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UGANDA INDIGENOUS PARTNERS' PROGRAMS ASSESSMENT

DECEMBER 2009

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ACRONYMS

ACE	AIDS Capacity Enhancement Project
AIC	AIDS Information Center
AIDS	acquired immunodeficiency syndrome
AIM	AIDS/HIV Integrated Model District Program
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CDD	community drug distribution
CEO	chief executive officer
COP	Country Operational Plan
COTR	Contracting Officers' Technical Representative
CSF	Civil Society Fund
CSO	civil society organization
DANIDA	Danish International Development Assistance
DFID	U.K. Department for International Development
FBO	faith-based organization
FDA	U.S. Food and Drug Administration
GOU	Government of Uganda
HAU	Hospice Africa Uganda
HCT	HIV counseling and testing
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
HR	human resources
ICOBI	Integrated Community Based Initiatives
IDP	internationally displaced person
INGO	indigenous non-governmental organization
IP	indigenous partner
IRB	institutionalized religious bodies
IRCU	Inter-Religious Council of Uganda
JCRC	Joint Clinic Research Center
JMS	Joint Medical Store
M&E	monitoring and evaluation
MJAP	Mulago-Mbarara Teaching Hospitals' Joint AIDS Program

MOH	Ministry of Health
NDA	National Drug Authority
NGO	non-governmental organization
NORAD	Norwegian Agency for Development Cooperation
OD	organizational development
ODA	organizational development assessment
OI	opportunistic infection
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan
PLWHA	people living with HIV/AIDS
PMP	performance monitoring plan
PMTCT	prevention of mother-to-child transmission
PR	principal recipient
QA	quality assurance
RCE	Regional Center of Excellence
RFA	request for application
SCMS	Supply Chain Management System Project
SIDA	Swedish International Development Cooperation Agency
SOP	standard operating procedure
SURE	Securing Ugandans' Right to Essential Medicines
TASO	The AIDS Support Organisation
TREAT	The Regional Expansion of Antiretroviral Treatment
UAC	Uganda AIDS Commission
UHMG	Uganda Health Marketing Group
UHSP	Uganda HIV/AIDS Services Project
UNASO	Uganda Network of AIDS Service Organizations
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
UWESO	Uganda Women's Effort to Save Orphans
WHO	World Health Organization

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EXECUTIVE SUMMARY

Ugandan NGOs working on HIV/AIDS programs experienced tremendous growth during the first five years of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)—in resources, clients served, and services provided. In order to manage such growth effectively, these organizations had to adapt rapidly, making changes to organizational structure and management, expanding technical competencies, and improving procedures for reporting and financial management. As PEPFAR Phase II shifts focus from an emergency program to one that provides HIV/AIDS prevention, treatment, care, and support as an integral part of routine public health services, and as further growth in PEPFAR funding is unlikely, it is important to ensure that these HIV/AIDS programs operate as effectively and sustainably as possible.

The purpose of this assessment is to analyze the structure and capacity of indigenous organizations providing HIV and AIDS services in Uganda, and to determine the impact of USAID funding as part of PEPFAR, in order to identify ways to provide increased services at a reduced cost per unit of service—by building on partners' strengths, highlighting activities and practices that work well, and recommending areas where organizational and management changes can streamline operations and improve results. The assessment focuses primarily on four organizations: The AIDS Support Organisation (TASO), the Joint Clinic Research Center (JCRC), the Inter-Religious Council of Uganda (IRCU), and Hospice Africa Uganda (HAU). For comparison purposes, this assessment also considers in lesser detail five other organizations that have received USAID support. The assessment addresses:

- the structure and functioning of the organizations, as well as how increased PEPFAR resources have changed them and their functions.
- the ability of NGOs to plan and budget in compliance with U.S. Government regulations.
- organizational and management efficiencies in producing planned results.
- the quality of organizational results.
- the technical and organizational capacity of NGOs in procurement, distribution, and management of supplies for their projects.
- the individual and collective impacts, strengths, and weaknesses of these organizations.

KEY FINDINGS

Organization, Functioning, and How PEPFAR Resources Have Changed Them

USAID funding under PEPFAR I has allowed TASO, JCRC, IRCU, and HAU to greatly expand their programs of HIV/AIDS prevention, care, and treatment. NGOs have generally taken advantage of USAID's technical assistance in capacity-building to strengthen management systems in human resources, financial management, planning, monitoring and evaluation (M&E), supply chain management, and, to a lesser extent, quality assurance (QA). While not all four of the targeted NGOs have fully implemented the management systems that have been put in place, they are on track to do so. Some leadership and governance issues remain unresolved, but the highest priority has been on establishing the management systems needed to manage donor funds effectively, and this has been largely accomplished.

Challenges in working with PEPFAR under USAID included the timely submission of multiple reports to USAID, recruiting and keeping qualified staff, funding gaps between

USAID procurements, duplication of efforts among NGOs, and double counting and competition for clients.

Based on both the assessment team's observations and reports from other assessments, the organizational structure of the four targeted NGOs is generally appropriate, and has become more formal, functional, and useful over the last five years. Investments in organizational development by USAID have paid important dividends. All the NGOs now have a standard organizational structure that includes a board of directors, a senior management team led by a chief executive officer (CEO) chosen by the organization, and directorates or departments to handle finance, human resources, programs, M&E, and reporting. The extent to which organizational mechanisms and processes have been welcomed by these NGOs, and the skill with which they are being put into practice, vary according to the age and development of the NGO and the strength of its management structure.

TASO has fully embraced organizational excellence, and has done so to great effect. JCRC has functioning systems for its individual projects and has been strengthening overall organization structures and processes, but remains in the process of full implementation. JCRC needs more active oversight from its board and greater focus within the organization on succession planning. HAU has established appropriate structures and practices, and has the organizational will fully to implement them. However, the hospice needs help in relinquishing the single-founder model of leadership and allowing the management team to get on with the business of implementing productive organizational practices. IRCU, a coordination and grant-making organization, has a very complex governance structure in which roles have not yet been fully developed and the grant-making process remains awkward, but the council is aware of these problems and working to resolve them.

All four NGOs conduct care and support services with sensitivity to gender concerns, although women remain underrepresented in their governance and leadership bodies.

Ability to Plan and Budget In Compliance With U.S. Government Regulations

The four targeted NGOs have developed systems that should allow them to follow USAID and PEPFAR rules and regulations. Administrative policies and procedures have been developed; M&E systems to respond to PEPFAR's reporting requirements are in place; budgeting and financial management systems are operating; and internal controls have been established. While JCRC has been receiving substantial direct support and oversight from USAID financial managers in order to resolve outstanding financial management issues, the assessment team believes that this is largely because of the extended vacancy of the financial controller position, and that this will be resolved once the recently selected candidate is on board. The other NGOs have all made significant improvements in their financial management and reporting as well.

Organizational and Management Efficiencies

Although the assessment team was unable to carry out detailed costing studies that would have identified potential areas for increased efficiencies within the NGOs, the team concluded that the greatest gains in reducing costs will come from reduced duplication of effort and improved collaboration among NGOs, rather than from internal improvements. Unfortunately, most of the partners are not seriously exploring ways to reduce their cost, and more could be done in this area. While the NGOs are partnering with other organizations to share services and are eliminating competition and duplication, these steps are taking place at the service delivery level rather than resulting from national discussions among key partners. There is no single, agreed-upon strategy for partnering with or building capacity of government, and sustainability planning is nascent. Furthermore, the existence of several parallel structures for pharmaceutical management appears to be a costly means of ensuring reliable supply and distribution.

Quality of Organizational Results

While indigenous partners have strengthened much of their management, the development and strengthening of their quality assurance (QA) systems have received less attention, as many of the NGOs readily admit. The capacity to develop and monitor quality service delivery is quite strong in a few of the larger indigenous NGOs but is weaker in others. Client interviews by the team indicated that client satisfaction with quality is high, but some of the organizations have not yet implemented QA systems and have no regular way to obtain stakeholder input on quality. This is an area that needs work in order to avoid quality issues in the future.

Procurement, Distribution, and Management of Pharmaceutical Supplies

PEPFAR funding over the past three to five years has greatly contributed to scaling up and expanding access to and use of ARVs and other HIV-related commodities by indigenous partners. As part of the expansion of HIV/AIDS services, the NGOs have had to strengthen logistics staff, procurement procedures, distribution mechanisms, storage capabilities, and inventory management systems. Much progress has been made in building and strengthening supply chain management systems for expanded access to HIV/AIDS services including ART; however, this has been done by using several different systems outside of government rather than a single procurement and distribution system. While JCRC and TASO have made more progress in managing procurement and standardizing pharmaceutical management procedures at all levels, IRCU and HAU have increased the level of skilled pharmaceutical and logistics personnel on staff as well. With direct technical assistance and procurement support from the USAID Supply Chain Management System (SCMS) Project, IRCU has invested in staff to improve knowledge and skills related to supply chain management, including quantification. Since HAU primarily focuses on pain management, this partner provides a more limited range of pharmaceuticals compared to the other indigenous organizations. HAU has increased staff knowledge of supply chain management and is strengthening procedures and policies. Among the other NGOs dealing in pharmaceuticals, Uganda Health Marketing Group (UHMG) manages its own procurement, packaging, and distribution within its product facility unit, while the AIDS Information Center (AIC) receives its supplies from various sources, which has led to problems in coordination.

Individual and Collective Strengths and Weaknesses

This report identifies the strengths and weaknesses of individual organizations in some detail. Regarding their strengths, these NGOs have dramatically expanded access of people living with HIV/AIDS to treatment, care, support, and increased prevention knowledge. The NGOs have shown flexibility in making the changes needed to allow rapid scale-up without sacrificing client focus, and have demonstrated some innovative approaches to service delivery. Regarding their weaknesses, these NGOs depend to varying degrees on donor (particularly PEPFAR) funding, and most have a long way to go to diversify their funding bases. Governance and management issues need to be addressed. Although the NGOs partner with each other in the field, they have made little conscious effort at the central level to ensure that they collaborate wherever possible to eliminate duplication and expand their services cost-effectively.

SUMMARY RECOMMENDATIONS

Recommendations specific to the four targeted NGOs

1. Provide grant-making expertise to IRCU to clarify and strengthen its relationships with its institutionalized religious bodies (IRBs) and improve supportive supervision of grantees.
2. Offer executive coaching to HAU to facilitate its board's and senior management's transformation to an institutionally based, professionally managed organization.
3. Assist JCRC in strengthening its board and in succession planning.

4. Provide targeted support to build HAU's staff skills in pharmaceutical management.
5. Ensure that IRCU provides sufficient medical supervision to provide quality assurance of grantee activity.
6. Conduct a comparative analysis of TASO and JCRC adherence models for cost-effectiveness.

Recommendations Applicable to All USAID INGO Partners

7. Recognize and program technical support as a two-step process in which development and implementation of basic operating systems take the highest priority, with improved governance and leadership as a longer-term effort.
8. Make it possible for the Contracting Officers' Technical Representatives (COTRs) to play a strong, direct supportive role with the INGOs on management and technical issues.
9. Require INGO partners to develop concise succession plans for board members and management leadership positions, to ensure sustainability.
10. Consider developing a simple, standard, quickly administered ODA [organizational development assessment] tool to be used for all PEPFAR grantees. This will aid in measuring organizational development progress, reduce the burden on grantees, and facilitate participation by Ugandan organizations.
11. Include requirements in all NGO agreements to operationalize QA systems, and provide assistance as needed. This should include development and maintenance of performance monitoring plans that track quality indicators.
12. Work with MOH, NGOs, and other donors to upgrade comprehensive national quality standards for HIV/AIDS service delivery.
13. Ensure that IPs have mechanisms for stakeholder feedback on quality issues.
14. Support NGO cost-effectiveness studies as needed.
15. Build in incentives for partnerships within requests for applications (RFAs).
16. Require resource mobilization and sustainability plans with clear indicators (both qualitative and quantitative) and monitoring plans within the RFAs for all USAID-supported INGOs. USAID should consider providing support for partners who request it to help refine and implement their sustainability plans.

I. BACKGROUND AND CONTEXT

Uganda's early response to the HIV/AIDS epidemic was characterized by mass mobilization and education efforts by a wide range of community-based and faith-based organizations and as such was a model for sub-Saharan Africa. Uganda had already achieved a reduction in HIV/AIDS prevalence from a high of over 18% in 1992¹ to under 7% by 2004–2005.² With the launching of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, the United States Government greatly increased the resources available to Uganda to fight the epidemic, with \$90.8 million in FY 2004, an amount that grew to almost \$286 million in FY 2009. Nearly half of this amount was programmed by USAID.

A significant amount of these resources went to the Ugandan non-governmental organizations, including nonprofit and faith-based organizations, that had already proven so successful in implementing activities for prevention, care, and support. With these added resources came targets for reaching increasing numbers of people, and the opportunity to add antiretroviral therapy (ART) to the services PEPFAR partners provided.

As a result, Ugandan NGOs working on HIV/AIDS programs experienced tremendous growth during the first five years of PEPFAR—in resources, clients served, and services provided. To manage their growth effectively, these organizations had to adapt rapidly, making changes in organizational structure and management, expanding technical competencies, and improving mechanisms for reporting and financial management.

Some observers question, however, whether the need to expand quickly came at the expense of other concerns such as efficient operations, duplication of services, competition for clients, lower quality, or deterioration of other public health services. As PEPFAR Phase II shifts focus from an emergency program to one supporting HIV/AIDS prevention, treatment, care, and support as an integral part of routine public health services, and with further growth in PEPFAR funding unlikely, it is important to ensure that programs operate as effectively and sustainably as possible.

¹ Uganda AIDS Commission. "Section 1.1.1—The Burden of HIV/AIDS in Uganda." *Accelerating HIV Prevention: The Road Map Towards Universal Access to HIV Prevention in Uganda*. Kampala: April 2007.

² Uganda Ministry of Health, and Macro International. *Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005*. Calverton, MD: 2006.

II. PURPOSE OF THE ASSESSMENT

The purpose of this assessment is to analyze the organization and capacity of indigenous organizations providing HIV and AIDS services in Uganda, and to determine the impact of USAID funding as part of PEPFAR. The overall goal is to identify ways to provide increasing services at a reduced cost per unit of service by building on partners' strengths, highlighting activities and practices that work well, and recommending areas where organizational and management changes can streamline operations and improve results. The assessment addresses the following areas:

- the organization and functioning of the organizations, including how increased PEPFAR resources have changed them and their functions.
- the ability of indigenous partners to plan and budget in compliance with U.S. Government regulations.
- organizational and management efficiencies in producing planned results.
- the quality of organizational results.
- the technical and organizational capacity of indigenous partners in procuring, distributing, and managing supplies for their projects.
- the individual and collective impacts, strengths, and weaknesses of these organizations.

Special attention is focused on four USAID-supported HIV/AIDS partners that have received significant amounts of funding under PEPFAR:

- the AIDS Support Organization (TASO)
- the Joint Clinic Research Center (JCRC)
- Hospice Africa Uganda (HAU)
- the Inter-Religious Council of Uganda (IRCU).

In order to gain a broader picture of the indigenous organization experience with USAID under PEPFAR, the assessment team also reviewed (in less detail than with the above four) five other Ugandan organizations that have received USAID funds:

- AIDS Information Center (AIC)
- Uganda Women's Effort to Save Orphans (UWESO)
- Integrated Community Based Initiative (ICOB)
- Meeting Point—sub-grantee of IRCU
- Uganda Health Marketing Group (UHMG)—offshoot of the AFFORD project.

The scope of work calls for identification of “best practices.” A “best practice” implies that it is the standard method of achieving the best result. The assessment team felt that the term “promising practice” was more appropriate in this circumstance because the examples identified describe practices that work well for a particular INGO, but that require more careful study to determine whether they would transfer well to other NGOs. The team also wished to acknowledge that many of these “promising practices” have not been formally designated as such by an expert body, nor have they been extensively studied for cost-effectiveness, but that a more comprehensive analysis of the practices is warranted. “Promising practices” are described in sidebars as appropriate throughout the report.

III. SUMMARY METHODOLOGY

A more comprehensive description of the methodology is found in the appendices.

A. STAFFING

This assessment was carried out by a five-person team: a team leader experienced in USAID procedures and regulations, an organizational development specialist, an HIV/AIDS technical specialist, a procurement and supply chain specialist, and a Uganda-based NGO specialist.

B. PROCESS AND INSTRUMENTATION

The team's methodology consisted of:

1. A review of documents related to the Ugandan organizations involved in the HIV/AIDS program (listed in the appendices).
2. Key informant interviews in Washington and Uganda with knowledgeable observers and technical support providers, PEPFAR partners, other donors to the HIV/AIDS program in Uganda, representatives of people living with HIV/AIDS (PLWHA), and staff and grantees of USAID's NGO implementing partners at the central and field levels (listed in the appendices).
3. Application of various information-gathering instruments:
 - a. A senior-management questionnaire for the four targeted organizations.
 - b. An organizational development assessment for the four targeted organizations.
 - c. A short-form organizational development assessment for the other NGO implementing partners.
 - d. A senior management questionnaire for the other NGO implementing partners.
 - e. Questionnaires for PEPFAR partners, other donors, Government of Uganda officials, and other informants.
 - f. A pharmaceutical management questionnaire.
 - g. Client interview discussion guides and questionnaires.

Special attention was given to determining how organizational structure, capacity, and functioning have changed in the past three to five years with PEPFAR funding.

C. FIELD VISITS

The team visited field sites and grantee operations of partners in Mbarara, Lyontonde, Kakira, and Jinja to confirm whether management reforms made at the center had also been implemented at the field level, to learn about the quality and frequency of interaction between the center and the field, to observe the quality of services, and to confirm findings from the central level. The team sought the following information from site visits:

- staffing and supervision
- reporting and finances

- services and service quality
- relationships with government, headquarters offices, and other service providers
- supply chain management issues
- client satisfaction.

IV. BRIEF SUMMARY OF KEY FINDINGS

USAID funding under PEPFAR I has enabled these indigenous partners greatly to expand their programs of prevention, care, and treatment of HIV/AIDS. Rapid funding growth from PEPFAR did not distract the NGOs from their original missions; in some cases it forced the NGOs to better focus their missions. NGOs have generally taken advantage of USAID's technical assistance in capacity building to strengthen management systems in human resources, financial management, planning, monitoring and evaluation (M&E), supply chain management, and to a lesser extent, quality assurance (QA). While the indigenous partners targeted in this assessment have not all fully implemented the management systems that have been established, they have the intent and the capacity, and are on track to do so. The fact that not all of their leadership and governance issues have been resolved is not surprising. The highest priority was placed on establishing the management systems needed to manage donor funds effectively, and this has been largely accomplished.

Because of this the assessment team sees no need for the kinds of broad systems development support provided in past capacity-building efforts. By "broad systems development support" the team means the kinds of basic systems strengthening that, for example, ACE worked on with several partners—M&E, financial management, health management information systems, human resources systems, and other administrative and reporting systems and practices. Instead, targeted assistance is recommended for some of the NGOs to address the remaining governance and management issues specific to those organizations.

NGOs have faced some challenges in working with PEPFAR under USAID, which include the timely submission of multiple reports to USAID, recruiting and keeping qualified staff, funding gaps between USAID procurements, duplication of efforts between NGOs, and double counting and competition for clients. Achieving greater cost efficiency through improved collaboration, learning from each other's service delivery models, and taking action to mobilize resources and diversify donors are key goals they must address in the future. Each of the major NGOs faces additional unique organizational challenges, as well.

Nonetheless, the partnership of these NGOs with USAID has been far more positive than negative. The structures and organization of the NGOs included in this assessment are generally appropriate and have become stronger and more functional over the past five years. Some implementing partners (IPs) still have weak quality assurance systems, and this should be addressed, but the overall quality of care and service delivery is considered high, and clients remain highly satisfied.

V. ANALYSIS AND DETAILED FINDINGS

A. IMPACT ON UGANDAN PARTNERS OF EXPANSION OF SERVICES UNDER PEPFAR FUNDING

PEPFAR resources have vastly expanded the scope of many Ugandan organizations' activities. For example:

- IRCU, a new organization in 2001, relied on small grants from the Norwegian Agency for Development Cooperation (NORAD) and USAID's Policy II Project prior to PEPFAR. In 2006 IRCU received a \$15 million, three-year USAID contract, which has now been extended to a \$17.7 million contract. In 2006 IRCU had a staff of 14 and about 60 sub-grantees. By 2009 it had more than doubled its staff and now has 85 sub-grantees, expanding into new program areas including ART and prevention.³
- JCRC, with funding from the six-year, \$50 million, USAID-supported The Regional Expansion of Antiretroviral Therapy (TREAT) program (2003–2008), has set up six Regional Centers of Excellence (RCEs), 51 TREAT sites for ART, and 25 outreach clinics.⁴ TREAT was later extended, bringing its total to \$69 million.
- TASO's USAID budget has grown from \$2.5 million in 2002 to a \$17 million, five-year grant beginning this year, while also capturing significant PEPFAR resources from the Centers for Disease Control and Prevention (CDC) for treatment services—a new activity for TASO—and from the Civil Society Fund. TASO's staff has increased from about 400 in 2002 to 1,000 today.⁵

1. Organizational and management changes

“USAID makes us focus on policies and organizational changes....USAID has helped us to become better as an organization....Now other organizations want to partner with us.”

— official of a USAID-supported NGO

With technical assistance from USAID, these organizations dramatically improved their systems and skills in HR management, financial management, administration, and M&E. They improved job descriptions to clarify roles and responsibilities of staff at various levels, and they introduced internal controls. As described in the next section, not all of these systems have been fully implemented. But all of the organizations interviewed believe that the changes that have been made and those that are underway make them stronger, better able to manage resources, and more marketable to other donors.

2. Changes in mission

The organizations interviewed did not change their vision or mission statements as a result of the influx of PEPFAR funds, and they believe that their activities, while expanded, have stayed within their broad mandates. Rather than causing partners to stray from their original missions, partnership with PEPFAR has helped them to stay focused because of the high priority PEPFAR places on delivery of services to a targeted number of clients.

³ Information on the number of sub-grantees comes from the draft IRCU strategic plan. Information on staff size was gained from interviews.

⁴ Sources: JCRC-TREAT End of Project Evaluation, June 2008; and PEPFAR database.

⁵ Sources: Interviews and USAID financial information.

“PEPFAR support helped the organizations to drive their agenda. They have done very well, thanks to PEPFAR, in sticking to their mandate, especially in care.”

— a Government of Uganda official

Partner Mission Statements

TASO: To contribute to a process of preventing HIV, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease.

HAU: To support affordable, suitable and accessible Palliative Care to those in need in Uganda and other African countries.

IRCU: To promote peaceful coexistence, moral and spiritual integrity, social-economic welfare and collaborative action through sharing knowledge and resources for the common good.

JCRC: To conduct quality medical research and training, provide equitable and sustainable HIV/AIDS care and other healthcare services in Uganda and internationally.

IRCU, the organization with the broadest mission statement (encompassing peace and justice, education, and HIV/AIDS), considers that PEPFAR resources enabled the council to demonstrate to other donors that it could manage funds effectively. This has convinced DANIDA to support its peace and justice program. Thus for IRCU the PEPFAR focus on HIV/AIDS has resulted in funding for another of IRCU’s key priorities.

Like IRCU, most NGOs interviewed are convinced that implementation of the management reforms introduced to meet USAID’s funding requirements have enhanced their professionalism and made them more likely to attract funding from other donors. NGOs cited no disadvantages or problems resulting from application of USAID requirements to their programs.

3. Challenges faced by indigenous organizations in partnering with USAID and scaling up for PEPFAR

There are various challenges that all the partners have faced in ramping up service delivery while adjusting to USAID’s and PEPFAR’s reporting requirements:

- Getting reports in on time. Manual and sometimes late reporting from field sites causes delays in reports to USAID. Because USAID disburses funds monthly, which is based on prior months’ progress, this sometimes results in funding delays and gaps in service delivery. Some partners noted that they have different reporting requirements for different donors, and this can cause some confusion.
- Staffing. These NGOs have made important strides in increasing the skills and qualifications of their employees. However, once staff members become more qualified, they also become attractive to other organizations. Experienced staff are sometimes enticed away, leaving vacancies that can be open for months (as was the case with JCRC’s financial controller). TASO has been an important training ground for individuals who have become senior members of other organizations.
- Uncertainty about future funding and gaps in funding. An issue facing some partners now is how to plan for the future when existing grants are coming to an end and there is no certainty that new funding will be forthcoming from USAID. They are reluctant to fill vacancies or to make new commitments when funding is uncertain. Gaps between USAID funding mechanisms result in loss of key employees to other organizations. Clients also expressed concern over what would happen to them during program gaps. USAID has made an effort to

ensure that the life of existing projects extends at least nine months after new projects have been awarded, to ensure that there is adequate time for phase-over of activities and clients to the winning organizations. However, this has not eliminated the insecurity felt by partners in their final grant year.

- **Competition.** The partners were more focused on meeting number targets for PEPFAR than on collaboration with other organizations. This has led to duplication of efforts, double counting, and competition for clients in some areas, while in other areas there remain gaps in accessibility to services. The situation can become complicated where PEPFAR has funded several organizations working at the same institutions or service outlets. For example, JCRC/TREAT and TASO both have operations set up at the Jinja Regional Hospital. CRS and IRCU have conducted PEPFAR-funded activities at the same faith-based hospitals and clinics.

“PEPFAR’s biggest mistake was funding multiple organizations at the same institutions. This caused lots of confusion, lots of problems in reporting, different numbers, and double-counting.”

— an NGO official

- **Selection of medicines.** Although this is an issue outside of USAID’s control, and progress has been made in the availability of generic HHS/FDA-approved antiretrovirals (ARVs), indigenous organizations have found it challenging to identify in-country vendors with HHS/FDA-approved OI medicines as required by PEPFAR. In addition, the registration process for medicines through the National Drug Authority (NDA) can be long.
- **Greater expectations by clients and volunteers.** With ample PEPFAR funds available, it has become common to “facilitate” community volunteers with a small stipend, transportation costs, T-shirts, and the like. As a result, volunteers now expect compensation in greater measure. Similarly, clients invariably request more services, particularly for food and income generation. As PEPFAR funds are no longer growing, it has become more difficult for NGOs to cope with the increasing demand—not only to serve more clients, but to provide existing clients with more services.

Promising Practices in Capacity Building.

IRCU credits its ability to scale up quickly while also getting improved management procedures in place, in part, to its contractual relationship with USAID. Under a contract, IRCU got significant hands-on support from USAID that served as technical assistance and mentoring to help IRCU understand and comply with USAID's reporting and financial procedures. While more time-intensive for USAID to monitor, this mechanism allowed IRCU greater scope for guidance and oversight by the Contracting Office. As the IRCU staff put it, “You need to keep close to your baby, to make sure your baby grows well.” Now that IRCU has instituted more professional management systems and procedures, it is ready to move to a cooperative agreement.

The NGOs assessed by the team faced individual challenges as well:

IRCU. As a coordinating body for five major religious groups, IRCU has a complex governance structure, consisting of a Council of Presidents with the heads of the five faiths and a rotating chairmanship, an Executive Board with members from each religious group, a secretariat for each of the five institutionalized religious bodies (IRBs), and the IRCU’s secretariat, headed by a Secretary General. The IRBs have religious medical bureaus that supervise faith-based hospitals and clinics. The relationships between IRCU, the IRBs, and

the grantees have been unclear and are frequently changing. In the three years of the PEPFAR grant, there have been three different grant-making procedures, and only recently have the medical boards played a role in technical supervision of grantees. Despite these hurdles, IRCU has met its targets, introduced programs of treatment and prevention, and trained new grantees. The confusion regarding responsibilities for grant oversight may have resulted, however, in inadequate oversight of quality of services by some grantees.

IRCU has also been criticized for not “demonstrating its comparative advantage as a faith-based organization,” as one official put it. The assessment team understood this to mean that while IRCU has been effective in making grants to faith-based and community-based organizations, it has not mobilized the clergy of the five religious groups to become advocates for prevention, stigma reduction, counseling, testing, and treatment. IRCU is aware of this criticism and, in the process of implementing its new and ambitious strategic plan, is taking steps to obtain member commitment to increase advocacy. *“A year from now, you’ll see a big difference.”* [IRCU official]

JCRC. The center managed its scale-up well and met its ambitious targets, but it has had difficulty in recruiting adequate staff. JCRC’s regional centers are at varying levels of development. JCRC has incorporated government medical staff in service delivery for TREAT, but the Ministry of Health’s policy of rotating providers has meant that continuous training is needed and that salary allowances do not always get to the right people.

Through support from the ACE project, JCRC put in place financial management systems and procedures in 2008. Throughout most of 2009 its financial controller position has been vacant, which contributed to JCRC’s “high risk” status with USAID. A new finance director has been identified and will begin soon.

JCRC’s Executive Director is an internationally renowned expert with many demands on his time. JCRC’s board meets infrequently—twice in 2008 and twice in 2009—which is not sufficient to provide the direction and oversight to JCRC’s leadership that is needed to ensure accountability. For example, the assessment team learned that although key information regarding HR challenges is shared with senior management, recommendations to address these challenges are not always acted on by senior management in a timely manner. A more active board role could ensure that important HR issues are acted upon, or that further decentralization occurs which would enable HR decisions to be made more efficiently. In addition, JCRC has taken no steps to prepare for succession of leadership, which is an important element needed to ensure the organization’s sustainability. As a result, JCRC runs the risk of a leadership crisis at some point in its future, and most likely a crisis in accountability as well. JCRC’s current financial management issues with USAID may be a precursor of such problems.

HAU. The hospice has not been able to meet its targets for serving HIV/AIDS clients. While it has made good progress in developing management systems and policies and in instituting training programs, these changes are being implemented slowly. This is the result of an evolving leadership and governance structure, a lack of agreement among board members as to how to manage expansion of the hospice into a center of training for other organizations, and to what extent HIV/AIDS, rather than cancer, should lead the hospice’s services. There has also been a difference between the hospice’s World Health Organization (WHO)-based definition of palliative care, and PEPFAR’s definition, although recent changes to the PEPFAR definition may obviate this issue.

TASO. This NGO has not had the same scale-up organizational or leadership challenges as did other organizations during PEPFAR I. Several factors contributed: TASO was already a relatively large and established NGO before PEPFAR began, it received several years of

technical assistance from UPHOLD during its early growth phase, and it had a flexible governance and leadership structure that enabled the organization to make decisions and adapt its operations quickly, while still obtaining stakeholder input into decisions. TASO put in place a scale-up team to aid the transition, and then disbanded the team when the scale-up was completed. Although some observers have expressed concern that TASO may have grown too large or runs the risk of compromising quality if it takes on more activities, the assessment team saw nothing to support this view. TASO's own strategic plans call for limited and focused geographic growth to underserved areas and an increased role in building the organizational capacity of smaller partners.

As for **the other five organizations** included in this assessment, all of them have improved management systems, particularly financial management, monitoring and evaluation, and human resources management. None expressed concerns about understanding USAID's reporting requirements. Those organizations that received technical assistance to introduce key management systems prior to scale-up have been able to manage their scale-up well.

In short, Ugandan partners have done very well in meeting the challenges of scale-up to achieve PEPFAR service delivery targets.

4. How partnership with USAID has influenced their activities

Respondents were universally positive about the USAID support they had received, including technical assistance to improve their overall management. Those who are sub-grantees believe they have improved their skills sufficiently and would like to be direct grantees. They appreciate USAID's substantive inputs into project design, as well. For example, HAU agreed with USAID's requirement that the hospice change its comprehensive district training to a model targeted on specific service providers who would be able to use the training more effectively.

There are a few areas where the NGOs suggested some changes in the way they work with USAID:

- A shift to quarterly allocations of funds rather than monthly (although monthly reporting would continue) in order to avoid the funding gaps that some organizations now face because of delays in getting their monthly reports in.
- Some means of enabling the partners to do better advance planning, perhaps by issuing and awarding Requests for Application (RFAs) earlier so that they can plan future activities before their current grants end. (As noted above, USAID has already tried to address this issue.)
- More visits from USAID staff (as opposed to contractors), particularly to regional centers and grantee sites. Partners want more direct communication and feedback on substantive issues. Periodic reviews with their Contracting Officers' Technical Representatives (COTRs) tend to discuss only day-to-day issues. One respondent viewed USAID's role—focused as it is on making sure that reports are adequate and targets are met—as a “policing” role. This was viewed as a shift from the past, when there was a much closer and more substantive relationship between the NGO and USAID COTR.

“USAID should balance the supporting angle vs. the policing angle. It used to be more supportive.”

— an NGO partner official

B. APPROPRIATENESS OF CURRENT STRUCTURE AND ORGANIZATION OF KEY UGANDAN PARTNERS

Based on the team’s observations and reports from other assessments, the structures and organization of the NGOs included in this assessment are generally appropriate, and have become more formal, functional, and useful over the last five years. In most cases clients have input into decision-making in the organization, at times through formal input and feedback processes. All organizations have established strategic planning processes, albeit with varying degrees of skill and seriousness of implementation.

Investments in organizational development in the past three to five years by USAID have paid important dividends. Among the four targeted organizations, all now present a standard and appropriate organizational structure that includes a board of directors, a senior management team led by a chief executive officer (CEO) who is chosen by the organization, and directorates or departments to handle the daily business of a well-run organization—finance, human resources, programs, monitoring & evaluation, and reporting. Technical assistance from the U.S. Government via the ACE project and other mechanisms has especially strengthened these organizations in terms of finance, M&E, and HR management.

While all of the partners know the proper structures and processes that should be used, the extent to which they have been embraced, and the skill with which they are being implemented, vary from organization to organization. This is due to two main variables—the age and general development of the NGO, and the strength of its management structure, starting with the board of directors. Organizations with weak or inadequately engaged boards of directors, including founder-based organizations, depend on autocratic management by one or two people, which reduces the organization’s adaptability and willingness to implement management reforms. The team’s observations confirmed previous assessments that TASO is fully embracing organizational excellence, and doing so to good effect. JCRC has functioning systems for its individual projects and has been strengthening overall organization structures and processes, but remains in the process of full implementation. HAU has put in place appropriate structures and practices, and has the organizational will to fully implement them. However, HAU needs help in relinquishing the single-founder model of leadership and allowing the management team to get on with the business of implementing productive organizational practices. IRCU, a coordination and grant-making organization, has a very complex governance structure in which roles have not been fully developed and which contributes to an awkward grant-making process.

Each organizational structure and process area is discussed in more detail below. In addition, Appendix D provides a summary table of organizational progress of the four targeted partners in each process area.

1. Management structure and governance

All the organizations studied by the assessment team had in place an organizational structure and organizational chart as expected for organizations of this type. The charts show a senior management team comprised of directorate or department leaders for the important functions of the organization. All management structures include a board of directors for providing high-level leadership, governance, and approvals. The extent to which this organizational structure is actually implemented, however, varies. TASO and IRCU use this structure for decision-making and leadership of the organization. With them and with HAU, vacant board seats are filled by the sitting board members, and the management team makes most decisions by consensus, seeking outside input as necessary. The board serves as an appropriate check on management decisions, usually through technically savvy board committees (e.g., finance committee). Due to the unique circumstances that formed JCRC as a collaboration mandated by the President of Uganda between the Ministry of Health, the Ministry of Defense, and Makerere University, the board is

appointed by the President of Uganda. Although the board tries to meet quarterly, this is often difficult to coordinate and in fact occurs less frequently. While TASO has a clear succession plan—each senior manager must identify and build the capacity of two subordinate staff members to take on his or her current role—the other organizations have no clear succession plans.

The clarity and professionalism with which the partners manage field operations and sub-grantees vary. TASO field operations are mirrors of the headquarters operation, each reporting to headquarters on a timely basis, and receiving direct support and supervision from TASO Kampala. Likewise the JCRC Regional Centers of Excellence (RCEs) that the team visited near Jinja and in Mbarara described a clear and supportive process of supervision, quality control, and logistics management from headquarters, although JCRC's RCEs have not experienced the same level of delegation of authority as have the TASO regional centers. Greater delegation of authority by JCRC to its regional centers in the areas of non-pharmaceutical procurement and HR decision-making could streamline their operations, at least in the RCEs that have sufficient staff on board to carry out these functions. IRCU labors under a process of managing sub-grantees that clouds supervisory responsibility in its effort to include the IRBs and medical bureaus, and that has changed three times in three years. Some grantees are not getting the support and supervision they need and desire.

2. Mission, vision, and values

All organizations the team studied have clear, written mission and vision statements. TASO has been most vigorous in embracing its mission and using it as a daily motivator and decision-making tool. The TASO leadership team makes decisions based on the organizational mission, including what assistance to accept (e.g., turning down funding from a tobacco company), and which RFAs to respond to. At IRCU, business cards carry the mission statement, and it is in evidence on placards throughout the headquarters. HAU and IRCU have published their mission statement for all employees, and have made funds-seeking decision based on the mission statement. JCRC has a written mission statement that was posted at the RCEs visited.

3. Strategic planning

All the organizations the team questioned could produce a written strategic plan that contained long-term (three to five-year) goals, and the short-term objectives and activities needed to reach those goals. The goals are driven by the organization's mission, and the strategic plans are approved by the board of directors. With the exception of JCRC's plan, strategic plans are informed by a formal process of seeking input from clients, donors, community leaders, and other stakeholders. Most strategic plans include sections on program, human resources, funding, and expenditure planning. All strategic plans except JCRC's have a direct link to annual workplans that specify activity-level plans to accomplish yearly and longer-term organizational goals. These yearly workplans contain responsibilities by job title, along with measurable indicators and targets. TASO's strategic and annual plans are the most professional of the four targeted NGOs, and the organization has embraced the strategic planning process with great care. TASO's strategic plan was created with greater stakeholder input; followed a more rigorous, prescribed, and lengthy process of creation; and was written in greater detail than the others examined by the team. The plan was realistic in terms of funding availabilities, followed from national HIV/AIDS plans and guidance, and is implemented through annual workplans whose progress is monitored. Most importantly, TASO is actually guided by the strategic plan for daily operations and decision-making. IRCU, under its new leadership, has also recently engaged in a thorough and painstaking process to get all necessary stakeholder input and to produce a plan that is guiding the day-to-day activities of the organization. HAU's strategic planning process, while in place, is somewhat weaker in implementation. While JCRC has a written strategic plan, each project including TREAT also has its own workplan, and results are measured against the individual project workplans, not the strategic plan. Focusing workplans on project (and donor) priorities

rather than on an organization's overall strategic plan can foster a piecemeal approach and cause the organization to stray from its mission. The other NGOs the team studied were able to use their strategic plans to drive decisions about how to approach tasks (workplans), as well as to decide what work to accept.

By comparing current and previous strategic plans, it is easy to see that the skill and degree of professionalism with which these organizations engage in the strategic planning process has improved greatly over the last five years. TASO and IRCU specifically mentioned technical assistance from USAID as being instrumental in their ability to plan well.

4. Human resource management

These organizations have all come very far in the last three to five years in human resource management practices. All the NGOs the team studied have in place a modern, professional HR function. All have produced a written HR policy and procedure manual governing organizational practices such as selection, placement, compensation and benefits, performance evaluation, discipline, and employee record-keeping. All organizations have written policies to protect employees from HIV/AIDS, and which speak directly to discrimination against those with HIV/AIDS. All have job descriptions for every position in the organization. While IRCU's HR director post is currently vacant, it was previously filled by a degreed HR professional, as is the position at the other three partners. TASO's HR function is the most professional and is on a par with that from nonprofit agencies from any developed country. For example, TASO and JCRC have implemented a computerized HR information system and the HR director reports turnover figures to the senior management team and the board on a quarterly basis. At present, TASO's and JCRC's turnover rates are 9% and 10% respectively. HAU's HR policies and procedures are new, and while the management team seems motivated to implement them fully, the team needs the full support of the board, including the founder, to do so. At JCRC, HR policies and procedures have been recently updated. However, employee and volunteer recognition and motivation are neglected by all organizations the team studied. In no case is there a formalized system to recognize superior performance with monetary or non-monetary incentives.

5. Financial management

Financial management is perhaps the area in which PEPFAR funding has helped most to develop these organizations. TASO, IRCU, and JCRC are using Navision financial management software, purchased and implemented with help from PEPFAR, although Navision has not yet been implemented at JCRC's regional centers. HAU is using the Tally software implemented prior to PEPFAR support, but has purchased upgrades and has done additional training with USAID assistance. In the opinion of a senior Kenyan chartered accountant the team consulted, Navision is a well-regarded standard financial management software, used widely in East Africa. In all the organizations the finance function is headed by a chartered accountant, and subordinate financial staff members are likewise formally qualified for their positions. The NGOs complete their annual activity-based budgets and compare financial reports to the budgets. The budgets are used for decision-making for capital expenditures and resource mobilization. The organizations have written policies to protect their assets, such as procurement checks and balances. All organizations complete at least weekly backups of financial data, and TASO and IRCU keep offsite backups to protect against fire or other like calamity. The organizations undergo yearly external audits by firms chosen by the boards of directors. Financial reports are produced monthly and quarterly. While there is some room for improvement in the timeliness of these reports, they are generally produced within two weeks of the period close. There is a finance committee of the board of directors which meets to review financial reports and frequently requests explanations and changes to the accounts. JCRC's current financial issues with USAID appear to be a result of an extended vacancy of the financial controller position, a vacancy that appeared soon after the new financial system was put into place and that has delayed its full implementation.

USAID assistance has clearly helped to improve the financial acumen of these NGOs. In no case did producing financial reports for USAID require undue extra effort, as the organizations have built necessary USAID report formats into their computerized systems.

6. Staffing levels

The NGOs have all increased staff significantly because of PEPFAR funding. TASO's staff has grown from 400 to 1,000 since 2004 (not just to meet USAID needs, but to meet those of CDC and other donors, as well). IRCU has doubled its staff to 33 as of 2009. JCRC's staff increased from 132 in 2003 to 402 in 2009. HAU's staff has grown from 77 employees in 2004, to 117 employees in late 2009.

Staffing does not appear to be inappropriately large for the kinds of programs these NGOs are implementing.

- TASO's strong field operations, including its work with mini-TASOs and community-based organizations (CBOs), require a large field staff. There was some anecdotal information that field staff are stretched because of the huge client demand and TASO's tendency to venture into new areas (one might question whether providing aromatherapy at outreach operations to relieve stress is really essential).
- IRCU's management staff appears to be stretched too thin to provide the supportive supervision that is needed with relatively inexperienced grantees, and it appears that IRCU's reliance on the IRBs to provide supervision to the grantees is not yet entirely successful. Its continued implementation of management reforms also seems highly dependent on the leadership of one individual—its programs director.
- HAU has a running difference of opinion with PEPFAR over the number of individuals a nurse can counsel in a single day in providing palliative care. HAU's much more staff-intensive mode of end-of-life counseling limits the numbers of clients it can reach. However, USAID advises that PEPFAR is now defining palliative care as separate from "care and support," and this may resolve the definitional issue. Further, as HAU implements its plan to move more staff into training and fewer staff into patient care, its staffing issues should resolve themselves.
- JCRC appears adequately staffed for the services it provides, as it often collaborates with MOH staff and other project staff to cover client loads at sites with multiple projects. However, it may lack backup when there are senior staff vacancies, as was the case with the financial controller.

7. Monitoring, evaluation, and reporting

Along with financial management, these NGOs have benefited significantly from USAID assistance in M&E and reporting. Partially because of the need to produce reports for PEPFAR and USAID, the organizations have, with significant technical assistance, built a strong data-gathering and reporting function, staffed by individuals dedicated to that function. Staff gather information on program quantity results (e.g., number of clients treated), as well as the quality of services. They seek feedback from clients and other stakeholders on the quality of their services. They have in place formal instruments and methods for reporting results, which are reviewed regularly against annual workplan targets. The senior management team makes decisions based on results, and the results are reported to the board of directors on a regular basis.

Across the board, these organizations have made significant improvements in implementing formal systems of reporting and in using the resulting data for decision-making.

8. Resource mobilization and sustainability plans

All the organizations are either completely or in large part dependent on donor funding for their continued existence. The main path to ensure the sustainability of the services is donor diversification. No NGO is employing user fees as a means of cost recovery; while some user fees are being collected, they are so small as to constitute an insignificant contribution to the organizations' financial health. For example, TASO charges about 25 cents for certain services. JCRC, on the other hand, competes for research projects which bring in additional resources, and charges fees for private clients. The formality with which these organizations approach resource mobilization and donor diversification varies considerably among the organizations. TASO has employees dedicated to resource mobilization, and already has a diverse funding base. In addition to U.S. Government funding, TASO receives donations from Danish International Development Assistance (DANIDA), the United Kingdom's Department for International Development (DFID), the Swedish International Development Cooperation Agency (SIDA), Irish Aid, and various foundations. TASO also has in place a four-stage contingency plan for the reduction or cessation of U.S. Government funding. While other organizations have resource mobilization plans, dedicated staff time for these activities, and multiple donors, their success in diversifying funding, and in making contingency plans, has generally been lower than TASO's.

9. Results for other NGOs

While the assessment team did not conduct an in-depth organizational assessment of the other five NGOs studied, the team did query the organization's representatives on key questions taken from the assessment, to get a sense of their progress on these same organizational and management elements. Specific information for each of the five smaller NGOs can be found in Appendix E.

All have introduced significant management changes over the past three to five years, attributed to USAID assistance, that range from improved financial and HR management practices, to organizational changes, to better strategic planning. Four have strategic plans and clear distinctions in decision-making roles of the board versus the management team. Four of the five monitor their annual workplans at least quarterly. All have detailed procedures and policies for HR management, including management of volunteers. All have appropriately trained financial managers, procedures to provide checks and balances, and financial management procedures that have been upgraded. All have clear procedures for data collection and analysis. Collection is generally done manually and entered electronically at the district or central level. All but one are weak on quality assurance, as is discussed in more depth below. Two of the five have clear systems in place for board succession, but there is generally little activity to prepare management staff for assuming leadership positions. Stakeholder input into planning and decision-making varies from one organization to another, and only two of the NGOs have clear-cut methods for obtaining client inputs and feedback. Similarly, sustainability planning varies greatly from one organization to another, as also is discussed below. Two of the five NGOs include partnering with other organizations as key elements of sustainability planning, while the other three focus primarily on competition for available donor funds.

In short, while the five organizations show significant variation in organizational development, all have been affected positively by USAID funding, particularly in improving their financial, human resources, activity monitoring, and decision-making practices. All have organizational deficiencies and would benefit from further support tailored to their progress and needs.

C. CAPACITY TO PLAN AND MANAGE IN COMPLIANCE WITH U.S. GOVERNMENT RULES, REGULATIONS, AND STANDARD PROVISIONS

The four targeted NGOs have all developed systems that should enable them to follow USAID and PEPFAR rules and regulations. Administrative policies and procedures have been developed, M&E systems to respond to PEPFAR's reporting requirements are in place, budgeting and financial management systems are operating, and internal controls are functioning. Although the assessment did not include a separate section on procurement (aside from pharmaceutical procurement), this did not appear to be a major issue, except for some misunderstandings as to definition of allowable costs under USAID regulations.

Most of the audit issues identified in the recent past are for relatively minor problems, not unlike those of international organizations. USAID's financial and contracting staff have found that the ability of these organizations to adhere to USAID rules and regulations is similar to that of international organizations with whom USAID works. The exception is JCRC, which is now receiving more direct support and oversight from USAID financial managers to resolve outstanding financial management issues, for reasons discussed above.

The five other partners interviewed have all undergone improvements in their financial management and M&E systems in the past several years. Most could point to internal controls such as segregation of responsibility for approvals of expenditures of funds. All have qualified accountants in charge of their financial operations. However, they rely on donors for in-service training, so any training required by staff turnover must be financed from project funding. The assessment team was unable to tell, from the team's brief interaction with these organizations, whether their ability to meet USAID's reporting and financial requirements is adequate, but it is clear that they have made progress in improving these management systems.

D. QUALITY OF THE ORGANIZATIONS' RESULTS

Much of the capacity development work carried out with indigenous partners in Uganda to date has focused on strengthening financial and HR management, M&E, and strategic planning. The development and strengthening of quality assurance systems has received less attention, as many of the partners readily admit. The capacity to develop a systematic process for and monitoring the quality of service delivery is quite strong in several of the larger indigenous organizations but weaker in the smaller organizations the team observed.

In assessing each organization's capacity to provide QA and the quality of their outputs, in addition to stakeholder feedback on perceived quality of HIV/AIDS prevention, care, and treatment, the team looked at:

- the extent to which each organization is committed to QA as demonstrated by a focus on quality in the organization's mission statement, management support of a QA strategy that incorporates minimum qualifications for clinical and counseling staff, regular staff refresher training, and supportive supervision.
- client satisfaction with services and the extent to which services and the organization are client-oriented and accessible.
- the quality of outcomes and results as evidenced by adherence to national guidelines for ART and national standards for HIV/AIDS care and support, as well as monitoring and reporting against quality-oriented objectives and indicators. Most PEPFAR and organizational indicators measure service delivery in terms of quantitative outputs rather than in terms of quality of services delivered. Where available, the team also considered adherence rates, TB screening rates, and treatment of multiple infections as measures of quality since they result in improved health outcomes.

The table below summarizes the results of this review, followed by a detailed narrative.

Organization	Organization's commitment to QA	Client orientation, client satisfaction	Adherence to national guidelines and use of quality indicators to measure service delivery outputs
TASO	Mission statement is oriented toward quality. QA policy and QA manuals exist and are used. Regular refresher training and supportive supervision for clinical and counseling staff.	Multiple mechanisms used to obtain client feedback. Strong client satisfaction indicated in team interviews.	National and MOH guidelines being used, but modified for stricter quality standards. 2009 Workplan indicators focus on quality indicators, but no PMP available to confirm use of the indicators for monitoring.
JCRC	Strong QA system exists and comprehensive QA management plan with QA point person for each area. Regular refresher training and supportive supervision for clinical and counseling staff. Focus on quality is reflected in mission statement.	Monthly meetings with "patients" for feedback. Strong client satisfaction indicated in team interviews.	Follows MOH and national standards, but modifies them for JCRC's more rigorous quality standards. Strong adherence model followed and high rates of ART adherence. No PMP for regular tracking of quality of service delivery.
HAU	No defined QA system, but some staff are specifically assigned to QA, and mission statement focuses on quality.	No system for regular client feedback on quality, but strong client satisfaction indicated in team interviews.	Has its own standards based on MOH and other sources. No PMP for regularly tracking quality of service delivery.
IRCU	QA plan completed March 2009; not yet implemented.	Client satisfaction survey procedures developed but not yet implemented. Strong client satisfaction indicated in team interviews.	Has modified/added to government guidelines. No PMPs for regularly tracking quality of service delivery.

TASO:

- Its mission statement is quality-oriented in that it focuses on improving the quality of life of persons, families, and communities affected by HIV infection and disease.
- It has a written QA policy, a QA manual, standard operating procedures for clinical services, and two staff members responsible for monitoring QA of clinical and counseling services.
- Counseling staff participate in continuous counseling education sessions held weekly and periodically meet with the Uganda Counseling Association to discuss new procedures and topics of interest. Clinical staff attend regularly scheduled in-house clinical and ART review meetings, and a CME program is available to clinical staff at all 11 centers.
- Supportive supervision is carried out regularly by the technical director and the counseling supervisor, with a focus on problem-solving for improved performance.

- The “TASO culture” is closely focused on the client. Multiple mechanisms exist to solicit client feedback. Two seats on the board of directors are reserved for clients, and these client board members are charged with visiting all 11 centers yearly to collect client feedback for consideration by management and the board.
- Client feedback obtained by the team on service quality was very high. (A more in-depth discussion of findings on client satisfaction appears in Appendix E.)

Both TASO’s Strategic Plan (2008–2012) and the 2009 workplan indicator framework under their USAID cooperative agreement include objectives, activities, and indicators to improve and measure quality of care. These include dissemination of guidelines and standards of care, in-service training, diagnosis and treatment of multiple OIs, client education and counseling for improved adherence to ART, cotrimoxazole prophylaxis, and other treatment. No PMPs were available to confirm outcomes against these program quality indicators. The PEPFAR indicators for care and support against which TASO has been reporting are largely quantitative, but services are provided against the national standards that they have modified for increased quality of care, and targets are generally exceeded.

JCRC:

As a National AIDS Research Center, JCRC required a strong QA system from inception in order to attract research funding.

- Its focus on quality is reflected in its mission statement—“to conduct quality research and training, provide equitable and sustainable HIV/AIDS care....”
- It has a comprehensive QA system and QA management plan that monitors and supports quality of lab, adherence, medical, data, and counseling services with a QA point person for each area. All technical staff fulfill the basic diploma requirements, and most exceed the minimum.
- QA manuals and SOPs are used, and regularly scheduled refresher training is required of all technical staff, based on needs assessments and provided through weekly continuing medical education (CME) for medical staff.
- Supervision of all technical staff at the center is described as supportive with a focus on problem solving. Staff at a Regional Center for Excellence confirmed that supervisory visits from Kampala only take place every six months, but when they do occur the visits are extremely helpful in providing relevant feedback for quality improvement.
- JCRC holds monthly meetings with clients to collect feedback and has placed two suggestion boxes for anonymous feedback, but could be doing more to encourage and facilitate client feedback. Clients are consistently referred to as “patients,” and the team noticed a subtle but slightly more formal interaction between patients and providers at JCRC, particularly at the center. Nonetheless, client satisfaction as obtained by the team was high, and clients praised the treatment and care they receive at JCRC.

Lab quality at JCRC is maintained through annual competency testing, periodic validations as procedures change or new equipment arrives, regular maintenance of equipment, and external quality control sampling carried out every two months. JCRC has developed its own HIV/AIDS laboratory QA standards that are reviewed and revised as needed on an annual basis. JCRC follows its own SOPs for conducting quality research and the national ART guidelines. Other national guidelines for HIV/AIDS care and support are modified and tailored to JCRC’s needs, undergoing review and revision on an as-needed basis.

Promising Practices to Maintain Quality: JCRC's Adherence Model

This model looks at multiple levels of intervention. Counseling focuses on the unique challenges the client faces, including the disease pattern and family issues, and the client's interactions with the community. The counselor tailors frequency of counseling to the client's needs. While frequency can be weekly during the first several months, after each client stabilizes most willingly cut back to quarterly counseling. The model allows the counseling to continue at the facility, community, and/or family level, and provides opportunities for supportive follow-up with community-based peer counselors, as well as family counseling with multiple family members. This rigorous strategy is achieving adherence rates of 96% to 97%.

High ART adherence rates of 96% to 97% are achieved through use of a rigorous adherence strategy that was adopted in 2003 to cover all JCRC and TREAT sites, and is overseen by the adherence officer. JCRC consistently exceeds its targets for improved access and utilization of HIV services, increased availability of ART, and a strengthened medical supply system. No PMPs were available for review of targets and achievements. Although JCRC's 2007–2009 Strategic Plan contains several outcome indicators focused on tracking improved quality of services, the plan does not appear to be used as a working document, nor are outcomes reported against.

HAU:

- Its mission statement does not refer specifically to quality of care, but to improving the quality of life among the sick; however, its strategic objective for patient care and support is *“to provide access to comprehensive, high quality palliative care to people living with HIV/AIDS or cancer and their families.”* Central to HAU's philosophy is the delivery of services at times and places convenient for the patient and his/her caregivers in a culturally and socially sensitive way.
- While there are staff specifically responsible for QA, and recommendations of these staff are acted upon, there is no defined QA system and at best an informal system with irregular monitoring.
- Staff refresher training is provided through staff rotations to give nurses on-the-job training and mentoring. Every Friday technical staff from peer organizations are invited to present or participate in discussions of current topics of interest.
- No system is in place for gathering and acting upon client feedback on the quality of services, although HAU's services are very focused on client needs. Clients interviewed by the team were highly satisfied with HAU's services.
- HAU adheres to its own standards for palliative care (the “Blue Book”) that were developed by its founder and based upon MOH guidelines, those of the African Palliative Care Association, and European guidelines for palliative care. These were last reviewed and revised in 2008. HAU uses a particularly comprehensive definition of palliative care that includes pain and symptom management, adherence to treatments, prophylactic care and treatment of opportunistic infections, HIV prevention, and psychosocial and spiritual support, to optimize the quality of life and to ensure peace and dignity at the end of life.

HAU has a strategic plan framework with an objective and indicators in support of “improved quality of services,” but management does not develop annual workplans or track indicators. No PMPs were available for review. Indicators tracked by PEPFAR measure quantity, but there is a

strong perception by HAU staff and stakeholders that their palliative care services are both unique and of high quality.

IRCU:

- While the organization's mission and strategic plan do not emphasize quality of care and service delivery, its stated program objective under USAID funding is *to scale up access to and utilization of quality HIV/AIDS prevention, care and treatment for people living with HIV/AIDS and their families through religious institutions and community organizations.*
- A QA plan covering prevention, care, ART, and OVC has been developed under ACE, but was only completed in March 2009 and has not yet been rolled out.
- There are several IRCU staff currently responsible for QA, and recommendations of these staff are acted upon.
- Clinical staff hired by the sub-grantees have the appropriate medical credentials, but may not have specific training in HIV/AIDS and need to be trained by IRCU for their specific responsibilities. There is no formal system for clinical supervision or refresher training of clinical staff other than peer support.
- A system for conducting client interviews and taking client satisfaction surveys during supervisory site visits has been developed, but has not yet been rolled out. Client interviews with the assessment team, however, indicated full satisfaction with services provided by the two grantees visited.

According to IRCU, all of their 85 implementing partners are using MOH standards and guidelines for ART, HIV counseling and testing (HCT), and prevention of mother-to-child transmission (PMTCT), but, lacking prevention guidelines, they have created their own. It is not clear that an adequate QA monitoring system exists or is being used regularly and consistently for all 85 IPs. IRCU has also modified and supplemented the government guidelines to customize them for faith-based organizations, e.g., adding spiritual support to other kinds of counseling. No PMPs were available for review; PEPFAR indicators reported on by IRCU are primarily quantitative.

The other five partners:

Among UHMG, AIC, UWESO, ICOBI, and Meeting Point, none has a fully articulated and implemented QA system. In fact, most admitted to having weak or rudimentary QA systems although all had some basic component of QA in place.

- AIC is using a 2002 QA manual based on WHO guidelines that was developed by the AIDS/HIV Integrated Model District Program (AIM), along with guidelines for HIV/AIDS service delivery. A combined MOH/AIC team carries out two visits per year to assess adherence to standards using monitoring procedures and instruments developed by AIM and the MOH. The quality of testing services is assured by sending samples of HIV tests to the national reference lab for checking; TB slides are also tested through district government sampling. Counseling messages are monitored by counseling supervisors, and a ratio of four counselors to one supervisor is maintained. Quality checks are done periodically through client exit interviews. Although there is no overarching QA plan, most of the QA pieces are in place and being used, and the overall quality of AIC's work is considered by stakeholders to be good.
- UHMG uses MOH standards and guidelines to ensure basic quality but would like to develop stronger guidelines. No one individual is responsible for QA, so the organization relies on the MOH.

- UWESO has worked with the Ministry of Gender and other NGOs to develop standards for providing a comprehensive package of services to OVCs. They have not yet disseminated them to their field offices, however, because they consider their QA system to be “incomplete.”
- No one is formally in charge of QA at ICOBI, although it is trying to hire someone to take on QA. CDC has helped ICOBI develop quality standards for each program area.
- Meeting Point has no QA system in place, but counselors are following MOH home-based care guidelines and receive supervision from a senior counselor.

A note on national standards and PMPs: The fact that each partner finds it necessary to tailor the MOH’s national standards in order to meet its own quality standards indicates that the national quality standards themselves are in need of revision. As one government official remarked, the standards for care and support, in particular, have been fragmented into too many parts to be really useful. If PEPFAR is to continue measuring quality by adherence to national quality standards, there must be a concerted effort, by government, donors, and partners to bring those standards to a minimum that all can accept. Given PEPFAR’s heavy reliance on quantitative indicators, it is especially incumbent on USAID to ensure that each INGO develops and updates individual PMPs that track the quality of services delivered, not just the quantity of clients reached and services delivered. TASO’s 2009 USAID workplan indicator framework is an excellent model for measuring the quality of service delivery outputs.

E. PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

A critical component of Uganda’s ongoing effort to address the HIV epidemic is to provide lifesaving ART and other medicines to prevent and treat HIV-related illnesses including opportunistic infections such as tuberculosis and malaria. One of the challenges in providing such treatment is creating an uninterrupted supply of high-quality medicines and supplies, including laboratory materials such as rapid test kits. Based on interviews conducted by the assessment team and supporting documents, PEPFAR funding over the past three to five years has greatly contributed toward scaling up and expanding the access to and use of ARVs and other HIV-related commodities through indigenous organizations. Unfortunately, this has led to the development of several parallel systems for supply chain management outside of government, likely increasing the costs of system maintenance.

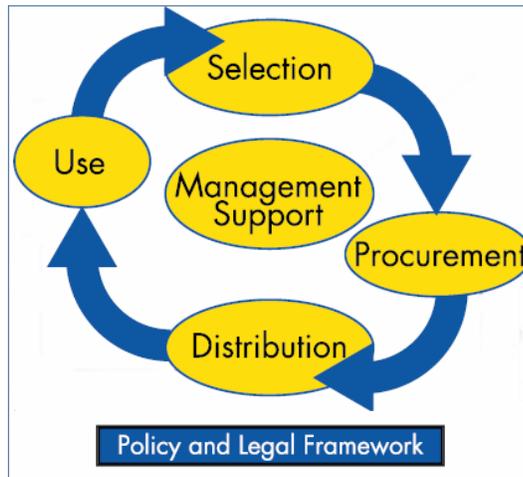
As part of the expansion of HIV/AIDS services, indigenous organizations had to strengthen logistics staff, procurement procedures, distribution mechanisms, storage capabilities, inventory management systems, and mechanisms to ensure rational use. Much progress has been made to build and strengthen supply chain management systems for expanded access to HIV/AIDS services including ART. While JCRC and TASO are at more advanced stages in managing procurement and standardizing pharmaceutical management procedures, IRCU and HAU have also improved their levels of skilled pharmaceutical and logistics personnel on staff. With direct technical assistance and procurement support from the USAID Supply Chain Management System (SCMS) Project, IRCU has invested in staff to improve knowledge and skills related to supply chain management, including quantification. Since HAU primarily focuses on pain management, it provides a more limited range of pharmaceuticals compared to the other IPs. However, HAU has increased staff knowledge related to supply chain management and is in the process of strengthening procedures and policies for supply chain management.

PEPFAR funding has strengthened indigenous organizations that were already providing ARVs and has expanded the capabilities and services provided by indigenous organizations that were not providing ART before PEPFAR. This has been accomplished by directly funding IPs and by providing technical assistance for supply chain management and procurement through PEPFAR

projects such as DELIVER (2001–2006) and SCMS. In order to help ensure a consistent supply and appropriate use of HIV commodities to an expanding client base, indigenous partners used a variety of approaches made possible through PEPFAR funds. These include decentralization of ARV distribution points, use of community volunteers for adherence counseling, expansion of training opportunities in logistics, creation of regional reference labs, increased use of generics, and aggregated procurements through SCMS. Embedded in many of these approaches are increased opportunities for training related to pharmaceutical management and linkages with the national system including MOH facilities, staff, and clients. Even though these linkages with the MOH exist to varying degrees, exploring different mechanisms for collaboration will be beneficial. In addition to support provided by IPs to government facilities and staff, the recently initiated five-year PEPFAR-funded Securing Ugandans’ Right to Essential Medicines (SURE) program will work to strengthen the national pharmaceutical supply system and integrate parallel supply systems down to peripheral levels.

Pharmaceutical management can be represented by a cycle of steps which contribute to ensuring consistent access to and appropriate use of high-quality medicines and supplies. In the sections that follow each step of the pharmaceutical management cycle will be discussed.

Source: Management Sciences for Health and World Health Organization. 1997. *Managing Drug Supply*. 2nd ed. West Hartford, CT: Kumarian Press.



1. Selection

PEPFAR implementing partners, including indigenous NGOs, base their selection of medicines and supplies on the MOH guidelines. For ARVs, these guidelines are updated by the ART Clinical Care Subcommittee of the National ART Committee of the MOH. This subcommittee receives support directly from PEPFAR. Many indigenous organizations who also receive PEPFAR funding participate directly on this subcommittee. In addition to following the MOH guidelines, PEPFAR funds must be used to purchase Health and Human Services/Food and Drug Administration (HHS/FDA)-approved ARVs and HIV-related medicines, such as for OI treatment. PEPFAR funds can be used for any branded or generic ARVs that are approved or tentatively approved by the FDA. Over the past three to five years, under an expedited review process, approximately 100 ARV formulations have received approval or tentative approval from HHS/FDA. This increase in available generics has resulted in huge cost savings which allowed further expansion of HIV/AIDS services. The IPs interviewed reported that about 90% of ARVs procured are generic. Medicines must also be registered for use in Uganda by the National Drug Authority (NDA), or they must be waived for importation. Registration can be a long process, and some indigenous partners have established strong relationships with the NDA in order to expedite the process. There have been challenges with acquiring NDA registration of HHS/FDA approved cotrimoxazole, which in turn have affected procurement opportunities.

2. Procurement

The indigenous partners interviewed that procure their own commodities have procurement policies that include guidelines for pre-qualification processes and competitive bidding procedures for suppliers. In addition to purchasing commodities, each organization also receives some donations and has a policy for accepting donations.

Important procurement partners for supplying HIV-related commodities to indigenous organizations include SCMS, Joint Medical Store (JMS), and Medical Access Uganda Limited. JMS is a not-for-profit organization originally established by the Uganda Catholic Medical Bureau and the Protestant Medical Bureau to facilitate the management of relief supplies. Since its formation in 1979, JMS has developed into an organization which procures, stores, and distributes products to faith-based organizations and NGOs across the country. Recently JMS has expanded to provide training to FBOs, NGOs, and government health workers, as well.

Medical Access Uganda Limited is a nonprofit organization which supplies and centrally stores ARVs and other medicines to treat HIV-related illnesses. Medical Access was initiated in 1998 as a pilot program of UNAIDS in collaboration with the GOU to increase access to ARVs. Thanks to its early success, Medical Access has since become a self-sustaining organization and now supplies and distributes ARVs and other medicines to accredited MOH facilities and PEPFAR implementing partners, including TASO, Mildmay, and Catholic Relief Services. In addition, Medical Access provides technical assistance for supply chain management to its clients and provides training opportunities for staff from NGOs and the MOH. Medical Access has recently begun to pilot a mentorship program in three TASO centers. IPs interviewed that are supplied through JMS and Medical Access reported that they are satisfied with the services received.

Indigenous partners that procure through SCMS, such as IRCU, have worked closely with SCMS to establish clear roles and areas for support, so that IRCU may build staff skills in pharmaceutical management with guidance from SCMS. IRCU has a Memorandum of Understanding with SCMS that outlines specific support related to quantification, procurement, and warehouse and delivery support by JMS. USAID is currently working on streamlining services provided by JMS for PEPFAR partners to reduce costs by consolidating storage, determining a flat percentage handling fee across PEPFAR partners, and aggregating orders to benefit from economies of scale. In addition, USAID has worked with JCRC to review its procurements and identify areas to achieve cost savings, which included switching to generics in some cases, identifying lower-cost but high-quality projects, and revising arrangements with selected donors to increase products received.

3. Storage, distribution and inventory management

All indigenous partners interviewed have mechanisms to track HIV commodities and help ensure that they reach the appropriate levels of the service delivery system. At the central level these systems are computerized.

JCRC's computerized system was installed with technical support from DELIVER, and training for staff on the system was provided by DELIVER. Although the system is functional at the central level and at some RCEs, implementing it remains a challenge for at least one RCE visited, which has the training and software but lacks a server and thus cannot implement the system. Currently TASO is working with Medical Access and partners to improve its computerized logistics system. Beyond the central level systems, a continuing challenge for tracking commodities at the facility level is that multiple sources of commodities and multiple programs can result in parallel registers and reporting requirements. Staff have been flexible about sharing tasks across different projects and following different tracking mechanisms for different programs. For example, at one site where two PEPFAR partners are located (JCRC and the Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)), pharmacy staff had to use

different computers which had different tracking systems installed depending on the particular project under which a client was enrolled.

JCRC has historically handled all of its own procurement, storage, and distribution with its own vehicles and storage facilities at the central and regional levels. Recently JCRC has received direct support from SCMS for procurement under the TREAT extension, which began in October 2009. UHMG also handles its own procurement, storage, and distribution. In addition, UHMG brands and packages pharmaceuticals appropriate for the local context. Although HAU does not carry ARVs, it does manage its own procurement for pain management. SCMS manages the procurement process for IRCU, although IRCU performs its own quantification with technical input from SCMS.

JCRC centrally places all orders based on consumption data from regional centers and sites. Regional centers and sites must report on their consumption but do not give the specific order to JCRC at the central level. RCEs and sites do have the authority to procure emergency orders of commodities outside the central level ordering process as needed. HAU and IRCU have a similar arrangement in which they centrally place orders based on consumption reports from sites. IRCU has an arrangement with JMS to store and distribute its medicines. All TASO centers place their orders centrally through the TASO headquarters and then travel to Kampala to pick up their commodities and supplies. Reports of stock-outs among the IPs by staff and clients interviewed were few.

In addition, each organization interviewed has a system for redistributing medicines that are close to expiry. In some cases, the IPs also receive stock from the MOH that is close to expiry to ensure that the medicines will be used. All the IPs consistently and frequently fill gaps during MOH stock-outs by providing individual MOH clients with HIV-related medicines.

4. Rational use

As mentioned in the selection section, indigenous NGOs use standard treatment guidelines in accordance with MOH recommendations. Organizations have integrated approaches, such as community volunteer counselors and job aids, into their structures that should improve adherence. For more information related to systems to help ensure rational use, see section D on quality assurance.

JCRC, which had been procuring ARVs prior to PEPFAR, was able to strengthen its supply chain management system by extending its reach to lower levels, standardizing procedures and practices, increasing supply chain management staff, updating stock tracking systems, and improving systems to ensure rational use. Although TASO had not been procuring ARVs prior to PEPFAR, through PEPFAR funding TASO was able to build a strong supply chain management system, which it is continuing to improve with technical assistance from Medical Access and PEPFAR through CDC. Both JCRC and TASO are in a position to share information related to their experiences with mechanisms to expand access and improve efficiencies with other IPs that are working to develop stronger supply chain management systems.

Because of its focus on pain management, HAU has a more limited range of pharmaceuticals compared to the other IPs. Although HAU has support from volunteer pharmacists to increase its ability to manage its supply chain management system, the hospice can benefit from additional targeted support to build staff skills in pharmaceutical management, including implementing SOPs in pharmacies at HAU sites.

IRCU has benefited from receiving technical assistance and procurement support from SCMS. As the council develops stronger organizational structures and systems, it will have to assess and consider the level of support necessary and appropriate from SCMS or other partners, including JMS, to ensure that while IRCU continues to build its own capacity to manage pharmaceuticals

and supplies, it receives the technical input and guidance required to ensure a continuous supply of ARVs and other HIV-related medicines and supplies.

Supply Chain Management Information for Four Indigenous Partners

Organi- zation	USAID-Funded Products	Other HIV- Related Products	Main Sources of Procurement	Storage and Distribution	Push vs Pull System	Supply Chain Management Technical Assistance
JCRC	ARVs OI treatment Cotrimox-azole prophylaxis	HIV testing kits Family planning Pain management	Self, but through SCMS since October 2009 during the TREAT extension	Self	Push (receive consumption reports at central level)	Yes–DELIVER and SCMS
HAU	Some basic supplies	Pain management OI treatment Cotrimox-azole prophylaxis Family planning	JMS	JMS	Push (receive consumption reports at central level)	
IRCU	ARVs OI treatment Cotrimox-azole prophylaxis	Family planning	SCMS	JMS	Push (receive consumption reports at central level)	Yes–SCMS
TASO	OI treatment STI treatment Family planning	ARVs (PEPFAR CDC) HIV test kits Cotrimox-azole prophylaxis	Medical Access JMS UHMG (cotrim)	Self	Pull	Yes–CDC in collaboration with Medical Access

5. The other five partners

Of the five other local partners interviewed, neither UWESO nor Meeting Point directly provide any medicines to clients, but instead refer clients to local partners and/or health facilities as appropriate. Meeting Point did note that it can sometimes be difficult for referral facilities to address the needs of pediatric clients, who must therefore seek medicines at private pharmacies.

UHMG has the most robust pharmaceutical management system since it provides 12 products, including cotrimoxazole for prophylaxis and family planning products. UHMG has a product facility unit and manages its own procurement, storage, and distribution. In addition, UHMG brands and packages pharmaceuticals appropriate for the local context. Standardized procurement procedures are followed. One noted challenge was the length of time it takes for the registration of products by the National Drug Authority.

Although through its USAID-funded program, ICOBI does not provide any pharmaceuticals, with CDC funds it does provide products such as HIV test kits and specific pharmaceuticals for PMTCT.

AIC offers some pharmaceuticals and other products to clients including HIV test kits, cotrimoxazole prophylaxis, family planning products, and medicines to treat malaria, TB, and pneumonia. These pharmaceuticals are procured from a variety of sources (not always consistently), which include the MOH, CDC, UNFPA, and directly by AIC. Receiving pharmaceuticals and other products from multiple sources is challenging to coordinate and often results in insufficient medicines and supplies. The MOH at times provides AIC with HIV test kits

that are close to expiry because AIC can use the test kits before they expire. AIC uses only one CDC vehicle to distribute the medicines and supplies, which limits timely and efficient distribution as well.

F. GENDER EQUITY

1. Gender in the epidemic

Women are more likely to be HIV positive than men (7.5% to 5.0% respectively⁶). The figures for client testing and treatment carried out by the NGOs in this assessment support this, showing a preponderance of women over men in HIV-positive status. In most NGO treatment centers women form 60% to 75% of clients irrespective of location. In both urban and rural areas and at all levels of treatment, there are fewer men receiving counseling than women.

2. Gender in the management of the indigenous partners

Uganda is a patriarchal society where most power positions are occupied by men. Thus it is not surprising that in the IPs interviewed by the assessment team women are underrepresented on boards of directors, in senior management positions, and on staffs in general, excluding health workers at lower levels. The justification given for this was the lower educational level of women relative to men (although this is not borne out by recent survey information). Several of the NGOs have gender mainstreaming as a goal and are trying to increase the numbers of women even if parity has not yet been realized.

GENDER PARTICIPATION IN THE LEADERSHIP OF TASO, IRCU, HAU, JCRC				
Management Level	TASO: Women/total	IRCU: Women/total	HAU: Women/total	JCRC: Women/total
Board of Directors	5 of 13	4 of 10	3 of 10	0 of 8
Senior Management	5 of 8	1 of 4	3 of 4	4 of 9

Branch/site/community staffing levels: Women tend to be the majority at the community level because they are highly represented in the nursing professions from which counselors and health workers are recruited.

3. Gender issues in the provision of services

Client interviews indicated that women are more willing to come to the centers to receive services than are men, as well as being more willing to admit that they are HIV-positive. In discussion groups several male clients and volunteer counselors reported that men suffer more from stigma and embarrassment than women. It may be that women are more willing to come for treatment because their power position relative to men does not usually allow them to negotiate safe sexual practices and therefore they are more willing to seek other solutions to their dilemma. Religious practice is also a factor for Muslim men who are not comfortable talking to women counselors. However, the counseling and service process has built in equity in that men are able to choose male counselors if they wish. Counseling modalities take into consideration the different issues faced by different genders. In the prison outreach program visited by the assessment team, the young offenders seemed to prefer the more mature female counselors. A positive element of all

⁶ Uganda Ministry of Health. *Uganda Service Provision Assessment Survey. Key Findings on HIV/AIDS and STIs*. Kampala: 2007, p. 2.

the service provision activities observed by the team is the strategies used to reach people in their cultural milieu, such as the composition of drama groups (including people from many of the different ethnic groups of the area), the variety of ways in which the messages are relayed, and the testimonies of respected “opinion makers.”

The concerns of USAID and other donors regarding gender equity have probably had a positive impact on the inclusion of women in the operation and management of the NGOs involved in HIV/AIDS campaigns in Uganda. However, gender equity remains a work in progress since NGOs have not yet attained equitable representation of women on the boards and in senior management of their organizations. For example, among the four targeted NGOs, none has more than 37% women on its board. Only HAU, whose services have a heavy nursing bias, has achieved gender equity in its senior leadership structure.

G. ORGANIZATIONAL AND MANAGEMENT EFFICIENCIES ACHIEVED BY THE INDIGENOUS PARTNERS IN PRODUCING PLANNED RESULTS

There is a common belief, expressed by several key informants interviewed by the assessment team, that because PEPFAR pushed out so much money to partners so quickly, with no time to focus on organizational efficiencies, partners developed staffing and expenditure patterns that were sometimes inefficient and wasteful. Comments have been made on overstaffing, over-expenditure on infrastructure, and provision of services that were not always needed, e.g., counseling of all ART clients regardless of their health or previous adherence.

The team was not able to review each IP’s operations in depth, nor to undertake costing studies. Reviewing potential efficiencies is complicated by the fact that the four main partners covered in this assessment use very different approaches to service delivery, making comparisons difficult.

- TASSO relies mainly on its own staff, at both central and field levels, to implement programs. This has the advantage of giving the organization greater flexibility and control over staff qualifications, training, and performance, as well as improved program outcomes, and it maximizes efficiency in decision-making and communication. It does not, however, strengthen MOH staff, nor does it maximize involvement of CBOs with their strong community knowledge and volunteer spirit.
- IRCU programs its funds entirely through community-level grantees, primarily faith-based organizations. This enables IRCU to take advantage of the knowledge of community needs, the influence of local leaders, and communications channels through local networks of the FBOs and CBOs, as well as to rely on volunteers from these organizations. While this approach pushes funding to the grass-roots level, which is usually preferable, it also requires IRCU to engage in significant technical assistance, training, supervision, and advocacy of local organizations that may otherwise lack the skills to carry out program activities—tasks which IRCU does not yet appear to have entirely mastered.
- JCRC achieves most of its targets by working in collaboration with government hospitals and clinics. This promotes partnership and helps strengthen the government health system by increasing skills for government health workers and access to equipment. However, this approach can also lead to challenges with government staff such as turnover, which requires more training of newly positioned staff.
- HAU has a single focus and emphasizes the training of others rather than increasing its own service delivery. This increases the skill base in Uganda for palliative care. However, by taking responsibility only for training, rather than also taking responsibility for the increased service delivery by other organizations, HAU’s measure of success becomes “people trained”—which leaves its real impact in question.

To examine potential efficiencies and organizational sustainability, the team looked briefly at five indicators:

- each organization’s internal growth versus increases in clients served.
- partners’ efforts at collaboration.
- interaction with the national health system and whether parallel structures have been set up that weaken this system.
- deliberate internal efforts of partners to increase cost-effectiveness.
- the presence and quality of partner sustainability and resource mobilization plans.

Based on these five indicators, which are described in greater depth below, the team concluded that while there is always room for increased efficiency, the scale-up for PEPFAR has not involved high levels of inefficient or wasteful staffing and expenditure patterns. Nonetheless, most of the partners are not seriously exploring ways of reducing their costs, although TASO and JCRC have begun to take steps.

Some NGO collaboration in service delivery is already occurring, but appears to occur more at the service delivery level than as a result of national discussions among key partners. There is no single, agreed-on strategy for partnering with or building capacity of government, and sustainability planning is nascent.

The team’s chief conclusion is that the greatest potential for gaining efficiencies in operations lies not in internal operating adjustments within the NGOs, but in improved partnering with other organizations to share services and eliminate competition and duplication, and in reducing the multiple parallel procurement systems described in section E above. Of course, the funders and NGOs should continue to examine their operations to identify areas where efficiencies can be made, but potential gains from these areas were not readily apparent to the team.

1. Organizational growth versus clients served

The assessment team was unable to conduct an analysis of how scale-up affected cost per client per organization over time because of the lack of consistent data for comparison. However, examining each organization’s growth—by whatever measures were available to the team—and increase in clients over the same period, was indicative. (Readers may draw their own conclusions about cost-effectiveness, but to do the job right, a much more comprehensive, data-driven analysis would be required than was possible under this scope of work.)

Between 2005, the year before its USAID agreement was signed, and 2009, IRCU increased its staff by about 135% (from 14 to 33 people), excluding the USAID-financed positions at the IRBs which changed from year to year. Over the same period, with its \$17.7 million four-year USAID program, IRCU increased its counseling and testing activities by 275% to 108,800 people in 2009; increased its palliative care by 108%; served 33% more OVC clients; initiated an ART program that served more than 6,000 people by 2009; began lab testing for HIV that reached 110,000 tests in 2008 and 2009; and reached 6 million people in 2008 and 2009 with prevention activities and messages.

TASO’s staff increased 28% from 786 staff in 2005 to 1,009 in 2008. During this period of rapid scale-up under PEPFAR funding, clients served in the OVC program increased 83% from 8,156 in 2005 to 14,952 in 2008. HIV+ clients receiving palliative care and basic health services rose 31% from 88,673 in 2006 to 116,479 in 2008. These same employees were responsible for tremendous scale-up in treatment activities under CDC’s PEPFAR funding (378% increase in the

number of ART clients, from 4,794 in 2005 to 22,925 in 2008), as well as for implementing additional and complementary activities under the Civil Society Fund and other donor programs.

From the initiation of the TREAT program in 2003 through 2008, JCRC TREAT staff increased by more than tenfold, from 16 to 182 people. With its \$50 million budget over this five-year period, JCRC increased the number of its clients receiving ART by 577% to reach over 75,000 people (from 10,333 in 2004); increased lab services delivered for HIV disease monitoring to 416,804 performed in 2008; and increased counseling and testing to over 66,000 people.

Between 2005, when it started receiving PEPFAR funding, and 2009, HAU increased its staff by about 50% (from 77 to 117 people). Over the same period, with its \$3 million agreement from USAID, it doubled the number of clients provided with palliative care from 1,088 patients in 2004/2005 to 2,396 in 2007/2008. HAU also increased the number of service providers trained to 694 in 2008.

From this limited information, it appears that increased staffing by these four NGOs resulted in proportionately greater increases in clients served, as well as in the range of services offered. Even HAU, while unable to meet its PEPFAR targets, increased its patient load and training activity greater than its staffing. These facts, in conjunction with the conclusions of the team's organizational development assessment that overall organization and staffing appear appropriate for the NGOs observed, led the team to conclude that additional efficiencies to be derived from internal management changes are limited.

2. Indigenous partners' efforts at collaboration

Competition still exists among the non-governmental partners. PEPFAR has actually encouraged competition over collaboration by placing such great emphasis on meeting targets that grantees would rather provide all services themselves and maintain control, rather than risk sharing responsibility.

"The competition causes breakdowns in partnerships. Those who used to be close partners are now competitors."

— an indigenous partner official

There are indications of partners' willingness to combine efforts in order to provide more comprehensive services, and to institute strong referral systems. Some examples:

- TASO and IRCU collaborated to become the NGO Principal Recipient (PR) for the Global Fund 9th Round.
- HAU regularly refers clients to TASO for palliative care services that it cannot provide.
- The team visited a prison outreach program in which TASO and AIC collaborated and then sent CD4 lab work to JCRC.
- NGOs regularly go to JCRC centers for their lab work.
- IRCU is making an effort to negotiate with Catholic Relief Services to better coordinate grants to faith-based and community-based organizations.
- At the Mbarara Regional Referral Hospital, JCRC, MJAP, and MOH staff share responsibilities to serve clients irrespective of the particular program to which the client belongs.

- TASO’s and IRCU’s recent strategic plans both discuss engagement with the National Civil Society Organization (CSO) Cluster of the Self-Coordinating Entities and with UNASO to better coordinate services, although no specifics are provided as to practical collaboration and referral mechanisms at the service delivery level. This appears to be a missed opportunity for regional or nationwide collaboration, rather than relying on site-level collaborative activities.

While there are many instances of collaboration to be found at the local level, the missing link is national-level agreements among the NGOs as to how to foster this collaboration. The national coordination bodies mentioned above are engaged in information-sharing and advocacy, but have not made significant inroads in achieving collaboration among NGOs, and to some extent look to the donors to support collaboration. Collaboration at the national level could result in agreements among the NGOs as to general areas where each has a comparative advantage; particular services for which NGOs working in a particular region would rely on other partners to provide; joint mapping to determine where competition or service gaps exist to enable partners to agree on how to resolve these issues; and better sharing of training opportunities and best practices. An agreement or action plan on staff training alone would likely yield cost savings, since, as discussions with informants indicate, training opportunities are one of the factors that cause staff to move from one organization to another, not to mention the fact that staff training is an area characterized by duplication and multiple trainings of the same individuals.

Lack of growth in PEPFAR funding is forcing IPs to rely more on each other, and this will increase over time if future funding from PEPFAR demands it. Mechanisms should be established within PEPFAR’s funding criteria that encourage partnering where this can lead to increased efficiencies.

Promising Practices in Reaching Hard-to-Reach Client Groups through INGO Collaboration

Collaboration occurs monthly at Jinja Remand Prison through a partnership activity involving TASO, AIC, and JCRC. TASO realized in 2008 that several clients had been lost to care and support because they had been imprisoned. TASO already had several other outreach activities in this area that were using most of their outreach staff, so a partnership activity was established whereby TASO organized the outreach and sent five to six counselors for adherence and client counseling and took blood samples for CD4 testing; AIC performed HIV counseling and testing; and JCRC did the lab analysis of HIV tests and CD4 counts. This not only allowed for follow-up of regular clients but provided an opportunity for increased HIV testing/counseling and identification of new clients. Presently 105 prisoners are receiving services through this outreach activity, including women who are bused to the site each month from a nearby women’s correctional facility.

3. Indigenous partners’ interaction with the national health system

A frequent charge is that the non-governmental partners are building systems parallel to that of the Ministry of Health, and that doing so has weakened the Ministry’s capabilities to provide services, not just for HIV and AIDS but for other health services as well. One respondent noted that as NGO programs have grown, MOH district health teams have been reduced from 12 people to 4—too few to coordinate the public health response for an entire district.

On the other hand, most respondents, including those in government, accept that it will be many years before the Ugandan Government is able to assume major responsibility for implementing an HIV/AIDS program without substantial involvement from the NGO community.

With the exception of JCRC, whose programs work in collaboration with the MOH, there does not appear to be much effort at collaboration between NGOs and the Ministry at the service delivery level. There are referrals to government facilities by NGOs which cannot provide services, and there are frequent cases when NGOs provide government clients with drugs because of stock-outs. (This was mentioned at the JCRC Mbarara RCE. No formal, written arrangement exists on an individual client basis, but if the MOH requests that medicines close to expiry be given to local partners such as JCRC to use before expiry, the local partner may ask for the request to be written in a letter.) However, there is no single vision, shared by government, donors, and NGOs, as to the appropriate relationship between the NGOs and the MOH. Without such a strategy, it is questionable whether the NGO community will be able to partner effectively with government on its own.

The case is somewhat different for the orphans and vulnerable children programs carried out by the IPs, which fall under the oversight of the Ministry of Gender, Labor and Social Development. The Ministry views its relationship with the NGOs as a partnership, with the NGOs doing the implementation because of their human resources, while the Government works on development of policies and standards. There is some concern, however, that since TASO and IRCU both support local grantees outside of the Civil Society Fund, they do not receive the same level of government monitoring.

4. Deliberate efforts by indigenous partners to increase cost-effectiveness

As PEPFAR funding dwindles, some IPs are making preliminary efforts to reduce the costs of providing services. For example, JCRC has reduced the costs of lab tests by pushing them down to the regional centers. The ability of the regional centers to measure viral load reduces costs and enables clients to get results faster. TASO's community drug distribution program, described in the text box below, is an effort to combine cost-effectiveness with convenience to clients. On the whole, however, the need to increase cost effectiveness was not a topic raised by partners except by TASO, which is doing costing analysis of various services and plans to explore ways of reducing these costs. (TASO's 2003–2007 strategic plan already called for costing studies of various service delivery options.) Cost-effectiveness studies of organizations' proposed service delivery models could be built into each of the cooperative agreements, to stimulate greater NGO awareness of the need to operate efficiently.

Promising Practices to Increase Cost-Effectiveness: TASO's Use of Field Officers and Community Drug Distribution (CDD) Points

- The Field Officers are non-medical professionals trained to ensure client adherence to ART, provide counseling and testing, and encourage family and community support for the client.
- ARVs and other medicines are dropped off at multiple (80 to 105 depending on the district) CDD points every two months. Field Officers then take the drugs from these points and distribute a two-months' supply to each client in the presence of a peer Client Agent. The Client Agent notes which clients fail to show up for their drugs and assists the Field Officers in following up on them.

This system improves client access to comprehensive services, reduces TASO's counseling load, and enables TASO to follow up on clients in their homes. Preliminary results from a CDC cost-effectiveness study show little cost difference between home-based and facility-based care, but provision of care close to home is likely to improve client adherence to drug regimens and is costly and more convenient for the client. It's a delivery model worth further long-term analysis.

5. Sustainability planning

Nearly all of the organizations the team interviewed have begun thinking about sustainability planning, but any implementation of such plans is in the early stage. While donor diversification is part of all plans, they include other revenue generating techniques as well. For example, JCRC already is engaged in funded research and believes it can fund its entire operations through funded research when TREAT ends. IRCU's plans include membership contributions, consultancies to other organizations, and partnering with other organizations to improve services cost-effectively. Other elements of sustainability planning were discussed briefly in Section 2 above. The five organizations observed in less depth also have different strategies, some relying primarily on consultancy and contractual work, some on donor diversification, and one on increased donations and land rental fees. As mentioned above, two of those five noted partnering with other organizations as a means of improving their service delivery cost-effectively. User fees do not feature as revenue-generating features for any organization observed except UHRC, which acknowledges that commodity sales will provide only limited resources. More needs to be done by all the organizations to develop and implement these strategies.

VI. RECOMMENDATIONS FOR FUTURE PROGRAMMING

A. RECOMMENDATIONS SPECIFIC TO THE FOUR KEY INGOS OBSERVED IN THIS ASSESSMENT

Especially in the areas of strategic planning, financial management, human resources management, and monitoring and evaluation, technical support provided through PEPFAR has had a universally positive impact on the NGOs in this assessment. All four targeted IPs now have the capacity to implement these functions fully, and it appears that the other five organizations have made substantial progress as well. The next step is to diagnose the unique needs of each organization so it can resolve remaining issues of leadership and governance, and can fully implement the systems that have been developed, to maximize their effectiveness. While the team's brief study of these organizations cannot take the place of a thorough needs assessment, some programming areas are suggested here.

1. Provide grant-making expertise to IRCU to strengthen relationships with IRBs and grantees.

The relationship between IRCU, the IRBs and medical bureaus, and sub-grantees is convoluted and has changed frequently. The original paradigm of inserting IRBs between IRCU and sub-grantees for proposal making, funding, technical supervision, and reporting has been changed at least twice. The current practice of using IRBs to assist with proposals and evaluations, and removing them from the funding process while they remain involved in supervision, is sub-optimal at best. Some IRB officials have suggested that the IRBs be removed from these processes and funded as advocacy agencies themselves.

If IRCU wins the pending RFA, the assessment team recommends that USAID, while continuing its funding of IRCU for sub-granting, provide technical assistance from a grant-making expert to streamline and simplify the relationships and processes between the IRCU, IRBs, medical bureaus, and sub-grantees. The resulting process (and related orientation and training) should have clear lines of authority, responsibility, reporting, and supervision. The grant-making review process may determine that the staffing levels of IRCU, even with IRB involvement, are too limited to provide the kinds of hands-on support that sub-grantees need to provide high-quality services. It should be acknowledged that IRCU's strategic plan contains a detailed description of relationships and grant-making procedures for the next five years. This plan, if approved by all stakeholders, should be the basis for future grant-making technical support.

2. Offer executive coaching to HAU to facilitate reforms on its board and management.

While the HAU senior management team has both the management tools and the desire to professionalize the hospice further, issues remain as to how to proceed, on which there is not full agreement within the board or senior management. Because of the strong desire of HAU's founder to continue to direct its future, and because of the great respect and deference paid to her by other board members and hospice management staff, HAU's transformation from a founder-based organization to a professionally managed organization with potential to expand has been difficult. Nor is it desirable for the founder to disengage entirely—her vision, her attention to quality, and her skills in developing strong training programs have been key elements of HAU's success and reputation. There is a real need, however, to negotiate an appropriate role for the founder that enables her to continue her strong contributions to the organization, while allowing a move to a more professional, systems-oriented organization.

The assessment team recommends that USAID provide intensive, ongoing executive coaching for the founder, board, and CEO. By that the team means one-on-one, regular coaching of these

individuals to improve their ability to communicate, build rapport, persuade, and handle conflict in order to achieve specific organizational objectives. In addition the team recommends that an organizational facilitator provide ongoing (e.g., one or two days per week) assistance to support implementation of the organizational changes that have recently been made. This assistance and facilitation will give the senior management team the confidence and counsel it needs to solidify recent gains in structure and effectiveness.

3. Assist JCRC in board strengthening and succession planning.

JCRC now has in place the organizational structures and practices needed for professional management. However, the board appears to lack sufficient oversight to hold the CEO accountable to the board. The CEO is an extremely capable and influential individual. But the lack of board oversight combined with the absence of any effort to create a succession plan to prepare others within the organization to assume greater responsibility, works against the long-term sustainability of the organization. This has become particularly clear as JCRC has struggled to recruit qualified staff such as the finance controller at the central level and the accountant at the Mbarara RCE. Insufficient board oversight and succession planning may also have resulted in less delegation of authority to RCEs than would seem appropriate. Improved board oversight and conscious succession planning—both at the center and at the RCEs—are needed for the organization to function at its best.

If JCRC wins the RFA, the assessment team recommends that USAID provide ongoing support to the board to facilitate more frequent meetings and with the senior management team to develop a succession plan that prepares individuals to take on expanded responsibilities.

4. Provide targeted support to build HAU staff skills in pharmaceutical management.

As noted in the pharmaceutical management section above, this would include implementing SOPs in the pharmacies located at the three HAU sites.

5. Ensure that IRCU institutes sufficient medical supervision to provide quality assurance of grantee activity.

The IRCU 2008 mid-term evaluation recommended that “a physician should be placed in the Health Unit of each IRB, preferably with cost sharing with the IRB as a move toward sustainability.” IRCU has responded to this recommendation by involving the medical boards of the IRBs in supervision of the sub-grantees. USAID should work with IRCU to ensure that whatever grant-making mechanism is implemented, there is sufficient medical supervision, whether through the medical boards or some other means.

6. Conduct a comparative analysis of TASO and JCRC adherence models for cost-effectiveness.

Both TASO and JCRC have developed successful counseling and treatment delivery models that deserve to be studied, particularly for cost-effectiveness. Two examples include TASO’s ongoing counseling model that provides counseling and support to clients on a monthly basis, and JCRC’s adherence model. Both are reportedly highly effective and client-oriented although both are also potentially personnel-intensive and costly.

B. RECOMMENDATIONS APPLICABLE TO ALL USAID INGO PARTNERS

1. Organizational and management support

Because of the great variety in the way that INGOs are organized and operate, there are few general findings regarding how to improve capacity, increase cost efficiencies, and reduce unit costs that would apply to all INGOs. There is no uniform ideal design for an organization's management or service delivery. The important point is that INGOs develop the systems and practices, and possess qualified staff, that allow them to analyze their activities and adapt accordingly. If they can do this, they can ensure accountability and transparency, obtain and act on stakeholder input, engage clients in outreach, and collaborate with other service providers to achieve better service delivery.

i. Recognize and program technical support as a two-step process.

Development of good systems for management operation that enable the INGO to work effectively with PEPFAR is at best a two-step process and takes longer than the typical three-year project period. The first step is to get the basic operational systems in place—financial management, M&E, HR, procurement, administration, and reporting—since the highest priority is to ensure that the organization can program, use, and account for USAID funds appropriately. The second step, which often has a longer timeframe, is to ensure that the governance of the organization is based in a strong, engaged board of directors and management team, whose responsibilities, terms of office, and provisions for succession are clearly laid out. This is necessary for the organization to adapt to changing situations and to foster sustainability. It requires support much more tailored to the individual organization than does the first step. USAID's technical support activities should be designed with these differences in mind.

ii. Make it possible for the COTRs to play a strong, direct supportive role with the INGOs on management and technical issues.

Many of the INGOs commented that more substantive interaction with USAID (rather than focusing only on reporting or financial problems), and more frequent monitoring visits to their field and main offices, would provide the supportive oversight that they need and desire, and might better inform PEPFAR decisions on policy and procedure. IRCU's experience under a contract gave the council the hands-on support it needed to develop its management systems, with help from ACE. USAID officers should provide more substantive oversight and advice to INGOs, rather than relying so heavily on TA contractors. USAID's regular, strong, one-on-one interaction with the INGOs on substantive issues carries enormous weight with them. The team realizes how heavy a workload USAID project staff carry for PEPFAR programs, but urges USAID to rethink their roles to allow for a stronger direct relationship with INGOs.

iii. Require INGO partners to develop concise succession plans for board members and management leadership positions in order to foster sustainability.

This is an important element of professionalization of an organization, fostering both organizational sustainability and the ability to recruit and retain qualified management staff. Most of the organizations the team observed have not made adequate plans for leadership succession, and because of the political and personal issues involved in such planning, may be able to move faster on this with the outside pressure from USAID that such a requirement would provide.

iv. Consider developing a simple, standard, quickly administered ODA tool to be used for all PEPFAR grantees.

In carrying out the ODA called for in its scope of work, the assessment team learned that many, if not all, of the NGOs observed have undergone organizational assessments, some quite recently and some multiple times. However, information available to the team from past ODAs did not provide comparable data that the team could use for its own analysis because of different

categories of information and different rating systems applied. ODAs are time and staff-consuming for the NGOs, so it is important to find ways of minimizing this burden. One way to do this is for USAID, possibly in collaboration with the Civil Society Fund, to develop a standardized ODA tool that focuses on the management areas of greatest concern for Ugandan NGOs. Use of a consistent tool would allow USAID to use successive assessments to measure organizational progress, and swiftly to identify areas where further technical support is needed. In addition, use of a standardized tool may facilitate involving Ugandan social science institutions in carrying out assessments, rather than relying on expatriate firms.

2. Quality improvements

- i. Include requirements in all NGO agreements to operationalize QA systems, and provide assistance as needed. This should include development and maintenance of performance monitoring plans that track quality indicators.

There must be stronger emphasis on developing quality assurance as an integral part of NGO operations from the start. Those indigenous NGOs that have not yet fully developed or deployed their QA systems to the field level should receive assistance to fully develop and operationalize their QA systems. Both TASO and JCRC have the capability to mentor other NGOs in strengthening and fully operationalizing their QA systems. Future funding to NGOs should factor in the need to strengthen QA systems.

NGO performance monitoring plans should include indicators that will permit them to track quality of services on an ongoing basis. The current PEPFAR indicators are largely quantitative and give inadequate attention to quality issues. As PEPFAR moves into its second phase, with greater attention to sustainability issues, quality and adherence should become more important elements of performance monitoring.

- ii. Work with MOH, NGOs, and other donors to upgrade national quality standards.

While most NGOs report that they follow the national ART standards, some NGOs (notably TASO and JCRC) have developed their own standards to fill gaps or improve quality of service delivery further. All NGOs should combine their efforts and work with the MOH to revise and upgrade the existing national standards, and should also work with the MOH to establish quality standards for services not currently covered by national standards, e.g., lab services, prevention, and counseling. JCRC and TASO have already taken the lead in this area but should combine efforts for comprehensive and strong national standards.

- iii. Ensure that IPs have mechanisms for stakeholder feedback on quality issues.

Indigenous partners generally reported that there is no system of receiving regular stakeholder feedback (with the exception of client feedback) on QA, which would allow them to modify and improve the implementation and monitoring of QA. USAID should insist that IPs and sub-grantees include mechanisms for stakeholder feedback into their QA plans.

3. Improving cost-effectiveness

- i. Support NGO cost-effectiveness studies as needed.

NGOs may need specialized help in determining how to improve the cost-effectiveness of their operations without sacrificing quality. USAID should consider engaging experts, or supporting studies undertaken by the NGOs, to improve cost-effectiveness of their operations.

- ii. Build in incentives for partnerships within RFAs.

Within its own contracting and cooperative agreement processes, USAID should include incentives that encourage NGOs to enter into partnerships with other organizations in order to provide a full range of services and take advantage of the comparative advantage of different organizations. For example:

- RFAs should award more points to proposals that have strong, detailed, and well-justified plans for partnering with other organizations.
- Performance monitoring plans should be required to measure both the extent of collaboration and its actual impact on costs and effectiveness.
- Small-scale operations research grants might test different models for partnering in order to determine cost-effectiveness of alternative models, and grantees could be encouraged to include such operations as research models in their annual workplans.
- In-service training for staff and community volunteers is a particularly important area for potential cost savings, as this has been identified as an area with significant duplication. Partnership agreements that make efforts to rationalize training among NGOs working in the same areas should be encouraged. Training descriptions within RFAs or workplans that do not recognize the need to coordinate with other organizations' training programs should not be accepted.

If technical expertise is required to help the NGOs enter into such agreements, USAID should consider supporting such expertise. In doing so, USAID should avoid “forced” partnerships that are not based on comparative advantage. The Civil Society Fund has found that forced partnerships (for example, in which a larger NGO is expected to build the capacity of a smaller NGO partner) can be counterproductive.

4. Sustainability, resource mobilization, and donor diversification [CH]

- i. Cooperative agreements with indigenous NGOs should require resource mobilization and sustainability plans with clear indicators and monitoring plans. USAID should consider providing support for partners who request it to help refine and implement their sustainability plans.

Most of the NGOs the team reviewed have at least preliminary plans for sustainability; and some already have good experience in diversifying their donor bases. USAID should make sustainability and resource mobilization a serious component of all NGO agreements, and should consider providing support to those organizations that request it, to help them in refining and implementing their sustainability plans. For example, INGOs are now expected to compete directly with international cooperating agencies for procurements. The INGO representatives with whom the team spoke requested technical assistance in helping build their proposal preparation skills.

APPENDIX A. SCOPE OF WORK

**Global Health Technical Assistance Project
GH Tech
Contract No. GHS-I-00-05-00005-00**

**SCOPE OF WORK
(GH Tech revised: 9-10-09)**

I. TITLE

Activity: **Uganda: NGO Indigenous Partners' Program Assessment**

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

It is expected that this assessment will be conducted in two phases with Phase 1: September - October 2009 and Phase two: October 2009 - December 2009.

III. FUNDING SOURCE

This activity will be funded by USAID/Uganda. Two of the four consultants will be provided by and funded by the USAID-funded Health Systems 20/20 Project (core funds).

IV. PURPOSE AND OBJECTIVES OF THE ASSIGNMENT

The purpose of this request is to assess the institutional organization and capacity of indigenous organizations providing HIV/AIDS services in Uganda and to assess the institutional impact of USAID funding as part of PEPFAR. Special attention will focus on selected USAID-supported HIV/AIDS partners notably:

- The AIDS Support Organization (TASO),
- The Joint Clinic Research Center (JCRC),
- Hospice Africa Uganda and
- The Inter-Religious Council of Uganda (IRCU).

Other organizations will be interviewed for this assessment as one way of determining the institutional impact of PEPFAR funding.

This is not an evaluation of any of the organizations but rather an exercise that will gather information about the current capacity and capability of USAID-funded institutions. This assessment will also document best practices that have been developed and implemented by the NGOs during the period that they were receiving USAID funding. The information gathered during this assessment will allow USAID to take advantage of institutional capacities and best practices in the design of future USAID-funded interventions. The analysis of the information collected during this assessment could also be used as the baseline for future strategy development.

The assessment will address:

1. How USAID-supported indigenous organizations are organized and how they function, including how increased PEPFAR resources have changed these organizations and their original functions.
2. The ability/capacity of indigenous organizations to plan and budget in compliance with U.S. Government rules, regulations, and standard provisions.
3. Organizational/management efficiencies in producing proposed/planned results.
4. The quality of organizational outputs/results.
5. Technical and organizational capacity of indigenous organizations in forecasting, procurement, distribution, and management of supplies (including drugs and equipment) for their projects.
6. The individual and collective impact, strengths, and weaknesses of the indigenous organizations.

The analysis of data collected during the assessment will be used to recommend strategies and priorities to build capacity and strengthen service delivery, the supply chain, and advocacy interventions for/with indigenous organizations, with the overall goal of providing increasing services and a reducing cost per unit of service (i.e., greater efficiency).

V. BACKGROUND

In 1992, JCRC pioneered the use of ARVs in Uganda and Africa as a Zidovudine (AZT) clinical trial. From 1998 to 2000, JCRC was one of five facilities that participated in the five UNAIDS Drug Access Initiative in the country. It became the first and largest provider of ART in Sub-Saharan Africa. As of December 2003, JCRC has enrolled 9,000 individuals on treatment. The six-year TREAT program, funded at a total of \$ 62m under PEPFAR, began in December 2003 and saw JCRC implement the ART program expansion to all regions in the country reaching 35,000 patients. Phase one ran from December 2003 to 30th September 2009.

IRCU was founded in 2001 as a consortium of five traditional religious institutions in Uganda, namely the Roman Catholic Church, the Anglican Church of Uganda, the Uganda Muslim Supreme Council, the Orthodox Church and the Seventh Day Adventist Church to work together in areas of common interest. IRCU also works with the evangelical and independent churches. Since 2001, IRCU has received funding and technical support from USAID/Uganda. Cumulatively IRCU has received \$18,779,050 over the past seven years. From a small network of religious organizations, IRCU has rapidly grown into a major umbrella grant mechanism for HIV/AIDS prevention, care and treatment services, and currently offering care to 49,000 PLHA, 11,000 OVC and treatment to 4,800 individuals.

Hospice Africa Uganda is a non-governmental organization founded in 1993 to provide care and support to individuals with life limiting diseases such as AIDS and cancer. It is the leader in Uganda in the delivery of pain management and end-of life care to HIV/AIDS patients. Hospice Africa Uganda is also in the leadership position in training of health workers and other professionals nationally to integrate pain management, symptom control including dispensation of morphine and end of life care into their programs. Its primary approach is to empower communities by training health and non-health professionals, religious leaders and community volunteers in skills to deliver palliative care. Because of their predominant capability in delivery of pain management

and end-of life care in Uganda, Hospice Africa Uganda is receiving PEPFAR funds to build palliative care competence within PEPFAR supported Ugandan AIDS service organizations.

TASO was established in 1987, as the first indigenous non-governmental organization (NGO) in Africa to respond to the needs of people living with HIV/AIDS (PLWHA). TASO is the largest indigenous AIDS support organization providing palliative care and psychosocial support to PLWHAs. Within the country and the region TASO has been a pioneer in developing counseling and comprehensive care and support models. An important feature of TASO's program is the preventive community outreach programs using radio programs, drama groups, community health AIDS workers and individual counseling. TASO currently provides direct services through a network of 11 centers and several village outreaches covering a total of 52 out of the 81 districts. TASO also supports 15 Ministry of Health sites (mini-TASOs) and 7 Community Based Organizations (CBOs) to provide care and support services.

VI. SCOPE OF WORK

The assessment team will review any evaluations or old assessments and other relevant documents to assess the progress made to date by the organizations in achieving the objectives of their respective cooperative agreements. The assessment will also review the programmatic and technical efficiencies, strengths, and weaknesses of working with indigenous organizations in Uganda and provide strategies that the Mission can implement to improve collaboration with such organizations.

Illustrative questions to guide the assessment are provided in Annex 1.

VII. METHODOLOGY

This assessment will be carried out in two phases: Phase I—Planning and Data Collection, and Phase II—Field Work and Report Preparation as follows:

- **Phase I: Planning/Data Collection.** Phase I, which will be primarily DC-based, will provide a clearer vision of what steps are required to undertake and complete this assessment during the field work phase. Documentation and data collection including identification of initial key informants and background documents, archival materials and other relevant sources, as required, extensive focused interviews with USAID/W and other US/DC-based key informants and stakeholders, and preparation of a preliminary work plan and methodology framework for Phase II.
- **Phase II: Field Work/Reporting.** In country work including Uganda-based Team Planning Meeting, key informant interviews, site visits, and continued information/data collection to enrich the areas of inquiry identified during Phase I. This phase will continue to collect information from expert informants in Uganda and will produce an assessment report. It will include a draft report discussions/analysis and writing; debriefings with USAID and stakeholders, and draft report revision and submission, final report revisions and final writing; editing/formatting and final submission, and release of final report(s).

The assessment team is expected to propose a detailed work plan for collecting the necessary information and data. This should include a description of how the work plan responds to the above tasks and questions; and from whom, and how the data will be collected and analyzed. The work plan should be collaborative and participatory, including plans for conducting interviews with implementing partners and key stakeholders at the local, district and national level. The plan should also include a full

review of background materials provided, such as the cooperative agreements, quarterly reports, annual reports and semi-annual reports. In addition, methods to be used in completing this evaluation will include, but not be limited to: reviewing documentation, interviews, site visits, stakeholder meetings, etc.

Document Review

Prior to arriving in country and conducting field work, the team will review various project documents and reports including but not limited to annual project workplans, progress reports and results reports; national health strategy and population reports; Government and other monitoring data; project documentation of accomplishments, including process documentation, USAID strategy documents. A list of key documents is included in Annex I. The USAID/Uganda team will provide the relevant documents for review.

Team Planning Meetings

A two-day planning meeting will be held, with the team members only, prior to official onset of meetings and work with USAID and others. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the assessment and redesign, and refinement of agenda. In the TPM the team will:

- share background, experience, and expectations for the assignment
- formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
- agree on the objectives and desired outcomes of the assignment
- establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- develop data collection methods, instruments, tools and guidelines, and methodology and develop an assessment timeline and strategy for achieving deliverables

De-briefings

Oral briefing meeting will be approved by USAID/Uganda and held with USAID/Uganda and other key stakeholders after the site visit work is completed and prior to the departure of the team from the country. The objective of the debriefing would be to share the draft findings and recommendations, solicit comments and inputs, and clarify any remaining questions or issues upon team arrival and before departure.

Field Visits/Key Informant Interviews

Site visits will be critical to understand how the NGOs actually provide services (and sufficient time should be allotted for this). See Annex 1 for an illustrative list of site visits and approximate field work time.

Key interviews with the following informants will include but not limited to Ministry officials, USAID Implementing Partners, private and commercial partners. A complete list of key informants and their contact information is included in Annex 2.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

The assessment team should consist of 4 international consultants, one local NGO Specialist, one local logistics coordinator (if needed) and a Research Assistant. Collectively the team members should have strong backgrounds to comprehensively

cover programming and working with indigenous organizations in the context of HIV/AIDS.

Team Leader (GH Tech)

The Team Leader will be responsible for managing the team in conducting the assessment and in preparing and finalizing all deliverables. This individual will be responsible for achieving assignment objectives as well as briefings and presentations, and will be the key liaison with USAID/Uganda. The Team Leader needs to be an innovative thinker and have a strong understanding of USAID systems and procedures.

Team Leader should have at least 10 years of experience with USG-funded projects including program design, implementation and analysis. He/she should have experience in program assessment and evaluation methodologies; and experience in indigenous civil society organizations. Experience in HIV/AIDS programs, and knowledge of PEPFAR is highly desirable. He/she should have a graduate degree and excellent oral and written English skills. The Team Leader should also have experience leading assessment teams and preparing high quality project documents.

The Team Leader will:

- Finalize and negotiate with client for the team work plan for the assignment
- Establish assignment roles, responsibilities, and tasks for each team member
- Ensure that the logistics arrangements in the field are complete
- Facilitate the Team Planning Meeting or work with a facilitator to set the agenda and other elements of the TPM
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report
- Manage the process of report writing
- Manage team coordination meetings in the field
- Coordinate the workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.) in coordination with team assistant/logistics coordinator.

HIV/AIDS Program Expert (GH Tech)

The HIV/AIDS Program Expert will have substantial experience in HIV/AIDS programming in Africa or other relevant regional context including work with NGO and/or PVO groups is required. He/she should have knowledge of USG policy on HIV/AIDS and USAID and PEPFAR programs and related regulations and requirements, is strongly recommended. Knowledge of USAID operations and principles would be helpful. He/she should have experience in program assessments and evaluations.

Supply Chain Management Specialist (provided by Health Systems 20/20 Project) (Suggested language)CH

Please specify what SCM capabilities the team would be assessing in each of the organizations. This would include but is not limited to the following—

- IRCU and Hospice— they manage own sites so it is useful to assess their internal SCM capabilities;
- JCRC and TASO—focus on if these organizations have the capability to strengthen the MOH SCM capability (e.g. people trained in logistics who actually/actively provide TA to MOH personnel, etc).

Specific duties include:

- 1) Develop, in conjunction with additional team members and Team Leader inputs, the questionnaires to be used for in country data collection;
- 2) Travel to Uganda and conduct interviews with USAID/Uganda and the NGOs who are the focus of this work; and
- 3) Other duties, as assigned by Team Leader.

Organizational Development/Management Expert (provided by Health Systems 20/20 Project) (suggested language)

- 1) Review documentation and data and participate in identification of initial key informants, and other relevant sources, as required. Conduct focused interviews with USAID/W and other US/DC-based key informants as needed to understand USAID Washington perspective and objectives for this intervention
- 2) Develop, in conjunction with additional team members and Team Leader inputs, the questionnaires to be used for in country data collection
- 3) Travel to Uganda and conduct interviews with USAID/Uganda and the NGOs who are the focus of this work
- 4) In participatory process, develop recommendations for NGO actions to address technical effectiveness and organizational efficiency
- 5) Use an internationally accepted organizational assessment tool, and administer the tool to see how well the organization and the sites under them are managing their medicines and health supplies.
- 6) Participate in USAID debrief and report preparation as directed by Team Leader

NGO Specialist (Local Consultant—GH Tech)

The NGO Specialist will be a local consultant who has a background in public health and/or HIV/AIDS programs and who is very familiar with the Uganda indigenous NGO community. It would be desirable for this consultant to have USAID program management experience, but it is not required.

Research Assistant (GH Tech)

Because of the substantial requirements for historical program and related materials collection that are required for the assessment, GH Tech will include the services of a research assistant/analyst for approximately 3 months. S/he/they will be responsible for the following tasks:

- Identifying, collecting and cataloging (either filing in a database or other format for easy retrieval by the team members) relevant documents, surveys and other related background and historical reference materials as requested by the team leader.
- Set-up, maintain, and upload the Uganda NGO Assessment ProjectSpaces.com website
- Assisting with identification of key informants.
- Providing scheduling support for US-based interviews, as required.
- Compiling, organizing and synthesizing stakeholder input collected through interviews conducted by the Core Team.
- Compiling, managing and overseeing information database including information collected through key informant interviews, focus groups, site visits and other background research.
- Producing a final bibliography of all sources utilized in the assessment.
- Providing additional research support to the team leader, as required.

Local Logistics Coordinator (GH Tech- 7 days)

Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.) in coordination with Team Leader.

DC-Based Team Planning Meeting Facilitator (GH Tech - 4 days)

The TPM will be led by a Team Planning Meeting Facilitator. The facilitator will organize and plan, in collaboration with the GH Tech Project and USAID, the Team Planning Meeting. He/she will facilitate the TPM meeting and foster consensus on the following items:

- Work plan (including work plan for field visits)
- Timeline
- Roles and responsibilities of team members, USAID clients, and stakeholders
- Methods/approaches to be used in implementing the assessment
- Communications between team members, and with USAID and GH Tech
- Outline for report
- Other topics, as appropriate

Please see next page for an illustrative table of Level of Effort (LOE) for this activity.

Task/Deliverable	Duration/LOE	
	Team Leader	4 Team Members (TM)
Phase I: DC-based Planning/Data collection		
Prepare for fieldwork		
<ul style="list-style-type: none"> Preliminary TPM and organizing meeting for DC-based consultants 	2 day	2 day TMs ½ day for NGO Specialist (via phone)
<ul style="list-style-type: none"> Begin review/collection of background & archival documents & development of database format (Research Assistant) 		
<ul style="list-style-type: none"> Catalog all documents using End Note; upload to Project Spaces 		
<ul style="list-style-type: none"> Preliminary Document Review 	3 days	3 days
<ul style="list-style-type: none"> Prepare work plan and timeline for assessment 	1 day	1 day
<ul style="list-style-type: none"> Prepare draft questionnaires for key informants & stakeholders 	1 day	1 day
<ul style="list-style-type: none"> Interviews w/ USAID/W & DC-based key informants 	5 days	5 days TMs; 1 day-NGO Specialist; 2 days-SCM Specialist
<ul style="list-style-type: none"> Schedule in-country interviews and site visits 	3 days	1 day other TMs, 3 days NGO Specialist
Phase II: Fieldwork/Report Preparation		
<ul style="list-style-type: none"> Travel to Uganda 	2 days	2 days 0 day for NGO Specialist
<ul style="list-style-type: none"> Kampala-based Team Planning Meeting 	2 days	2 days
<ul style="list-style-type: none"> In-country briefing with USAID/Uganda; mid-brief 	2 days	2 days
<ul style="list-style-type: none"> Conduct informant interviews and site visits 	11 days	11 days
<ul style="list-style-type: none"> Debriefing with USAID/Kampala (and partners) 	1 day	1 day
<ul style="list-style-type: none"> Discussion, analysis and draft report writing in-country 	3 days	3 days
Return to Washington, DC	2 days	2 days 0 days-NGO Specialist
<ul style="list-style-type: none"> Complete analysis of all information collected to date, continue draft report writing 	5 days	5 days TMs 3 days- SCM Specialist

• Prepare presentation and debrief in Washington, DC	2 days	2 days TMs 1 day- SCM Specialist
• Complete and submit draft report to USAID for comments and feedback	3 days	3 days 1 day- SCM Specialist
USAID completes final review (10 working days)		
• Incorporate Mission & USAID/W comments on draft report and finalize report	5 days	3 days 1 day- SCM Specialist
GH Tech edits/formats report (30 days)		
Total Estimated LOE (Core Team Members)	53 days	49 days each 39 days-SCM Specialist 41.5 days—NGO Specialist

*A six-day workweek is approved while in country.

IX. LOGISTICS

Phase I: GH Tech will provide support for the Phase I team when they are working in Washington, DC including work space, projectspaces.com access, set up interviews and meetings, host the mini-Team Planning Meeting, etc. GH Tech will also prepare logistics arrangements for the team’s fieldwork portion of the assignment. The GH Tech team will be responsible for all in country logistics, team meeting space and other related support services.

Phase II: USAID/Uganda will arrange, at a minimum, the following meetings:

1. **Arrival Meeting** upon the assessment team’s arrival in Kampala. This meeting will allow the team and USAID/Uganda to review the scope of work and assessment methodology, finalize the key research questions and examine the assessment schedule.
2. **Mid-assessment Meeting** mid-way through the team’s field work the team and USAID/Uganda will discuss the findings to date and troubleshoot possible obstacles towards completing the assessment as planned.
3. **USAID Debrief Meeting** to be held at the conclusion of the field work for USAID/Uganda staff. In this meeting the assessment team will present the major findings and recommendations through a PowerPoint presentation. The preliminary report will be presented and discussed at this meeting. This meeting will be conducted in English.
4. **Stakeholder/Partner Debrief Meeting** to be held at the conclusion of the field work and following the USAID debrief. The audience will include USAID partners and stakeholders (as appropriate). In this meeting the assessment team will present findings on past accomplishments and activities, with no recommendations for future programming. USAID will send out the invitations and GH Tech will cover costs/ expenses for this meeting, including meeting space.

USAID/Uganda will provide overall direction to the assessment team, identify key documents and assist in facilitating a work plan. USAID/Uganda will assist in arranging

and/or participate in meetings with key stakeholders as identified by USAID prior to the initiation of field work.

USAID/Uganda personnel shall be available to the team for consultations regarding sources and technical issues, before and during the assessment process

GH Tech: The assessment team is responsible for arranging other meetings as identified during the course of this assessment and advising USAID/Uganda prior to each of those meetings. The assessment team is also responsible for arranging vehicle rental and drivers as needed for site visits around and outside of Kampala (all site visits will be within driving distance of Kampala, no flights will be required).

X. DELIVERABLES AND PRODUCTS

The following deliverables are to be prepared:

- **Work Plan:** During the initial work in Washington, DC a preliminary work plan will be prepared. During the in country Team Planning Meeting, the team will finalize a detailed work plan which shall include the methodologies to be used in this assessment. The work plan shared with USAID/Uganda for approval and agreed to by the Mission prior to initiation of key informant interviews and site visits.
- **USAID Debrief:** The team will present the major findings to a USAID/Uganda audience through a PowerPoint presentation before the conclusion of the in-country assessment work. This debrief will include a discussion of achievements and issues, as well as any recommendations the team has for future programming.
- **Stakeholder/Partner Debrief:** The team will present the major findings to USAID partners and stakeholders (as appropriate) through a PowerPoint presentation before the conclusion of the in-country assessment work and following the USAID debrief. This presentation will include only findings on past accomplishments and activities, with no recommendations for future programming.
- **Preliminary Draft Report:** The team will submit a preliminary draft report including findings and recommendations upon completion of the field work and before the team departs Uganda. The draft report will incorporate comments and feedback from the debriefings. This report should not exceed 50 pages in length (not including appendices, lists of contacts, etc.). This draft will include findings and recommendations for Mission review. USAID/Uganda and USAID/W will have 10 days to provide comments and suggestions to the assessment team, which shall be addressed in the final report.
- **Final Report:** The team will submit a final report no later than one week after USAID/Uganda and USAID/W provide written comments on the team preliminary draft report (noted above). This report should not exceed 50 pages in length (not including appendices, lists of contacts, etc.). The format will include executive summary, table of contents, findings and recommendations. The report will be submitted in English, electronically for dissemination among implementing partners and stakeholders.

GH Tech will be responsible for editing and formatting the final report, which takes approximately 30 days after the final unedited content is approved by USAID. GH Tech makes its evaluation reports publicly available on its website and through the Development Experience Clearinghouse unless there is a compelling reason to keep the report internal (such as procurement-sensitive information).

An Internal Memo for USAID Only will be prepared that includes any potentially procurement sensitive information including any future directions recommendations.

XI. RELATIONSHIPS AND RESPONSIBILITIES

The Mission will be responsible for ensuring that the consultants have all of the relevant documents for review, provide technical guidance to the team on the plans, outputs and feedback, and commit time, effort and necessary support to the consultants to enable them to execute their task. Review draft report and provide feedback, sign off on final report and submit evaluation report to USAID/PPC/CDIE. Support from GH/OHA will be provided as the Mission requests.

The Uganda mission is managing this team and the results with support from GH/OHA, as the Mission requests.

XII. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON

USAID/Uganda: Aleathea Musah, MPH, HIV/AIDS Team Leader, Tel. 256-77-2221697

GH/OHA: John Novak, GH/OHA/SPER, 202-712-4814

XIII. COST ESTIMATE (Reserved)

XIV. REFERENCES/Annexes (Project and Relevant Country Documents)—

Annex 1—Illustrative Questions

1. How have these organizations and others similar to them been able to respond to the growing needs of their clients as well as increased resources and expansions as a result of PEPFAR?
2. What have been the challenges of working with USAID in accomplishing the results of PEPFAR while trying to stay focused on your vision?
3. From the perspective of indigenous organizations, how has the partnership with USAID influenced their activities? What has worked well, what has not, and what needs to change?
4. When looking at structure please look at how the work is divided into components to achieve the overall corporate objectives. How are these components managed? Is the structure well aligned with the corporate strategy? Are the work teams well managed, motivated and empowered?
5. Are there any mechanisms for client participation in key policy and program decisions?
6. What is the role of the beneficiary community?
7. How transparent are the activities and systems of the agency?
8. What are the mechanisms for leadership development (delegation, training, job enrichment, etc)?
9. Do any of the organizations have a strategy?

Annex 2—Field Visits/Key Informant Interviews

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Mr. George Bekunda
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APPENDIX B. PERSONS CONTACTED

UNITED STATES

1. **Annette Bongiovanni**, QED, Director of Health Practice, HAU evaluator
2. **Elizabeth Marum**, CDC
3. **Jawara Lumumba**, TRG, Consultant on ACE Project
4. **John Palin**, GH/OHA/TLR, Member, Uganda Country Core Team; expert on palliative care
5. **Kathryn Goldman**, Uganda-based Chemonics staff for the ACE project
6. **Kathy Panther**, USAID Division Chief for GH/PRH/SDI
7. **Ken Sklaw**, Organizational Capacity Advisor, health systems, team, USAID/OHA
8. **Sandra Blanchard**, ACDI/VOCA
9. **Saul Helfenbein**, Chemonics Uganda-based staff
10. **Tonya Himelfarb**, Team Leader for Uganda, OGAC
11. **Krista Stewart**, Uganda country core team leader, USAID/GH
12. **John Novak**, USAID/GH/OHA
13. **Thomas Minion**, USAID/GH/OHR/TLR

KAMPALA, UGANDA

1. **Amr Elatter**, Controller, USAID/Kampala
2. **Alege Stephen Galla**, District Networking Programme Officer, Uganda Network of AIDS Service Organizations (UNASO)
3. **Bruce McFarland**, Contracts Officer, USAID/Kampala
4. **Dan Wamanya**, Co-Chair, HIV Team, USAID/Kampala
5. **Herbert Mugumya**, OVC Program Manager, HIV/AIDS team, USAID/Kampala
6. **Justine Mirembe**, HIV/AIDS Team Member, USAID/Kampala
7. **Crispus Kamanga**, M&E Specialist, HIV/AIDS Team, USAID/Kampala
8. **Sheba Bamutiina**, Budget Specialist for Investing in People Team, USAID/Kampala
9. **Andrew Kyambadde**, Deputy Team Leader for HIV/AIDS Team, USAID/Kampala
10. **Jacqueline Calnan**, HIV/AIDS Team Member, USAID/Kampala
11. **Donna Kabatisi**, Director for Programs, CDC
12. **Dr. David Kihumuro Apuuli**, Director General, Uganda AIDS Commission
13. **Dr. N. Asingwire**, Senior Lecturer, Faculty of Social Work, Makerere University
14. **Dr. Raymond Byaruhanga**, Executive Director, AIDS Information Centre
15. **Dr. Zainab Akol**, Manager, HIV/AIDS Program, Ministry of Health
16. **Elise Ayers**, Team Leader Health, USAID
17. **Emily Katarikawe**, Managing Director, AFFORD/UHMG

18. **Gordon Twesigye**, HIV Coordinator, Peace Corps Uganda
19. **Shiphrah Mutungi**, PEPFAR Program Manager, Peace Corps Uganda
20. **Gary Vizzo**, Associate Director for Administration, Peace Corps Uganda
21. **Jeanette Robinson**, Peace Corps Volunteer, Nakasese District
22. **Joyce Mpanga**, Director, NGO Registration Board, Ministry of Internal Affairs
23. **Mercy Mayebo**, Civil Society Program Manager, DFID
24. **Musa Bungudu**, UNAIDS Representative
25. **Naomi Watiti**, Chief Executive Officer, UWESO
26. **Nickson Ogwal**, ACTIONAID Uganda
27. **Noelina Namukisa**, Director, Meeting Point
28. **Rose Nampiima**, Head Accountant, Meeting Point
29. **Peter Ndawula**, Deputy Chief of Party, Civil Society Fund Deloitte Uganda
30. **Rebecca Coleman**, HIV/AIDS Team Procurement Officer, USAID
31. **Reuben Haylett**, Deputy Coordinator, PEPFAR
32. **Joseph Kamoga**, SI Coordinator, PEPFAR
33. **Sam Nagwere**, Acquisition and Assistance Specialist, USAID/Kampala
34. **Seyoum Dejene**, Deputy HIV/AIDS Team Leader, USAID/Kampala
35. **Stephen Galla**, UNASO
36. **Tony Mugasa**, Country Coordinator, ICOBI
37. **Huntington Mutabarura**, ICOBI
38. **Vento Auma**, Director for Programs, CDC
39. **H.W. I. Otim**, Commissioner of Youth and Children's Affairs, Ministry of Gender, Labour and Social Development
40. **William Salmond**, Country Director, Elizabeth Glaser Pediatric AIDS Foundation
41. **Byenkya Julius Atwooki**, Partnerships Advisor, UNAIDS
42. **Paul Njala**, Head of Stores & Operations, National Medical Stores
43. **Robert Downing**, Laboratory Director, CDC/Uganda
44. **Jimmy Opio**, General Manager, Joint Medical Store
45. **Ivan Makumbi**, Operations Manager, Medical Access Uganda Limited
46. **Sowed Muyingo**, General Manager, Medical Access Uganda Limited
47. **Saul Kidd**, Technical Advisor, MSM/SURE
48. **Caroline Ntale**, ARV Procurement Advisor, SCMS
49. **Rebecca Copeland**, Commodity & Logistics Specialist, USAID/Uganda
50. **Michael Kabugo**, TREAT Director, JCRC
51. **Dr. Cissy Kityo**, Deputy Executive Director, JCRC
52. **Nina Shalita**, Executive Director, Hospice Africa Uganda

53. **Anne Merriman**, Founder and International Training Director, Hospice Africa Uganda
54. **Dr. Jennifer Ssenooba**, Clinical Director, Hospice Africa Uganda
55. **Alfred Nimungu Duku**, Education Manager, Hospice Africa Uganda
56. **Andrew Sentumbwe**, Finance Manager, Hospice Africa Uganda
57. **Juliet Bowuga**, Clinical Manager, Hospice Africa Uganda
58. **Martin Othieno Radooli**, Programs Director, Hospice Africa Uganda
59. **Mr. Joshua Kitakule**, Secretary General, IRCU
60. **Johnson Masiko**, Director of Programs, IRCU
61. **Charles Serwanja**, Monitoring and Evaluation Specialist, IRCU
62. **Agnes Nabawanuka Ssali (ACCA)**, Finance Manager, IRCU
63. **Allan Mugisha**, Grants Manager, HIV/AIDS, IRCU
64. **John K. Byarugaba**, HIV/AIDS Programme Coordinator, IRCU
65. **Stephen Kunya**, IRCU
66. **Adrabo J.B. Mily Kidega**, IRCU
67. **Nyanzi Deo**, Uganda National NGO Forum
68. **Robert Ochai**, Executive Director, TASO
69. **Robert Mwesigwa**, Director of Planning, TASO
70. **Juliana K. Nyembi**, Director of Capacity Development, TASO
71. **Harriet Mabonga**, Director of Advocacy and Networking, TASO
72. **Millie Kasozi**, Director of Human Resources and Administration, TASO
73. **Nicholas Mgumya**, Deputy Executive Director, TASO
74. **Peter Ssebbanja**, Director of Special Duties, TASO
75. **Charles Barugahare**, Chief Internal Auditor, TASO
76. **Patrick Okiria**, Director of Finance, TASO
77. **Dr. Ekufioit**, Deputy Director, Medical, TASO
78. **Alene McMahan**, CSF, M&E Agent, Chemonics
79. **Maj. Rubaramira Ruranga**, Chief Executive Director, NGEN (National Guidance and Empowerment Network of People Living with HIV/AIDS)

JINJA, UGANDA

1. **Sarah Khanakwa**, Jinja Centre Manager and other Centre staff, TASO
2. **Loy Twesigye Kanyoma**, Jinja Branch Manager and other Centre staff, AIC
3. **Dorcas Atieno Musubaho**, OVC Coordinator, Catholic Diocese of Jinja

KAKIRA, UGANDA

1. **Dr. Samuel Kiirya**, Senior Medical Officer, JCRC Regional Center of Excellence Kakira and other Centre staff

MBARARA, UGANDA

1. **Abel Asimwe**, Manager, TASO Mbarara Center
2. **Ramula Ssegujja**, PRA, TASO Mbarara Center
3. **Sophia Monica Apio**, HR Officer, TASO Mbarara Center
4. **Kyasimire**, Social Support Officer, TASO Mbarara Center
5. **Dr. Michael Irige**, Medical Coordinator, TASO Mbarara Center
6. **Isaac Mwanje**, Accountant, TASO Mbarara Center
7. **Joyde Nagasha**, Counselling Coordinator, TASO Mbarara Center
8. **Darius Kato**, Assistant Information Management Officer, TASO Mbarara Center
9. **Martha Rwaboni**, Health Services Manager, HAU
10. **Jackson Mucunguzi**, Finance Manager, HAU
11. **Noel Mwebaze**, OVC Program, ICOBI
12. **Dr. Henry Mugerwa**, JCRC RCE at Mbarara Regional Referral Hospital
13. **Dr. Peter Ssebulinde**, JCRC RCE
14. **Dr. Abbas Lugemwa**, JCRC RCE
15. **Emily Ninsuma**, Lab Department, JCRC RCE
16. **Judith Kukumdakwe**, Adherence Department, JCRC RCE

LYONTONDE, UGANDA

1. **Dr. Hajati Aisha Ssenyonga**, Program Director, Lyontonde Muslim Health Center (IRCU sub-grantee)
2. **Zepha Muhesi**, Project Officer, Lyontonde Muslim Health Center
3. **Wilson Kizza**, Counseling Coordinator, Lyontonde Muslim Health Center

APPENDIX C. DETAILS OF THE METHODOLOGY

The purpose of this assessment of USAID’s partners’ HIV/AIDS programs is to analyze the institutional organization and capacity of indigenous organizations providing HIV and AIDS services in Uganda, and to determine the institutional impact of USAID funding as part of PEPFAR. Special attention is focused on four USAID-supported HIV/AIDS partners that have received significant amounts of funding under PEPFAR:

- The AIDS Support Organisation (TASO)
- The Joint Clinic Research Center (JCRC)
- Hospice Africa Uganda (HAU)
- The Inter-Religious Council of Uganda (IRCU).

In order to gain a broader picture of the indigenous NGO experience with USAID under PEPFAR, the team also reviewed (in less detail than with the above four) the following five other NGOs that have received USAID funds as sub-grantees to larger organizations:

- AIDS Information Center (AIC)—sub-grantee of the UPHOLD project
- Uganda Women’s Effort to Save Orphans (UWESO)—sub-grantee of JCRC
- International Community Based Initiative (ICOBİ)—sub-grantee of JSI (New Partners Initiative)
- Meeting Point—sub-grantee of IRCU
- Uganda Health Marketing Group (UHMG)—offshoot of the AFFORD project.

This assessment gathers information about the current capacity of USAID-supported institutions and documents “best practices” that have been developed and implemented by the NGOs during the scale-up with USAID funds. The overall goal is to identify ways to provide increasing services at a reduced cost per unit of service, by building on the NGOs’ strengths, modeling best practices, and recommending areas where organizational and management changes can streamline operations and improve results. The assessment addresses the following areas:

- Organization and functioning of the organizations listed above, including how increased PEPFAR resources have changed them and their functions.
- Ability of indigenous institutions to plan and budget in compliance with U.S. Government regulations.
- Organizational and management efficiencies in producing planned results.
- Quality of organizational results.
- Technical and organizational capacity of indigenous organizations in forecasting, procurement, distribution, and management of supplies (including drugs and equipment) for their projects.
- Individual and collective impact, strengths, and weaknesses of these organizations.

This assessment has been carried out by a five-person team, consisting of a team leader experienced in USAID procedures and regulations, an organizational development specialist, an

HIV/AIDS technical specialist, a procurement and supply chain specialist, and a Ugandan NGO specialist.

The team's methodology consisted of (1) a wide-ranging review of documents related to the Ugandan NGOs involved in the HIV/AIDS program; (2) key informant interviews with knowledgeable observers and technical support providers, PEPFAR partners, Ugandan NGO representatives, other donors to the HIV/AIDS program in Uganda, and staff and grantees of USAID's NGO implementing partners at the central and field levels; (3) application of an organizational development assessment for the four targeted NGOs and a short version of the same for the other NGO implementing partners, including a pharmaceutical management component; and (4) interviews with clients to determine client satisfaction.

The ODA tool contains modules for assessing various components of each organization:

- Management systems and skills
 - Mission, vision, and values
 - Policy and procedures development
 - Strategic and tactical planning
- Human resource management
- Financial resource management
- Effectiveness (monitoring and evaluation and quality assurance)
- Leadership
- Board of Directors
- External linkages (e.g., to donors or clients)
- Reporting
- Sustainability and resource mobilization
- Supply chain management.

Each module asks the respondents to describe how that particular management function has changed in the past three to five years with PEPFAR funding.

For other USAID-supported NGOs interviewed by the team, a shorter set of questions, drawn from the ODA tool, was asked.

The team visited field sites and grantee operations of NGOs in Mbarara and Jinja in order to confirm whether management reforms made at the center had also been implemented at the field level, to learn about the quality and frequency of interaction between the center and the field, to form judgments about quality of services, and to confirm comments made at the central level. The team sought the following information from site visits:

- Staffing and supervision
- Reporting and finances
- Services and service quality
- Relationships with government, headquarters offices, and other service providers

- Supply chain issues
- Client satisfaction.

The team carried out interviews with clients at both headquarters facilities of the targeted NGOs, and at field or grantee sites. Interviews were carried out individually or in groups, depending on the situation, and included clients who only received services, clients who were also volunteers, caregivers, and some volunteers who were not HIV+. Prior to each interview or group discussion, the clients or volunteers were advised that their participation was entirely voluntary, that the information they provided would not be attributed to them, and that they could feel free to end the interview at any time. At the interviews and group discussions the following information was sought:

- Kinds of services provided
- Any problems met in obtaining services
- Reception and treatment by health workers
- Whether there are other sources of services in the same area and if so, why the interviewee chose this provider
- Whether they receive counseling, and whether they value it
- Whether there are services they need that are not available to them
- What this provider does best, and what it could do better
- If a volunteer, why the interviewee has chosen to volunteer.

The OD tool, pharmaceutical question set, and other question sets are available on request.

APPENDIX D. SUMMARY OF OD FINDINGS: TASO, IRCU, JCRC, HAU

Category	Key Elements	TASO	IRCU	JCRC	HAU
Management structure and governance	Clear management structure, roles, and duties of key board and management personnel clearly defined.	Fully implemented.	Fully implemented, although relationship with IRBs and medical boards in change process.	Partly, but role of board not clearly defined, irregular board meetings, no succession plan.	Partly. Mgmt structure and roles & duties in place, but not fully implemented. At sites, structure also in flux.
Mission, vision	Written mission statement that defines purpose and relevant to clients, and is used in decision-making.	Fully implemented.	Fully implemented.	Fully implemented, revised in 2008.	Yes, but not modified since founder developed it.
Policies and procedures	Written policies are in place and updated for all key functions.	Yes except for external communications.	Fully implemented.	Fully implemented –all through ACE.	Fully implemented. “It has been very very challenging.”
Strategic planning	Comprehensive strategic plans, with stakeholder input and approved by board, are in place, and annual workplans are based on them.	Yes, 2008–2012 plan, reconciled w/ budget availabilities, basis for annual workplans.	Yes, 2009–2013 plan, basis for detailed annual workplans.	Partly. Plan covers 2006 –2009, new plan in process. Not used for planning work.	Partly. Plan in place, but new plan dev. just starting, no agreement yet on process.
Human resources management	HR manager & budget, annual HR plan, comprehensive personnel policies and manual, including use of volunteers.	Fully implemented, no changes due to PEPFAR.	Yes, except have only part-time HR manager.	Yes, but no HR staff at RCEs, no written volunteer policies.	Fully, but no HR plan. At sites, finance/admin officer handles HR.
Financial management	Annual budget based on strategic plan & approved by board, adequate financial systems and reporting, qualified finance staff.	Fully implemented, no changes due to PEPFAR.	Fully implemented	Fully implemented, but key finance position vacant for nine months.	Fully implemented.
Staffing	Appropriate for nature of programs	Yes, at both central and field	Quite thin at senior and	Relatively thin management	Yes.

Category	Key Elements	TASO	IRCU	JCRC	HAU
	at central and field levels, for management and technical staff.	levels.	middle mgmt levels, need more staff support (from IRBs) for supervision.	layer at center and RCEs.	
Monitoring, evaluation	M&E framework with indicators and targets, appropriate data tools and collection, specialized M&E staff, data used to analyze short and long-term outcomes, include stakeholder feedback.	Fully implemented, although analysis of long-term outcomes is on ad hoc basis.	Yes, for PEPFAR (not for peace and justice), but no written report for stakeholder feedback.	Fully implemented including stakeholder feedback; M&E staff at RCEs need more training.	Fully implemented, but no formal mechanism for stakeholder feedback.
Reporting	Reporting responsibilities clearly defined, reports submitted on time.	Fully implemented	Yes, but reports not always in on time.	Fully implemented	Partly. Reports late more often than not.
Quality assurance	Technical personnel trained to national guidelines, receive regular supportive supervision, system for continuous quality monitoring in place, client satisfaction tracked-	Yes, including staff assigned to QA and regular client feedback.	Partly. QA systems developed but not yet implemented. Technical supervision not yet adequate.	Fully implemented. QA team and adherence officers in place. Regular client feedback.	Partly. QA is informal, relies on technical supervision and staff rotation. No system for client feedback.
Sustainability and resource mobilization	Staff assigned to resource mobilization, sustainability plan in place including plans for continued operation when donor grants completed.	Yes, including staff assigned and contingency plan, but no changes in fundraising practices in recent years.	Not clear if staff assigned to resource mobilization, but strategic plan has sustainability plan.	Yes, based on using research as funding mechanism, but no staff dedicated to resource mobilization.	No staff assigned, no plan in place, but founder works on attracting donors, and HAU aware of the need.
Central policies mirrored at field sites	District or regional sites have same policies/procedures in place and adequate capacities to implement organization's M&E, finance, quality assurance, human resources functions.	Yes in the two sites (Mbarara and Jinja) visited by team.	No regional sites. Grantees go to center quarterly for updating and discussions.	Yes at the two sites visited, although IT software not yet in place. RCEs would like support for TOT training for clinical staff.	Yes, according to HAU center staff.

APPENDIX E. SUMMARY SHORT-FORM OD RESULTS: SMALLER NGOS

Subject	ICOB	UHM	AIC	UWESO	Meeting Point
Management Systems					
Written mission statement	Yes, but very broad	Yes, good	Yes; core mission focuses on counseling & testing.	Yes, "Commitment to improving the quality of life for orphans and vulnerable children"; their earlier mission statement mentioned orphans and the destitute, but they found it to be too broad. Change made around 2005.	Yes, re. quality of life for people with HIV/AIDS.
Changes in mgmt practices over past 3–5 yrs	Have instituted financial management policies, HR policies and procedures, improved board composition, put in place a plan for succession planning, developed office management procedures, developed manuals, including HIV/AIDS in workplace, drug abuse policies. Board has strategic plan committee. Beginning to focus on gender concerns. Key area to work on is quality assurance.	"We are now an organization, not a project." Created structure with three components— (1) consultants department that works on donor funded social marketing and communication s to package these into market-able products; (2) products facilities; (3) franchise for the afford family.	Coached by ACE to improve financial management system and to develop systems and manuals for HR, procurement and logistics management.	In 2005 UWESO developed its first strategic plan covering 2006–2010. They developed an integrated approach model.	PEPFAR-funded executive management training through IRCU has enabled director to make staff changes, delegate more responsibility, empower and train staff, especially the counselors.

Subject	ICOB	UHMG	AIC	UWESO	Meeting Point
Process for making strategic decisions	Senior management discuss issues and make strategic decisions, particularly regarding consistency with their mandate and compliance with U.S. Government rules and regulations. Board involvement is limited to approval of major procurements.	Except for strategic plan development, other strategic decisions are made by senior management. Board is only involved in providing overall strategic direction.	During staff retreat, analyzed past three SPs, considered SWOT aspects & came up with five core results areas for focus (C&T, staff training, knowledge, systems strengthening in IT & finance, research); reviewed with stakeholders and Board.	The 2006–2010 strategic plan was developed by pulling in stake-holders, consultants, and their beneficiaries.	No written strategic plan.
Monitoring workplan	Quarterly meetings review overall progress. Monthly meeting for each project and monthly report for all projects. Monitoring visits include executive director, head of HR, and head of finance.	No clear monitoring workplan.	Monthly meetings at the branch level held with senior management to review reports, compare data inputted into system, and review issues from the data reviews. Quarterly meetings focus on program accomplishment, financial tracking, etc. End-of-year retreat compares results against targets.	Annual work plan is monitored against the workplan indicator framework on a monthly basis.	Annual workplans are monitored through a program monitoring plan (PMP) that looks at outputs in terms of numbers of home-based visits, care-givers trained, clients referred, outreaches conducted, drama shows held.
HR management					
Recruitment & hiring procedures	All permanent posts (220 employees) are advertised, reviewed through regular process, go through short-list to interview panel. All	Yes, standard process.	Rigorous procedures in place; Board provides oversight to recruitment policies.	There is an operational manual for HR that includes policies and procedures.	There is an HR manual that details procedures and policies for the organization. By the director's admission, "the manual needs to be improved and

Subject	ICOB	UHM	AIC	UWESO	Meeting Point
	employees get orientation after hiring. They use supportive supervision.				standardized in line with other good organizations.”
In-service training	Relies on external funding to finance in-service training.	No information.	Funds limited for staff in-service and refresher training so AIC takes advantage of Institute of Public Health Mulago for short courses in M&E, HR, admin. No regular program.	Lack resources for in-service training.	System appears to be ad hoc and based on the availability of funding from IRCU.
Volunteer supervision	One employee supervises six volunteers. Has volunteer book.	Interns are supervised by project staff.	Ratio usually one counselor to six volunteers.	Volunteers are field-based and supervised weekly by the project officers.	There is a ratio of three volunteers to one supervisor.
Financial management					
Board's role	ICOB only has project budgets. The board only gets involved with strategic procurement, which is reviewed by the finance and procurement committees of the board.	Board approves annual budget. Senior management reports to the board quarterly on finances; the board has a finance and audit committee that reviews budget and brings issues to the board and also initiates audits.	No information.	Senior management develops the annual budget; the board reviews, approves, and monitors it quarterly.	The Executive Committee prepares the annual budget and sends it to the Board for review and approval. The Board monitors expenditures and receipt of funds periodically through the year.
Financial managers' qualifications and training	Bachelor's degree in commerce, Master's in management and administration, and ACCA (British certification for accountants).	Financial manager has ACCA. Also supervises two accountants.	Master's in accounting and ACCA; experience in external audits.	Finance manager has a BCOMM and is in the third & final stage for completing her ACCA certificate.	The senior accountant has a BCOMM and is currently working on her ACCA.
Internal controls	Authorization control (how much different	Prequalification of suppliers, external auditor	Salaries all paid through bank. Salary payment	The accounting manual contains all procedures and	Procurement committee reviews bids and

Subject	ICOB	UHMG	AIC	UWESO	Meeting Point
	staff can approve); segregation of duties on transactions.	is part of the team that evaluates bids. Separation of responsibilities for cash management (e.g., the person who generates the request is not involved in the procurement); predetermined cost of accommodations for site visits.	generated through time sheet & daily register. No money ever paid to AIC staff directly.	controls including procurement policy and rules. There are multiple levels of expenditure approval that include finance manager, program manager, and CEO, depending on the amount.	recommends payment against written procurement guidelines given to them by IRCU. IRCU has made it very easy for them to understand USAID regulations and requirements.
Changes in financial practices over past five years	Procurement manuals and other financial system manuals spell out who does what. Responsibilities are clear-cut. There has been a tremendous improvement in financial (and other) systems. Other innovations they have adopted include pre-award survey, reporting and payment procedures improvements, use of a travel plan, a regular internal audit system. Shifted from Excel to Quickbooks.	Putting much more emphasis on bringing money in from different sources.	Financial procedures have improved as a result of UPHOLD audit that showed loose accountability.	With increase in funding, activities, and number of donors, there has been a constant improvement and increase in finance staff. Multiple donors require multiple systems for reporting and different time-frames. Donors currently include DFID, IFAD, CSF, FAO, UNICEF, UN Habitat, and CARE, plus smaller donors.	Financial management staff has increased (from one to two) and are better trained; they now only use USAID-certified auditors for better audits.

Subject	ICOB	UHMG	AIC	UWESO	Meeting Point
M&E: Data collection system	Data are collected by the people at the sub-county level, assisted by volunteers. The office staff at district receive the data, do data entry and reporting. The system is different for different projects, depending on donor requirements. There is no computer facility at the field level, so electronic entry occurs at the district level that aggregates the data.	They use AFFORD's HMIS system. From districts, M&E information goes to both MOH and UHMG. There is an M&E officer at central level who manages the PMP.	Data is collected at branch level and sent to data analyst at HDQ, then given to M&E. Quality of data is checked through counselor officer at frequency of six-month intervals.	Data are collected at the field level from the communities by the community-based volunteers and regional offices. Data collection is done manually onto forms and inputted into the computer back at the regional level. Database and central server all at the head-quarters; hard copies of every-thing are in files. There is no offsite electronic back-up.	Data collection forms are used to collect and report on the indicators in the PMP. This information is sent to IRCU on a monthly basis. Data are collected daily and summarized once a month for reporting to IRCU.
Quality assurance of service delivery	Weak in this area.	This is still a challenge. We have standards to assure basic quality of services delivered. Infection from injections is a key issue. There is no one individual in charge of quality assurance, so MOH is relied on by providing stipend for MOH officer who carries out this role.	Quality check through random survey questions given to clients at exit interviews. MOH/AIC Team inspect for compliance and standards adherence twice yearly. Counseling officer monitors quality of counseling.	Worked with the Ministry of Gender to develop standards for working with OVCs, but have not yet disseminated them to all field staff. Their QA system is still incomplete by their own admission.	There is no QA system, nor does quality seem to be incorporated into the indicators they listed for us from the PMP in place. Teachers follow the Ugandan MOEd curriculum and are supervised by the head teacher and the administrative director of the orphans' school, and the counselors follow the MOH's home-based care guidelines and are supervised by the senior counselor.

Subject	ICOB	UHM	AIC	UWESO	Meeting Point
Leadership					
Succession plans	New leadership is developed by mentoring, coaching, and the annual appraisal process.	No succession plans described.	No succession plan in place, however, executive director allows each director to take turns acting as executive director for training purposes.	No.	No.
Changes in leadership over three to five years	As the organization has grown, new positions with higher-level capacity have been created as needed.	No information.	Board members are elected by General Assembly for maximum of two two-year terms. Two HIV+ members (one male, one female) must be included. Founding members are no longer voting members on Board, nor does executive director vote either.	The board changes every four years according to the guidelines; their direction and oversight have remained constant to the new mission.	
Stakeholder input	Stakeholder involvement is minimal throughout Uganda, including in this organization, because the stake-holders are at the community level, where it is difficult to get their inputs. At implementation level, staff at kids' clubs get informal input from the stakeholders at grass roots level. Rely on employees	For the work planning cycle, we get input from the Board, USAID, and AFFORD. No one else.	Solicits input from donors, former directors, peer groups, branch staff, and clients.	The General Assembly is included in regional planning meetings to get their input; workshops are held with their representatives. The General Assembly is made up of all their grass-roots members.	General meetings are held quarterly and the surrounding community is invited—including clients and local and religious leaders from all faiths.

Subject	ICOB	UHMG	AIC	UWESO	Meeting Point
	within the organization to ensure stakeholder views are represented.				
Reporting: Changes in past three to five years	Every project has different reporting requirements.	UHMG basically writes the report that AFFORD submits.		Reporting has become more complicated with increased funding and multiple donors.	Follow the guidelines set down by IRCU and USAID.
Sustainability plans?	One of the new executive director's mandates is to develop new programs for donor funding. The new strategic plan calls for providing consultant services to other NGOs as a revenue generator. ICOBI is considering collaboration & integrated services with other NGOs working in the same areas to avoid duplication. Entering into a consortium arrangement with TASO and others for an RFA.	(1) Target is for two concept papers for unsolicited proposals, or one major response to RFA every two months; (2) always seeking partner-ships—want to get involved with the “giants” who have been here before us; (3) increase awareness of UHMG among donors and other organizations who are potential clients. Every senior manager is involved in this. Commercial sales of commodities should provide some funds to support this marketing, though the margin is very low.	No sustainability plan, but multiple sources of funding. Revenue received from subscription fees; contracts from MOH to do a specific task, e.g., training, deliver medications. Have smaller grants from Civil Society Fund & corporate donors to support specific core things, e.g., community mobilization, evaluation for MOH sites, etc.	UWESO is 87% donor-funded with multiple donors. The remaining 13% comes from donations, rental income from land purchased or donated, and membership dues collected. Membership fees vary by region, but in general it is Ush20,000 for Kampala members and Ush2,000 to 5,000 in the regions. Their goal is to decrease donor dependence to 60% over the next five years.	Meeting Point is totally donor-dependent but they do have multiple donor sources, no strategy for sustainability.

APPENDIX F. CLIENT INTERVIEW RESULTS

1. METHODOLOGY FOR OBTAINING FEEDBACK FROM CLINIC CLIENTS, COMMUNITY-BASED VOLUNTEERS AND CAREGIVERS

Informed Consent

Prior to all interviews and focus groups, potential interviewees were advised that their participation in the interview or group discussion was completely voluntary, that their responses would not be attributed to them, and that they could feel free to stop the interview at any time or decline to answer any question. In all cases, the interviewees were happy for the opportunity to describe their experiences and the services they received.

Clinic Client Satisfaction Survey

The questions for clinic clients are meant to solicit information on:

- the kinds of services provided on and offsite
- their level of satisfaction with delivery services
- availability of drugs, supplies, and counseling when needed
- reception and treatment of clients by health workers
- client's perception of what site does best for them.

Community-based Volunteer Survey

The questions for community-based volunteers are meant to solicit:

- direct information on volunteer motivation and facilitation
- volunteers' perceptions of the services provided by the organization at the community level and what more the organization could be doing for the clients.

Caregivers Survey

The questions for caregivers are meant to solicit feedback on:

- the extent of caregiver involvement with provision of care to the client
- the range of services obtained for those they care for and their satisfaction with the services provided by the organizations.

Discussion/Focal Groups—When possible, groups of client or volunteers were interviewed through focus group discussions. Many of the same questions were asked from the three questionnaires. Group discussions were facilitated by team members who asked questions on customer satisfaction, volunteer motivation, and what the organization could do better. The purpose of these group discussions was to obtain information similar to that obtained in one-on-one interviews. The groups were organized in a user-friendly manner to allow for free group expression and to allow the group members to question the team interviewers.

2. SUMMARY RESULTS OF SURVEY AND DISCUSSANT GROUP RESPONSES

Total of 103 respondents in all categories

Clients from all four of the organizations in this assessment were interviewed. However, since there is no difference in client satisfaction from one organization to another, their responses have been aggregated for this summary.

Clients & Discussion/Focus Groups

The response to services was overwhelmingly positive. Clients reported that:

- They felt overwhelmingly grateful for the clinics and very optimistic about their futures because they had been enabled by the projects.
- They received monthly treatment and counseling.
- Drugs were usually available for HIV/AIDS symptoms, although sometimes they had to go elsewhere for drugs for opportunistic infections and those for cancer were very expensive, and unable to them. The exception to this is HAU, whose specialty is cancer treatment.
- They had been referred by family, friends, other clinics, NGOs, and outreach service volunteers.
- Drama groups in the rural areas were getting the messages out to the communities.
- PEPFAR projects have given them hope and extended their lives.
- Some had been receiving services for over 16 years but most were one–five years.
- Transport, income generation training, and capital or micro loans were needed for business start-up in order to support themselves.
- Funds for food, upkeep, and children’s school fees are always needed.
- Some clients who had enrolled earlier had received vocational or agricultural training; those who had enrolled more recently had not.
- Clients visited clinics on a regular basis unless they fell ill and needed home-based care which was available.
- Men are more reluctant than women to declare their HIV status or to seek services.

Community-Based Volunteers

- Volunteers felt the projects were a lifeline to individuals and communities.
- Volunteer responses varied by examples of what the specific NGO provided in terms of services, but most received testing, drugs, palliative care, and counseling.
- Volunteers in some of the NGO projects were also clinic clients, while some TASO volunteers were recent school/university graduates who are HIV-negative but who sought volunteer jobs as interns in order to gain experience for job entry positions.
- TASO, until end of project funding, recruited volunteers into full-time staff positions.
- Volunteers said they wanted to serve and help their communities.

- Volunteers reported that they needed more “facilitation” funds, as almost all were unable to afford to volunteer for “free” due to economic realities.
- Other volunteers who had received income generation training requested start-up funds for tools to start income generation enterprises. One client has started a successful sunflower oil extraction business, but he needs a larger oil press machine in order to expand his business.
- Some volunteers said their greatest challenge was to carry the message into the communities, yet when new clients visit sites to register, the sites are unable to offer services due to funding limitations.

Caregivers

- Caregivers are most grateful for the assistance that they currently receive.
- Caregivers tend to be a highly stressed group.
- Caregivers are often family members who may also be HIV-positive.
- Caregivers in the HAU program receive kits containing soap, antiseptics, adult diapers, sheets, etc., and provide home-based nursing care assistance for clients when needed.
- Family members who are HIV-negative often have to put their lives on hold while serving as caregivers due to the emotional, physical, and economical strain, e.g.,
 - an uncle could not marry as he was unable to afford the marriage dowry since he was spending his entire income on his nephew’s care and school fees and a granddaughter had to leave her job to care for her grandmother.
- Some caretakers are elderly grandparents with little income or land to grow food to provide for large numbers of grandchildren.
- Some elderly caretakers are also “squatters,” as their economic situation does not allow them to be stable renters or consistent providers of food or clothing for children.
- Many caretakers cannot even afford the nominal fee charged for school porridge for children even in “free primary” schools.
- Some caretakers are IDPs from conflict areas with tenuous social support systems in the new settlement areas.
- Some caregivers receive some assistance (school uniforms, scholastic materials, school bags) from faith-based organizations who have grants from IRCU.

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