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FINAL EVALUATION OF UPHOLD PROGRAM FOR HUMAN AND HOLISTIC DEVELOPMENT (UPHOLD)

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FINAL EVALUATION OF UPHOLD

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Final Report

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EXECUTIVE SUMMARY

UPHOLD is a 5 year integrated social services program, implemented under USAID's strategic objective 8, which aims to improve human capacity. UPHOLD was contracted under a cooperative agreement, originally scheduled to end in September 2007.

The evaluation took place between April 16th and June 22nd 2007. The evaluation team of five carried out a range of interviews, undertook a number of district and site visits and read through a wide range of documents. The details of these are contained in the appendices of this report.

The evaluation report has a number of limitations. These include the fact that no previous evaluations were done so there was no baseline to which the evaluation team could refer; some of the key program objective changed during the duration of the programme (e.g. introduction of PIASCY); the funding climate in USAID changed fundamentally during the lifetime of the program which had considerable impact on UPHOLD (e.g. introduction of PEPFAR).

The heart of the report deals with answering the question: *"To what extent has UPHOLD achieved its overall HIV/AIDS and health goals and results"?* The report highlights the extent to which external factors such as the delay in the selection of districts, the process of "re-districting" impacted on the operations of UPHOLD. It also highlights the many issues in the design of the programme, (e.g. constraints placed upon, and the prescriptive nature of the funding), that impacted on the ability of UPHOLD to maneuver. The report also gives details of the achievements, or lack thereof, of a number of direct activities carried out by UPHOLD. These include activities of child health including EPI and growth promotion, reproductive health, malaria (including the function of CMDs and the distribution of ITNs), TB, HCT and PMTCT, AB and other HIV prevention, palliative care and PIASCY.

A number of cross-cutting activities that were important in ensuring capacity development were also detailed. These were the areas of grant making and decentralization, improvements in quality assurance and monitoring and evaluation. A number of lessons have been learned and a number of recommendations have been made. These are listed below.

1) There is a danger that cooperative agreement arrangements leave programme goals 'too loose'. This was the case in UPHOLD where the programme tried to 'do everything, everywhere' with limited and finite resources. The consequence was that some activities were very thin on the ground. It took two years before there was a "Focus for Impact". This resulted in a narrowing and deepening of activities. *Future programmes should ensure that the parameters are more targeted and that interventions should have sufficient depth to make meaningful changes on the ground.*

2) The strategic decision making in UPHOLD was not as clear as it could have been. The major decisions around funding flows were made by USAID and did not leave the UPHOLD management with a huge amount of discretion around implementation. In addition UPHOLD management did not have a steering committee or reference group which could provide an oversight role in terms of strategic direction. Finally UPHOLD did not adequately tap into the intellectual resources available in its consortium partners with regard to strategic direction. *It should be built into the design of future programmes that there should be a formal annual strategic decision making meeting where key stakeholders' input is provided and which is based on a strategic review of performance, direction and focus.*

3) The relationship between the donor, USAID, and the key stakeholder, the GoU, was not as clear as it should have been and resulted in a loss of 6 months at the commencement of

the project through a delay in district selection. *Large programs should be endorsed within the GoU prior to commencement with clear goals and objectives.*

4) UPHOLD was not subject to any formal evaluation during the five years of operation. There was no mid-term review nor were there any formal annual reviews. As a result it was difficult to assess whether the programme was 'on track' in relation to the big picture. All stakeholders were thus deprived of the opportunity to engage with the strategic direction of the programme. *For a program of this size, a formal mid-term review is imperative, and annual reviews would also ensure that the programme is heading in an appropriate direction.*

5) Without systems strengthening to link with the services programme, UPHOLD 'walked on one leg', trying to implement a district based programme but always having to consider systems issues at the delivery (LG) level as well as at the central MoH level. *Programs that are trying to improve service delivery need to take into account constraints in the formal health system.*

6) Central MoH involvement in large programs is essential. This involvement can:
   a) assist the strategic direction in ensuring that program goals are consistent with health system policy
   b) help with sustainability by getting MoH participation in and buy-in to activities of the program (e.g. LQAS)
   c) open doors to the program through providing it with continued endorsement
   Programs should build into their design a more formal relationship with the central MoH, where roles and responsibilities are clearly delineated.

- Many of the excellent activities implemented by UPHOLD have question marks against their sustainability after the end of the program. Examples of this include the future of the CMDs and the LQAS. *Sustainability strategies should be transparent and a critical consideration in the design and implementation of large programs.*
- Although UPHOLD had the laudable aim of integration of activities at the district level, this is difficult to achieve when the health systems are running different projects in a vertical fashion (e.g. PMTCT). *Programmes need to design their activities around the realities of the health system and feed back to central level well documented policy briefs to encourage systemic change of service innovations.*
- Although this program was designed as a multi-sectoral program (health and education) to be delivered at district level, there was no prototype or pilot on which the design was based. *Large scale programs should be based on tested methodologies. Innovative activities have an important role but they should be tested in small scale pilots before going up to scale.*
- The efficiency and effectiveness of interventions and activities by grantees was compromised by the uncertainties around the funding flows in terms of the length of time of these and the amounts. The funding used generally by UPHOLD, to a large extent determined by its own funding streams, meant that grants were made for a single year or less; and that the amounts of the grants were uncertain. This resulted in pulsed, uncertain and inefficient grant making to CSOs. *There should be more certainty in programme funding flows and more flexibility given to the program to make grants for periods longer than one year. Where circumstances are appropriate grants should be made to allow for continuity of activity.*
- The differing financials years of UPHOLD, USAID and the LGs often meant that funding did not fit into the financial framework of LGs and did not coincide with budgeting cycles. *Funding should plug in the existing planning frameworks and cycles as much as possible.*

- The RFA method of grant making ensures that CSOs have sufficient technical ability to write grant proposals and demonstrate their likelihood of success and so results in the choice of CSOs who are likely to deliver. It however limits the grant making to certain kinds of CSOs and results in much CSO time being spent on writing proposals at the expense of service activity. *The best features of the RFAs should be coupled with the targeted selection and capacity development of particular CSOs, in order to ensure sustainability and overall long-term development of these CSOs.*
- There is a tension between being focused on short term achievements and taking on a developmental role through improving human capacity (which is generally a softer and longer term achievement). *Programs need to be clear, transparent and realistic as to what their mission is and what they are trying to do.*
- UPHOLD has an excellent monitoring system where all program activities were tracked. However, over-prescriptive target setting, together with unrealistic expectations of the accuracy of data, can result in too much attention being placed on the numbers. *Monitoring has an important role to play but it should be complemented by strategic analysis and overview, where the big picture is constantly kept in mind.*
- One of the positive achievements of the program was the use of CSOs who in certain instances made important and large contributions (e.g. in home mobilization of HCT). *Future programs should look at the positive ways in which CSOs were harnessed and build upon these. UPHOLD itself should write short policy briefs on the success of this (and other interventions) and the lessons that it learnt in the process.*
- UPHOLD encouraged and facilitated the relationships between CSOs and LGs. *Future programs should further encourage in all ways, including financial, the closer working together of these parties.*
- Some activities of UPHOLD took a very long time to mobilize, e.g. start-up of TB programme; others were started and then curtailed because of lack of resources e.g. growth promotion. There needs to be a balance between the depth and breadth of the range of activities and also the geographical areas in which they work. Programs cannot be all things to all people. *Activities taken on by programs need to be carefully thought through in terms of financial, human and other resources required prior to their commencement and there needs to be a balance between the number of activities and how widespread they are implemented.*
- There were a number of activities of UPHOLD that resulted in spin-offs that were not anticipated in the original plan. Examples of these include:
  - Distribution of LLINs through CMDs exposed a channel that had not been used before. This resulted in the CMDs becoming a point of reference for health issues in the villages. This model of CMD distribution has been taken up by the MoH.
  - LQASs have been well accepted as a means of getting population based information.
  - PIASCY has resulted in community and household involvement in education. On the other hand it has been reported that some schools not involved in the model school process, have had negative reactions.
  - Use of CSOs has resulted in high mobilization of decentralized and household HCT and also led to increased utilization of family planning.
  - Although CMDs and CSOs have been highly successful in certain activities, they now face an uncertain future and their sustainability is not assured.

The overall conclusions of the evaluation team are that most of the operational targets set by UPHOLD have been attained and especially in the last year UPHOLD seems to have moved into top gear. At the operational level much has been achieved and CSO capacity has been increased as has LG capacity, though to a lesser extent. Although the evaluation team obviously could not assess the operation of UPHOLD in the initial years 2002-2004, it

appears in our assessment that UPHOLD in 2007 is a well functioning, hard working, efficient and effective organisation.

However, UPHOLD suffered from being an over-ambitious project with inadequate strategic direction, both from without and from within, in the initial years. This resulted in the project having too much breadth and too little depth. The changing of key implementation objectives, (e.g. through PEPFAR, PIASCY implementation), did not help this process.

Our overall assessment is that UPHOLD has successfully evolved over time and is making successful and useful interventions. However, with more strategic direction and focus initially, this program could have achieved more.

ACRONYMS

ABC	Abstinence, Being faithful, and Condoms
ACT	Artemesinin-based Combination Therapy
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS Integrated Model District Programme
ANC	Antenatal care
ARVs	Anti-Retroviral Drugs
BCC	Behavior-Change Centered Communication
CAO	Chief Administrative Officer (local government)
CB TB	Community Based TB treatment
CB TB DOTS	Community Based TB Directly Observed Therapy Short Course
CBGP	Community-based growth promotion
CMDs	Community Medicine Distributors
COP	Chief of Party (UPHOLD)
CPD	Continuous Professional Development
CPTCs	Core Primary Teacher Colleges
CSO	Civil society organization
CV	Curriculum Vitae
DCOP	Deputy Chief of Party (UPHOLD)
DDHS	District Director Health Services
DDs	Drug Distributors
DEO	District Education Officer
DHACs	District HIV/AIDS Committees
DHT	District Health Team
DOTS	Directly Observed Therapy, Short course
EPI	Expanded Programme on Immunization
FP	Family planning
FPP	Focal Point Person
FSG	Family Support Group
FY	Fiscal Year
Global Fund	The Global Fund Against AIDS, Tuberculosis and Malaria
GOANC	Goal-oriented antenatal care
GoU	Government of Uganda
HBMF	Home Based Management of Fever
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP II	Health Sector Strategic Plan II
HUMC	Health Unit Management Committee
IDP	Internally displaced persons
IEC	Information, education, communication
IPT	Intermittent preventive treatment
IRH	Integrated Reproductive Health
ISSP	Integrated Social Services Programme (UPHOLD)
ITNs	Insecticide-Treated Nets
JCRC	Joint Clinical Research Centre
JSI	JSI Research and Training Institute, Inc.
LCs	Local Councils
LG	Local Government
LLINS	Long-Lasting Insecticide Treated Nets
LQAS	Lot Quantity Assurance Sampling
M&E	Monitoring and Evaluation

MEEPP	Monitoring and Evaluation of the [US President's] Emergency Plan for AIDS Relief Progress Project
MIP	Malaria in pregnancy
MIS	Management Information System
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoUs	Memorandum of Understanding
NMCP	National Malaria Control Programme
NMS	National Medical Stores
NTLP	National TB and Leprosy Programme
OVC	Orphans and Vulnerable Children
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PIASCY	Presidential Initiative on AIDS Strategy for Communication to the Youth
PLHA	People Living with HIV/AIDS
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PTC	Post-test clubs
PTC	Primary Teachers Colleges
PY	Programme Year
QA	Quality Assurance
RFA	Request for Application
RH	Reproductive Health
SNIDS	Sub-National Immunization Days
SO8	USAID Strategic Objective 8: Improved human capacity
STI	Sexually Transmitted Infections
TA	Technical Assistance
TASO	The AIDS Support Organization
TB	Tuberculosis
TPI	Training and Performance Improvement
TPI/QA	Training and Performance Improvement/Quality Assurance
UAC	Uganda AIDS Commission
UACP	Uganda HIV/AIDS Control Project
UDHS	Uganda Demographic and Health Survey
UNAHCO	Uganda National Health Consumers Organization
UNEPI	Uganda National Expanded Programme for Immunization
UNICEF	United Nations Children's Fund
UPE	Universal primary education
UPHOLD	Uganda Program for Human and Holistic Development
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
US$	United States Dollars
USG	United States Government
VCT	Voluntary Counseling and Testing
VHT	Village Health Team
YSP	Yellow Star Programme

1 INTRODUCTION

1.1 PROJECT BACKGROUND

UPHOLD is a 5 year integrated social services program, implemented in terms of USAID's strategic objective 8, which aims to improve human capacity. UPHOLD was delivered under a cooperative agreement, originally scheduled to end in September 2007 but extended to September 2008. The aim was contribute to USAID/UGANDA strategic objective of improved human capacity intermediate results (IR) of effective use of social services (IR1); increased capacity to sustain social services (IR2) and; strengthened enabling environment for social sector services (IR3). Within IR2, UPHOLD has 5 key performance areas namely Public service delivery, quality of public service delivery, support to public service delivery, private sector delivery and Grants Programme.

The project was thus designed in the RFA to deliver a package of high quality technical assistance, targeted training and capacity building activities, and financial and material support to 20 district, their sub-counties and selected private organizations in public health and education systems. The theory was to achieve success by (1) learn from the processes adopted by AIM for selecting districts and rapidly cover all 20 target project districts with innovative approaches within the first project year; (2) direct most effort toward specific vulnerable groups in every district; (3) building cooperation and collaboration especially between Health, Education and HIV/AIDS sectors at every level; (4) going national by replication and expansion to achieve nationally measurable improvements.

UPHOLD activities were thus implemented in seven broad technical domains some strictly within one of the three sectors: (1) Health, (2) Education, (3) HIV/AIDS and the remaining four areas integrated these sectors: (4) Education/Health, (5) Education/HIV/AIDS, (6) Health/HIV/AIDS and, (7) Education/Health/HIV/AIDS.

An Integrated Coordinating Committee (ICC) that includes major stakeholders from public (MOH, MOES and MoLG), partners, private and professional sectors and USAID was planned to maximize breadth and depth in joint strategic and annual planning exercises and regular meetings among stakeholders especially in unfolding Services Agreements and the Contracts.

1.2 EVALUATION PURPOSE

This evaluation was awarded under the Scope of Work shown in *Appendix 1*. The evaluation purpose was to extract lessons that would benefit the USG/Uganda and GOU partner institutions with future programming and inform implementing partners of what worked and what did not work during implementation of the program.

Four key evaluation questions guided the process:

1) *"To what extent has UPHOLD achieved its overall HIV/AIDS and health goals and results? How did the following factors contribute to the achievement of goals and results?*
   - *Program design strengths and limitations*

- *Technical competency to undertake the planned activities*
- *Technical support and capacity building for districts and grantees*
- *External factors*

2) *How did UPHOLD develop and manage relationships with USAID implementing partners, GOU partners and the civil society?*
3) *Did UPHOLD yield any unintended positive/negative results*
4) *What are the key lessons learned from the design and implementation of this large multi-sectoral, district based program?"*

The evaluation provides both quantitative and qualitative assessments of the approach UPHOLD applied and determines whether UPHOLD is on track to achieve its impact objectives. USAID showed interest in continuing support to HIV/AIDS and health service delivery in a decentralized environment. While learning from old and ongoing activities within and outside the USG portfolio, USAID seeks to garner lessons learned regarding design and implementation of large, multisectoral programs as one means of rapidly scaling up HIV/AIDS and health services in a decentralized setting. The evaluation provides answers both at program and strategic level by addressing the question of whether UPHOLD is on track to achieve the intended goals of its HIV/AIDS and health interventions. The evaluation also distills lessons learned about program implementation that have a bearing on scaling up HIV/AIDS and health interventions nationwide.

1.3 EVALUATION METHODOLOGY

A team of five evaluators composed of four external consultants, two of whom were public health doctors, one with experience of local government and decentralization, the fourth seconded from the Ugandan Ministry of Health and the fifth, a senior staff member seconded from UPHOLD provided a wide range of work and background experience and included.

The evaluation took place between April 16th and June 22nd 2007, implemented in two phases. The team leader and one of the team spent a week in Kampala from April 16th to April 21st 2007 to set the platform for the subsequent in-depth phase of interviews and field trips that took place between May 20th and June 9th 2007. Given the time and logistical constraints, the district review was confined to 2 regional offices, 2 districts in depth and, another 2 districts more superficially. The report was written from June 10th to 21st 2007.

Based on an initial review of the documentation, the time available and the geographic constraints of visiting districts, the evaluation team prepared an evaluation framework and proposed field trip, including the selection criteria for the districts visited. These documents, shown in *Appendix 3*, comprised the essential components of the inception report. This inception report was presented at a meeting held on the 23rd May 2007, attended by representatives of USAID, the GoU, and other stakeholders.

The team carried out in-depth interviews with a range of national and district stakeholders, undertook a number of district and site visits and took part in a number of activities in the districts visited. The details of these are contained in *Appendix 2.* The interview questionnaires are contained in *Appendix 5* and the documents reviewed are listed in *Appendix 6.* The evaluation was limited to the Health and HIV/AIDS domains thus excluding Education which was undergoing a separate evaluation.

1.4 LIMITATIONS OF THE EVALUATION

UPHOLD, is reportedly the largest USAID programme in the whole of Africa in terms of monetary value. It is also a very complex programme in terms of the range of interventions and the geographical coverage. The time allocated to this evaluation was relatively small and therefore, by definition, the evaluation could not be in-depth and cover every aspect of UPHOLD over a 5 year period.

There were no previous evaluations, such as a mid-term review, which could have been expected in a programme of this scale, with which to compare this evaluation. Neither were there formal annual reviews with which to compare and therefore the evaluation team had to cast their eyes back over a period of 5 years without any real landmarks or baselines upon which they could rely[1].

Over the lifetime of the programme, some of the key implementation objectives changed. So in fact what UPHOLD does in 2007, is quite different in a number of ways from what was envisaged in 2002. (For example there are very little child health or reproductive health activities in 2007 and there is a massive activity around PIASCY, which was non-existent, nor even conceptualized at the commencement of the programme).

During the lifetime of the programme the funding climate considerably changed and PEPFAR, with its emphasis on results, numbers and monitoring and evaluation had a significant impact on how UPHOLD implemented its activities and how it relates to its various partners.

Notwithstanding the above comments on the limitations of this evaluation, the team feels confident that with the information obtained through our interviews, document reviews and field visits that we are able to give a balanced assessment of UPHOLD, based on our collective judgement of the programme. The remainder of the report follows generally along the lines of the structure of the key evaluation questions.

[1] There was reportedly an internal JSI management review approximately midway through the programme, following which there was a sharper focus of UPHOLD and its activities. This review was not made available to the evaluation team.

2 EVALUATION FINDINGS

"How did the programme design's strengths or limitations contribute to the achievement of goals and results?"

2.1 PROGRAMME DESIGN

The original RFA put out by USAID was broad in concept and was extremely ambitious in envisaging the integration of the three broad areas of work. The range of interventions spanned across a very wide scope of work and the number of districts chosen was also large for the range of interventions proposed. The concept had not been piloted prior to the RFA and in the opinion of the evaluation team was too broad both in the number and range of interventions and in the geographic area.

Although designed as a district-based programme the design was not altogether coherent and over one third of the programme budget was for UPHOLD to act as a funding conduit for channeling USAID funds to two large national CSOs, namely TASO and AIC. It appeared to the evaluation team that for this component of the budget, as if USAID was using UPHOLD to carry USAID's management responsibility.

In the original RFA, it was envisaged that a "sister" programme strengthening support systems would be awarded. UPHOLD and this systems programme were supposed to be complementary to each other, with the systems programme focusing on central and national levels. The systems programme was never awarded, for reasons that were not made clear to the evaluation team. As a result of this gap, UPHOLD needed to be more involved at the central level. Consequently, UPHOLD has faced a constant balancing act in trying to meet its district level commitments with trying to meet some of the demands of central level ministries and departments.

The programme was awarded as a cooperative agreement, which allows for flexibility in the deliverables. However, the actual implementation objectives were too open-ended and this resulted in too many activities being implemented (e.g. each of the specific components in health such as malaria and child health had a variety of different activities). As a result the programme had different deliverables in different geographical areas and was subsequently thin on the ground.

The programme design was highlighted by very specific and earmarked donor funding. This resulted in the overall strategic direction of the programme being dependent on the decision of the funding allocation by the donor (e.g. US$ 2.3million, equivalent to 3% of the total programme budget was allocated to reproductive health. Spread over 5 years and 20[2] districts this is equal to around US$ 23,000 per district per year; and is probably insufficient to have had a significant impact on overall reproductive health.) This funding affected the strategic decision making around the key implementation objectives and gave the programme management limited scope for maneuverability.

The programme was designed to be implemented in a structurally integrated manner. However, in practice it was difficult to implement in this manner. For example in the Ministry of Health, many of its HIV/AIDS programmes are managed in a vertical manner such as PMTCT. In addition a major component of UPHOLD, added at an advanced stage of the programme implementation, PIASCY, was designed as a national programme implemented country-wide in all districts, not only in the UPHOLD designated ones. Further evidence of the lack of an integrated programme is evidenced by the fact that this evaluation team has specifically had the education component excluded from the evaluation.

[2] Redistricting increased districts to 34

2.2 TECHNICAL COMPETENCY EVALUATION

How did the programme team's technical competency to undertake the planned activities contribute to the achievement of goals and results?

Assessment of the impact of the technical competency to undertake the planned activities on the achievement of the goals and results of UPHOLD was extremely difficult to evaluate. There were two main reasons for this. The first is that the staff composition has changed over the five years of the programme and the second is that the evaluation team generally had to rely on indirect assessments of technical competency.

The evaluation team found that UPHOLD in 2007 to be an organization with an extremely high work ethos with the key personnel clearly on top of their work. UPHOLD's organizational ability was very efficient and was exemplified by flawlessly organized field trips and presentation of documents for the evaluation team. UPHOLD was found to have impressive financial and administrative standards.

UPHOLD appeared to have a culture of sharing among staff and it also appeared to be an organization where staff learned on the job and it has a pro-active approach to staff development. UPHOLD generally seemed to have recruited a high caliber of skilled staff that have been competent to do the work expected of them. Over the lifetime of the programme the number of expatriates employed by UPHOLD has decreased from twelve to three.

In essence the staff of UPHOLD have appeared to have high technical competency and have been in control of the areas of work for which they have been responsible. However, there have been certain exceptions where the technical competence has not been as high as it could have been and this has influenced the activities. Examples of this have been in tuberculosis and at times in reproductive health.

Although UPHOLD has made use of the partners in the consortium, who have all contributed to the staff complement, it was reported that UPHOLD did not make optimal use of the available expertise in the consortium partners. A corollary to this is that generally the operational technical competency has been good and operational implementation carried out in a thorough and expert manner. However, insufficient attention was given to the strategic direction of the programme, and consortium partners were not adequately utilized to assist in this most important aspect of the programme.

2.3 CAPACITY BUILDING EVALUATION

"How did the programme's technical support and capacity building for districts and grantees contribute to the achievement of goals and results?"

As part of its overall implementation framework, UPHOLD adopted the grants strategy as a modality to achieve programme goals and objectives. In the programme start up period it became increasingly clear that LGs and CSOs grantees would require capacity building to shore up existing capacities and enhance achievement of results, especially considering the fact that resources channeled through both represented a significant proportion of UPHOLD grants. While capacity building inputs targeted assistance to all grantees, a significant proportion targeted CSOs specifically focusing on core technical competencies areas such as planning, budgeting, programme implementation (in technical areas), partnering (writing MoUs and mediation skills), reporting related to activities and finances, as well as monitoring and evaluation.

In the case of LGs, targeted capacity building efforts occurred at three levels. There was specific training that focused on imparting skills and knowledge to functionaries in technical areas to facilitate improvement in access to and use of services; there was on the job training, hands on support and other forms of focused training to familiarize financial and technical functionaries with activity and financial reporting templates; while the third level focused on training elected officials in the area of advocacy. The general assessment is that these capacity building efforts targeted at LGs may not have resulted in the magnitude of expected impact on implementation performance. However, the LGs that were interviewed did report that the capacity development efforts made some contribution to achievement.

In general, the evaluation reveals that the tailored capacity building efforts significantly improved core and technical competencies of CSOs. This was manifested in the documented and observed implementation performance. In respect of LGs, the achievements were more modest but there were noticeable improvements in respect of implementation performances.

While the rigorous RFA process would account for the CSO performance, it is worth noting that the tailored training delivered by UPHOLD also contributed significantly to this outcome. The results of a CSO follow up capacity exercise reveals that as far as core and technical capacities were concerned there was great improvement in planning, reasonable improvement in financial and technical reporting as well as M&E and partnership relationships. However, the evaluation also revealed that the least improvement was in the area of budgeting, which has proved to be a challenging area for all CSOs. The evaluation team found it difficult to find a linear link between improved capacity and improved results.

The only other issue with regard to capacity building was the extent to which it focused on achieving results. As a result of the focus on numbers, capacity development efforts were oriented to enhance capacities in that direction. As a result there were diminished efforts and resources placed on systems and institutional strengthening as a process.

2.4 EVALUATION OF EXTERNAL FACTORS

"How did external factors contribute to the achievement of goals and results?"

UPHOLD was essentially designed as a district based programme where there would be integrated capacity development in the three areas of health, education and HIV/AIDS. The programme was designed to be implemented in 20 districts and the selection of these districts was fundamental to UPHOLD initiating activities. However, for a number of reasons that are not clear to the evaluation team, the final selection of districts was delayed for a period of 6 months, from November 2002 until May 2003, when the districts were agreed upon by GOU and USAID. In effect, the delayed decision making around the selection of districts resulted in a loss of the essential implementation component by around 10% (6 months out of 5 years) of the total programme time.

There were a number of other issues related to the districts that had an adverse effect on the functioning of UPHOLD. Over time the number of districts has increased from 20 to 34, in a process known as "redistricting". Although the geographical area in which UPHOLD is working has remained the same, the number of LGs, CAOs, DDHSs and DHTs, with which UPHOLD has to interact have multiplied, resulting in increased work for UPHOLD staff especially the regional office teams.

The conflict areas in which UPHOLD has worked have changed over the lifetime of the programme. The intensity of the conflict has changed and the geographical areas in which the conflict has occurred have also changed. As a result of this UPHOLD has had to constantly adjust its work to take into account the impact of the conflict on the people and organizations in these areas.

Districts have been heavily reliant on the graduated tax for raising revenue to pay for aspects of service delivery in the districts. This tax was abolished leaving districts short of essential funding. As a result there was pressure on UPHOLD to use some of its resources to plug the gaps left by the abolition of the graduated tax.

In 2006 there were national and presidential elections. As a result of political activity there was a marked reduction in service delivery and activity throughout the districts. This reduced the ability of UPHOLD to function effectively for a period of around 2-3 months.

During the lifetime of the programme the funding climate of USAID changed radically with the introduction of PEPFAR and PMI. These presidential initiatives had far-reaching effects on UPHOLD in terms of narrowing the focus of the programme, prescribing the deliverables and influencing the monitoring and evaluation components of UPHOLD.

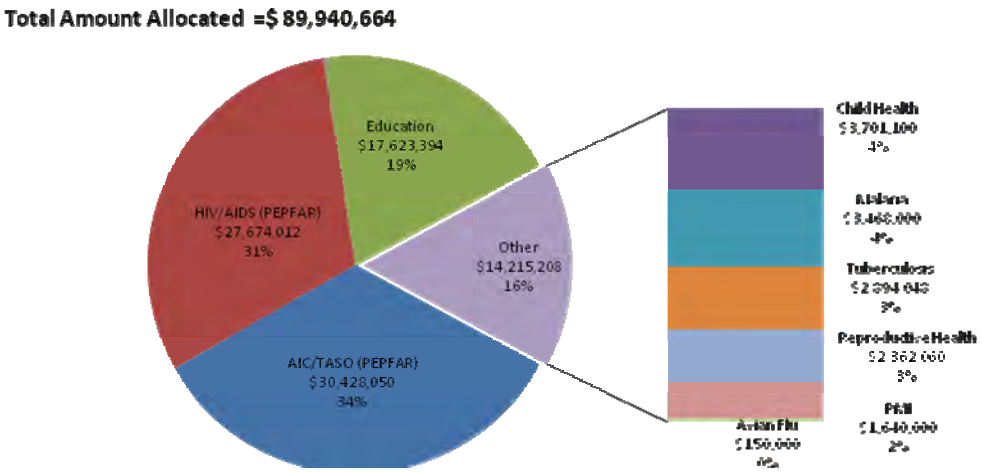
2.5 PERFORMANCE EVALUATION IN SPECIFIC INTERVENTIONS

To what extent has UPHOLD achieved its overall HIV/AIDS and health goals and results?

The USAID's Integrated Services Cooperative Agreement (ISCA) called for a careful crafted package of high-quality technical assistance, training and capacity building, as well as financial and material support to districts and non-governmental organizations.
Strategically focused to increase access, utilization, quality support and sustainability of services in Education, Health and HIV/AIDS through an integrated approach, UPHOLD works in six broad technical areas and which include 1) Child Health; (2) Adolescent Health (Youth Friendly Services); (3) Integrated Reproductive Health; (4) Communicable Disease Control (Malaria and TB); (5) HIV/AIDS and; (6) Primary School Education.

The overall effort was assessed through level of funding for the UPHOLD programme by area of intervention is shown in Figure 1. This table clearly indicates the main funding thrusts with education taking one fifth of the total budget; HIV central level grants to TASO and AIC, where UPHOLD was used as a conduit for funding with limited responsibility for the outcomes of the use of the funds, took one third; HIV/AIDS under the guise of PEPFAR used just over 30%; whilst all of the health related activities took up 16%.

Figure 1: Funding for UPHOLD by USAID by intervention area



In the health section it can be seen that malaria took the lion's share with 6% (including PMI) of the total and the remainder was thinly spread across the major areas of reproductive health, child health and tuberculosis with around 3% each. The funding flows had wide and far-reaching implications for the activities and results obtained in each of the specific areas of intervention.

There were a couple of general issues which impacted on all of UPHOLD's activities. One of the key issues was to develop UPHOLD's annual plans so that these simultaneously reflected UPHOLD's priorities as well as national and district priorities and consequently ensured stakeholder buy-in. This required much flexibility on UPHOLD's part and as a result much of the impact seen in UPHOLD districts was an accrual of efforts from many actors and is difficult to attribute to UPHOLD alone.

As mentioned in the section on design issues impacting on UPHOLD, with the systems programme not being funded, a number of health sector challenges had to be overcome.

These included a shortage of health workers, a lack of facilities, and inadequate supply of basic equipment and supplies. UPHOLD tried to address some of these issues in some of the districts by providing grants to the district local governments and CSOs to improve delivery of services in health units.

2.5.1 Child Health Interventions

UPHOLD's provided 4% of its budget to improve child health focusing on immunization and a less extent on support to community-based growth promotion (CBGP) as an entry point to integrated child health care.

A. Childhood Immunization

UPHOLD's child health component focussed on disease prevention through supplementing (1) Routine immunization, including strengthening delivery in hard to reach areas; (2) National Bi-annual Child Days; (3) Sub-National Immunization Days and (4) Mass Measles, Polio and Tetanus campaigns.

UPHOLD support included national level coordination and planning for the mass campaigns; training and follow up of service providers; technical assistance in programme design; planning, monitoring and evalution; funding for social mobilization; BCC and job aids to improve the functioning of health support personnel in districts where activities were carried out. UPHOLD's support to the EPI contributed to the following :

- Coverage of children between 12 and 23 months who received their 3rd dose of DPT by 12 months increased from 50.8% to 72.2% to 84% in 2004, 2005 and 2006 respectively, in UPHOLD districts.[3]
- Achieved more than 100% coverage during the 2006 mass measles campaign in targeted areas. The high percentage was because some children over the target age were provided immunization and vitamin A supplementation.
- Coverage of 2003 Mass Measles, Polio and Tetanus Campaign – achieved more than 98% coverage in UPHOLD districts.
- Coverage of Vitamin A supplementation for children 6 to 59 months reached 82% in 2006 Child Days Plus[4]

Since UPHOLD is only one of the many contributors to EPI, it is difficult to single out success areas and apportion these directly to UPHOLD.

Illustrative examples of BCC materials produced for Child Health.

- 'Health Worker Matter' newsletter on routine immunization with MOH (10,000 copies for 34 districts),
- Posters for Child Days,
- Radio spots on 10 stations, instructions and support,
- Mr. Immunizer poster in 6 languages and Mr. Immunizer sticker for children
- BCC support to SNIDS in North and North West – flyers, posters, radio spots, banners in 3 languages
- Radio programmes for Radio Listening Clubs on 10 stations in 9 languages produced and boadcast (35,000 active club members; topics included immunization, child feeding, fatherhood)

[3] LQAS 2004, 05 and 06
[4] Based on health facility data

B. Growth Promotion

Community-Based Growth Promotion was the principal strategy for promoting and contributing to integrated child health services at the local and household level. In line with the MoH Village Health Team (VHT) approach, UPHOLD trained and facilitated community volunteers to empower communities to take responsibility for their own health.

Through monthly village-level weighing sessions for young children, these volunteers identify children with sub-optimal feeding and care practices. These problems are then addressed through individual counseling to help mothers to improve on these and to re-establish or maintain adequate growth. The monthly weighing sessions are also an opportunity to address issues of immunization, antenatal care, childbirth practices, and other child and maternal health issues.

Since 2005, UPHOLD focused these efforts in 6 districts. These were chosen based on child health needs, the likelihood of sustainability due to district priorities and geographic location. Complete training and counseling materials as well as tools for record keeping and reporting have been developed and community volunteers have been trained to implement the strategy. Results of this intensive work and prototype materials are intended for adaptation and use throughout Uganda in conjunction with other activities to improve child health. Some of the selected results are shown below:

- 80 district and sub county level trainers and 1,225 Community Growth Promoters trained to cover on-going growth monitoring and promotion in 500 villages in 6 districts.
- 15,000 children attended the monthly village level growth promotion sessions for weighing and individual counseling.
- Discussions indicated a decline in missed immunization as a result of Community-Based Growth Promotion.

2.5.2 Integrated Reproductive Health

UPHOLD's primary interventions in IRH focus on maternal health, particularly GOANC and family planning. UPHOLD supported reproductive health interventions are primarily delivered through CSOs[5]. These organizations carry out advocacy activities and community mobilization for increased use of services, with some of them providing services as well. Additionally, UPHOLD supports the Uganda Private Midwives' Association (UPMA), whose members offer integrated reproductive services at their private clinics.

Availability of RH services

IRH activities were implemented in 14 UPHOLD-supported districts with varying approaches in response to local district priorities. These were mainly through strengthening existing RH service delivery points by training health workers in better logistics management for provision of commodities. UPHOLD supported the promotion of service utilization through BCC. By using CSOs, the hard to reach populations especially in conflict areas were reached.

[5] These include Rakai AIDS Information Network (RAIN), Rukungiri Women Development Company (RWODEC), Tooro Kingdom, Bushenyi Medical Centre, Straight Talk Foundation and Rural Health Concern (RUHECO).

Quality of RH service delivery

By engaging CSOs with expertise and experience in specific IRH areas, quality was maintained. Furthermore, UPHOLD assisted in the expansion of youth-friendly sexual and reproductive health programming and participated in the national policy dialogue about these issues with the MoH and with other partners. Training and education focused on increasing capacity in the health system, extending networks for better private care and supporting community reproductive health workers. Extensive community mobilization and advocacy were also important components. Of the 55 UPHOLD supported sites for PMTCT, health workers in 52 of the sites have received training in GOANC.

Utilization of RH services

Utilization of FP services has been high with over 300,000 women counseled on FP during their 1st ANC visit in 2006. ANC attendance exceeded the annual targets and was expected to surpass the end of programme target of 2,900,000 visits. Over 11,000 mama kits were procured and distributed to IDP camps in 5 conflict affected districts.

Coverage of RH services

GOANC training for service providers in UPHOLD districts played a part in improving the percentage of women who completed their 4th ANC visit to 53%, up from an original 48%. There has been a 28.8% increase in the number of women accessing clean and safe delivery kits in UPHOLD districts. The percentage of women receiving IPT1 and IPT2 during their last pregnancy has risen to 35.8% since 2005[6].

Impact

UPHOLD largely achieved its stated targets in the districts were IRH was implemented. In FP over 265,000 couple years of protection were reached. In the last two years the percentage of women who have delivered at a health unit has risen to 50% in UPHOLD districts, up from 41% in 2004. In UPHOLD districts 20.5% of women aged 15-49 use modern methods of contraception.

Issues

Though ANC attendance of at least four times in UPHOLD supported districts may be higher than the national average the coverage remains low at 53%. The uptake of IPT2 is still low.

The IRH intervention was thinly spread across the UPHOLD districts and the resources made available were insufficient to achieve meaningful changes in reproductive health.

2.5.3 Malaria

Malaria activities were allocated 6% of the total programme resources made available by USAID. Malaria interventions were strengthened in FY2005/6 when UPHOLD was tasked by USAID, under the PMI, to focus on selected interventions[7] in specific districts. Prior to this, resources were provided to districts across many activity areas and while results were realized, the scale and depth of these was mainly seen in the training of CMDs. Consequently, most of the malaria intervention impact is seen after FY2005/6.

Eight of the twenty districts supported by UPHOLD were in areas where conflict and insecurity presented significant challenges to the implementation of core interventions. Two of the districts, Kitgum and Gulu, had major population displacements with over 600,000 IDPs, comprising 80% and 45% of their populations respectively. UPHOLD's approach to

[6] LQAS 2006.

[7] Distribution of ITNs, net re-treatment, supporting home-based management of fever and increasing utilization of intermittent preventive treatment of malaria in pregnancy.

these districts was adaptive and flexible with a sharing of effort with other humanitarian community stakeholders including USAID and other USAID-funded partners.

Modifications made to UPHOLD from the start of PMI included procurement and distribution of 260,000 long lasting ITNs in four districts with IDP Camps, and in five non-conflict districts which on the basis of LQAS surveys had the lowest bed net coverage.

UPHOLD continued its intensive support to the HBMF strategy and purchased new Homapak®[8] stocks, and also used existing MoH stocks of Homapak®, throughout the life of the programme even though the government's malaria treatment policy at facility level changed to ACT.

A. Home Based Management of Fever

The HBMF component targeted 4,949,795 children below 5 years of age. Implementation was through the existing HBMF structures and geared to support district efforts within the parameters of the national malaria control strategic plan of 2005/10.

HBMF Service delivery

HBMF interventions were initially started in 14 districts in 2003 and were later expanded to all UPHOLD districts by the end of 2004. During FY2006/7 UPHOLD was still training CMDs to cover the gaps created by attrition. At the same time UPHOLD was still supporting the existing CMDs.

The programme had a target of ensuring increased accessibility to services at the community level by having two trained CMDs in each of the 19,203 villages which covered most of the UPHOLD supported districts. By training 25,570 CMDs out of the targeted 38,406, the programme reached two thirds of its stated target. This is approximately equivalent to 1 CMDs per 130 children under 5, though it was much higher in the designated districts. These CMDs served as community based outlets for malaria treatment and they also were a source of prevention against malaria messages. The CMDs provided an additional resource to the alleviation of malaria and supported the work of other facility based health providers.

Quality of HMBF Services

The programme improved the quality of malaria services. This was achieved especially through supporting the sharing of experiences at quarterly CMDs meetings, provision of logistics such as bags and, supporting the integration of CMDs reports into the routine district reporting systems. Use of registers by CMDs increased from 60% in 2003 to 71% in 2006.

One of the reasons for failing to increase the use of registers further is attributed to the weakness in supervision of CMDs by facility staff and the appropriate use of CMDs information contained in the registers. Discussions also revealed that, in some cases, parallel systems for distributing medicines to CMDs by UPHOLD still persisted and is indicative of low integration of the CMDs into the community and facility management systems.

UPHOLD did however attempt to improve the data management and utilization in all the health units in the districts by training health workers on the HMIS, incorporating the record-keeping by the CMDs as well as information on Intermittent Preventive Treatment (IPT). As evidenced by their reporting and programme records, on average, 71% of the CMDs are active.

[8] HOMAPAK is an antimalarial tablet formulation for children under 5 years combining Chloroquine and Sulphadoxine/Pyremethamine (CQ/SP)

UPHOLD was also involved in more sophisticated training around malaria and was involved in the training of 62% of facility workers in management of severe and complicated malaria to support referred cases.

Utilization of HBMF Services

Though use of home treatment declined nationally from 13% in 2002/3 to 2.4% in 2005/6, UPHOLD supported districts showed a doubling in the use of Homapak® from 8% in 2005 to 16% in 2006[9]. Particular efforts were made to obtain emergency supplies, especially when the national medicine supply system failed. The percentage of households reporting that they had ever used Homapak® (or other home based treatment package) was 26% in 2006.

Available records indicate that over 2.5 million episodes of fever in children under five were treated by the trained CMDs in the 29 districts. Sixty five per cent of the children with fever were treated within 24 hours with 92% recovering on Homapak® treatment alone without needing referral.

Coverage of HBMF Services

The programme managed to reach most of the ill children. The target was to increase the proportion of children under five years old who get appropriate anti-malarial treatment within 24 hours of onset of fever from 40% to 45% in 2005 and by 2006 the programme had reached a coverage target of 77%[10].

Impact of HBMF services

It is estimated that by end of 2006, in UPHOLD districts around 92% of children with malaria recovered without requiring referral to next level. The 2004/05 HBMF results show that 94% of the almost 1.6 million children who utilized community medicine distributor services fully recovered. A review of the community based LQAS surveys shows that in 2006, 77% of children with fever received recommended treatment compared to 31% in 2004.

There were a number of contributing factors in programme design to achievements in the HMBF interventions. Working at community level ensured that existing systems of CMDs were used. These included building capacity among the facility health workers to train and support the CMDs, supporting the CMDs quarterly review meetings with transport allowances, supporting the integration of CMDs reports into the district reporting system on malaria and, promoting the utilization of CMDs through messages in the media.

There was a high attrition rate among CMDs. After national training, UPHOLD had to fill a gap of 62% to restore coverage to 2 CMDs per district. Based on reporting only 49% of those trained reported back on their activities by end of PY3 but this increased steadily from 67% in PY4 to 71% in PY5 to program efforts. More study is needed to look at those factors that reduce attrition of community volunteers

However, reliance on UPHOLD programme funding for meetings undermines their sustainability. Support provided by UPHOLD for review meetings of CMDs, including support supervision and refresher training, will only continue into part of FY07/08 when these allowances will be stopped with the programme winding down its activities. To ensure the continuity of CMDs will require extra resources and is dependent upon funding from external donors such as the Global Fund and PMI.

Systems for support supervision of health workers, delivery of medicines to different levels in the district and data retrieval especially at community level remained weak. This is increasingly vulnerable with the roll-out of the new malaria treatment policy.

[9] Based on LQAS 2006 results.
[10] Based on LQAS results.

Little support was given to the CMDs by the private for profit providers despite their training in malaria case management. (This was seen especially in Mbarara)

A number of external factors hindered achievements in this technical area. These included lack of CSOs working in the area of malaria lead to few implementing partners, with little implementation of HBM through CSOs; irregular and delayed distribution of Homapak through the NMS system, parallel activities with other partners in the north, especially the Malaria Consortium and UNICEF and poor linkages developed through district and sector working groups.

B. Intermittent Preventive Treatment

UPHOLD supported an increase in IPT uptake especially under the PMI. Training in GOANC was the main vehicle of support between 2003 and 2005. Under PMI, the focus is on whole site support supervision of health workers to improve service delivery including communication to clients and BCC activities, including job aides and radio media articles developed with Health Communications Partners.

ANC Service delivery

In an attempt to promote ANC services UPHOLD supported training of 168 health workers in GOANC covering IPT as well as PMTCT. Under PMI, focused whole site supervision was also carried out to 236 health workers in 79 health facilities in 17 districts.

IPT uptake tracked over time shows that targets were met up to FY 2004/05 when IPT coverage was 65% but show a decline in FY 2005/06, where there was coverage of 36%. This latter figure is similar to the national figures of 34% obtained in HSSP II. The peak coverage in 2004/5 is probably due to the fact that this is when initial activities were at their highest level.

Quality

Activities included improving service delivery quality by building skills and improving performance using on the job training and on-site support supervision. Technical assistance for promoting IPT within the GOANC involved orientation of 43 mentors from 12 districts each to supervise 3-5 facilities to provide on-site support. There was additional training of 31 facility managers who supervise health workers and promote outreach visits.

The introduction of the Performance Improvement Approach (PIA) via supervision showed that service quality continued to be dogged by inadequate and irregular supplies of IPT drugs, poor record keeping, poor organization of work flow in the facilities to support IPT and limited skill among health workers. This latter is likely to have resulted in suboptimal impact of BCC activities. However, the 2006 LQAS shows that 72% of households reported hearing at least 1 IEC radio message on malaria prevention in the 12 months preceding the interview.

Impact

The impact of IPT intervention is expected to be low. This is partly due to low utilization of ANC and compounded by the low proportion of facilities providing IPT, by 2006.

Challenges and way forward

The continuing challenge is to increase early ANC attendance, which remains low. Just over a half (53%) of women attended ANC at least 4 times.[11] There is a need to promote the quality of ANC further by ensuring that health workers offer the full range of antenatal services, including IPT, to clients.

[11] LQAS 2006

Supervision tools have been developed and much information is collected. However, supervision needs to be more widely practiced. There has been some resistance to the implementation of supervision. Approaches that promote provider change should be studied more and documented.

UPHOLD later shifted to concentrate on GOANC with more emphasis on the context of PMTCT than IPT. However, systemic problems that have limited the availability of PMTCT services to all ANC clients certainly affect the IPT uptake as well.

C. Support National Malaria Treatment Policy

UPHOLD supported the MoH, the NMCP and districts to strengthen the implementation of the new malaria treatment policy of the Artemisinin-based combination therapy through two rounds of on-site support supervision of health workers in the 34 UPHOLD supported districts Results show that ACT was prescribed in only 41% of cases of malaria despite the fact that over 90% of health workers had been oriented and given the new policy guidelines on management of uncomplicated malaria.

Over 80% of the health workers in the UPHOLD supported districts had adequate skills in malaria case management. However over 70% of these health workers were not communicating effectively with patients regarding malaria and its treatment. Other problems included stock outs of ACT in 27% of the supervised facilities.

It is difficult to make an assessment of the impact when many health workers are not being adequately trained and supervised. In addition, despite the change in policy at facility level to ACT, the policy at community level (with the exception of the conflict districts of Gulu, Kitgum and Amuru) has not changed and CMDs are still using Homapak for treatment of uncomplicated malaria in the rest of the country.

D. Insecticide Treated Nets

The re-treatment of ITNs increased over the duration of the programme. The start of the PMI grant stretched the ITN distribution coverage in the northern districts beyond the UPHOLD designated districts in 2006, but in view of the real need in these areas this was seen as an important and necessary deviation from the initial UPHOLD targets.

ITN Availability

UPHOLD procured and distributed over 311,000 ITNs and thus met the targets for making ITNs available. As a jump start to the PMI activities, 260,000 long lasting insecticide treated nets (LLINs), secured with PMI funding, were distributed and these formed the bulk of the nets distributed. Most of this was in 2006 when there was a 10-fold increase in the volume of ITNs distributed. This distribution was largely supplementary to ITNs provided by other partners, especially the Malaria Consortium. UPHOLD also supported re-treatment of 144,615 bed-nets in six UPHOLD districts in 2004, 144,869 in 2005 and 505,573 in 27 PMI supported districts (including 12 in UPHOLD) in 2006. Overall number of ITNs procured and nets retreated met targets.

Accessibility

The accessibility for each designated target group was improved through specific delivery channels. Before the introduction of PMI, relatively few ITNs were distributed to pregnant women through facility-based ANC clinics. This occurred in only 3 districts. People living with HIV/AIDS (PLWA) were reached through post-test clubs and psychosocial support groups formed under HCT and PMTCT interventions.

The nets obtained with PMI funding were ably distributed through using 5,768 CMDs as end-point distributors of LLINs for the nine earmarked districts. These included the 5 districts where usage of bed nets in 2004 was shown by LQAS to be below 10%, and 4 districts in conflict situations (viz Gulu, Katakwi, Kitgum and Lira).

The distribution of ITNs through the CMDs was unique and proved effective in quantifying and identifying needy households. Subsequent surveys later found that there was a 95% net retention in households with beneficiary children, more than six months after the net distribution.

Utilization

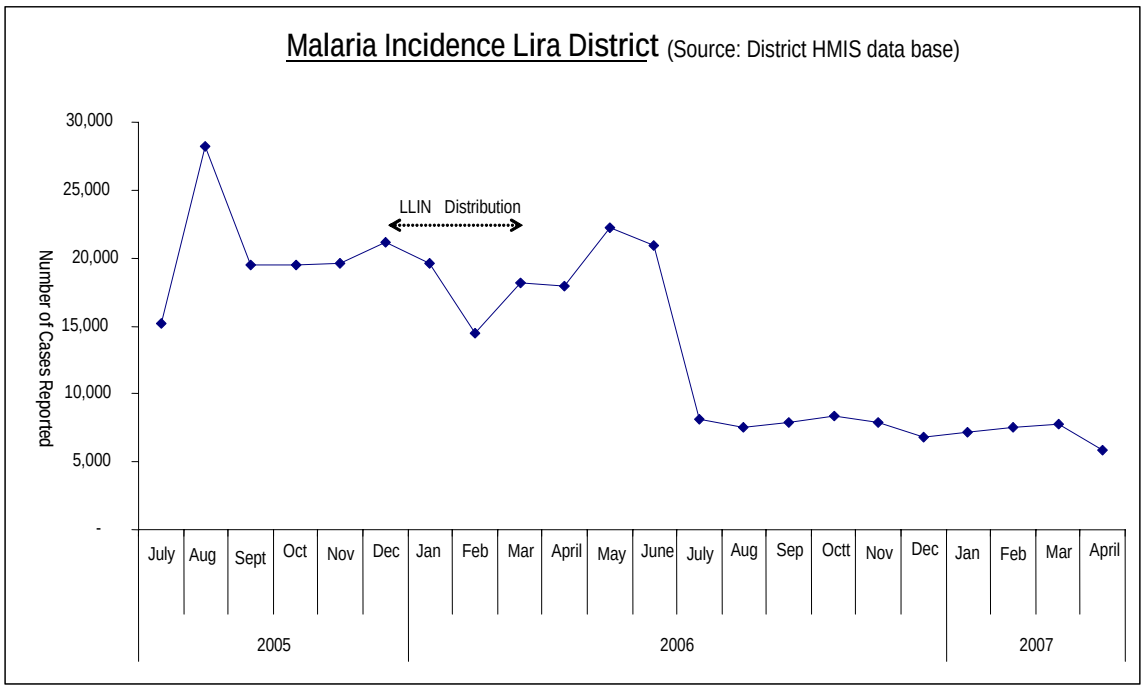
ITNs were distributed to the project target groups children below five years (243,1882 through CSOs in 2005; 224,183 in 2006); 25,612 pregnant women; 25,690 people affected by HIV/AIDS and 200 orphans and vulnerable children. A follow on study in the nine districts, six months after the net distribution, showed that 87% of children below five years slept under an insecticide treated net (ITN) the night before the study.

Impact

The percentage of children under five years who slept under a treated net the night before the LQAS surveys increased from 11.7% in 2004 to 17.2% in 2005. The national level[12] shows an increase in the under 5 population falling sick from malaria from 43% in 2002/03 to 56% in 2005. This contrasts with the reduction in under 5 malaria prevalence in the UPHOLD supported districts in the last 2 weeks preceding the survey from 56% in 2004 to 44% in 2006 (LQAS). This might be attributed to the increased availability of preventive services; in particular the ITNs distributed in the 9 districts identified as high risk.

An illustrative example is given for Lira district where UPHOLD supplemented on malaria control activities. Data from the district HMIS shows a marked drop in malaria cases though this could have been also influenced by disbandment of the IDP settlements among other factors. Since the figures show a huge drop in prevalence, there is need for further investigation by the project.

Figure 2: Incidence of Malaria in Lira District



[12] UNHS 2005/6 figures

2.5.4 Tuberculosis Prevention and Control

TB is a growing problem with at least 50% of those adults with active TB co-infected with HIV. The detection rate of new smear positive cases (53%) and treatment success were low (60%) at the start of interventions[13]. This was attributed mainly to limited recording and reporting, poor compliance to DOTS, poor access to health care services, insufficient number of skilled staff, inadequate diagnostic facilities and weak record keeping and reporting systems.

Availability

UPHOLD's response to the TB problem was to improve the quality of CB TB DOTS services through supporting refresher trainings on TB diagnosis and management for health workers and laboratory personnel and facilitation of supervisory activities. Originally implementation was focused in the 8 UPHOLD districts that did not overlap with the AIM Programme. However, after the AIM Programme ended in June 2006, TB activities were extended to the former AIM supported districts as well. Facility-based TB services supported UPHOLD's integrated HIV/AIDS /TB/STI/Malaria supportive supervision initiative that covered 61 health facilities and 325 service providers. In some districts where this was done, marked improvements were observed as early as 2004 (e.g. CBDOTS coverage was high in Rukungiri (87%) and Rakai (99%) districts.

Quality

Up to fairly recently, UPHOLD did little to improve facility based TB service provision. Although the reason for the lack of support stated by UPHOLD was that health facilities were being supported by other partners, this support was present in only 32% of the health facilities that subsequently received technical support from UPHOLD for provision of TB services.

Impact

The case detection rate, for districts whose reports were available, (measured by the case notifications) has remained lower than targeted. Only a cumulative total of 671 PLHAs were provided with treatment for HIV and TB up to 2006. The results show that community involvement in HIV and TB prevention and care through training of health workers and volunteers in the provision of community based directly observed tuberculosis treatment (CB-DOTS) has improved TB treatment success rate. This has been seen especially in some districts like Rakai (88%) which are above the national target of 85%.

However, the achievement in respect of the TB detection rates however remained lower than the targets set, with an increasing gap every year. Plans in 2006/7 to reach 13,000 health workers with support supervision and expand CB TB DOTS in 34 districts may not improve detection rates up to the targeted levels within the lifespan of the programme.

Issues

The late start was attributed to low prioritization of TB programmes by districts. This resulted in few requests for support by districts around TB and consequently there was minimal activity around TB. This prioritization changed after a stakeholders meeting was held. However, the expansion of the TB activities only took place in October 2006, close to the UPHOLD project to wind up time.

Local governments did not prioritize UPHOLD support in TB, mainly because earlier there were multiple programmes and partners supporting TB interventions. Recently this

[13] UPHOLD annual Report 2004

number has decreased in UPHOLD supported districts and requests for support by LG have increased. At this late stage, however, activities are not being rolled out intensively and additional funding is scarce.

It is not clear how this revamping, including making local government and CSO grants, and facilitating training via zonal NTLP programme staff support through the UPHOLD Regional Offices to the local governments will affect performance. Current monitoring data shows that case notification rates remain low.

Nevertheless efforts have concentrated on training of health facility supervisors and workers, facilitating support supervision activities that strengthened links from the district to the community (in only 6 districts) and provision of 10,000 copies of the Health Workers Matter newsletter on TB in the 34 districts.

2.5.5 HIV/AIDS

The HIV/AIDS interventions included HIV/AIDS Counselling and Testing (HCT), Prevention of Mother to Child Transmission (PMTCT), General Palliative Care, integrated HIV/TB Services, Abstinence and Faithfulness, Other Prevention and Orphans and Vulnerable Children (OVC). It was feasible to evaluate a few of these as agreed during the inception report discussions.

A. PIASCY

President Museveni's Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) was a unique component of the UPHOLD response to PEPFAR and has effectively been implemented in all primary schools throughout Uganda and not just in UPHOLD districts. The activity has been in existence since 2004 with training of 3 teachers in each of the 15,000 government aided primary schools.

Coverage

PIASCY I, implemented in 2004, facilitated the orientation of 45,000 primary school teachers nationwide, over a six month intensive period, on the delivery of the PIASCY programme. PIASCY II strategy is through school-based interventions focusing on the adoption of behavior change among pupils and the practice of supportive behaviors by teachers and peers. The comprehensive PIASCY II has been in existence for less than 1 year and as a result the implementation experience is limited and an evaluation of outcomes is therefore difficult.

PIASCY II was designed as a set of comprehensive and holistic activities at the school and household level to build on PIASCY I. It is an integral part of School Health and Nutrition programming.

The approach was to reach all schools through targeting the centralized system of teachers training colleges, under the MoES. A selected number of schools were targeted for an intensive pupil-centered training intervention, so-called "model schools". So far, 1,078 primary schools, representing approximately 2 schools in each of the 570 coordinating centers, have been reached. It is intended that these schools act as sites of excellence and mentor the surrounding schools, but the effect of this intervention has not yet been tested.

These activities included classroom support through radio programming for teachers; children's clubs activities to support life skills and critical thinking about gender and violence; school and community activities to protect girls from defilement; and home support by promoting parent and child communication about delaying and abstaining from sex.

Utilization

The percent of primary school children, aged 6-12, who regularly attended school, including all five days preceding the LQAS surveys, increased from 76.9% in 2004 to 82.2% in 2006. This offers a large potential to reach many young people with messages of abstinence.

Quality

PIASCY is a government programme supported by UPHOLD. Though UPHOLD supported the implementation of the programme, PIASCY largely remains a vertical MoES activity with little control at district local government level. It is envisaged that once training has extended to cover most primary schools, efforts will be made to transform it into a district managed activity.

Supervision and monitoring are still weak with almost all the indicators generated in the PIASCY proposal not being used.

Impact

Education impact is slow and little data are available to offer trends. However, qualitative information shows that enthusiasm has been built. A number of positive stories qualify improvement in school environments, and abilities of teachers, parents and pupils.

It was difficult for the evaluation team to use the LQAS results because at the time the survey was done, all schools were engaged in Performing Arts Festivals and this may have been responsible for the high rates found.

> "*I was surprised that all teachers had gone for HCT*"
> MoES Official
>
> "*We no longer have school drop outs and absenteeism by girls ever since we started this PIASCY programme last year*"
> Headmistress Model School Lira District

Issues

At this early implementation stage, many operational problems are expected to occur. For example, it has been realized that schools lacked trained HIV/AIDS counselor teachers to provide effective counseling services to pupils infected and affected by HIV/AIDS. This will require closer collaboration with specially trained HIV/AIDS counselors for the age group.

New programmes tend to add a burden of work to already over stretched staff. PIASCY has greatly increased the burden of recording and technical reporting on PIASCY school based activities. Many schools have allocated teachers to positions of focal point persons in implementing primary schools.

Through dialogue, resistance initially posed by religious leaders and cultural biases are being tackled. This is being done especially through the community participation components in the school programmes.

To facilitate continuity and integration of PIASCY, supervision should be integrated within the district, municipality and sub-county school inspectorate system. Efforts should be made to embrace private schools within the PIASCY reach.

PIASCY has not been integrated within the district education school program. The large effort applied in getting and harnessing the support from parents and teachers and the 7 day training of all teachers in the country will require enormous resources.

The District Education Departments were found weak in conceptualizing PIASCY objectives and planned activities[14]. More effort was needed in supporting them, especially in rolling out PIASCY as a district activity.

Though indicators were drawn, there is no baseline information for several PIASCY indicators.

Implementation of PIASCY is vertical with little connection to other UPHOLD activities. It was felt that UPHOLD districts were not performing any better, in relation to PIASCY, than other districts.

B. Abstinence Being Faithful and other HIV prevention

UPHOLD supports awareness and encourages positive behavior change through abstinence and faithfulness as a means to HIV prevention.

Other activities targeted the use of condoms in the most at risk populations. These include commercial sex workers, long distance truck drivers, urban motorcycle riders (commonly referred to as 'boda boda' riders), discordant couples, fishermen and the communities living at the landing sites, IDPs and other mobile populations.

Coverage

Half (17 out of the 34) of the UPHOLD supported districts implemented AB and other prevention activities. Activities in the former AIM supported districts are expected to commence in 2007.

The targeted number of youths and adults for abstinence and be-faithful messages was reached by end of 2006. Similarly, targets for reaching school going children were met. The multiple message channels used managed to reach the 1,078 model schools. Activities have also reached a few non-model schools and together, have managed to establish the conspicuous school abstinence clubs and "talking compounds".

Use of CSOs (e.g. TUKO) has improved the reach of abstinence, be-faithful and gender based violence reduction messages to out-of-school youth, couples and the general community. Increased coverage was also obtained through the use of the national CSOs viz AIC and TASO. Over 50 local music, dance and drama troupes were mobilized by CSO grantees to propagate messages on abstinence and mutual faithfulness in communities. The abstinence script entitled *The Clever Dancer,* was developed by UPHOLD, and adapted to local contexts. Other methods included using community based opinion leaders to increase and facilitate discussions on key HIV prevention behaviors.

Impact

After performances, the troupes engaged their audiences in interactive dialogues on the topic of abstinence and innovative solutions were arrived at. Abstinence commitment cards were also another innovation promoted by CSOs for youth who wished to make commitment.

C. HIV Counseling and Testing

HCT is one of the most important HIV preventive activities and is an entry point into HIV care. UPHOLD worked in partnership with thirteen districts, Local Governments and CSOs to provide HCT services. The UPHOLD HCT strategy aimed at creating demand,

[14] Annual report 2003 pp 12

increasing availability and improving the quality of HCT services. Particular emphasis was placed on serving populations vulnerable to infection, such as TB-infected individuals and persons with STIs, adolescents, internally displaced persons, pregnant women and their partners, couples, as well as people identified by districts and CSOs as engaging in high risk behaviors. UPHOLD targeted to increase HCT delivery sites from 32 to 500, train 300 service providers and reach 71,600 clients with HIV counseling, testing and results within the programme period.

Service Delivery

UPHOLD started operating in Uganda at the point where HIV Counseling services were provided at voluntary basis, via Voluntary Counseling and Testing (VCT). Both the coverage and utilization of services were very low. UPHOLD worked within the framework and policies of the MOH, supporting where gaps existed that may have impacted on district health service delivery. UPHOLD, for example, supported the MoH to review the HCT National Policy guidelines, and the HCT counselor training manual.

UPHOLD supported 13 districts to provide HCT services and by 2006 there were a total of 683 sites providing the service. The HCT package included pre-test counseling and information giving, HIV testing, giving results, post-test counseling and follow–up support. Follow up support includes counseling on positive living, linkage to basic HIV care which includes Cotrimoxazole for prophylaxis, referral for antiretroviral therapy and psychosocial support. Clients are supported to form or join post-test clubs for peer psychosocial support. Post–test clubs members also participate in community sensitization and counseling on HCT.

However, 88.9% (607/683) of these are outreach centers where a team of counselors and a laboratory person are sent out to provide services to lower level health facilities without staff or infrastructure to provide static services. Such activities are heavily dependent on the availability of funds to pay for fuel and allowances for the outreach team. Although the Health Sector Strategic Plan II recommends provision of static HCT services at Health Centre III level, only 35% of the HC IIIs in UPHOLD HCT geographical area are providing static services.

Quality of services

To ensure provision of quality HCT services, training was conducted for service providers in public and private health facilities on counseling, HIV testing, and logistics and data management. A total of 887 health workers were trained and service outlets increased from 32 in 2004 to 683 in 2006.

Health facilities and CSOs were supported in accessing HIV test kits from NMS and provided with HIV test kits in times of shortage. Regular support supervision was provided to CSOs and health facilities in collaboration with the LGs and MoH.

Utilization

UPHOLD supported districts in the development and dissemination of key messages on the benefits of HCT through a variety of communication channels including drama and radio talk shows which helped to create awareness and demand for HCT services. UPHOLD supported the formation and functioning of 1700 radio listening clubs reaching about 11 million people. Behavior change communication addressed stigma, gender based violence and other factors that hinder uptake of HCT services. Community Owned Resource persons (CORPS) trained on HCT and members of the post test clubs participated in these and other HCT community initiatives. This facilitated informal and formal dialogue at community level. From 2004 to 2006, a cumulative total of 228,475 clients had HCT and received results through UPHOLD support exceeding the 2007 target

of 150,000. Most of the clients were reached through community mobilization and provision of outreach HCT services by CSOs.

Challenges

- Human resource and infrastructure challenges greatly affected access to and quality of HCT services. High client to service provider ratios made it difficult to provide HIV testing and same day results especially during outreaches where there was good turn up in response to community mobilization. In response to infrastructure limitations, UPHOLD supported the renovation of health facilities to create counseling rooms and laboratory space.
- Another challenge included frequent stock out of HIV test kits resulting partly from stock-outs at national level, delayed or non reporting on part of the health facilities districts, or shortfall in the distribution system of the NMS.
- HIV related stigma is still prevalent particularly in Nakapiripirit district in Karamoja sub-region.
- Some areas are very inaccessible, especially in parts of the conflict districts.
- There is also limited access to HIV care and treatment services partly due to low coverage of ART.
- The procurement and distribution system for free medical supplies e.g. HIV test kits does not adequately cater for CSOs. The CBOs rely on the neighboring health facilities or the districts for these supplies. This has implications on reporting of consumption data and therefore re-supply of commodities to health facilities.

Impact

There has been a progressive increase in access to HCT services. Based on the annual LQAS, the proportion of adults aged 15 years and above who know their results has increased from 16% in 2004 to 28% in 2006.

Sustainability

Most of the HCT service outlets were outreaches whose operations are dependent on availability of funds.

D. Prevention of Mother to Child HIV transmission (PMTCT)

UPHOLD works in partnership with local governments and CSOs in 18 districts to increase access and utilization of PMTCT. Efforts are geared towards working in line with the MoH guidelines to support hospitals and health centers in the private and public sectors and CBOs. According to the national guidelines, the PMTCT package includes the provision of proper antenatal care, counseling and testing for pregnant women, use of antiretroviral drugs to prevent transmission of HIV, safe delivery practices, counseling and support for safe infant feeding practices, and counseling and support for future family planning practices and follow up for the mother and baby. The revised PMTCT guidelines[15] indicate a shift from single dose Nevirapine to combined ARVs for PMTCT, provision of routine HIV testing as opposed to voluntary testing and early diagnosis of HIV among infants among other changes.

Service delivery

Working through the public and private sector, UPHOLD has supported the scale up and provision of PMTCT to 55 service outlets in supported districts. Health workers in these service outlets have been trained on integration of PMTCT in GOANC, HIV counseling and rapid HIV testing. A total of 17 family support groups were formed and facilitated to provide peer psychosocial support, promote adherence to PMTCT and linkage to basic HIV care and ART when needed.

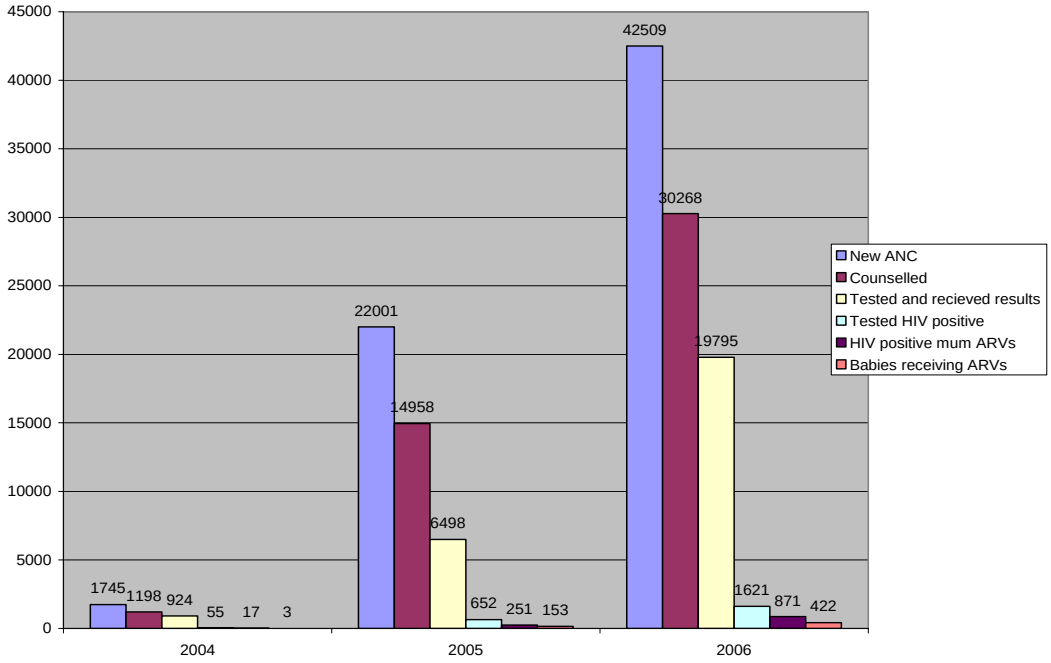
[15] Policy Guidelines for Prevention of Mother to Child HIV Transmission, August 2006

Quality

UPHOLD provide technical and financial support to improve the quality of PMTCT services. This included training and supervision of service providers, renovation of facilities to create suitable counseling rooms, waiting areas for ANC clients and laboratory rooms, community mobilization, sensitization and addressing gender based violence related to PMTCT in order to increase service uptake.

UPHOLD supported the MoH to launch the revised PMTCT policy which emphasizes provision of comprehensive family centered HIV care and use of combined ARV regimens for PMTCT, follow up of mother-baby pairs and infant testing. In this spirit, support is provided to HIV positive mother networks and CBOs to follow up mothers, identify HIV exposed children and link infected mothers and children to ART. A good example was seen in Gulu where CBOs work together with health facility staff to identify and follow up HIV exposed children and link them to JCRC for infant HIV testing. Malaria prevention is a key intervention in GOANC and basic HIV care. A total of 4,690 LLINs were distributed to members of the FSG as one of the measures for prevention of malaria during pregnancy in addition to IPT routinely provided in ANC.

Figure 2: Cascade of clients - PMTCT services in UPHOLD supported districts.



Although the number of clients utilizing PMTCT services is increasing progressively, the cascade shows a high drop out at every level. This is clear evidence of missed opportunities.

In 2006, 47% (19,795/42,509) of clients accessing PMTCT sites were tested and 53% (871/1,621) of diagnosed HIV positive pregnant women received ARVs for PMTCT; an increase from 30% (6498/22001) and 38% (251/652) of the same indicators in 2005. Although this is a massive improvement it is still far below the national average of 61% (244,956/402,125) testing rate for clients accessing PMTCT sites and 64% (12,353/19,509) ARV uptake for HIV positive mothers in 2005[16].

Utilization

UPHOLD has been instrumental in creating an awareness of and demand for PMTCT services. Community education programmes have been conducted to create awareness of

[16] MoH: Programmeme for prevention of Mother to Child Transmission of HIV, 2005 annual report

PMTCT, its benefits and the roles of the community and family members. Family support groups of HIV positive clients and their spouses have been formed, trained and supported to provide education on PMTCT at health facilities and conduct community mobilization.

CBOs have been supported to conduct health education and engage communities in dialogue on PMTCT and male involvement. A good example was given in World Vision, Gulu where regular dialogues are held on PMTCT in the camps and the FSG formed has many male spouses participating in the group. Activities are ongoing in the community to address gender based violence and promote male involvement. These are two of the key factors identified that affect PMTCT uptake.

Knowledge of MTCT has improved and 91% of respondents (LQAS 2006) know that it is possible to transmit HIV from the mother to the baby and 42% know all the three modes of MTCT.

Knowledge of personal HIV sero-status is an entry point into care. The proportion of mothers who have been tested for HIV and received results during pregnancy has increased over time from 11% in 2004 to 26% in 2006. This shows a similar trend as that of the national average of 34.5% of pregnant women who were tested in 2006[17].

Cumulatively 27,217 pregnant women have received HIV testing against a target of 41,900 and 1,139 HIV positive women received ARVs for PMTCT against a target of 6,950. Although the targets have not been cumulatively reached in the 3rd year, 2006, the performance was markedly improved.

Contributors to achievements

The increase in PMTCT sites from 9 in 2004 to 55 in 2006 has led to increased access and utilization of PMTCT services. Other contributing factors include community mobilization; the gender based violence prevention campaigns and increased access to ARVs in the country generally.

Challenges

- Low level of scale up of PMTCT services
- PMTCT service delivery is greatly affected by general health system challenges of lack of adequate human resources, infrastructure and other factors that affect health facility delivery rates.
- Other contributing factors include a low male involvement in PMTCT; stigma and lack of community support for HIV positive clients.
- Frequent stock outs of HIV test kits and Nevirapine at national level compounded with poor data and logistics management and reporting contribute to irregular provision of services.

Sustainability

Integration of PMTCT into GOANC through capacity building for health workers and use of existing health facilities will contribute to sustainability of services.

In summary, UPHOLD contributed significantly to increase the access to and utilization of PMTCT services. Although some targets set were not achieved, the strategy of integration of PMTCT into GOANC is evidence based, can be replicated and contributes to sustainability

[17] UACP 2006

E. Palliative care

Service delivery

Palliative care aims to provide comprehensive care and support services to PLHA. UPHOLD provides financial and technical support to both public and private health facilities to strengthen the delivery of comprehensive and integrated clinical services so that health facilities become a one stop centre for holistic HIV care. The package of palliative care includes clinical services for management of malaria, STIs and TB, pediatric AIDS management; and provision of Cotrimoxazole prophylaxis.

Other support includes psychosocial, spiritual and terminal care. Although provision of antiretroviral therapy forms part of the package in other programmes, it was outside UPHOLD's scope of work. Partnering with 13 local governments and 8 CSOs, UPHOLD supported these organizations to provide general palliative care services. By the end of 2006 a total of 42 sites were providing palliative services.

A family approach to delivery of palliative care services was promoted. Community based structures including post-test clubs, psychosocial support groups for HIV+ mothers and spouses. Religious leaders, faith-based organizations and volunteers were supported and utilized in carrying out community mobilization and in the delivery of care and referral services. The links between the health units and community support groups were also strengthened to ensure effective referral and follow up for PLHA.

Quality

UPHOLD undertook activities to improve quality of palliative care service provision at community, health facility and MoH level. UPHOLD supported the MoH in development and dissemination of "*Guidelines for Providing Home Based Care"* and *training* health workers in management of opportunistic infections. A total of 509 health workers were trained against a target of 222. At community level, home based care providers were trained in basic facts about HIV, basic counseling skills and home based management of common opportunistic infections. In addition support supervision to health facilities and community workers providing home based care was conducted.

Utilization

To improve utilization of palliative care services UPHOLD conducted community mobilization to create awareness of availability of services and efforts were made to address stigma and discrimination against PLHA. Community campaigns through multi-media activities were conducted to improve knowledge, attitudes and practices related to care and support, stigma and discrimination against PLHA. Family support groups and post-test clubs were formed and members supported to access care and support. A cumulative total of 16,438 PLWHA were provided with treatment for opportunistic infections by the end of 2006 rising from 2,785 in 2004. The cumulative target was 33,000. Though Insecticide treated bed nets were distributed to PLWHA, it was difficult to assess performance because no targets were set.

Impact

The GoU, with support from partners, has over the period of time improved comprehensive HIV care in the country. In 2004 the MoH launched provision of free ARVs for treatment. In addition, other organizations are providing ARVs at subsidized prices. The annual LQAS survey shows that 14% of households had a person who was very sick or bedridden for three or more months in 2006 compared to 21% in 2005. This change is attributed to increased availability of ART and prophylaxis against opportunistic infections.

F. RH in War Affected Districts

During 2005, UPHOLD extended HIV/AIDS services to 18 camps for IDPs in Kitgum and Gulu with plans to reach more than double this number of camps in 2006. This was done through a number of CSO grants to carry out HIV/AIDS related activities.

Straight Talk Foundation (STF) was funded to set up the Gulu Youth Centre with the purpose of attracting, through innovative approaches, the large number of scholars and out of school youth in the Gulu district who have a heightened vulnerability to HIV/AIDS and STIs. The Uganda Sero-Behavioral Survey 2004/05 reported an HIV prevalence of 8.3% in the northern part of the country, higher than the national average of 6.4%.

At the Youth Centre, information, education and communication (IEC) materials are distributed, educational films are available, and there is a drama group. Test kits and contraceptives are also available, and peers are now involved in delivering services, combining information with recreation and entertainment.

One of the shortfalls of this activity was that it was anticipated that UPHOLD would document and disseminate the results of this approach in Gulu. This does not appear to have been done in a systematic manner so that lessons could be learnt and shared with other stakeholders.

2.5.6 Quality Assurance

UPHOLD's QA component was a cross-cutting component involving training and performance improvement, behavior change communication, and the private sector, to inculcate a culture of quality at all levels of the education, health and HIV/AIDS interventions. QA focused on developing and establishing systems to monitor and improve performance standards at service delivery level, including scaling up existing best practices. There was also an element of community participation and involvement in the development of standards, and the development and monitoring of an incentive system and achievement of standards. Three key activities were undertaken.

- Scaling up the MoH's Yellow Star Programme (YSP) that covers improvement in 35 basic standards of service delivery through supervision and a reward system such as certification and presents.
- Community dialogue to increase participation and incorporate client perspectives through the 'Stars in Progress' initiative and promotion of active HUMCs
- Integration of facility HIV/AIDS services with tuberculosis, malaria and sexually transmitted diseases through the development of a supervision tool

Coverage

UPHOLD revitalized the YSP in all 34 districts and 68% of the facilities received yellow star supervision during last quarter before the 2006 LQAS survey. Coverage of 'Stars in Progress' covered only 6 districts in 2006. Consumer advocacy is still being piloted in two districts of Mayuge and Bugiri under a CSO grant to Uganda National Consumers/Users' Organization (UNHCO) and is working with Community Development Workers to develop an advocacy programme for health and HIV/AIDS services.

Quality

UPHOLD combined standards developed by other partners to develop and pretest a more user friendly version of YSP tool. This is now being adopted by the MoH. To further strengthen demand, utilization and quality of health services, UPHOLD worked with UNHCO to develop a training manual for district trainers and consumer advocates at

lower levels for consumer advocacy. Further BCC activities were developed and placed on radio spots and posters to support the advocacy initiative.

Impact

Slow progress has been made to improve standards. The major low scoring areas in YSP in LQAS 2004 included growth monitoring, management, and the availability of basic examination equipment, drug stock-out management and the functional referral systems. YSP reporting has now been incorporated within the routine HMIS reporting form. Nearly one third (30%) of facilities in UPHOLD-supported districts achieved 75% of basic health care standards.

Only 30% of the facilities had at least 4 HUMC meetings in the 12 months preceding the 2005 LQAS. A few examples exist (e.g. Pallisa district) where low scores have prompted establishment of new HUMCs. However, this was led more by the technical district officials than the community.

Working with CDWs in 3 districts also promoted dialogue especially in informing facilities providers to understand why health facilities were not being utilized.

Issues

Sustainability of reward systems, especially involving gifts and sponsored celebrations, has been a problem for many health promotion programmes in the country. These are unlikely to continue unless other donors continue the process.

Whereas the YSP tool serves as a good quality improvement tool, a number of system level factors seem to hinder government owned facilities from attaining and maintaining high scores. In districts visited, it was mainly the private not for profit facilities that scored higher. This was attributed to their ability to quickly respond to recommendations.

Implementation of most of the health quality assurance activities started late in the life of UPHOLD and achieved a very small coverage. It is difficult to envisage how they will cover all the UPHOLD districts by closure of the programme.

2.5.7 Supervision

The districts' supervision systems were weak. Only 56% of health facilities received regularly supervision from the DDHS's Office on a monthly basis.

Despite training activities carried out by UPHOLD to provide health workers with the technical knowledge and skills to perform on the job support supervision, several factors constrained the supervision system in districts. These included the limited allocation and availability of funds for supervision activities under Primary Health Care grants from Central Government to the districts and poor motivation and low demand for service data or supervision reports from managers.

This is compounded by the fact that the YSP is performed parallel to the routine district integrated quarterly support supervision. Efforts are needed to integrate these different models of supervision.

Though the system of community dialogue through UNACHO have been instrumental in developing community demand, it will be necessary to ensure that this is institutionalized. Efforts were needed to ensure that there was district buy in.

2.5.8 Monitoring and Evaluation

The M&E strategy was an important and central component of UPHOLD. The importance of M&E to UPHOLD was indicated by the upgrading of its status in the organization to be part of the executive management with the leader of the M&E cluster being promoted to a DCOP level and reporting directly to the COP.

UPHOLD's M&E results are essentially contained in the program's Performance Monitoring Plan (PMP) that is produced annually. The PMP highlighted the annual targets set by UPHOLD in its annual work plans as well as the actual results obtained. The PMP provided a regular concise monitoring of activities by geographic area by year. To display a summary of activities in a complex program in a clear and simple manner was a great achievement of UPHOLD.

Targets

- One aspect of the M&E process that was confusing for the evaluation team was the way in which PEPFAR targets were handled. As far as the evaluation team could understand, targets were set for a wide range of activities on an annual basis. The actual results obtained for the activities by UPHOLD were then compared against these targets. However, it appeared that because of differing financial years and PEPFAR having country targets that were allocated to USAID-funded projects and other reasons that were not made clear to the evaluation team, that the original targets set by UPHOLD were then retrospectively adjusted by MEEPP, which does the overall M&E for USG. This resulted in several targets, which were at variance with each other, being published in formal publications, which caused confusion in UPHOLD and also in the minds of the evaluation team.
- Another aspect of target setting that could be improved was the fact that these were determined centrally by UPHOLD's M&E cluster and then given to the regional offices to implement. The setting of targets could have been done in a more participatory manner and could also have been set done more transparently. This applied in relation to targets required by CSOs as well. The CSOs were given targets to achieve that were prescriptive and over-precise.
- Targets were also fine-tuned to a level of precision that was unwarranted by the data available and by the accuracy needed. So for example instead of saying that say 5000 people would be tested for HCT (which would be an estimate of what could be achieved based on previous performance and baseline), UPHOLD would set a target of say 4987.

All of these targets were categorized against the USAID's strategic objective 8, which aims to improve human capacity.

Both the targets and the results have been sub-categorized into the following objectives:

8.1	Effective use of social services
8.1.1	Improved quality of social services
8.1.2	Increased access and availability of social services
8.1.3	Improved behaviors adopted
8.2	Increased capacity to sustain social sector services
8.2.1	Improved decentralized planning, management and monitoring systems
8.2.2	Increased private sector role in service delivery
8.3	Strengthened enabling environment for social sector services
8.3.1	Increased community participation and advocacy
8.3.2	Effective sectoral policies and advocacy

This framework provided a very useful way of ensuring that the numerous activities of the programme were easily accessible, and is a model of how a programme should represent its monitoring activities over time.

This framework was then replicated down to district level where it formed the basis for data collection by the various UPHOLD staff, and associated partner organizations. The level of detail required by the monitoring process, as well as the time constraints to collect this data, placed considerable pressure on district and local partner institutions, and on occasion it seemed that there was more emphasis placed on the collection of numbers than the actual activity itself.

UPHOLD contributed to the national HMIS system by providing training of district staff in HMIS modules, supporting the MoH to develop a training manual aimed at improving HMIS data quality and training district Focal Persons for HMIS in supportive supervision.

However the pressure within UPHOLD to obtain data "speedily", and also external pressure from PEPFAR to show results, resulted in duplicate extraction of data from the HMIS by UPHOLD. This was costly to the program in terms of using program staff resources to carry out this extraction. It also had the effect of not boosting the HMIS and it is unhelpful to the HMIS that an external program like UPHOLD has better quality data than does the MoH.

2.5.9 LQAS

In an attempt to focus on population information, which is where the impact of activities is measured, UPHOLD introduced an innovative method to obtain household data through surveys at the household level called Lot Quality Assurance Sampling. Over 3 successive years from 2004 to 2006 these LQASs were carried out.

Issues

- Capacity was built at the district level to carry out surveys.
- Districts appeared to accept the results as useful in planning.
- The results have been well-accepted at a range of national meetings.
- However, the sustainability of LQAS has been questioned as the analysis, interpretation and reporting of results has not been institutionalised.
- The central level MoH has not been as actively involved with the strategic aspects of LQAS as it could have been. So for example the latest LQAS of 2006 was analysed, interpreted and reported upon by UPHOLD without any input from the HMIS unit of the MoH.
- There are cost implications of carrying out annual LQASs. Districts do not have sufficient resources to undertake these without external funding.

2.6 DEVELOPMENT AND MANAGEMENT OF RELATIONSHIPS

How did UPHOLD develop and manage relationships with USAID implementing partners, GOU partners and civil society.

2.6.1 UPHOLD Relationships with Central Government Partners

UPHOLD was designed to be a district based programme. It had not been anticipated at the design phase that the programme would have to establish formal relationships with Ministries although this eventually happened. This had been a designated role for the USAID Systems programme which was later abandoned. GoU and the ministries were not involved in the decision making and planning processes on strategic issues or directions of UPHOLD other than their involvement in the selection of the districts which took an inordinately long time (6 months).

UPHOLD's relationships with central government Ministries evolved around, and were defined by, the various mechanisms used to share information along the regular communication channels especially with particular sections in the MoH (e.g. PMTCT, Malaria). However it is important to point out that UPHOLD was considered a very responsive partner especially when approached to consider 'ad hoc' requests to address and jointly support national issues like mass immunization and implementation of the PIASCY interventions.

The relationship between the donor, USAID, and the key stakeholder, the GoU, was not as clear as it should have been and resulted in a loss of 6 months at the commencement of the project through a delay in district selection.

2.6.2 UPHOLD Relationships with its Consortium and USAID Partners

The strategic decision making in UPHOLD was not as clear as it could have been. The major decisions around funding flows were made by USAID and did not leave the UPHOLD management with a huge amount of discretion around implementation. In addition UPHOLD management did not have a steering committee or reference group which could provide an oversight role in terms of strategic direction. Finally UPHOLD did not adequately tap into the intellectual resources available in its consortium partners with regard to strategic direction.

UPHOLD was not subject to any formal evaluation during the five years of operation. There was no mid-term review nor were there any formal annual reviews. As a result it was difficult to assess whether the programme was 'on track' in relation to the big picture. All stakeholders, including USAID implementing partners, were thus deprived of the opportunity to engage with the strategic direction of the programme.

2.6.3 UPHOLD Relationships with Local Governments and CSOs

These relationships with local governments and civil society were evaluated through (1) grants (2) decentralised CSO and LG capacity building strategies and activities UPHOLD used.

A. Grants Management

The UPHOLD grant strategy features 6 funding mechanisms with different stakeholders accessing resources through different UPHOLD channels. (1) National e.g. AIC and TASO, (2) Central level with multi-district reach e.g. UPMA, Tuko Club, (3) Local Government, (4)

RFAs and competitive funding to CSOs, (5) Non-RFAs with solicited funding proposals e.g. Straight Talk Foundation, Madrasa and, (6) Core PTC type grantees.

The various grants were guided by fairly elaborate annual MoUs between grantees and UPHOLD and in the case of the CSOs, a manual defining the rules of engagement. In all cases grantees were required to submit activity and financial reports following prescribed UPHOLD templates. Accessing the grants was usually subsequent to approval of submitted proposals or applications following a prescribed format.

A main feature of the grants strategy implementation was the provision of tailored capacity building for the different grantees in the areas of planning, budgeting and proposal writing. CSOs specifically benefited from this. This capacity building effort covering additional areas was also extended to all grantees during programme implementation. Capacity building also focused on technical and financial reporting although LGs and CSO grantees reported that the new templates resulted in additional pressure placed on resources. A number of challenges were associated with timely technical reporting.

In addition, CSO proposals submitted in response to RFAs underwent a rigorous approval process that resulted in the sieving out of a significant proportion of CSO bids (42 out of 625 CSOs who applied in the first selection process). The criteria also required CSOs to have prior experience in target intervention domains and demonstrated partnership with LGs and other CSOs.

There is no doubt that the sieving process, by ensuring a minimum threshold of CSO capacity, also increased the likelihood of achieving desired results. This is borne out by the decision by UPHOLD to increase resource flows to CSOs instead of LGs in PY 5.

The issue of liquidation or absorption by grantees and especially by LGs consistently stands out as one of the biggest challenges in the grants strategy. Other challenges included the creation of new districts with the emergence of a whole new set of LG and CSO functionaries with limited capacities to implement UPHOLD activities and comply with UPHOLD requirements.

An internal study[18], to identify bottlenecks to the flow of funding and implementation, commissioned internally by UPHOLD concluded that ‘weak or inadequate coordination’ arising from unclear terms of reference of the LG focal point persons was one of the main reasons for bottlenecks. It appears that increasing pressure to deliver on the results strongly influenced UPHOLD responses to grantees. These responses varied from ‘more intensive planning’ (e.g. increased involvement in activity planning with LGs) sessions with grantees to the more ‘drastic’ change in funding mechanism through UPHOLD regional office arrangements.

The routing of funding via regional offices appears to have led to the affected LGs’ misunderstanding of the UPHOLD regional office role as having become that of an implementer. A close analysis of the various scenarios that prevailed in LGs reveal that UPHOLD had limited options other than to take over the joint responsibility for activity reporting and full responsibility for financial reporting and leaving implementation of activities to LGs.

There are however three issues requiring some further discussion with regard to the entire grants strategy design and implementation. The first is that from PY 1 to PY 5 LGs, irrespective of whether they had demonstrated minimum competencies or registered whatever level of performance during the PY of implementation, were ‘always’ assured of receiving an indicative planning figure for each PY for identification and prioritization of interventions. In

[18] Factors influencing flow of funds and implementation of programmes in Local Governments supported by UPHOLD 2005/06

addition, initial disbursements to LGs in the first FYs appear to have been made on an exact division of the total LG envelope. In the later years, demonstrated 'burn rate'/ liquidation capacities influenced individual LG funding levels suggesting a degree of linkage to utilization of funds and performance.

The second issue is to do with strengthening systems and institutions. It is clear that UPHOLD had limited room to maneuver in this regard. The 'need' to introduce USAID formats for activity and financial reporting, as well as for preparation of proposals, had both negative as well as positive spin offs from a systems strengthening perspective. On one hand grantees received training and support to enable them to implement activities while achieving a satisfactory rating on filling a USAID programme proposal template. This implied increased programme proposal development capacity reflecting an acceptable standard. On the other hand, the training and support to LGs tended to focus more on ensuring successful UPHOLD activity implementation and not necessarily the LG Health sector work plan activities. Again the USAID templates increased the LG periodic reporting 'burden'.

The third issue is that during implementation, due to the nature of the short one year grants, there were periods when grantees were uncertain of subsequent funding. This occurred especially when there was no communication on indicative planning figures from UPHOLD. This problem was linked to the varying financial years of the various sources of funding of UPHOLD (e.g. USAID, PEPFAR, PMI) as well as PEPFAR rules that pre-determined the funding period. However UPHOLD came up with innovative responses to ensure that funding flows were smooth to the extent possible.

B. Decentralized CSO and LG Capacity Building

One of the key strengths that influenced the UPHOLD implementation mode in 2003 was the decentralized system of governance at local government and service delivery level. This applied especially to the attendant systems and institutions that would define and influence the UPHOLD programme rollout. During the evaluation, it emerged that UPHOLD engagement with local government focused strongly both at higher LG as well as lower LG levels. This engagement was defined by the relationships established with key technical, management and political functionaries that included the CAO and nominated UPHOLD Focal Point Persons, DDHS, members of the DHT and the DEO.

The relationships between UPHOLD and LGs evolved initially in the preparatory processes necessary for rollout and were nurtured during key LG routine annual processes like planning, budgeting, prioritization, monitoring and evaluation. The relationships were also cemented by the annual provision of indicative planning figures conveying ceilings in which LGs would prioritize UPHOLD activities. They were also cemented by the periodic arrangements in which coordination with other stakeholders in the health sector exchanged information on planned activities and level of efforts. This resulted in strong efforts to avoid duplication and ensure LGs and communities benefited from appropriately planned complimentary interventions.

Particular outcomes arising from LG planning and rollout of programme activities also defined the nature of engagement with UPHOLD. For example, after occurrences of unfocused prioritization ("LGs wish to do something of everything"), there was eventually more prescriptive UPHOLD guidance and development of the 'Focus for Impact' strategy that shrunk the potential activity menu.

Delayed activity and financial reporting by LGs resulted in routing the funding of activities through the regional offices in some LGs[19]. In addition, country wide 'emergencies' arising from problems associated with national procurement systems, resulting in UPHOLD procuring supplies through MoH systems (e.g. to address HIV test kit stock outs).

A large proportion of UPHOLD responses was also embodied in provision of significant technical assistance or support either in the form of 'on job training' or other appropriate capacity building interventions to address critical LG capacity needs.

Changes in the programme environment like 'redistricting', implementation of the LG restructuring report[20] commissioned by MoLG, and specific central government policies that negatively impacted on LG local revenue generation also influenced the relationships in the districts. In all these cases, UPHOLD should be commended for the studies conducted to analyze and understand the changes and assess various options with a view to identifying practical 'win-win' alternatives. Some of these included the decision to expand interventions from 20 to 34 districts and amending existing MoUs, while in effect maintaining the same geographical area, as well as training and providing hands on support to the few new staff in the created districts. The expansion to 34 districts served to further redeem the UPHOLD regional arrangement as this provided the most appropriate modality to deal with the increase in 'body corporate' entities, more functionaries with limited core functional capacities and limited knowledge of UPHOLD goals, interventions and implementation frameworks.

Issues of coordination were significant especially in LGs (e.g. Acholi and Lango) with high CSO development support presence in the health and HIV/AIDS sector. Inevitably, UPHOLD interventions also increased the already high transaction costs and the administrative and financial reporting burden that LGs were already carrying. This was not helped by the fact that different support partners, including UPHOLD's capacity building efforts, focused on strengthening (only) those systems that enhanced implementation of 'own programme' activities and not necessarily the LG systems[21].

It emerged that there is a clear recognition by all stakeholders of the fact that the variety and complexity of donor procedures associated with various support instruments places a substantial burden on LGs especially in multi-donor aid effort settings. Secondly, the management capacities of LGs tend to be overstretched, which hinders efforts to strengthen existing beneficiary institutions and systems. However, the reality seems to weigh heavily in favor of the *status quo* prevailing. Although there was a commendable effort in Gulu district to attempt to get this issue[22] on the agenda, this was not seen through or 'led' by the LGs.

The issue of the 'abolition' (suspension) of graduated tax and its effect on LGs, especially with regard to LGs disablement in their ability to generate and utilize revenues to address district priorities, needs some thought. While it is fact that LG locally generated own resources gave them complete discretion in terms of decision making on expenditure areas, it is also fact that the greater proportion of these resources were used on council activities that were not necessarily always the most appropriate with regard to impact on service delivery[23]. It is true however that these resources did at one point and for a period meet salaries for a selected cadre of health workers (health facility support staff) and council activities sittings. But there is limited precedent to inform the supposition that these resources if present or available would have in the prevailing circumstances been utilized in an optimal manner to impact positively on LG service delivery.

[19] This was mis-understood by these LGs to mean UPHOLD regional office transformation into a direct implementer of activities which was not the case as UPHOLD's only involvement was to pay for activities directly

[20] The report recommended three 'model' appropriate and affordable district structures which LGs would choose to suit local situations

[21] In Lira DLG the health department accountant reported she had different formats for UNICEF, UPHOLD, DANIDA, WHO, SHSSPP

[22] Harmonization and alignment to the 'extent possible' taking existing donor aid requirements in consideration but focusing on reducing LG burden

[23] First Joint Annual Review of Decentralization 2004, thematic paper 5: Sustainability of LG, issues and the importance of local revenues

UPHOLD has been very responsive to the decentralized arrangement in LGs in the areas of operation. This is evidenced by:

- the integration of UPHOLD activities in DDPs and DHSSPs
- reported increases in volumes (both access and use) of health and HIV/AIDS services
- increases in the quality of services in an increased number of health facilities and in Lira DLG, the Yellow Star intervention being a case in point.
- LG functionaries as well as members of the VHT all reported having benefited from the training and other forms of capacity building interventions provided through UPHOLD
- UPHOLD focus at the LG level further enabled the fostering of 'working' relationships between LGs

2.7 UNINTENDED RESULTS

Did UPHOLD yield any unintended positive/negative results?

There were a number of activities of UPHOLD that resulted in spin-offs that were not anticipated. Examples of these include:

- Distribution of LLINs through CMDs exposed a channel that had not been used before. This resulted in the CMDs becoming a point of reference for health issues in the villages. This model of CMD distribution has been taken up by the MoH.
- LQASs have been well accepted as a means of getting population based information.
- PIASCY has resulted in community and household involvement in education. On the other hand it has been reported that some schools not involved in the model school process, have had negative reactions.
- Use of CSOs has resulted in high mobilization of decentralized and household HCT and also led to increased utilization of family planning.
- Although CMDs and CSOs have been highly successful in certain activities, they now face an uncertain future and their sustainability is not assured.

3 KEY LESSONS LEARNED

What are the key lessons learned from the design and implementation of this large multi-sectoral district based programme.

a) There is a danger that cooperative agreement arrangements leave programme goals 'too loose'. This was the case in UPHOLD where the programme tried to 'do everything, everywhere' with limited and finite resources. As a result, the programme was not sufficiently focused. The consequence was that some activities were very thin on the ground. It took two years before there was a "Focus for Impact". This resulted in a narrowing and deepening of activities.

   Where cooperative agreements are used, the lower level goals should be made more specific than they were in this programme so that all stakeholders are clear as to what the programme is trying to achieve.

b) Without systems strengthening to link with the services programme, UPHOLD 'walked on one leg', trying to implement a district based programme but always having to consider systems issues at the delivery (LG) level as well as at the central MoH level.

c) Central MoH involvement in large programs is essential. This involvement can:
   i) assist the strategic direction in ensuring that program goals are consistent with health system policy
   ii) help with sustainability by getting especially MoH and Uganda AIDS Commission participation in and buy-in to activities of the program (e.g. LQAS). This was evident with PIASCY in the Education sector.
   iii) open doors to the program through providing it with continued endorsement

d) Many of the excellent activities implemented by UPHOLD have question marks against their sustainability after the end of the program. Examples of this include continued motivation of the CMDs and funding of district LQAS.

e) Although UPHOLD had the laudable aim of integration of activities at the district level, this is difficult to achieve when the health systems are running different projects in a vertical fashion (e.g. PMTCT).

f) Although this program was designed as a multi-sectoral program (health and education) to be delivered at district level, there was no prototype or pilot on which the design was based.

g) The efficiency and effectiveness of interventions and activities by grantees was compromised by the uncertainties around the funding flows in terms of the funding schedules and the amounts. The funding used generally by UPHOLD, to a large extent determined by its own funding streams, meant that grants were made for a single year or less; and that the amounts of the grants were uncertain. This resulted in pulsed, uncertain and inefficient grant making to CSOs.

h) The differing financials years of UPHOLD, USAID and the LGs often meant that funding did not fit into the financial framework of LGs and did not coincide with planning and budgeting cycles.

i) The RFA method of grant making has both positive and negative results. It ensures that CSOs have sufficient technical ability to write grant proposals and demonstrate their likelihood of success and so results in the choice of CSOs who are likely to deliver. It

however limits the grant making to certain kinds of CSOs and results in much CSO time being spent on writing proposals at the expense of service activity.

j) There is a tension between being focused on getting results, achieving targets and ensuring that the 'numbers' are improving (which are generally short term achievements) and taking on a developmental role through improving human capacity (which is generally a softer and longer term achievement).

k) UPHOLD has an excellent monitoring system where all program activities were tracked. However, over-prescriptive target setting, together with unrealistic expectations of the accuracy of data, can result in too much attention being placed on the numbers.

l) One of the positive achievements of the program was the use of CSOs who in certain instances made important and large contributions (e.g. in home mobilization of HCT).

m) UPHOLD encouraged and facilitated the relationships between CSOs and LGs.

n) Some activities of UPHOLD took a long time to mobilize, e.g. start-up of TB programme; others were started and then curtailed because of lack of resources e.g. growth promotion. There needs to be a balance between the depth and breadth of the range of activities and also the geographical areas in which they work. Programs cannot be all things to all people.

o) Some intervention specific lessons include:

   i) Mass immunization presents a good opportunity to publicize and make popular the use of EPI services. There has been a general improvement in utilization of immunization services following on the mass campaigns.

   ii) Targeting of hard to reach areas enabled filling of gaps that other district funds were not able to cover.

   iii) Programme reports found that programme action on gender based violence is associated with increased PMTCT uptake.

   iv) The use of CMDs, who are conversant with their own communities, to target the beneficiaries is helpful in minimizing misallocation of the nets. This was adopted as strategy by the MoH and is a lesson for future approaches for the distribution of the 1.8 million ITNs purchased via the Global Fund.

4 RECOMMENDATIONS

As a result of this end evaluation, the following actions should be taken by USAID in its future programmes:

a) Future programmes should ensure that the parameters are more targeted and that interventions should have sufficient depth to make meaningful changes on the ground.

b) Large programs should be endorsed within the GoU prior to commencement with clear goals and objectives.

c) For a program of this size, a formal mid-term review is imperative, and annual reviews would also ensure that the programme is heading in an appropriate direction.

d) There should be a formal annual strategic decision making meeting where key stakeholders' input is continuously provided and which is based on a strategic review of performance, direction and focus. Programs should build into their design a more formal relationship with the central MoH, where roles and responsibilities are clearly delineated.

e) Sustainability strategies should be transparent and a critical consideration in the design and implementation of large programs.

f) Programmes need to design their activities around the realities of the health system and feed back to central level well documented policy briefs to encourage systemic change of service innovations. Programs that are trying to improve service delivery need to take into account constraints in the formal health system.

g) Large scale programs should be based on tested methodologies. Innovative activities have an important role but they should be tested in small scale pilots before going up to scale.

h) Future programs should further encourage in all ways, including financial, the closer working together of these parties.

i) There should be more certainty in programme funding flows and more flexibility given to the program to make grants for periods longer than one year. Where circumstances are appropriate grants should be made to allow for continuity of activity.

j) Funding should plug in the existing planning frameworks and cycles as much as possible.

k) Programs need to be clear, transparent and realistic as to what their mission is and what they are trying to do.

l) Monitoring has an important role to play but it should be complemented by strategic analysis and overview, where the big picture is constantly kept in mind.

m) The best features of the RFAs should be coupled with the targeted selection and capacity development of particular CSOs, in order to ensure sustainability and overall long-term development of these CSOs.

n) Future programs should look at the positive ways in which CSOs were harnessed and build upon these. UPHOLD itself should write short policy briefs on the success of this (and other interventions) and the lessons that it learnt in the process.

o) Activities taken on by programs need to be carefully thought through in terms of financial, human and other resources required prior to their commencement and there needs to be a balance between the number of activities and how widespread they are implemented.

5 CONCLUSIONS

The conclusions are arranged according to the evaluation questions.

5.1 Most of the operational targets set by UPHOLD have been attained and especially in the last year UPHOLD seems to have moved into top gear. UPHOLD start was much slower than designed but has successfully evolved over time and is making successful and useful interventions Although the evaluation team obviously could not assess the operation of UPHOLD in the initial years 2002-2004, it appears in our assessment that UPHOLD in 2007 is a well functioning, hard working, efficient and effective organisation. However, with more strategic direction and focus, this program could have achieved more.

On the basis of the main objectives of the UPHOLD's grants strategy, there is no doubt UPHOLD program expanded access and use of 'comparatively improved' quality services, registered a fair achievement in fostering the concept of integration across health and HIV/AIDS and increased the capacities of local CSOs to utilize grants. UPHOLD has also increased the capacities of LGs and especially CSOs to implement (UPHOLD) activities although while these capacities increased, LGs and CSO did not always implement and monitor activities in a manner consistent with the 'high' standards of transparency and accountability that was expected of them after the capacity building.

5.2 UPHOLD yield a number of unintended positive and negative operational results. Success stories, and lessons learnt in the project, need to be adequately marketed and publicized through targeted, short briefs produced by UPHOLD.

5.3 UPHOLD programme design suffered from being an over-ambitious project with inadequate strategic direction, both from without and from within, in the initial years. This resulted in the project having too much breadth and too little depth. The changing of key implementation objectives, (e.g. through PEPFAR, PIASCY implementation), did not help this process.

Despite plans to start quickly in a few districts and "go national" quickly, it takes a long time for large multi-sectoral, district based program to start off and focus the implementation especially when the system strengthening is actually needed.

There are a number of tradeoffs with annualized grants method used especially when they focus on reaching generally short term achievements rather than the developmental concept. Also, the grant process did not adequately propel UPHOLD programme to facilitate building capacity of Ministries and local governments to collaborate with CSO in implementation management.

5.4 UPHOLD management did not have a steering committee or reference group which could provide an oversight role in terms of strategic direction. Though UPHOLD developed good relationships with USAID implementing partners in the beginning, this waned as implementation progressed. Relationships with MoH did attain levels of collective ownership of achievements, which is needed for going national, in only a few innovative areas such as yellow star and net distribution through CMDs.

There is no doubt that UPHOLD has been responsive to the decentralized arrangement in LGs in the areas of operation. However, the relationship between the donor, USAID, and the key stakeholder, the GoU, was not as clear and UPHOLD did not adequately tap into the intellectual resources available in its consortium partners especially with regard to strategic direction in successive annual plans.

APPENDIX 1: Scope of Work for UPHOLD

1. BACKGROUND

Uganda Programme for Human and Holistic Development (UPHOLD) is funded through a Cooperative Agreement (CA) with the United States Agency for International Development (USAID) for five years, with a completion date of September, 2007. UPHOLD is funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), Basic Education, Health (Child Survival/Maternal Health, Reproductive Health/Population) and Infectious resources. UPHOLD is implemented by JSI Research and Training Institute, Inc., with support from World Education (WE), Education Development Center (EDC), The Constella Futures Group, Malaria Consortium, and The Manoff Group.

UPHOLD was designed to contribute to the "Improved Human Capacity" strategic objective of USAID/Uganda's Integrated Strategic Plan (ISP) for the period 2002 -2007. The objective aimed at assisting Uganda to improve its human capacity through addressing constraints to improving health and education status. Following a major review and reform of the United States Government (USG) foreign assistance strategy in 2006, the USAID/Uganda 2002-2007 ISP was ended in 2006. Under the new strategy, human capacity strengthening is now programmed under the new programme area, "Investing in People". USAID/ Uganda human capacity strengthening approaches remain the same as under the ISP integrating Health, Education and HIV/AIDS sectors and UPHOLD contributes to the new programme area.

Focusing on service delivery at the district level, UPHOLD's main goal is to increase the utilization, quality, support and sustainability of services in education, health and HIV/AIDS through an integrated multi-sectoral approach that seeks to:

- improve educational status;
- reduce the spread of HIV/AIDS and sexually transmitted infections;
- decrease child and maternal mortality; and
- stabilize population growth

UPHOLD activities are implemented in 34 districts (up from 20) covering about 42 percent of Uganda's s population. The program's core technical interventions cover:

- *Primary School Education*: improving teacher effectiveness; facilitating dialogue and consensus-building between families, communities, teachers and other stakeholders; building capacity in planning, management and supervision at decentralized levels; increasing parental involvement; and facilitating the use of innovative tools and approaches to improve children's learning in school and at home.
- *HIV/AIDS:* strengthening services for Voluntary Counseling and Testing; Preventing Mother to Child Transmission of HIV; managing Sexually Transmitted Infections; supporting People Living with HIV/AIDS; and innovative approaches to empower and involve young people and address gender and culture.
- *Integrated Reproductive Health:* promoting improved antenatal and postnatal care; safe and clean deliveries; essential obstetric care; post abortion care; gender-sensitive approaches; effective dialogue and decision-making in families and communities; increased access to and utilization of quality family planning services and methods; youth-friendly services; and efficient synergies with the control of HIV/AIDS, sexually transmitted infections, and malaria.
- *Child and Adolescent Health:* key interventions include the Integrated Management of Childhood Illnesses (IMCI) and Community IMCI; Community-Based Growth Promotion; improved strategies and indicators for Nutrition; Vitamin A & Micronutrient

supplementation; promoting Exclusive Breastfeeding; childhood immunizations; youth-friendly services; and innovative strategies promoting peer support groups, child-to-child activities, and parent-child communication.

- *Communicable Disease Control:* Malaria control activities include the effective Home Based Management of Fever, Intermittent Preventive Treatment of malaria during pregnancy, promoting use of Insecticide-Treated Nets. In addition, UPHOLD works to control tuberculosis, and other communicable diseases in a multi-sectoral approach.

In addition, UPHOLD has five cross-cutting technical interventions. These are:

- Performance Improvement
- Quality Assurance
- Management and Strategic Planning
- Behavior Change (BC) Communication and other BC Strategies
- Community Ownership and Involvement

2. PURPOSE OF THE EVALUATION

The Automated Directive System (ADS) 203.3.6.1 requires that an evaluation is conducted when there is distinct and clear management need to address an issue. USAID/Uganda is planning to evaluate the results of the HIV/AIDS and Health components UPHOLD programme. The purpose of this evaluation is to extract lessons that would benefit the USG/Uganda and GOU partner institutions with future programming. Secondly, implementing partners, have interest in this evaluation in terms of knowing what worked and what did not work during implementation of the programme.

The evaluation will provide quantitative and qualitative assessment of the approach that UPHOLD has applied and determine whether UPHOLD is on track to achieve its impact objectives. USAID is interested in continuing support to HIV/AIDS and health service delivery in a decentralized environment. While we continue to learn from old and ongoing activities within and outside the USG portfolio, USAID seeks to garner lessons learned regarding design and implementation of large, multisectoral programmes as one means of rapidly scaling up HIV/AIDS and health services in a decentralized setting. The evaluation will be able to provide answers both at programme and strategic level by addressing the question of whether UPHOLD is on track to achieve the intended goals of its HIV/AIDS and health interventions. The evaluation will also distill lessons learned about programme implementation that will have a bearing on scaling up HIV/AIDS and health interventions nationwide.

3. KEY EVALUATION QUESTIONS

This evaluation entails examining a number of questions:

1) To what extent has UPHOLD achieved its overall HIV/AIDS and health goals and results? How did the following factors contribute to the achievement of goals and results?
   - Programme design strengths and limitations
   - Technical competency to undertake the planned activities
   - Technical support and capacity building for districts and grantees
   - External factors

2) How did UPHOLD develop and manage relationships with USAID implementing partners, GOU partners and the civil society?
3) Assess whether UPHOLD yielded any unintended positive/negative results
4) What are the key lessons learned from the design and implementation of this large multi-sectoral, district based programme?

4. METHODOLOGY

The evaluation team will be required to come up with a clear methodology to answer all the evaluation questions. However, it is expected that data collection will be conducted using a combination of the following:

- Review of relevant documents
- Key informant interviews with relevant staff of USG/Uganda, UPHOLD and other key partners, and other key informants
- A survey or group interviews with a representative number of beneficiaries to assess their level of satisfaction with UPHOLD HIV/AIDS/ and health services
- Direct observations of service delivery sites

The evaluation team is expected to use a mixed methods approach. In order to achieve rapid analysis of the data, it is anticipated that the evaluation team will have working familiarity with both quantitative and qualitative data analysis tools and skills.

The evaluation team is expected to be familiar with USAID data quality standards (ADS 203 and 578), and able to apply them in the final report, by identifying such data limitations as may exist with respect to these standards.

For the Document review, USAID will provide the evaluation team with several documents including:

- GOU: National frameworks, policies and implementation guidelines from Uganda AIDS Commission, Ministries of Health, Local Government and Local Government Development Plans and reports
- The Role of Evaluation in USAID http://www.dec.org/pdf_docs/PNABY239.pdf
- UPHOLD:
    - Cooperative Agreement and amendments
    - JSI Proposal
    - Annual and quarterly reports
    - Annual work plans, results framework and performance monitoring plan
    - Website
    - Special study reports by UPHOLD etc.
    - Grantee stories, lessons learned, case studies
    - Internal assessments and reviews

6. EVALUATION TEAM COMPOSITION AND REQUIRED QUALIFICATION

6.1 Team Members

A team of international and Uganda experts is proposed. It is essential that all team members understand the development context and, while previous experience in Uganda is definitely advantageous, it is essential that team members have previous Africa experience in countries with high HIV prevalence. The team should number no more than five persons who should possess the skills and experience below:

International Lead Consultant (Team Leader):

- Demonstrated experience (7 years) in evaluation design, implementation and leadership experience and excellent writing skills is required.
- Practical experience (5 years) supporting or evaluating HIV/AIDS and health service delivery in a multi-sectoral decentralized, environment.
- Public/Private partnerships with a focus on local governments and civil society
- Knowledge of capacity building of key leadership and service delivery
- Knowledge of USG and USAID presidential initiatives

- Knowledge of Local Government service delivery systems in a decentralized setting. This will bring in international experience in this area

Local consultants (4) should collectively cover the following fields or experience:

- Capacity development in context of decentralization
- HIV/AIDS and health service delivery in a multi-sectoral, decentralized, environment
- Public/Private partnerships with a focus on local governments and civil society
- Evaluation experience

6.2 Roles and responsibilities

The key roles and responsibilities for the Evaluation Team Leader, USAID, and GOU and UPHOLD during the evaluation are:

USAID

Select and contract the evaluators

- Manage the evaluation process
- Provide briefing to team
- Review draft report and provide feedback
- Sign off the final report
- Submit evaluation report to USAID/PPC/CDIE

Government of Uganda (Ministry of Health (MOH), Ministry of Local Government (MOLG), and Uganda Aids Commission (UAC)

- Provide concurrence on the evaluation scope of work
- Serve as key points of reference and information, including key documents, for review
- Provide concurrence with the evaluation team's inception report and work plan
- Participate in oral debriefing
- Review and comment on draft report

UPHOLD

- Review inception report and work plan
- Serve as key points of reference and information, including key documents, for review
- Provide logistical support for the evaluation team including office space, assistance with setting up meetings, interviews and providing transport

Evaluation Team Leader's roles and responsibilities:-

- Guide and manage evaluation exercise
- Responsible for all deliverables to USAID (Work plan, draft and final reports)
- Coordinate preparation of the final schedule of meetings and field trips
- Ensure that the schedule, as agreed with USAID is adhered to
- Lead debriefing meetings

7. SCHEDULE

It is anticipated that the evaluation can be completed in eight weeks. The evaluation will begin on or about January 29th 2007 illustratively, it is proposed that team members spend approximately 18 days doing field work. It is not expected that the team will visit all

UPHOLD districts but will select a representative sample with the input of USAID. The Team Leader will provide a final report to USAID no later than March 19th 2007.

There will be an Initial conference (team planning meeting) with USAID/Uganda staff, UPHOLD, UAC and MOH representatives during which the team will present an inception report for undertaking the evaluation for input and finalization. In this meeting USAID will also clarify to the team the scope of the evaluation. There will also be oral debriefing meetings during which the team will present an initial draft of the evaluation report, highlighting key findings and recommendations while receiving clarification and input from stakeholders.

An illustrative time line for the evaluation is as follows:

- 1 week – Document review and preparation for field work
- 3 weeks – Field Work (UPHOLD districts and Kampala)
- 1 week – Preparation of initial draft report and oral presentation to USAID
- 1 week - Final draft report writing and submission to USAID
- 1 week – Review of final draft report by USAID and key stakeholders and comments sent to Evaluation Team
- 1 week – final report writing and submission to USAID

8. DELIVERABLES

Five (5) deliverables are required under this contract:

1) An Inception report including a proposed detailed methodology for carrying out the evaluation including draft copies of data collection instruments and a sampling framework. Detailed work plans for the evaluation complete with timelines for various activities that are envisaged i.e. fieldwork, document analysis, report writing etc.

2) Weekly e-mail progress reports to USAID on status of the evaluation

3) IA report and oral presentation of initial draft report highlighting key findings, conclusions and recommendations five working days of the conclusion of the fieldwork

4) Final draft report that should be submitted to USAID for review and written comments in both hard copies (5) and one electronic copy. It should be submitted within five working g days of submission of the initial draft report.

5) Final Report that should be submitted in both hard copies (5) and one electronic copy within five working days of receipt of USAID's comments o the final draft report. The report should conform to the following specifications:-

- Should not exceed 40 pages of text in the body of the report (excluding an executive summary and annexes)
- Must conform to report structure contained in Attachment A
- Should mainly focus on questions posed by this TOR/SOW and should include specific recommendations
- Must be processed using Microsoft Word 98 or higher and be in Times New Roman 12 point font

6) Data sets and copies of all the instruments used in the evaluation: cleaned labeled and ready to use electronic copies of datasets collected through fieldwork (preferable SPSS – PC format) and cleaned ready to use electronic copies of Focus Group Discussion responses if any. In addition, electronic copies of all the instruments used in data collection must be delivered to USAID

9. BUDGET

9.1 Budget in (person days) for Evaluation Team

The budget in person days for the Evaluation Team is shown in the table below.

Tasks	Team Leader	Consultants (4)
1) Document Review and preparation of Inception Report	3	3
2) Initial Team Planning Meeting with USAID and selected stakeholders and preparations for field work	2	2
3) Data collection[24]	18	18
4) Initial draft Report Preparation	5	5
5) Final draft report writing	5	5
6) Final report writing	5	3
Total	**38**	**36**

9.2 Financial budget for Evaluation Team

The tentative financial budget for the evaluation is in Attachment B.

10. TERMS OF PAYMENT

The consultants will be paid in accordance with their individual contract with USAID, but in no case will final payment be issued prior to USAID's acceptance of the final report.

[24] It is anticipated that the team will cover 6 UPHOLD districts i.e. 1 per UPHOLD administrative/geographical region. Each team consisting of 2 persons would cover 3 districts working 5 days in each district = 15 person days. The balance i.e. 3 days would be spent in Kampala to interview key stakeholders at national level. The team leader may switch days across activities, but the total numbers of days should not exceed 36 days for local consultants and 38 days for the team leader.

ILLUSTRATIVE STUDY REPORT OUTLINE

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

Preface or Acknowledgements (Optional)

Table of Contents

List of Acronyms

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

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

Main Part of the Report

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

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

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

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

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

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

Annexes

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

APPENDIX 2: Evaluation Framework

FRAMEWORK FOR EVALUATION OF KEY QUESTIONS

Evaluation Questions	Analysis of the questions	Methods for Data Collection		Data Analysis and Interpretation
		Method	Data Source	
1. To what extent has UPHOLD achieved its overall HIV/AIDS and health goals and results?	The UPHOLD conceptual formulation has 5 key performance areas (KPAs) viz. ▪ Public service delivery ▪ Quality of public service delivery ▪ Support to public service delivery ▪ Private sector delivery ▪ Grants Programme Within each of these 5 KPAs there are multiple: ▪ specific objectives ▪ geographical areas of focus (districts).			
	For the programme as a whole (central level) for each specific objective there will be a comparison between actual and baseline indicators Central level review	Review of baseline and periodic performance information collected against the programme Performance Monitoring Plan (PMP)	UPHOLD programme records and primary sources used by UPHOLD for PMP data	Quantitative comparisons of targets and actual performance.
		Review of other primary data pertinent to UPHOLD's result areas	National type surveys e.g. DHS, antenatal sero-prevalence surveys	Comparison of UPHOLD results with externally obtained results.
	Central level review	Interviews with key UPHOLD staff responsible for specific objectives e.g. -Health specialist plus manager of focal areas -Senior specialist HIV -Yellow star manager -Private sector specialist	Interview schedule and questionnaires	Qualitative review and interpretation of interviews

Evaluation Questions	Analysis of the questions	Methods for Data Collection		Data Analysis and Interpretation
		Method	**Data Source**	
		-Grants manager		
	Central level review	Review UPHOLD focus area specific reports	Focus area specific reports	Interpretation of both quantitative and qualitative information contained in reports
	Central level review	Interview key stakeholders. Ministry of Health counterparts and central level beneficiaries of UPHOLD activities	Interview schedule and questionnaires	Qualitative interpretation of interviews
	UPHOLD districts will be compared with non-UPHOLD districts	Review of comparable data from UPHOLD and non-UPHOLD districts e.g. tracking of relevant league table positions over time	MOH annual reports	Quantitative analysis. Interpretation and discussion of comparisons.
	District Level review The district level review will add color and flavor to the central level overview. Given the time and logistical constraints this review will be confined to reviewing 2 districts in depth and another 2 more superficially.	Review of district profiles and activities	UPHOLD central office and regional office records	Understand the reasons for the specific interventions; analyze and interpret the specific needs and reasons for these
		Interview regional office staff including regional director & community participation officer	Interview Schedule	Interpret the results of the interview
		Focus Group with technical officers from local government and the health sub-district in-charges	Focus group discussions	Interpret results of focus group
		Interviews with CSO grantees	Interview schedule	Interpret and analyze interviews
		Visits to facilities Community type visits and	Observation of relevant activities	Interpret results of visits

Evaluation Questions	Analysis of the questions	Methods for Data Collection		Data Analysis and Interpretation
		Method	**Data Source**	
		communication with beneficiaries e.g. community medicine distributors and their clients Interview/discussion with psychosocial groups for HIV	Observation of relevant activities; Discussion with community members where possible Write up of discussions	Interpretation of visit and discussions Interpretation of visit and discussions
1a How did the programme design's strengths or limitations contribute to the achievement of goals and results?	Identification of design (and implementation) factors most critical for success, and relevant for scaling-up programme elements to the district or national level. Also identification of any design factors that had negative effect on the programme results	Interviews with: ▪ UPHOLD staff ▪ Key stakeholders ▪ USAID staff Review of programme design documents and any modifications.	UPHOLD programme team and programme records Programme design documents and modifications	Analysis of interviews with questions specifically focused on this area Critical review, analysis and interpretation of programme design and modifications
1.b. How did the programme team's technical competency to undertake the planned activities contribute to the achievement of goals and results?	Description of the level of competency (or lack thereof) of key UPHOLD staff.	Interviews with UPHOLD staff Interviews with key informants Interviews with USAID staff	Interview schedules/questionnaire results	Analysis and interpretation of interviews
1.c. How did the programme's technical support and capacity building for districts and grantees contribute to the achievement of goals and results?	Description of capacity building activities and results and grantee support	Interviews with UPHOLD staff Interviews with key informants Interviews with USAID staff Case studies from districts/interviews at district level	Interview schedules/questionnaire results Reviews and write up of district visits	Analysis and interpretation of interviews Reviews and write up of district visits
1.d How did external factors contribute to the achievement of goals and results?	Review of the external environment, (global, national and regional) and analysis of factors that impacted on the programme	Key informant interviews Review of UPHOLD reports Review of other reports	Questionnaires UPHOLD annual reports e.g. MOH annual report, WHO annual reports	Interpretation of interview schedules Interpretation of reports Interpretation of reports
2. How did UPHOLD	Analytic descriptions of relationship	Interviews with UPHOLD staff	Interview	Analysis and interpretation of

Evaluation Questions	Analysis of the questions	Methods for Data Collection		Data Analysis and Interpretation
		Method	Data Source	
develop and manage relationships with USAID implementing partners, GOU partners and civil society.	between UPHOLD and: ▪ USAID ▪ MOH ▪ Civil society ▪ Consortium partners ▪ Grantees, specifically including local government	Interviews with key informants Interviews with USAID staff Interviews with consortium members Interviews with grantees Review of programme documents	schedules/questionnaire results Minutes of key meetings/documentation of decisions taken	interviews Analysis and interpretation of documentation
3. Assess whether UPHOLD yielded any unintended positive/negative results?	Review un-anticipated results of the programme	"What else" questions integrated into all key informant interviews including partner and beneficiary interviews Inclusion of broader questions about "what's different" and "why" in district, partner and beneficiary situations Document reviews	Review of Interviews UPHOLD annual reports	Analysis and interpretation of interviews Analysis and interpretation of reports
4 What are the key lessons learned from the design and implementation of this large multi-sectoral district based programme.	This question requires conclusions based on answers developed for previous questions. Note: given that only the HIV/AIDS and health care aspects of UPHOLD are to be covered by this evaluation, lessons learned will not be multi-sectoral, i.e., lessons will not be derived concerning the education component of this programme.	N/A	N/A	Analytic examination of findings on all previous questions.

APPENDIX 3: Schedule of Activities

A. Central (Kampala) Interviews and activities

Date	Person interviewed
21st June 2007	Ekaru Stephen- National TB and Leprosy Programme
	Commissioner for Quality Assurance, Ministry of Health, Emmanuel Kaijuka
22nd June 2007	Assistant Commissioner, Health Promotion and Education Ministry of Health, Paul Kaggwa
	Senior Medical officer and Focal Person for Malaria Case Management, Malaria Control Programme Ministry of Health, Kato Frederick
	Chief of Party, UPHOLD Presentation
	Deputy Chief Of Party Technical, UPHOLD Lucy Shillingi,
	Senior Health Adviser UPHOLD Margaret Kyenkya
	Deputy Chief of Party Regional UPHOLD Barbara Durr,
	Senior HIV/AIDS Specialist UPHOLD Alexander Mugume,
	Deputy Chief of Party Monitoring, Evaluation and Dissemination UPHOLD Elizabeth Ekochu
	Senior Communicable Disease Specialist, UPHOLD Betty Mpeka
May 23rd 2007	Inception report and discussions with Stakeholders
	UPHOLD CTO, USAID Andrew Kyambadde ,
	HIV/AIDS Team Leader, USAID Elise Ayers
	Senior Malaria Technical Adviser, USAID Gunawardena Dissanayake
	Education Specialist, USAID Sarah Mayanja
May 24th 2007	Ag. Principal Education Officer, Ministry of Education and Sports, (PIASCY)-Kusemererwa E. Araali
	Programme Director, Monitoring and Evaluation of Emergency Plan Progress Programme, Vincent Owarwo Mugumya
	AIDS Information Centre Ag. Executive Director, Samali T. Lubandi, Monitoring and Evaluation Manager Cissy Kirambaire, Programme Director Francis Nahamya
	Ministry of Local Government Assistant Commissioner, Patrick Mutabwire
	Uganda Private Midwives Association (Grantee) Executive Director Micheal Matsiko, Branch Coordinator Mary Musisi, President Sakina Kiggundu
	Assistant Commissioner, HIMS and Resource Centre Ministry of Health, Eddie Mukoyo
	Deputy Director Programme Management, The AIDS Support Organization - Robert Ochai
May 25th 2007	Sekimpi –Kirwana Lawrence , Programme Manager Tuko Club
	Programme Manager, STD/AIDS Control Programme, Ministry of Health, Elizabeth Madraa
	Assistant Commissioner, Health Services Ministry of Health, (EPI) Makumbi Issa ,
	Principal Assistant Secretary Ministry of Education and Sports (PIASCY)- Aggrey D Kibenge
	Behavioral Change and Communication Specialist, Kenneth Mulondo

Date	Person interviewed
June 4th 2007	Programme Management Specialist USAID, Jessica Kafuko
	Senior Technical Adviser USAID, Serene Thaddeus
	Deputy Chief of Party Finance and Administration, UPHOLD Katrina Kruhm
	Malaria Consortium Africa Director Graham Roots, Vector Control and Emergency Specialist, Kate Kolaczinski
June 5th 2007	Chief of Party, UPHOLD Samson Kironde
June 7th 2007	Presentation to USAID, MEMS and UPHOLD.
Teleconferences	President, Manoff Group Marcia Griffiths
	World Education Inc. Vice President, Africa Division Burchfield Shirley, Senior Technical Adviser Education Inc. Gill Garb
June 8th 2007	Presentation of findings to Stakeholders
	Principal Medical Officer, Ministry of Health Zainab Akol

B. District Visits

The evaluation of UPHOLD had two main components, viz central level activities and district level activities. Although it was desirable that as many districts and as many activities as possible be reviewed in the field, where the ultimate impact is felt, this was constrained by (1) size of review team of 4 to 5 people (only two teams possible) and, (2) need to meet and interview key central level stakeholders

It was planned that the Evaluators visit and review UPHOLD activities and impact in 4 selected districts in reasonable breadth and coverage. The review team also considered going to non-UPHOLD districts to try and compare differences, if any between UPHOLD and non-UPHOLD districts. However this option was discarded for a number of reasons:

- It would be unlikely that in the short time available that quantifiable differences would be found in a field visit
- Time is of essence and reviewing activities and impact in UPHOLD districts should be maximized
- Central level review of key indicators relevant to UPHOLD activity could be based on available information (e.g. MOH HMIS data, DHS data) and that comparisons between UPHOLD and non-UPHOLD districts, would be done based on this information.

In the light of the above factors a number of selection criteria were made and based on these, 4 districts were selected and agreed by both UPHOLD and USAID. Each team visited two districts.

District Selection Criteria

1. Regional representation
2. Coverage of technical areas
3. Status (conflict/Post Conflict/Normal)
4. Security situation
5. New/Old district
6. Location in relation to other choices

Selected Districts

1. GULU
- Northern region
- Conflict transition
- Has both ITN and HBMF(using Coartem)
- Non AIM district
- Has been split to form Gulu and Amuru

2. LIRA
- Northern region, Post conflict
- No UPHOLD supported HIV/AIDS interventions,
- Has both Child Heath IRH CSOs
- AIM district
- Next to Gulu (time and travel consideration)
- Has been split to form Lira and Dokolo

3. KYENJOJO
- Western region
- All activities apart from Growth promotion
- Old district and not split
- Has been supported by UPHOLD since the beginning
- Presents in depth assessment

4. ISINGIRO
- Western region
- New district
- All activities apart from Growth Promotion
- Non AIM district

TEAM 1

DATE	DISTRICT	TIMING	ACTIVITY	COMMENT
Sunday May 27th 2007	GULU	Depart KLA 2pm and arrive 6 pm	Travel	Stay in Gulu
Monday 28th May 2007	GULU	8:30 am meet with regional office	Continuation of meetings and visits	Stay in Gulu
Tuesday 29th May 2007	GULU	Whole day	Continuation	Stay in Gulu
Wednesday 30th May 2007	GULU	Work up to 3:00 pm then leave for Lira	Continuation and travel	Depart for LIRA
Thursday 31st May 2007	LIRA	Whole day	Regional Office Visit LG Visit CSOs	Stay in Lira
Friday 1st June 2007	LIRA	Whole day	Visit LG Visit CSOs	Stay in Lira
Saturday 2nd June 2007				Depart for Kampala

TEAM 2

DATE	DISTRICT	TIMING	ACTIVITY	COMMENT
Sunday May 27th 2007	KABAROLE	Depart 12:00 a.m.- Arrive Fort Portal	Travel	Stay in Fort Portal
Monday 28th May 2007	KABAROLE and KYENJOJO	Meet with Regional office Travel to Kyenjojo	Visit LG Visit CSO	Stay in Fort Portal
Tuesday 29th May	KYENJOJO	Whole day	Continuation	Stay in Fort Portal
Wednesday 30th May 2007	KYENJOJO		CSO visit and travel to Mbarara	Depart at 4:00 pm for and stay in Mbarara
Thursday 31st May 2007	MBARARA and ISINGIRO	8:30 am Afternoon travel to Isingiro	Visit Regional Office Visit LG Visit CSO	Stay in Mbarara
Friday 1st June 2007	ISINGIRO	Whole day	Continuation	Stay in Mbarara
Saturday 2nd June 2007				Depart for Kampala

APPENDIX 4: Persons Involved

Stakeholder's meeting May 23, 2007 - Registration

	Name of guest	Organization	Title
1	Adoko George	Lira District	DCAO /FPP
2	Aggrey D. Kibenge	MOES	Principal Asst Sec
3	Alex Mugume	UPHOLD	S/HIV/AIDS Adv
4	Alice Mugoya Ibale	UPHOLD	PIASCY Prog Mgr
5	Allen Kebba		Evaluation Team
6	Andrew Balyeku		Evaluation Team
7	Andrew Kyambadde	USAID	UPHOLD CTO
8	Anthony K. Mugasa	UPHOLD	IRH Specialist
9	Augustine Wandera	MEMS	M&E
10	Barbara Durr	UPHOLD	DCOP
11	Betty Mpeka	UPHOLD	SCDS
12	Christine Oryema-Lalobo	UPHOLD	Regional Director North
13	Cissy Kirambaire	AIC	M&E Mgr
14	E. Mukooyo	MOH / RC	ACHS/KC
15	E.F. Katumba	MOH/RH	PMO
16	Elise Ayers	USAID	H/A Team Leader
17	Elizabeth Ekochu	UPHOLD	DCOP / M&E
18	Elizabeth Madraa	MOH/ACP/STD	PM
19	Francesca Akello	UPHOLD	CPC North
20	I. Makumbi	MOH	ACHS
21	J. C. Okello	UPHOLD	Regional Director
22	Katrina	UPHOLD	DCOP / FA
23	Kusemererwa Araali E.	MOES	Ag. PEO/PPE
24	Luwa John Charles	Gulu DLG	HIV/AIDS FPP
25	Margaret Kyenkya	UPHOLD	Snr. Health Adv
26	Matsiko Michael	UPMA	Executive Director
27	Musisi Geoffrey	UPHOLD	Grants Mgr
28	Namusisi Mary	UPMA	Branch Coordinator
29	Nyehangane W	Isingiro DLG	DHO
30	Owarwo Vincent	MEEP	Programme Director
31	Patrick K. Mutabwire	MOLG	C/LCD
32	Peter Barron		Evaluation Team Leader
33	R. Walusimbi	USAID	M&E Specialist
34	Robert Ochai	TASO	D. ED
35	Samali T. Lubandi	AIC	Ag. ED
36	Samson Kironde	UPHOLD	CEO
37	Saul Onyango	MOH	SMO
38	Sekimpi-Kirwana Lawrence	TUKO	Programme Mgr
39	Specy Kakiiza	UPHOLD	CPC / Ag. RD
40	Tumukurate Espilidon	UPHOLD	Regional Director

Evaluation Debrief June 08, 2007 Participant list

	Name	Organization	Title
1.	Adoko George	Lira DLG	DCAO (FP)
2.	Akol Zainab	MOH	PMO
3.	Alice M. Ibale	UPHOLD	Prog Manager-PIASCY
4.	Allen Kebba	Evaluation Team	Evaluation Team Member
5.	Andrew Balyeku	Evaluation Team	Evaluation Team Member
6.	Anthony Kihika Mugasa	UPHOLD	IRH Specialist
7.	Apollo Nkwake	UPHOLD	M&E Specialist
8.	Barbara Durr	UPHOLD	DCOP
9.	Buzaalirwa Lydia	UPHOLD	HIV/AIDS Specialist
10.	Byaruhanga Raymond	TASO	Executive Director
11.	C.Okello	UPHOLD	Regional Director,
12.	Christine Oryema-Lalobo	Evaluation Team	Evaluation Team Member
13.	Dorothy Aanyu Angura	UPHOLD	Snr. Ed Advisor
14.	Francesca Akello	UPHOLD	CPC North
15.	Geoffrey Musisi	UPHOLD	Grants Manager
16.	Jessica Kafuko	USAID	Prog Manager Specialist
17.	John Kyakulaga	UPHOLD	Private Sector Specialist
18.	Josephine B. Kasaija	UPHOLD	OD Specialist
19.	Joshua Kakaire Kibedi	UPHOLD	Data Manager
20.	Justine Nankinga	MOH	Evaluation Team Member
21.	Kenneth Mulondo	UPHOLD	BCC Specialist
22.	Kikaffunda Richard	UPHOLD	CPC
23.	Kusemererwa Araali Emmanuel	MOES	Ag. PEO/PPE
24.	Lucy Shillingi	UPHOLD	DCOP Tech
25.	Mugume A. B.	UPHOLD	Snr. HIV/AIDS Advisor
26.	Mutebi Perez	TUKO Club	Member
27.	Nyehangane William	Isingiro DLG	DHO
28.	Opwonya John Odong	Gulu DLG	DTLS/UPHOLD
29.	Paul Kagwa	MOH	ACHS HP&E
30.	Peter Barron	Evaluation Team	Evaluation Team Leader
31.	Rhona Walusimbi	USAID	M&E Specialist
32.	Robert Ochai	TASO	Deputy ED
33.	Samson Kironde	UPHOLD	COP
34.	Souleymane Barry	MEEPP	Advisor
35.	Specy Kakiiza	UPHOLD	Regional Director
36.	Xavier Nsabagasani	UPHOLD	Snr. Action Research Specialist

Internal debrief June 07, 2007 – Participant list

	Name	Organization	Email
1.	Alex Mugume	UPHOLD	amugume@upholduganda.org
2.	Alice M. Ibale	UPHOLD	aibale@upholduganda.org
3.	Allen Kebba	ET	arkconsult@siticable.co.ug
4.	Andrew Balyeku	ET	abalyeku@gmail.com
5.	Augustine Wandera	MEMS	awandera@mems.co.ug
6.	Barbara Durr	UPHOLD	bdurr@upholduganda.org
7.	Christine Lalobo	UPHOLD	clalobo@upholduganda.org
8.	Elise Ayers	USAID	eayers@usaid.gov
9.	Geoffrey Musisi	UPHOLD	gmusisi@upholduganda.org
10.	Justine Nankinga	MOH	nankingaj@yahoo.co.uk
11.	Lucy Shillingi	UPHOLD	lshillingi@upholduganda.org
12.	Pascal O. Okello	UPHOLD	pokello@upholduganda.org
13.	Rhona Walusimbi	USAID	rwalusimbi@usaid.gov
14.	Roy Thompson	MEMS	roy@mems.co.ug
15.	Samson Kironde	UPHOLD	Skironde@upholduganda.org
16.	Xavier Nsabagasani	UPHOLD	xnsabagasani@upholduganda.org

List of People Interviewed in Districts

Kyenjojo District

Kyenjojo Local Government

Peter Nsugura Ruhweeza:
Ag. Deputy Chief Administrative Officer/UPHOLD Focal Point

Julius Bahinda:
District Health Officer

Musinguzi:
DCCA

Kimara H.E:
DRS

Ruhweza F.
Senior nursing Officer/District Health Visitor

Mujaasi David
District Health Inspector

Asiimwe S. D
Senior Education Officer

Tibakamya G
District Education Officer

Inkasiimire A. Peter
District Inspector of Schools

Bwerere George
District Health Educator

Mbabazi Jullet
Community Medicine Distributor

Kyegagwa Health Centre 11

Dr. Mucunguzi
Medical Officer in Charge

Akello Tabitha
Nursing Officer

Busibye Lawrence
Senior Clinical Officer

Kyakatara Health Centre and Fort Portal Diocese

Fr. Kaahwa Leopold
HIV/AIDS Focal Point

Rev. Kalyebara Stephen
Exec. Director DEFORA Diocese

Baguma Monic
PSS Group member

Marunga Beatrice
Administrative assistant

Kobisingye Doreen
Accountant

Kamaningo I
PSS Group member

Bagonza Joseph
PSS Group member

Mbabazi Consolata
PSS Group member

Kanunyazi Jennifer
PSS Group member

Isoke Tom
PSS Group member

Ayebala Josephine
PSS Group member

Tooro Kingdom

Mirembe Justine
Programme Officer

Tumuhairwe Raymond
Programme Manager

Mawambi Wilson
Programme Finance and Admin. Officer

Rwamuhokya Robert
Programme Field Officer

Hunhhilda Angela
Nursing Officer

Basemera Esther
Enrolled Midwife

RWIDE
Mubiru Vincent
Technical Adviser

Mukasa Robert
Finance and Administrative Officer

Kanyambe Godfrey
Agricultural Programme Officer

Byansi Ben
Coordinator KAAC)RWIDE partner

Asiimwe Charles
OVC officer (Volunteer)

Post Test Club Members RWIDE
Mwesige
Kantagomba
Asiimwe Beth
Asiimwe Catharine
Musa
Kemigisa Grace
Kobusinge Veronica
Tuhaise Rest
Mwanuttya Erick
Kumhendo Rose
Mbabazi Maga
Tumuhibmise Kristina
Kajumba Leya
Kiza Asa
Nyangireki Sisiria
Kemigisha S
Kobusinge M
Fibasaga F
Banaura Joana
Banobere E.
Kirokimu Felista
Akelo Katalina
Manyindo Mbabazi
Tibakanya Felista
Kanyunyuzi Keeti
Kemigisha Violet
Razigata Mary

Isingiro District

Isingiro District s
Byakatunda Tom
Ag. Chief Administrative Officer

Nyehanganew
District Health Officer/ UPHOLD Focal point

Monday Justus
District Immunization Focal Point

Byaruhanga Grace
Ag. DEO

Oyesigye Fred
District Malaria Focal Point

Kansiimwe Juliet
Katusiimwe Mwesige
Kasukale Gres
Kabosomi Margaret
Kobosinge Macureti
Kabakidi Mary Kaddina
Kabagenyi Sitela
Kagaba Oliver
Tibakanya Efurazia
Kabajuma Erinora
Ahebirungi Robati
Kimanya Jona
Kajumba Kikitoliya
Kasembo Jennifa
Kembabazi Olivia
Kengozi Mary
Asiimwe Feluku
Sunday Jasi
Edikana Kamuhendo
Kisembo Asa
Katusabe Grace
Kabajwara Oliver
Kezabu Sarah
Kabagombe Rest
Akugizibwe B
Tibasage Fatima
Abas Kasaija
Kabosinguzi H
Kabonera G
Ahugizibwe Oliver

Be Faithful Couple Counselors
Kaganda George
Kaganda Grace
Rukooba Angelica
Rukooba Abwooli John Bosco
Nkoko William
Nkoko Gorett
Baguma K. Richard
Baguma Stella
Basaliza Wilson
Basaliza Jamima
Kaya Beatress
Kaya William
Rwaheeru Taddeo

Mugisha Godson
District TB/Leprosy Supervisor

Maturity Audio Visual
Namara Joseph
Chairman Maturity Audio Visuals

Tumesigye Wycliff
Coordinator

Rev Canon Francis Mutatwine
Greater Mbarara

Zimbeiha Joseph
Programme Manager

Rwabogo Annet
Kugonza Enid
Mwebesa Moses
Asaba K Faith
Asaba K Arthur
Zainabu Karungi
Mujaasi Abdul Noor

Kyembogo Holy Cross Mission Health Centre
Tusiimwe Florence
Chairperson PLWA

Ayabale Owen
Deputy Director

Sr. Angelica Birungi
Director

AIFIA Post Test Club
Tinka Mary
Halwima Y
Musiime E
Sayuni M
Katusabe R
Atuzarirwe B
Tungumisirize O
Bazimazikyi M
Kyesirikora M
Kazigati Beatrice
Tumwesigye M
Shera Kabaganda
Katushaba Cozi
Banyenzaki Amos
Kabanyaka Marga
Kusenene Edward
Majara Mary Grace
Kabasambu Enid
Kobusinge Hope
Twesigye Robert
Nsungwa Anazia
Maliya
Murungi
Yazefu Amanyire
Rusia Ahaisibwe
Yovani

Mayanja Memorial Hospital Foundation
Mugerwa Benon
Hospital Director

Yvonne Natukunda
Programme Manager

Oniel Patrick
Data Manager

Tumwebaze Henry
Homebased HCT and care supervisor

Mugisha Naboth
Finance Officer

Baketunga Johnson
Counselor

Aisha Muslim Girls School Abstinence Club
Nakatoogo Nazifah
Chairperson

Mpeirwemukama Dorothy
Assistant Chairperson

Namuddu Mariam
Secretary

Nabakooza Amisah
Assistant Secretary

Nankabirwa Rose
Choir Mistresss

Akandanaho Privah
Assistant Choir Mistress

Linday Kamay
Speaker

Gulu District

Otto Langoya Sahid
Chief Administrative Officer, Gulu

Opwonya John Odong
UPHOLD Focal Person

Luwa Jogn Charles
HIV/AIDS Focal Point for Gulu District

Ojul Lakop Christine
Yellos Star Focal Point Person

Ojok Richard Napthali
HIMS In Charge

Awuru Felix
Odwar Santa
Assistant Chief administrative Officer

Samalie Nabossa
Programme manager, World Vision

Christine Lamuno
Councilor Bungatira LC3

Catherine Aromorach
HIV/AIDS Coordinator, world Vision, Gulu

Beatrice Acan
Clinical Officer, Bungatira Health Centre 11

Ayoo Phoebe Ocan
Community Development Facilitator, World Vision

Sanya Gilbert
Community Development Facilitator, World Vision

Charles Wasswa
Community Development Facilitator, World Vision

Abwola Sunday
Technical Adviser, ACCORD

Jack Walter
Staff member ACCORD

Charles Otto
Staff Member ACCORD

Obutu Francis
Health Alert

Ojok walter
Redeemed Bible Way Church Organization

Auma Lily
Community AIDS Resources

Opira George William
Accountant, Redeemed Bible Way Church Organization

Luom Timothy
Secretary, Agonga Youth Alliance

Awany John
Treasurer, Agonga Youth Alliance

Akullu Jane
ACCORD

Geoffrey Okello
Treasurer District Network PHAS

Kitara Nelson
Field assistant CARPP

George Opeluk
Chairman District Network PHAS

Aouny Michael
Chairperson, Lacwec Ber

Akwero Jacinta
Programme Officer, ACCORD

Geoffrey Binaisa Opiri
Accountant, Gulu Youth Centre

Lanyero Sarah
Medical Clinical Officer, Gulu Youth Centre

Kibwola Denis
Centre Manager, Gulu Youth Centre

Lira District

Benard Otim
Vector Control Officer, Lira District Local Government

Issac Ogwal
Chain Technician Officer, Lira District Local Government

Ocao John Bosco
HMIS in charge Lira District Local Government

APPENDIX 5: Interview tools

Interview Questionnaire - Standard

Introduction
Evaluation team commissioned by USAID to do end of programme review. 5 people

- What do you know about UPHOLD? *Probe for specific area*
- What has been the nature of the relationship with UPHOLD
- What contribution has UPHOLD made?
  Probe specific KPAs
  What was done where and when?
  Service delivery quality
  Public sector
  Private sector
- How has your department engaged with UPHOLD?
- What areas has UPHOLD achieved/contributed?
  Probe for limitations
- Has UPHOLD done a good job?
  Probe for what should have been done differently/weaknesses/limitations
  Probe yes/no
- What has UPHOLD achieved? *Illustrate with examples*
- Why was this achieved? *Illustrate with examples*
- Should there be another UPHOLD? *Probe yes/no*
- Is there anything else about UPHOLD that we haven't asked?

THANK YOU

Interview Questionnaire UPHOLD staff

Introduction

- Describe your job in UPHOLD

- What is your understanding of UPHOLD?

Probe what is nature of programme; what is the big picture? What are the interventions? Was the intention to have integrated interventions a success or not? What were the problems related to integration and multi-sectoral programme? What was the influence of external factors?

- What have been the achievements of your section/department/area made?

  Probe specific KPAs
  What was done where and when?
  Service delivery quality
  Public sector
  Private sector

- How have these achievements contributed to the overall health goals of Uganda?

- Has UPHOLD done a good job?
  - UPHOLD generally
  - Your Department/section specifically

  Probe for what should have been done differently/weaknesses/limitations
  Probe for what activities/targets have not been achieved and why?

- How has UPHOLD managed relationships?

  Probe for implementing partners/MOH/civil society/USAID (for DCOPs)
  Probe communication/interaction with stakeholders/focus/centre vs district (relationship with LG as well)
  Probe for other implementing agencies (e.g. UNICEF)

- What could have been done differently/better?
  - UPHOLD generally
  - Your Department/section specifically

- Were there any unanticipated activities? Did these result in positive/negative outcomes/results
- What are the main lessons that you have learnt?

- Should there be another UPHOLD? *Probe why? Why not just SWAPS where money given to the government?*

- Have you personally benefited/been capacitated by working for UPHOLD

Is there anything else about UPHOLD that we haven't asked which you think is important?

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