - 1	Positive - 1	Yes – 1	Fully - 1
No 2	HC III - 2	Negative - 2	No - 2	Partially - 2
DR 3	CSO - 3	Other (write in)		Ran out - 3
	Other - 4	DK/DR - 4		Other - 4
				DK/DR - 5
~~~~~~~~~~~~~~~~~~

308 b. Medical Treatment Utilization: Sick Person #_____ (page 4)

Type Test	Tested	Where Done	Results	On Medication Now	Treatment completed
HIV					
TB					
STI					
OI					
Malaria					

Key:

Tested:	**Where Done**	**Results**	**Medication Now**	**Completed**
Yes – 1	HC IV - 1	Positive - 1	Yes – 1	Fully - 1
No 2	HC III - 2	Negative - 2	No - 2	Partially - 2
DR 3	CSO - 3	Other (write in)		Ran out - 3
	Other - 4	DK/DR - 4		Other - 4
				DK/DR - 5

308 c. Medical Treatment Utilization: Sick Person #_____ (page 4)

Type Test	Tested	Where Done	Results	On Medication Now	Treatment completed
HIV					
TB					
STI					
OI					
Malaria					

Key:

Tested:	**Where Done**	**Results**	**Medication Now**	**Completed**
Yes – 1	HC IV - 1	Positive - 1	Yes – 1	Fully - 1
No 2	HC III - 2	Negative - 2	No - 2	Partially - 2
DR 3	CSO - 3	Other	Ran out - 3	
	Other - 4	DK/DR - 4	Other - 4	
			DK/DR - 5	

309. Please tell us some of the problems you have in using the services that are available.

Interviewer: Probe for problems/constraints respondent has in using the services, such as distance, can't leave home, no money for transport, facilities not open when they are supposed to be, bad treatment by workers, medicines not available, medicines not given freely. Synthesize respondent's remarks, then enter code as appropriate in table below.

_____
_____
_____
_____

310. Respondent Household Access and Utilization Constraints
Table

Problem/constraint As mentioned	Minor problem Or inconvenience	Major problem But Manage	Problem Too Big to Overcome	No Answer
1. Distance too great				
2. No money for transport				
3. Can't leave home; duties				
4. Facilities often not Open.				
5. Medicines often not Available.				
7. Don't like going when other people (men/women) are there.				
8. Don't treat us with respect.				
9. Don't know who/where to go				
10. List?				

311. As you think about the future, what is your greatest hope for dealing with the health problems you and your family are facing? (Open ended: synthesize response)

Response:_____
_____
_____
_____
_____
_____
_____
_____

This completes the interview. THANK the respondent for taking the time to give you responses, and for being open and truthful. Assure Respondent that all answers will be confidential and no names will be used in the report.

APPENDIX E: NATIONAL LEVEL ORGANIZATIONS SUPPORTED BY AIM

National Youth Council
UPMA
IMAU
Uganda Business Coalition
Straight Talk Foundation
AIC
THETA
NACWOLA
CHUSA
Youth Alive
IMAU
Uganda Private Midwifes' Association
UNANM
UWESO
THETA
NGEN+
HOSPICE
UPDF
National Youth Forum
UNASO
Reach Out Mbuya
AID CHILD
NAFOPHANU

APPENDIX F: POLICIES, GUIDELINES, MANUALS AND TOOLKITS SUPPORTED BY AIM

Title	Content Area	Authorship	Document Type	Date	Ownership
Toolkits					
HIV Counselling and Testing: A Toolkit for Coordinators and Supervisors: 2005	Counselling and testing	AIM Led	Toolkit	2005	MoH
Integrated Care for OVC: A Toolkit for Community Service Providers:2006	OVC	AIM Led	Toolkit	2006	MoGLSD
TB Management Desk Aide	Tuberculosis	AIM led	Job Aid		MoH
Policies					
Uganda National Policy Guidelines for HIV VCT	Counselling and testing	AIM led	Policy	2003	MoH
Uganda National Policy Implementation Guidelines for HIV VCT	Counselling and testing	AIM led	Policy	2003	MoH
Uganda National Policy on HIV Counselling and Testing	Counselling and testing	AIM led	Policy	2005	MoH
Curricular Materials					
Curriculum for In-Service Course for Medical Laboratory Personnel	Laboratories	AIM led	Curricular	-	AIM/AMREF
Home-Based Care for People Living with HIV/AIDS: A Handbook for Community Volunteers: 2005	PHA	AIM led	Curricular	2005	MoH
Home-Based Care for People Living with HIV/AIDS: A Resource Trainer's Manual for Community Volunteers: 2005	PHA	AIM led	Manual	2005	MoH
HIV Counselling and Testing: A National Counsellor Training Manual	Counselling and testing	AIM Equal Partner	Training Manual	-	MoH
Home-Based Care Trainers' Guide for Health Workers	PHA	AIM Equal Partner	Curricular	-	
National Treatment Algorithms for STDs in Uganda		AIM led	Curricular	-	MoH
PMTCT: Training Orientation of Health Workers-Facilitators' Manual	PMTCT	UNICEF led – AIM input	Curricular	-	Left as draft
Training Health Workers in Counselling for PMTCT Service Provision	PMTCT	AIM Equal Partner	Training Manual	-	Left as draft

Title	Content Area	Authorship	Document Type	Date	Ownership
Toolkits					
Promoting Integrated Care For Orphans, And Other Vulnerable Children *A Trainers Handbook (Draft), For* CBOs And Community Workers In Uganda	OVC	AIM Equal Partner	Curricular	-	
STI Training Manual for Trainers of Operational Level Health Workers in Uganda: June 2004	STI	AIM led	Training Manual	-	MoH
STI Treatment Guidelines for use by Operational Level Health Workers in Uganda: June 2004	STI	AIM led	Curricular	-	MoH
NTLP Tuberculosis Case Management Desk Aide: 2005	TB	AIM Led	Curricular	2005	MoH-NTLP
Facilitator's Manual for Training District Health Workers in Tuberculosis:	TB	AIM Led	Training Manual	2005	MoH-NTLP
UNASO Training of Trainers Manual		AIM Led	Training Manual	2005	
Training Manual for Health Workers on the Management of Opportunistic Infections: 2005	OI	AIM Equal Partner	Training Manual	2005	MoH
Integrated Care for Orphans and other Vulnerable Children: A Training Manual for Community Service Providers:2005	OVC	AIM Led	Manual	2005	MoGLSD
HIV Counselling and Testing: A National Counsellor Training Manual		AIM Led		2005	MoH
UNASO Organisational Development Curriculum – Participant and Trainer's manual for each of five topics: Strategic Management, Resource Mobilisation, Human Resource Management, Financial Management, and Monitoring and Evaluation	Cross-cutting	AIM led		2005	

APPENDIX G: LIST OF GRANTEES SUPPORTED BY AIM

Name of Organization Supported
AACAN
Aakum Child & Family Program
Abarilela Community Development Organization
Abele Community Living With HIV/AIDS
Aber Hospital
Aber Hospital PHA Network
Acenlworo CCF Project
ACFODE
Acholi Bur Mot Mot Aye Donog Association
Acori Child & Family Program
ACOWA CCF
ACOWA Family Helper Project
Action for Socio-Economic Development (ASED)
Action for Youth Development (AYODE)
ADEVIN
ADSSE
Adventist Development & Relief Agency ADRA
African Child Care Foundation
Agency for Cooperation & Research in Development
Agency For Young Adults Development
AIDS Orphans Education Trust
Alenga HC III
Alice Labol Foundation
All Nations Christians Care
Amach Health Centre IV
Amai Community HC
Amuria HSD
Ankole Cultural Dramactors
Apac DDHS
Apac DHAC
Apac DHS TB
Apac Empowerment Network of PHA
Apac Hospital PMTCT
Archbishop Desmond Tutu Home for Orphans
Aringa disaster Preparedness Forum
ARISE
Arua DDHS
Arua DHAC
Arua DHS TB
Arua District Farmers' Association
Arua District Local Government

Name of Organization Supported
Arua District Network Forum
Arua Hospital
Arua Pentecostal Church
ASDE (U)
Atiira Church of Uganda
Atutur Hospital (PMTCT)
AVSI
AWODNET
AYODE
Balyalwoba Rehabilitation & Development Agency
Bananyole Youth Development Association
BARDEA
Bidi-bidi Co-operative Savings Society
Boke Sero Status
BUCASI
BUDNET+
Bugangaizi HSD
Bugangaizi Self Help Alliance Group
Bugangari H.C IV (PMTCT/VCT)
Buhweju HSD
Bukada HSD
Bukeadea HSD
Bukedea Jazz Band
Bukedi Diocese Church Of Uganda
Bunyaruguru HSD
Buseta Community AIDS Initiative
Bushenyi Dept of Gender (Probation)
Bushenyi DAC
Bushenyi DDHS
Bushenyi DHAC
Bushenyi DHS
Bushenyi District Education Sector
Bushenyi District Human Resource Sect
Bushenyi District Probation & Social Welfare
Bushenyi Medical Centre
Bushenyi Production Sector
Bushenyi Rural Women Development Group
BUSO Foundation
Busolwe Hospital PMTCT
Busujju/Mwera HSD
Butebo HSD
Buwekula HSD
Buwekula Women Development Association
Buyanja HSD

Name of Organization Supported
Buyanja Integrated Community Development
Caritas Arua
Caritas Nebbi
Caritas Pader
Catholic Education Research Development Org.
CAWODISA
CEREDO
Child Support Organization
Children And Wives of Disabled Soldiers
Community Alert
Community Initiative for Development
Community Unity for Participatory Action
Community Vision
Concerned Parents
COU Kisiizi Hosp STI, OIs, TB Management
COU Kisiizi Hosp VCT+
COU Kisiizi Hospital HBC
CPAR Uganda
CREATE
CUAMM - Doctors With Africa
CUAMM - Doctors With Africa, Arua
Deaf Development Organization (DEDO)
Dokolo Health Centre (PMTCT)
Dr. Ekirapa Elizabeth
Ediofe Health Centre
Edrema Psychotherapy & Couns. (EPCOC)
Emmaus Community Programme
Entebbe All Christian Women Association
Equator Dramactors
Erussi Women Initiative
Erute North Health Sub-District
Family Planning Association of Uganda Apac
Family Planning Association Soroti
Family Planning Association of Uganda Bushenyi
Family Therapy Foundation
FPAU Bushenyi Branch
FPAU, Mubende
Friends of Orphans
Fukui- Uganda Friendship Association
Gen Rwot Family Care Association
Goli Health Centre
Good Samaritan AIDS Association Ayivu
Gospel Believers Fellowship
Gwo Kwo Family Care Association

Name of Organization Supported
HealthNeed Uganda
HealthNeed Uganda, Soroti
Hope Ministries
ICOBI
Igara East HSD
Igara West HSD
IHADO
Integrated Programme for Orphans (IPOC)
Integrated Programme for Orphans (IPOC)
Islamic Out-reach Centre
Itojo Hospital
JESTA
Jule Integrated Development Foundation
KABA (Kasambya)
KABA CBO Forum
Kabasuma Maanyi
Kagadi Hospital
Kaina Youth Dramactors (KAYODA)
Kajara Community Development Association
Kangai
KANGAI (KICDI)
Kapebyong HSD
Kasambya HC III
Kasilo Community Based Health Care Program
Kasilo HSD
KASO
Kassanda North HSD
Kassanda South HSD
Katakwi DDHS
Katakwi DDHS (VCT)
Katakwi DDHS TB
Katakwi DHAC
Katakwi District Youth Department
Katakwi Egangakinos PLWA
Katakwi Participatory Initiatives for Development
Katakwi Probation Department
Katakwi Traditional Healers' Association
Kebisoni Health Centre (PMTCT)
Kibaale DDHS
Kibaale DDHS TB
Kibaale DHAC
Kibaale District Action for Development (KIDADE)
Kibaale Network of PLWA (KIBAANET)
Kibuku HSD

Name of Organization Supported
Kipabbusawa
Kisiizi Hospital
Kitenga CBO Forum
Kitwe HC (PMTCT)
Kiyora Dramactors Club
Koboko HSD
Koboko United Women's Association(KUWA)
Kole HSD
Kolir Women Development Organization
Kolping House Mityana
Kolping Hse Mityana Women's Project
Kuluva C.O.U Hospital
Kumi DDHS
Kumi DHAC
Kumi DHS TB
Kumi District Probation Department
Kumi Hospital
Kumi Medical Centre
Kuru Youth Effort for Healthy Life
Latwo Pe Ling HIV/AIDS Group
LICODA
LIDNET
Lira Community Development Association (LICODA)
Lira DDHS General
Lira DDHS TB
Lira DHAC
Lira District Local Government Education Department
Lira Hospital (PC)
Lira Hospital PMTCT
LIRUBO
Lucia Youth Development Foundation
Maracha Action For Development (MAFORD)
Maracha HSD
MIRUDA
Mission for All Kitokolo Development Project
Mityana North HSD
Mityana South HSD
MRC - CAWODISA Post Test Club
Mubende DDHS
Mubende DHAC
MUDNET+
Mukali Mbega Women's Group
Multipurpose Youth Development Initiative (MUYODI)
NACWOLA Pallisa

Name of Organization Supported
NACWOLA Soroti Branch
NACWOLA, Kumi Branch
NACWOLA, Lira Branch
NACWOLA, Lira Branch
NACWOLA, Pallisa Branch
NACWOLA, Rukungiri Branch
NACWOLA, Tororo Branch
Nagongera Youth Development Projects
Nebbi Cultural Troupe
Nebbi DDHS General
Nebbi DDHS TB
Nebbi DHAC
Nebbi DLG - Community Services Direct.
Nebbi Private Sector Promotion Centre
Nebbi Women Community Centre
Nebbi Youth and Orphans Development. Union
Needy Kids Orphans Support Centre
Neighbourhood Women Group
Ngariam Women's Group
Ngoma Vivid Theatrical Features
Ngora Hospital (PMTCT)
NIFAED
Ntungamo DAC
Ntungamo DDHS
Ntungamo Development Network
Ntungamo DHAC
Ntungamo DHS
Ntungamo DHS (CHBC Workshop)
Ntungamo District Network of PLWA (NTUDINET)
Ntungamo District Probation & Social Welfare
Nyabushenyi Women Development Association
Nyakibale Hospital
Nyarweshama Widows Association
Obimileku Youth Association
Odravu Popular Initiative for Development
Office Of The Prime Minister, Arua
Ogongora Calvary Chapel
OLILO PLWAS Support Initiative Project
Orungo Youth Integrated Development Organization
Otuke Health Sub-District
Oyam North HSD
PACEGO Women's Group
PACOVIDA
Pader DDHS TB

Name of Organization Supported
Pader District Local Government (DDHS)
Pader DLG Education Department
Pader PLHA Network Forum
Pallisa AIDS Support Organization
Pallisa Community Development Trust
Pallisa DDHS TB
Pallisa DDHS VCT
Pallisa DHAC
Pallisa District Local Government OVC Para-Legal
Pallisa HSD
Pallisa Post Test Club
Parombo HIV/AIDS Orphans Rec Project
Partners in Compassion
Pelican Youth
Philly Lutaaya Initiative PLWA
Planning & Development Secretariat
PLWHA Role Model Action Group
Popular Action For Development
Progressive HIV/AIDS Care Community Organ
Reiko Women & Youth Organization
REPEHAC
Revival missions of Uganda
RUCOHE
RUDATCO
RUDINET+
RUGADA
Ruhinda HSD
Ruhinda Women Integrated Development Foundation
Rukungiri DDHS
Rukungiri DHAC
Rukungiri District AFS Centre
Rukungiri District Probation & Social Welfare
Rukungiri District Veterans Association
Rukungiri Empowerment (RESTA)
Rukungiri Rural Integrated Community (RURICDO)
Rural Health Care Foundation
Rural Health Development Organ (RHEDO)
Rural Integrated Development Organization (RIDON)
Rushenyi Health Centre IV
Rushenyi Youth Dramactors (RUYODA)
Rushooka Orphans Education Centre
Rwashamaire HC (PMTCT)
Save Foundation
Save Owere

Name of Organization Supported
Save Youth From Drugs Abuse (SYDA)
SCORE Uganda
Scripture Union Of Uganda (S.U. AFA)
Serere Health Centre IV (PMTCT)
Sheema North HSD
Sheema South HSD
Solidarity for AIDS Organization
Soroti DDHS General
Soroti DHAC
Soroti DHS (Disaster)
Soroti DHS TB
Soroti District Local Government Prob. Department
Soroti Environment Concern
Soroti HSD County
Soroti Medical Associate Nursing Home
Soroti Municipal Council
Soroti Referral Hospital
Soroti Youth Aid Organization
St. Anthony Hospital
St. Joseph Integrated Orphanage Home
St. Mary's Ediofe Sec. School
St. Padre Pio H/C III, Mirembe
St. Theresa Vocational Training Centre-Zigoti
SUPORT UGANDA
TASWA
TB Leprosy Control Programme DHS
Teso AIDS Project
Teso AIDS Project (Disaster)
Teso Family & Vulnerable Children Support
Teso Islamic Development Organization
Teso Private Sector Development Centre
Teso Students Association
TOFPHANET
Tororo County
Tororo County HSD
Tororo DHAC
Tororo District Probation & Social Welfare
Trans-cultural psychosocial organization
Tuliki CHBC
Tusitukirewamu Kayunga K.Women's Group
Twegatte Kisekende
Twegatte Kisekende Women's Association
Uganda Medical Association
Uganda National Scouts Association

Name of Organization Supported
Uganda Orphans Rural Development Project
Uganda Red Cross Arua
Uganda Red Cross Nebbi Branch
Uganda Red Cross Soc. Tororo Branch
Uganda Red Cross Society Pallisa Branch
Uganda Red Cross Society, Bushenyi Branch
Uganda Red Cross Society, Mityana Branch
Uganda Red Cross Society, Rukungiri Branch
Uganda Red Cross Society, Tororo Branch
Uganda Red Cross, Kumi Branch
Uganda Red Cross, Lira
Uganda Rural Community Development Programme
Uganda Rural Literacy and Community Development
UMOJA Women's Association
UMSC- Mityana Health Care Centre
UMSC Yumbe District
United Christrian Development Organization
United Muslim Women Association
UPDF 5th Division Acoli Pii Pader
UPDF HIV/AIDS Initiative Project
Usuk HSD
UWESO
UWESO, Bushenyi Branch
UWESO, Lira Branch
VAPCODE
Venus Uganda
Vision Terudo
Wagwoke Wunu Group
West Ankole Diocese
West Budama North HSD
West Budama South HSD
Willa AIDS Support Organization
World Vision Tubur ADP
World Vision Tubur ADP (Disaster)
Young Adults Association
Youth Alive Apac Branch
Yumbe DDHS
Yumbe DHAC
Yumbe DHS TB
Yumbe Safe Motherhood

APPENDIX H: LIST OF PEOPLE INTERVIEWED DURING THE EVALUATION SURVEY

A. List of people interviewed in Arua and Moyo District

Name	Title /Position	Organization
Geoffrey Niku	Program Director	Africa Child Care Foundation (Arua)
Adure Keith	HMIS Officer	Arua District
Richard Ozima	TB Focal Person	Arua District
Patrick Anguzo (Dr)	DDHS	Arua District
Philiam Eyoku	HIV/AIDS Clinical Officer	Koboko Health Centre IV
Emmanuel Odar (Dr)	PMTCT Focal Person	Arua Hospital
Godfrey Atiku	Records Assistant	"
Alex Atiku	Laboratory Assistant	"
Jack Kokore	PHA Chairperson Arua	PHA Network
Hassan Rahama	Director ASED (U)	ASED (U)
Sr. Paula	In-Charge	Ediofe Health Centre III
John Anguyo	Records Assistant	"
Fr. Robert Ayiku	Coordinator	CARITAS Arua
Sr. Ezaru	Midwife	Adumi Health Centre IV
Angelo Embama	Laboratory Technician	"
Sr. Aciro	HIV/AIDS Focal Person	DDHS Office
Simon Edami	Laboratory Focal Person	DDHS Office
Isodo	CAO Arua	Arua District
Jimmy Andama	In-Charge	Omugo Health Centre IV
Sr.	In-charge maternity ward	Arua Hospital
Omen	Community Development Officer	Moyo District
James Adu	Program Coordinator	Youth Anti AIDS Services Association (YAASA)
Onzima Murujan	Chairperson Moyo AIDS Heroes' Association	MAHA
Vicky Mundura	Coordinator MAHA	MAHA
Samuel Tako	ACAO Moyo District	Moyo District
Jimmy Opigo (Dr)	Deputy DDHS	Moyo District
Sr. Adupio	In-charge HIV Clinic Moyo Hospital	Moyo Hospital
Alex Atiku (Dr)	In-charge Health Programs (ADEO)	Africa Development Emergency Organization
George	Planner Moyo District	Moyo District
George	Economist Moro District	Moyo District
Angelo Otitia	In-charge Obongi Health Centre IV	Obongi Health Centre IV
Stephen	HIV Focal Person Obongi Health Centre IV	Obongi Health Centre IV

B. List of people interviewed in Bushenyi District

Name	Position /Title	Organization
Mr. Kiberu Kibirige	CAO / Chairman DAC	CAO Office
Dr. Katureebe	DDHS / Member of DAC	DDHS Office
Dr. Barigye	Deputy DDHS / Coordinator PMTCT / Member of DAC	DDHS Office
Sister Wagama	District Nursing Officer / Acting HIMS	DDHS Office
Mr. Silver Katabarwa	Senior Population Officer	District Planning Office
Mr. Norbert Turyahikayo	District Community Development Officer / Secretary DAC / AIM Program Focal Person	District Community Based Office
Mr. Fred Ngabirano	District Probation and Welfare Officer / Member DAC / UPHOLD Focal Person	District Probation and Welfare Office
Nathan Ndyamuba	District Coordinator BUDNET+ / Representative of PHAs on DAC	BUDNET+
Asiimwe P	Finance Secretary	BUDNET+
Kabalungi Allen	Secretary	BUDNET+
Akahabwa F	Member of Executive	BUDNET+
Dr. Owembabazi M	Medical Officer / Medical Superintendent	Kitgata Hospital
Sr Jane Mugangizi	Sister In- Charge	Kitagata Hospital
Sr. Rose Kataryeeba	In- Charge MCH Department	Kitagata Hospital
Dr. Sebaduuka	Medical Doctor	Kigatata Hospital
Dr. Aidah Nakinga	Medical Doctor / In - Charge	Kabwhohe HSD
Sr. Beatrice Karuhaije	Senior Nursing Officer / HIV/AIDS Focal Person	Kabwohe HSD
Turyamureeba Vincent	Clinical Officer	Kabwohe HSD
Dr. Muwankusi J.	Medical Officer / Medical Superintendent	Comboni HSD / Hospital
Mrs Tukahirwa Jane	Enrolled Midwife	Kigarama HC III
SR Nyangoma Polly	Administrator / Registered Nurse	Bitooma HC III
Mr. Nuwagaba Posiano	Clinical officer / In-Charge	Bitooma HC III
Ms. Allen Centinery	Clinical officer / In-Charge	Kyagyenyi HC III
Ms. Nabirye Rebecca	Enrolled Nurse	Kyagyenyi HC III
Sr. Fedelesi Mucunguzi	Registered Nurse / Health Assistant	Kyamuhunga HC III
Group of PHAs (Kitagata Post Test Club	PHAs members	Kitagata sub county
Rev. Steven Bagumya	Director	Archbishop Desmond Tutu Orphans Home in Nyabubaare sub county
Mr. Tumwebaze Noel	Administrator	ICOBI
Mr. Mutumba Aron	Head of Counseling	ICOBI
Ayogyera Rogers and (Kamukama Edson	Orphans and graduates of Archbishop Desmond Tutu Orphans Home in Nyabubaare sub county.	Archbishop Desmond Tutu Orphans Home in Nyabubaare sub county
Mwesige George	Senior Clinical Officer	Sheema South HSD-Shuuka
Ampaire Safinat	In charge	Bushenyi UMSC Kakanju HCII
Dr. Nassinde Annet	Medical Officer	Mitooma HCIV Ruhinda HSD
Dr. Lutalo Kriss	Medical Officer	Kyabugambi HCVI
Mwesige George	Senior Clinical Officer	Sheema South HSD-Shuuka
Ampaire Safinat	In charge	Bushenyi UMSC Kakanju HCII
Dr. Nassinde Annet	Medical Officer	Mitooma HCIV Ruhinda HSD
Dr. Kasule Aaron	Medical Officer	Mittoma HCIV Buhweju HSD
Dr. Lutalo Kriss	M.O	Kyabugambi HCVI

C. List of people interviewed in Kiboga District

Name	Position /Title	Organization
Dr. Atikoro	CAO / Chairperson DAC	CAO's Office
Mr. Paddy Galabuzi	Planner	District Planning Office
Mr. Kizito Rebuga	District Statistician	District Planning Office
Mr. Sebaggala	District Population Officer	District Planning Office
Dr. Serebe	District HIV Focal Person /member	DDHS Office
Dr. Alan Nionzima Muluta	Director District Health Services (DDHS)	DD HS Office
Mr. Nsubuga Patrick	District Probation and Social Welfare Officer/member of DAC	District Community Based Services Office
Mr. Muhanguzi Abel	District Community Based Services Coordinator	District Community Based Services Office
Mr. Balinda Fred	HMIS Officer	DDHS Office
Dr. Batibwe	Hospital Superintendent , Kiboga Hospital	Kiboga Hospital
Dr. David Lubogo	In charge HIV Clinic /Coordinator, Kiboga Hospital	Kiboga Hospital
Phoebe Nandawula	Registered Nurse	Ntwetwe HSD
Olivia Tusiimwe	Comprehensive Nurse	Ntwetwe HSD
Sr. Betty Mary Nansamba	Focal Person HIV/AIDS	Bukomero HSD
Ms. Regina Nabukeera	Project Manager, KCIIDP	Community based OVC project funded by AMREF
Ms. Kusiima Enid	M& E Coordinator – World Vision, Katwe Development Area	World Vision- Katwe Development Area - Bukomero
Isabirye David	In-charge	Lwamata HC III
Fred Kasule	Public Health Officer	Lwamata HC III
Elizabeth Komujuni	Nursing Assistant	Lwamata HC III

D. List of people interviewed in Tororo District

Name	Position /Title	Organization
Mr. Silver Oboth	CAO	Tororo DLG
Dr. Okumu	DDHS	Tororo DLG
Mr. Mungoma J. Willy	DHE	Tororo DLG
Mr. Kanamugire Mike	DTLS	Tororo DLG
Dr. Kakala M. Alex	MO	Mukuju HC IV
Naketcho Lydia	Nurse/Counselor	
Sr. Harriet Egesa	Nursing Officer	
Suzan Amari	Assist Probation Officer	Tororo District
Dr. Opete Andrew	In Charge	HSD/Nagongera
Pacutho Bernard	Lab Assistant	Mulanda HC IV
Tom Ochar		Mulanda HC IV
Charity K. Jaramoji	Programme Facilitator	Uganda orphans
Kukundakwe Kenneth	Programme Accountant	Uganda orphans
Hamaca Herbert	Operations officer	Uganda orphans

APPENDIX I: AIM PMP

AIM PROGRAMME MONITORING PLAN 2001-2006

Revised April, 2005

OVERALL PROJECT OBJECTIVE

For men, women and children in selected districts to access and utilize appropriate, affordable and quality integrated HIV/AIDS/TB prevention, care and support services.

Objective 1 Strengthening capacity of Government, NGOs, CBOs, FBOs and private sector to plan, implement and manage integrated services at the National, District and Sub-district levels.									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Established/strengthened district HIV/AIDS planning, monitoring and feedback processes	No. of AIM-supported districts with a functional official district level HIV/AIDS coordinating body (DAC) in place. **(1.01)**	An *official district level HIV/AIDS coordinating body established adheres to the UAC DAC Guidelines and has a strategic and monitoring plan in place, and providing at least one quarterly on-site visit to each of the AIM partners.* **Unit of Measure**: Number	TA visit reports Meeting minutes Activity reports Document review per quarter	0[1]	16	16	0		DAC in all AIM districts. Continued capacity building activities aimed at strengthening the districts to sustain this and other established structures
	No. of AIM-supported districts that have developed comprehensive and multi-sectoral HIV/AIDS strategic and annual work plans as part of the District Development plans. **(1.02)**	*AIM-supported districts that have a comprehensive and multi-sectoral HIV/AIDS strategic and annual work plans in place as part of the District Development plans* **Unit of measure**: Number	District strategic and Annual work plans Annual document review	0[1]	16	15	1		AIM continues to support district annual reviews and other planning exercises to update the HIV/AIDS plans

Objective 2 Increased Integration and Quality of comprehensive HIV/AIDS intervention at the District and Sub-district levels									
AIM PROGRAMME PERFORMANCE INDICATORS AND TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Established/strengthened capacity to deliver comprehensive and integrated HIV/AIDS interventions among district, government, NGO, CBO, FBO and Private Sector	No. of hospitals and Health Centre IVs that provide a combination of 6 clinical services (TB, VCT, PMTCT, STIs, LAB and OI) in all programme districts. **(2.01)**	*Public/private facilities from level IV and above which provide 6 (six) AIM-supported clinical core services in all AIM programme districts.* **Unit of measure**: Number	Facility records Document review	31[3]	11	30	4		All facilities at hospital and HC IV level will have the necessary capacity/infrastructure to provide a combination of the 6 clinical services by end of FY 06 78 is the cumulative number of facilities to be supported.
	No. of Health Centre IIIs that provide a Combination of 3 clinical services (TB, STIs, and OI) in all programme districts. **(2.02)**	*Public/private facilities at level III which provide a combination of three AIM - supported clinical core services in all AIM programme districts* **Unit of measure:** Number	Facility records Document review	67[3]	288	288	0		All 288 HCIII have the necessary infrastructure to offer a combination of the 3 clinical services Continued support for functionality through out the remaining period
	No. of HSDs in all programme districts that have a functional referral Network for HIV/AIDS service provision **(2.03)**	An *official HSD RNA committee established, that meets regularly (as per the guidelines) and has a well developed and utilized Referral Directory in place.* **Unit of measure:** Number	Quarterly reports Document review	0[3]	17	19	0		By the end of the programme 48/67 HSD in AIM-supported districts will have functional referral Networks

Objective 3 Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality HCT services	No. of individuals receiving counseling and testing services at AIM-supported HCT sites **(3.01)**	*Total number of individuals who received counseling and testing services during the fiscal year* **Unit of measure:** Number	Quarterly reports Document review	2,500[2]	136,800	160,445	114,400		
	% of people tested for HIV/AIDS in AIM-supported HCT sites receiving results **(3.02)**	*Proportion of total people tested for HIV/AIDS at HCT AIM-supported sites that receive their results* ***Unit of measure***: Percentage	Quarterly reports Document review	0[8]	95%	91%	98%		**New** emphasis under critical interventions for AIM.
	No. of couples accessing HCT services at AIM-supported sites **(3.03)**	*Number of couples testing at AIM-supported HCT sites during the fiscal year* **Unit of measure:** Number	Quarterly reports Document review	0[3]	5,700	3655	7,040		**New** emphasis under critical interventions.

Objective 3 cont'd Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality HCT services **cont'd**	No. of functional HCT sites delivering counseling and testing services according to national guidelines. **(3.04)**	*Number of New service outlets providing counseling and testing according to national or international standards* **Unit of measure:** Number	Facility records Quarterly Document review	28[3]	9	31	3		This is the number of sites to be initiated or enhanced by AIM in the fiscal year This does not include out-reach sites - 110 is the **cumulative** number of sites that were targeted to be supported by AIM by FY06. - 114 so far achieved. There has been increased demand for HCT services in the district so HCIII that were not initially targeted have also been supported. Number will go up to 117
	No. of personnel with enhanced skills to provide HIV counseling and testing services **(3.05)**	*Total number of individuals trained and/or re-trained in counseling and testing according to national or international standards* **Unit of measure:** Number	Activity reports/ document review	0[3]	600	1,292	300		These are **NEW** persons trained each year.
Increased access to and utilization of quality PMTCT services	No. of functional sites providing PMTCT according to national guidelines. **(3.06)**	*Number of **New** service outlets providing the minimum package of PMTCT services according to national or international standards.* **Unit of measure:** Number	Facility records Quarterly Document review	2[3]	10	30	6		The numbers refer to sites to be initiated or enhanced by AIM in the fiscal year 90 is the **cumulative** number of sites targeted to be supported by AIM by FY06. - 84 so far achieved.

Objective 3 cont'd Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality PMTCT services **cont'd**	No. of personnel with enhanced skills to provide PMTCT services. **(3.07)**	*Total number of individuals trained in counseling and testing according to national or international standards* **Unit of measure:** Number	Activity reports/ document review	0[3]	260	1,447	30		The numbers of personnel trained are **NEW** for each year No anticipated training in FY 06
	No. of pregnant women tested for HIV at AIM-supported PMTCT sites. **(3.08)**	*Total number of pregnant women provided with PMTCT services, including counseling and testing* **Unit of measure:** Number	Facility records Quarterly document review	300[2]	65,520	68,076	51,600		The numbers for each year are **NEW** cases
	% of **NEW** ANC attendees counseled and tested at AIM-supported PMTCT sites. **(3.09)**	*The proportion of all New ANC attendees who are counseled and tested at a PMTCT site in AIM districts* **Unit of measure:** Percentage	Facility records Quarterly document review	48[5]	60	37%	70		Based on **NEW** ANC visits to PMTCT sites

Objective 3 Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality PMTCT services **cont'd**	%. Of HIV+ women completing a course of ARV for PMTCT. **(3.10)**	*The proportion of all HIV+ pregnant women completing a course of ARV prophylaxis at a PMTCT site supported by AIM* **Unit of measure:** Percentage	Facility records Quarterly document review	32[5]	60	36%	65		
Increased access to and utilization of quality STI services	No. of service delivery outlets/sites providing STI services according to national guidelines. **(3.11)**	*Total number of STI service outlets/sites supported by AIM that offer STI services according to national/international standards* **Unit of measure:** Number	Facility records	178[3]	373	373	0		373 is the total no. of health units at level 3 and above in the 16 AIM-supported districts. All have been strengthened to provide STI services. Continued support for consolidation and functionality in the remaining period of the programme.
	No. of personnel with enhanced skills to provide STI services in the context of HIV/AIDS **(3.12)**	*Total number of individuals trained and/or re-trained for STI/HIV according to national/international standards* **Unit of measure:** Number	Activity reports/ document review	0[3]	300	264	0		These are **NEW** numbers of personnel to be trained in FY 05 No anticipated training in FY 06

Objective 3 con'd Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality STI services **cont'd**	No. STI patients counseled and tested for HIV at AIM-supported sites. **(3.13)**	*Total number of STI patients offered HCT counseling and testing services at AIM-supported sites* **Unit of measure:** Number	Facility records/Quarterly document review	0[3]	15,000	18,690	13,000		New emphasis under critical interventions for integrated STI/HIV services and increased identification of positives **NEW** cases each year
Increased access to and utilization of prevention services for at-risk populations	No. of service delivery outlets/programs providing HIV/AIDS prevention services **(3.14)**	*Total number of service outlets/programs supported by AIM that offer HIV/AIDS prevention services* **Unit of measure:** Number	Facility records/Quarterly document review	0[3]	71	81	0		81 is the no. of service outlets/programs that have been supported in FY05 and will continue in FY06.
	No. of personnel with enhanced skills to provide HIV prevention services **(3.15)**	*Total number of individuals trained and/or re-trained for the provision of HIV/AIDS prevention services* **Unit of measure:** Number	Facility records/Quarterly document review	0[3]	3,550	6583	0		These are **NEW** numbers of personnel to be trained in FY 05 No anticipated training in FY 06

Objective 3 con'd Increased access to and utilization of quality HIV/AIDS Prevention services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of prevention services for at-risk populations **cont'd**	Estimated no. of individuals reached with HIV/AIDS prevention services that promote abstinence and/or being-faithful and other behavior change by an AIM-supported program/outlet **(3.16)**	*Estimated no. of individuals reached with HIV/AIDS prevention services: abstinence and/or being faithful and other behavior change through mass media and community outreach* **Unit of measure**: Number	Facility records/Quarterly document review Survey data/statistical analysis	0[3]	2,164,000	2,164,000	2,164,000		Population 10-49 in AIM-supported districts.
	No. of condoms distributed **(3.17)**	*Cumulative number of condoms distributed by AIM-supported service providers* **Unit of measure:** Number	Grantee reports/Quarterly document review	67,543[7]	5,000,000	330,633	5,200,000		12.3million is the estimated **cumulative** number of condoms expected to be distributed by AIM-supported service providers**.**

Objective 4 Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
TARGETS/ACTUALS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 ((Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Improved laboratory capacity for HIV/AIDS/TB	No. of laboratories conducting diagnostic tests for HIV, syphilis, malaria and TB sputum microscopy. **(4.01)**	*Number New AIM-supported laboratories with capacity to carry out diagnostic tests for HIV, syphilis, malaria and TB sputum microscopy* **Unit of measure:** Number	Facility records Quarterly document review	31[3]	29 HC3	15	0		125 is the **cumulative** number of laboratories that were targeted for support by AIM by FY06. However, due to budget constraints, only the **103** reached will be supported.
	No. of laboratory facilities refurbished by AIM programme**(4.02)**	*Number New laboratory facilities refurbished by AIM in the fiscal year* **Unit of measure:** Number	Programme records Quarterly document review	0[2]	66	48	0		82 is the **cumulative** number of laboratories that was initially targeted for refurbishment by AIM by end of FY05. Only 78 achieved so far.
	No. of laboratory facilities supplied with Equipment**(4.03)**	*Number New laboratory facilities provided with equipment* **Unit of measure:** Number	Programme records/Quarterly document review	0[2]	15	5	13		AIM will supply equipment to a **cumulative** number of 100 labs. Facilities by end of FY05

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Improved laboratory capacity for HIV/AIDS/TB **cont'd**	No. of staff with enhanced skills in laboratory safety procedures and diagnostic tests for HIV, syphilis, TB and malaria in all AIM-districts**(4.04)**	*Total number of individuals trained and/or re-trained in laboratory safety procedures and diagnostic tests for HIV, syphilis, TB and malaria according to national or international standards* **Unit of measure:** Number	Activity reports/ document review	0[2]	70	46	20		These are **NEW** individuals trained each year
	No. of tests conducted at AIM-supported laboratory sites **(4.05)**	*Total number of HIV, syphilis, TB and malaria diagnostic tests conducted at AIM-supported sites* **Unit of measure:** Number	Facility records Quarterly document review	14,400[2]	400,000	614,663	294,000		These are **NEW** tests each year. FY 06: 8 months

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality TB/HIV prevention and treatment services	No. of service delivery outlets/sites providing TB care and treatment according to national standards **(4.06)**	*Total number of service outlets supported by AIM providing TB care and treatment according to national/international guidelines* **Unit of measure:** Number	Facility records/ Quarterly document review	116[3]	373	373	0		373 is the total of HCIII and above that have already been supported to have the full capacity to provide quality TB services. This is continuous support till the end of the programme.
	No. of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) according to national guidelines **(4.07)**	*Number of New service outlets supported by AIM providing clinical prophylaxis and/or treatment for TB to HIV-infected individuals according to national or international guidelines* **Unit of measure:** Number	Facility records/ Quarterly document review	0[5]	26	78	0		64 is the **cumulative** number of sites that were initially targeted for support by AIM programme. - 78 sites reached.
	No. of TB cases detected at AIM-supported TB sites who initiate treatment **(4.08)**	*Total number of detected TB patients at AIM-supported sites initiated on treatment.* **Unit of measure:** Number	Facility records Quarterly document review	2,136[2]	15,600		18,200		These are **NEW** cases for each year FY 06: 8 months

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality TB/HIV prevention and treatment services **cont'd**	No. of HIV-infected individuals (diagnosed or presumed) who receive clinical prophylaxis and/or treatment for TB, disaggregated by sex **(4.09)**	*Total number of HIV-infected individuals (diagnosed or presumed) receive clinical prophylaxis and/or treatment for TB at AIM-supported sites* ***(confusing definition-see PEPFAR)*** **Unit of measure:** Number	Facility records Quarterly document review	0[8]	2,000	1507	2,000		These are **NEW** numbers expected to be reached.
	No. of personnel with enhanced skills to provide clinical care for TB/HIV patients according to national standards **(4.10)**	*Total number of individuals trained to provide TB clinical prophylaxis and/or treatment to HIV-infected individuals (diagnosed or presumed) according to national or international standards* **Unit of measure:** Number	Activity reports/ document review	390[2]	296	802	20		These are **NEW** individuals to be trained each year.
	% expected TB cases that are detected and initiated on treatment **(4.11)**	*The proportion of TB cases expected to total number of cases detected* **Unit of measure:** Percentage	Facility registers DTLP register /quarterly document review	43%	60%		70%		This is an annual calculation

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality TB/HIV prevention and treatment services **cont'd**	% of TB cases who successfully complete treatment **(4.12)**	*The proportion of TB cases completing treatment to the total number of TB cases initiated on treatment in a cohort* **Unit of measure:** Percentage	Facility registers DTLP register /quarterly document review	53%[5]	70%		77%		This is an annual measure of the % of those initiated on treatment the previous year that complete treatment.
Increased access to and utilization of quality HIV/AIDS clinical, community and home-based care	No. service outlets/sites providing general HIV-related palliative care (non-ART care) excluding TB/HIV **(4.13)**	*Total number of clinical-based and home/community based programmes providing Basic Health care and Support to HIV-infected clients and their families supported by AIM* ***(confusing definition- see PEPFAR)*** **Unit of measure:** Number	Facility records /quarterly document review	391[6]	550	511	17		These outlets include PTCs, CHBCs, OI sites and PHA networks.

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality HIV/AIDS clinical, community and home-based care **cont'd**	No. of persons with enhanced skills to provide general HIV-related palliative care **(4.14)**	*Total number of individuals trained/or re-trained to provide general HIV-related palliative care to HIV-infected individuals (diagnosed or presumed) and their families according to national or international standards* **Unit of measure:** Number	Activity reports/ document review	0[3]	1,549	4,635	0		These are **NEW** individuals to be trained. No anticipated training in FY06

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality HIV/AIDS clinical, community and home-based care **cont'd**	Number of individuals provided with general HIV-related palliative care, disaggregated by sex. **(4.15)**	*Total number of individuals provided with clinical prophylaxis and/or treatment and support of HIV-related illness and their families at AIM-supported sites* **Unit of measure:** Number	Grantee quarterly reports/ document review	4[2]	53,617	25,607 M 11,573 F 14,034	13,152		This number includes PHAs reached through Networks, CHBC and clinical prophylaxis and/or treatment FY 06: Clinical prophylaxis and/or treatment plus PHAs reached through **NEW** networks in Pader district.
	All AIM-supported districts with a functional PHA network at HSD level linked to an existing RNA network. **(4.16)**	*AIM-supported districts with PHA networks at HSD level linked to an existing referral network for HIV/AIDS services* **Unit of measure**: Number	TA visit reports Meeting minutes Activity reports Document review per quarter	0[3]	65	67	0		All AIM districts will now have a PHA network at HSD level. FY 06 will mainly involve activities for strengthening the networks.

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of quality HIV/AIDS clinical, community and home-based care **cont'd**	No. of PHAs registered in a PHA network **(4.17)**	*Total number of identified HIV-positive persons registered with a PHA network*	Grantee quarterly reports/ document review	0[3]	33,500	61,264	1,000		
	% of identified PHAs accessing care and support services through the referral network of HIV/AIDS services **(4.18)**	*% of all identified HIV-positive persons receiving care and support services through the referral network of HIV/AIDS services* **Unit of measure**: Percent	Grantee quarterly reports/ document review	0[3]	70	44%	80		

Objective 4 cont'd Increased access to and utilization of quality HIV/AIDS care and psycho social support services									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05) Target	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of interventions for OVC	No. of OVC programmes supported by AIM in its districts **(4.19)**	*Total number of AIM-supported programmes providing OVC support service* **Unit of measure:** Number	Grantee quarterly reports/ document review	42[2]	80	81	0		81 is the number of programmes to be supported by AIM in the remaining period.
	No. of providers-caretakers trained by AIM in caring for OVC **(4.20)**	*Total number of service providers trained and or re-trained to provide OVC support services*	Activity reports/ document review	1250[2]	1,568	8509	0		Numbers trained are **NEW** providers per year No anticipated training in FY 06
	No. of OVC served by an OVC programme supported by AIM **(4.21)**	*Total number of OVC offered support services by an AIM-supported programme* **Unit of measure:** Number	Grantee quarterly reports/ document review	1600[2]	24,000	16,031	0		Actual reported represent **NEW** OVC served

Objective 5 Improved use of strategic programme information									
AIM PROGRAMME PERFORMANCE TARGETS									
INTERMEDIATE RESULT	**PERFORMANCE MEASURE**	**DEFINITION/ UNIT OF MEASURE**	**DATA SOURCE AND APPROACH TO DATA COLLECTION**	**BASELINE VALUE**	**TARGETS/ACTUALS**				
					FY05 (Oct,04-Sept,05)	**Actual Due Sept, 05**	**FY06 (Oct,05-Jun,06) Target**	**Actual Due Jun, 06**	**Comments**
Increased access to and utilization of strategic information	No. of AIM-supported districts that track HIV/AIDS indicators **(5.01)**	*AIM districts that have an HIV/AIDS district-based management information system* **Unit of measure:** Number	Activity reports Field visits document review	0[1]	16	12	4		To achieve this target, AIM will work in close collaboration with the MOH, UAC and other funders or partners.
	No. of persons with enhanced skills in strategic information for HIV/AIDS (including M&E, surveillance, and HMIS) **(5.02)**	*Total number of individuals in AIM districts trained and/or re-trained in strategic information for HIV/AIDS* **Unit of measure:** Number	Activity reports /document review	0[3]	323	1,082	0		This no. of **NEW** persons trained each year and includes all heads of district technical departments HMIS focal point persons, surveillance staff ,population officers and grantee staff FY 05 – M&E: 80 New grantees * 3 participants, 16 HMIS F/P, 67 HSD HMIS F/P No anticipated training in FY 06

59

[59] AIM Reconnaissance report 2002
2 Data from AIM grantees (Quarter 1of PY3 – July- September, 2003)
3AIM Situational Analysis/Needs Assessment exercise 2002/3
4 Uganda Demographic and Health Survey, 2000/1
5 Data from AIM grantees (Quarter 3 of PY3 – Jan – March, 2004)
6 Data from AIM grantees (Quarter 1 of FY5 – Oct - Dec, 2004)
7.Data from AIM grantees as of Sept 30, 2003