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END-OF-PROJECT EVALUATION OF THE ACE PROGRAM

FINAL EVALUATION REPORT

September 2009

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Executive Summary

This report presents the findings, conclusions and recommendations of an external evaluation of Chemonics' AIDS Capacity Enhancement (ACE) project in Uganda. The USAID AIDS Capacity Enhancement (ACE) Project was a three-year project (2006-2008) that was granted a one-year extension (2008-2009) to build various capacities of selected Ugandan organizations and institutions, for improved and sustainable program outcomes in HIV/AIDS prevention, care, and treatment.

The ACE project provided technical assistance, training, and material support (supplies and equipment) to two public institutions: the Uganda AIDS Commission (UAC) and the Ministry of Health Resource Center. In addition, it gave technical support to four HIV/AIDS service delivery non-governmental organizations (NGOs): the Inter-Religious Council of Uganda (IRCU) and its network of faith-based organizations, the Joint Clinical Research Center (JCRC), Hospice Africa-Uganda (HAU) and the Uganda Women's Efforts to Save Orphans (UWESO).

ACE's support to the above organizations was intended to focus on five thematic areas: organizational development, monitoring and evaluation, health management and information systems (HMIS), finance, and communications. The project also provided facilitation and coordination support to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in Uganda by supporting the U.S. team and in-country counterparts in planning, coordinating, and managing the PEPFAR investments in the national HIV/AIDS response in Uganda. This support was based in the 'three ones' framework: one national coordinating body for HIV/AIDS, one monitoring and evaluation framework, and one national strategic plan for HIV/AIDS.

Most of the ACE capacity building interventions (95% of direct expenditures) centered on three components: finance management, management information systems, and monitoring and evaluation. ACE's support in these areas was dominated by interventions in electronic applications: installation and introductory training in the use of selected software; development of databases and websites; and procurement of basic computer hardware (servers and accessories) to host the databases.

ACE's investment in organizational development was relatively modest at only 5% of the total direct expenditures but it stimulated major organizational change, especially in some of the targeted NGOs. This is perhaps indicative of the level of readiness of the organizations to undergo organizational change in order to improve the delivery of their programs.

a. Project Achievements

- Organizational Development (OD) interventions triggered positive developments in some organizations for capacity development at their headquarters. Non-profit organizations are committed to genuine improvements and are able to absorb changes. Thus, the potential for benefiting from the ACE support was based on the culture of the organizations. The two organizations benefiting most from ACE's efforts are HAU and IRCU. The key characteristics of these organizations were their participatory character, their focus on their target populations, a democratic leadership, and an authentic sense of independence from local politics.

- Some capacity building interventions contributed to reshaping the organizations to better position themselves for resource leveraging to expand services. This seems to have been the case with HAU with its significant effort to make palliative care more visible and acceptable and the case with UWESO with its new fund raising initiatives.

- The introduction of tools for data gathering and analysis brought about increased interest in activity monitoring and impact evaluation. Staff members are more sensitized, at least at the headquarters level, about results and their analysis. Progress in M&E interventions were minor but it may have triggered some openness for change in the future. Thus, improvements in some of the organizations could constitute the basis for future capacity building in service expansion.

b. Areas for Strengthening the ACE Capacity Building Interventions

- The project lacked an appropriate capacity building framework to guide the interventions. This absence facilitated the remarkable shift toward computer application and technology interventions with little attention paid to organizational development, resource development, community linkages, programming and services.

- Greater emphasis was placed on central offices without attention to the field/service delivery, thereby hindering the potential for capacity building within the organizations.

- The absence of a comprehensive conceptual framework for M&E promoted the development of 'tools' as 'systems.' No linkages were made between interventions and the service delivery level. Therefore, it is impossible to determine any measure of impact.

- Training was heavily emphasized as an intervention with little attention paid to its methodological aspects, evaluation and follow-up of its application by the trainees.

- Outsourcing most of the technical assistance to local consultants (57% of the contract), was an attractive strategy that did not produce the expected results.

- ACE itself was thinly staffed, particularly in the areas of OD, IT and M&E.

- Limited involvement of the targeted organizations in the leadership of the program triggered inadequate absorptive capacity.

c. Lessons Learned

To implement a powerful capacity building program it is necessary to focus on the entire organization and not only on the individuals who are part of the organization. More often than desired, the focus of the main intervention in capacity building is training and, indeed, while training is an important input but it is not capacity development in it's entirely. The most critical aspects of capacity building are the use of new information on the job and team building. It is important that the user team should review, streamline, and strengthen its capacity building framework. The ACE project should be considered as a key learning experience to better frame useful capacity building and organizational development interventions in the area of HIV/AIDS in the future.

As NGOs play increasingly important roles in the fight against HIV/AIDS, it becomes critical for them to perform effectively. A new development in this area is that NGOs have an interest in organizational practices that help build high-performing organizations and strong programs. Most NGOs are small and have limited resources, particularly when compared to the challenges and critical issues that they aim to address.

NGOs tend to focus on their programs. Their leadership and staff need to devote attention to capacity building – to think early and often about strengthening the organization simultaneously with implementing programs. One of the most discouraging barriers hindering the ability of NGOs to engage in capacity building is the sometime unhelpful funding environment. NGOs understand that a majority of donors prefer to allocate their contributions to support particular projects or programs. In this context, USAID has made a significant difference in facilitating the implementation of local capacity development ventures and this constitutes a most welcome exception.

Despite the emphasis on the importance of capacity building, the field still lacks a shared definition of the term and there is little information about what works and what do not work in building capacity in NGOs. Thus, while the benefits of improved capacity are undeniable, the effort of building capacity can seem daunting. Almost everything about building capacity in NGOs takes longer and is more complicated than one would expect and the need is not always apparent to staff, volunteers, board members, and donors. NGOs need to take on the difficult and painful task of assessing their own capacity and identifying the gaps that need to be filled.

The connection between increased capacity and increased impact is hard to measure and to quantify. However, a few successful experiences clearly indicate that one does lead to the other. After perfecting and streamlining their programs, NGOs necessarily need to invest in building their organizational capacity to deliver programs more effectively and efficiently or to replicate their success in other locations and among sister organizations. Unless they invest in capacity building, they will be incapable of fully sharing in the promise to control the HIV/AIDS epidemic in the country. For both institutions linked to the Ministry of Health such as the Resource Center and the AIDS Commission and the NGOs more directly associated with the delivery of HIV/AIDS services, the strengthened monitoring and evaluation must be directly connected to improving and expanding service delivery. However, while for the latter the main M&E task should focus on the timeliness and effectiveness of the activity monitoring, for the former the main task is organize and disseminate the key facts associated with the determinants explaining HIV/AIDS programmatic results.

It therefore rests with donors, founders, organization leaders and staff to support NGOs efforts to build organizational capacity. Coincidently, donors have become more and more committed to support the NGO organizational capacity. In addition, non-profit organizations need leaders who are committed to taking the initiative to make capacity building happen and are willing to “own” it and drive it down throughout the organization.’ Strengthened organizational capacity to improve services depends on available resources for program development.

There is a need for more capacity building but with an appropriate operational approach. The organizations need to focus on building the capacity of their entire organization if they want to maximize their social impact. Interventions putting the emphasis on the headquarters usually

miss the need to develop capacity at regional level, particularly in respect of coordination, supervision and timely supply, and at the service delivery level where, usually, people are in urgent need of new skills and knowledge to better organize services and plan service delivery strategies. Of course, to neglect the central level would also be a serious mistake.

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List of Acronyms

ACE	AIDS Capacity Enhancement Project
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBO	Community-based Organization
COP	Council of Presidents
FBO	Faith-based Organization
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HAU	Hospice Africa-Uganda
HCI	Healthcare Improvement Project
HMIS	Health Management Information System
HR	Human Resources
HSSP	Health Sector Strategic Plan
ICT	Information Communication Technology
IT	Information Technology
IP	Implementing Partners
IRCU	Inter-Religious Council of Uganda
JCRC	Joint Clinical Research Center
LAN	Local Area Network
L&M	Leadership and Management
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MIS	Management Information System
MOH/RC	Ministry of Health Resource Center
NCCS	National Comprehensive Communication Strategy
NGO	Nongovernmental Organization
NSP	National Strategic Plan
NUMAT	Northern Uganda Malaria, AIDS, and Tuberculosis program
OD	Organizational Development
OVC	Orphans and vulnerable children
PC	Palliative Care
PEAP	Poverty Eradication Action Plan
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLWA	People Living with AIDS
PMMP	Performance Measurement and Management Plan
PMRD	Patient Management and Reporting Database
PLWA	People Leaving with HIV/AIDS
RCB	Religious Coordinating Bodies
RCE	Regional Center of Excellence
TREAT	Timetable for Regional Scale Up of Antiretroviral Therapy
TRG	Training Resources Group Inc.
UAC	Uganda AIDS Commission
UMEMS	Uganda Monitoring and Evaluation Management Services
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

UWESO	Uganda Women's Effort to Save Orphans
wHMIS	Web-enabled Health Management Information System
WHO	World Health Organization

1. Introduction

USAID is a key donor working to improve the capabilities of people, institutions, and governments in order to enhance local expertise and strengthen countries ability to achieve their development objectives in health and particularly in HIV/AIDS. Capacity building would enable national programs – government, public, private, nongovernmental organizations (NGOs), and community-based institutions – to design, implement, finance, and evaluate sustainable HIV/AIDS programs. If successful they will become leaders in HIV/AIDS delivery and a source for technical assistance and training to other public sector institutions and private organizations. Capacity building is integral to the concept of sustainable programs; that is, the ability of individuals to identify priority problems, to propose reasonable solutions, and continue efforts to solve problems. The AIDS Capacity Enhancement (ACE) Project was a four-year project – it included a three-year (2006-2008) commitment with a one- year extension (2008-2009). The project's overarching goal was to build various capacities of selected Ugandan organizations and institutions for improved and sustainable program outcomes in HIV/AIDS prevention, care, and treatment.

The ACE project provided technical assistance, training, and material support (supplies and equipment) to two public institutions: the Uganda AIDS Commission (UAC) and the Ministry of Health Resource Center. In addition, it gave technical support to four HIV/AIDS service delivery organizations: the Inter-religious Council of Uganda (IRCU) and its network of faith-based organizations, the Joint Clinical Research Center (JCRC), Hospice Africa-Uganda (HAU) and the Uganda Women's Efforts to Save Orphans (UWESO). ACE assisted these organizations in five thematic areas: organizational development, monitoring and evaluation, health management and information systems (HMIS), finance, and communications. The project also provided facilitation and coordination of the PEPFAR team. ACE provided technical services that support the U.S. team in planning, coordinating, and managing its HIV/AIDS program in Uganda, including supporting achievement of the 'three ones:' one national coordinating body for HIV/AIDS, one monitoring and evaluation framework, and one national strategic plan for HIV/AIDS. In September 2008, ACE received a one- year extension to continue working with the same client organizations and to support the PEPFAR Country Team coordination and planning efforts. The ACE project committed to the following deliverables:

- Strengthened capacity of the UAC to provide strategic leadership to Uganda's HIV/AIDS program; to direct the formulation of one national monitoring and evaluation framework for HIV/AIDS, and to coordinate the overall HIV/AIDS response.

- Strengthened capacity of the MOH/RC to collect data, monitor, analyze, and report on key HIV/AIDS indicators that will be part of the national HIV/AIDS M&E framework.

- Strengthened capacity of the IRCU as well as to strengthen the capacity of the IRCU grantees in financial management, governance/strategic leadership of its program, monitoring, analysis, and reporting on program impact, and improvements in the application of quality standards and best practices to its grantees' programs.

- Strengthened capacity of selected national NGOs in specific targeted areas that lead to improved efficiencies and program outcomes. Specifically, strengthened capacity of the JCRC, HAU, and UWESO through improved systems in planning, finance, monitoring and evaluation, and ICT as well as an updated organizational structure.

- Support given to selected HIV/AIDS policies and strategies such as the National Strategic Plan and the palliative care advocacy strategy that contribute an improved policy environment.

The primary purpose of this evaluation, as defined by the USAID Mission in Kampala, was to analytically examine the overall project to:

1) Determine how appropriate the ACE approach was for capacity building to each client organization.

2) Determine the extent to which ACE has achieved its intended results for each client organizations, what factors facilitated and/or hindered the achievements of planned results and what are the remaining gaps/weaknesses in systems support for each organization.

3) Determine the extent to which the capacity building provided by ACE has contributed to the client organizations' overall performance in delivery of HIV/AIDS programs.

4) Determine the cost-effectiveness of the ACE interventions.

5) Identify the key lessons learned for capacity building programs in Uganda and elsewhere.

6) Identify positive or negative unintended results from ACE's interventions and what factors determined such unintended results. (see Appendix a for full scope of work)

2. Study Approach and Methods

2.1. The Conceptual Framework for Evaluating Capacity Building

The ACE Project was largely designed to develop the organizational and institutional capacities of six partners - UAC, MOH/RC, IRCU, JCRC, HAU and UWESO. Capacity building was identified as a need at the organizational level to enable these organizations to become fully capable of achieving their development tasks, focusing on addressing the HIV/AIDS needs of the Uganda people, and to have confidence in their future sustainability.

Thus, capacity building seems to be the primary concern of the project. Given this focus, the evaluation team required a capacity building framework in terms of which to conduct the assignment. The most appropriate option would have been to frame the evaluation using the conceptual reference used by Chemonics, that is, the Star Model developed by Jay Galbraith (1962) model for analyzing and developing organizational designs in the corporate world.

Unfortunately, this model is not a capacity building framework as discussed in greater detail in Section 3 of this report.

For that reason, conceptually, the evaluation team has followed a framework specifically designed to develop and assess capacity building interventions; namely the McKinsey model (2001)[1].

Capacity building can be conceptualized as comprising the following seven elements organized in three categories presented as depicted in Figure 1.

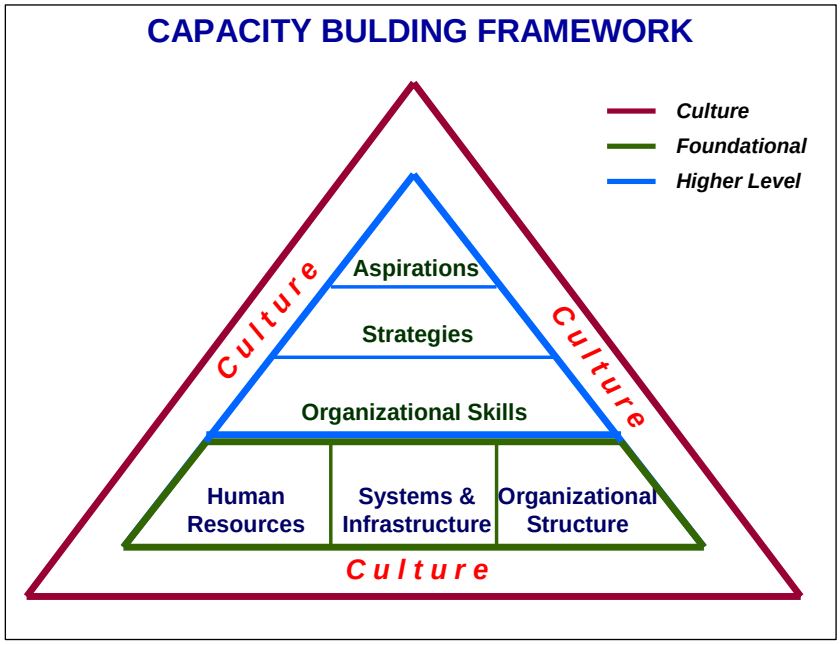


Figure 1: McKinsey Capacity Building Framework

Culture or connecting category, defined as the relational mechanisms binding the organization together, including shared values and practices, behavioral norms, and most important, the organization's orientation towards performance.

Superior level category, a category with three elements: *Aspirations* defined by the mission, vision, and overarching goals, *Strategy* defined by actions and programs aimed at fulfilling the organization's overarching goals, and *Organizational skills* defined by the capabilities, including performance measurement, planning, resource management, etc.

Foundational category, also with three elements: *Human resources* defined as the collective capabilities, experiences, potential and commitment of the management team, staff, and volunteers; *Systems and infrastructure* defined by the planning, decision making, knowledge management, and administrative systems, as well as the physical and technological assets that support the organization; and *Organizational structure* defined by the combination of governance, organizational design, inter-functional coordination, and job descriptions that shape the organization's legal & management structure.

By combining all the seven elements of organizational capacity in a coherent diagram, the pyramid emphasizes the importance of examining each element both individually and in relation to the other elements. Interestingly, in this framework, culture is the key factor that wraps and connects all the other elements, while in the Star Model, culture is merely a dependent variable.

Considering ACE's objectives and scope, the evaluation team has used this framework to review the implementation of its capacity building strategy. Thus, this review considered an inventory of

[1] Mckinse Co. (2001) 'Effective Capacity Building in Nonprofit Organizations' prepared for Venture Philanthropic Partners.

all the activities implemented in this area during the last four years. It also, proposes an alternative framework for future ventures. This framework has guided our assessment of the existing capacity at different organizational[2].

Operationally, this evaluation used the outline for evaluating organizational capacity building devised by Steven Mayer (2001)[3]. This capacity building evaluation outlines four focus areas as summarized in Table 1 below. **Organization Development** with particular attention on the Board, the Administration and the Staff; **Resource Development**, focusing in Fund Development, Communication and Operation Budget; **Community Linkages** with attention on Community Linkages, Leadership Skills and Contribution to Progress; and **Programming and Services**, focusing in Program Design, Strategic Activities and Learning from Practice.

Table 1: Meyer's Organizational Capacity Building Areas for Evaluation

Components	Areas
AREA 1: ORGANIZATIONAL DEVELOPMENT	
1. Board:	Board functioning that increasingly serves the development of the organization's mission, its administration, resources, community linkages, and programs
2. Administration:	Strengthened policies, procedures, and practices that enable the organization to make meaningful progress.
3. Staff:	Staff complement with enhanced skills and support to undertake the work addressed by the organization's mission.
AREA 2: RESOURCE DEVELOPMENT	
4. Fund development:	A fund development strategy that allows the organization to grow realistically, and sustainable.
5. Communications:	Increased visibility and attractiveness of the organization in appropriate segments of the community.
6. Operations budget:	Increased financial support, and broadened base of financial support.
AREA 3: COMMUNITY LINKAGES	
7. Community linkages:	Strengthened relationships between the organization and different segments of the community
8. Leadership skills:	Increased expertise in the variety of roles that the organization can play in addressing its mission.
9. Contribution to progress:	Increased momentum and support gained in the community for making progress on the organization's mission.
AREA 4: PROGRAMMING & SERVICES	
10. Program design:	Increased use of program designs that stand the best chance of delivering valued benefits to the program's intended beneficiaries.
11. Strategic activities:	A "portfolio" of projects, grants, or support activities conducive to achieving impact in the organization's chosen issue area.
12. Learning from practice:	Strengthened approaches to other issues or projects undertaken by the organization.

2.2. Methodology

This evaluation used multiple sources of evidence to obtain a comprehensive and in-depth understanding of complex, diverse and multiple phenomena present in ACE's assistance, to control the errors implicit in any chosen research method, to support sound analyses, to arrive at practical conclusions, and to make accurate inferences.

The ACE Project involved several groups whose activities significantly affect the final results of the interventions. At the core of the project, although unreachable, is the target population who are the beneficiaries of project interventions - People at risk of AIDS, People Leaving With AIDS (PLWA), Orphans and vulnerable children (OVC) and their families. Second, we have the implementation partners whose activities are key to achieving results. Third, we have the health

[2] McKinsey & Company. 'Capacity Grid', Investing in Social Change, Venture Philanthropy Partners 2001. www.venturephilanthropypartners.org

[3] S.E. Mayer (2001) Organizational Capacity Building: Areas for Evaluation. Effective Communities Project. www.efectivecommunities.com

managers at local, district and regional levels. Fourth, we have the country level managers directly involved in guiding project interventions and operations. And finally, we have the ACE management and staff who have implemented the enhancement capacity efforts and the USAID officers who monitor and guide the entire process. A list of respondents is included as Appendix B.

- **Review of relevant documents.**

Many publications were consulted and reviewed in order to obtain a comprehensive understanding of the HIV/AIDS situation in Uganda as well as the USAID Mission goals. They included: project annual and other reports, financial documentation, monitoring reports and accompanying databases, research reports and accompanying databases, training reports, curricula, protocols, (BCC) materials, and other materials. The Evaluation Team analyzed the results achieved against the targets and benchmarks set. ACE itself had conducted capacity assessments of its institutional partners and these, together with their data collection tools, were reviewed by the evaluation team. See Appendix C for a list of documents reviewed.

Other documents reviewed included more general contextual sectoral data on the status of HIV/AIDS capacity building in the health sector from the GOU, USAID and other donors. These included inter alia the Government of Uganda's National frameworks, policies and implementation guidelines from the Uganda AIDS Commission and the Ministries of Health and Gender. See Appendix D for a listing of technical documents consulted during the assignment.

- **Design and Preparation**

The agenda and protocol as well as evaluation instruments were developed in Kampala by the evaluation team before the start of data collection. A detailed agenda of visits to various sites was prepared and is included in the work plan. See Appendices E and F for further details.

- **Data Collection Methods and Instruments**

The evaluation methodology used a combination of the following qualitative techniques:

- **Key informant interviews** with relevant staff of USG/Uganda, ACE and other key stakeholders. Key Informant Interviews were held early in the evaluation process with the technical and management staff of the relevant USG agencies and the ACE project which enabled the evaluation team to understand the project**.**

- **In-Depth Interviews** with ACE's clients that had been supported by the project. The Evaluation Team visited each of the six partners at which in-depth interviews were held with a senior staff and a review of the current status of the organizations' capacity undertaken using the tools developed by the Team. Each visit took approximately one-half day with the full Evaluation Team working at each site with the exception of the visit to the MOH Resource Center that was undertaken by the M&E/HMIS Specialist alone.

- **Application of a standardized tool** to assess capacity in the six partner organizations and a sample of their branches/centers/regional offices. The Evaluation Team selected 24

branches, regional centers and/or sub-grantees of the six partners for further in-depth interviews using the assessment tool as summarized in Table 2 below.

Table 2: Organizations and Sites Visited by ACE Evaluation Team

Week 2	Week 3	Week 4
ACE: General ACE: M&E ACE: Finance PEPFAR ACE: L&M ACE: ICT ACE-Evaluation Team: debriefing UAC IRCU RCB Catholic RCB Muslim ACE: Cost-Effectiveness	IRCU: Jinja (AOET, Bugembe) IRCU: Jinja (St. Francis) MOH/RC: Jinja (Ref. Hospital) JCRC: Jinja-Iganga (Hospitals) UWESO: MBale (Regional OVC site) MOH/RC: Mubende (DHO/HC) JCRC: Mubende (Hospital) IRCU: Wakiso (RCB- Orthodox) MOH/RC: Wakiso (DHO/HC) JCRC: Kampala Eagle-Nest IRCU: Kampala (RCB Anglican Namirenbe)	IRCU Kabale: (IP-KIHEFO) MOH/RC Kabale: DHO-HC JCRC Kabale (Hospital) JCRC: Mbarara (Hospital) COU Kisiizi – JCRC site and IRCU IP UWESO: Mbarara HAU: Mbarara (Hospice) IRCU: Mbarara (Catholic KAMUKUZI) MOH/RC: Mbarara (Hospital) IRCU: Lyantonde Muslim HC Masaka MoH RC UWESO: Masaka (Reg. Off. OVC site) MOH/RC: Masaka (Referral Hospital)

- **Field Work**

This assignment was scheduled from August 24 to October 2, 2009. The evaluation team spent a week (August 26 and September 1) organizing the evaluation and another week (September 3 and 7) interviewing ACE managers, NGO leaders and staff as well as visiting program sites in the Kampala area. In addition, the team spent two weeks (September 7 to 18) visiting program office sites and interviewing regional and district managers and local NGOs in ten districts - Kampala, Jinja, Iganga, Mbale, Mubende, Wakiso, Kabale, Mbarara, Lyantonde and Masaka.

The team then spent the two weeks (September 21 to October 1st) reviewing project data, reports and records, writing draft report and briefing managers and partners on the preliminary results and recommendation.

3. ACE's Approach to Capacity Building

The ACE Project's interventions were largely designed to develop the organizational and institutional capacities of six Ugandan organizations critical to the national AIDS response. This was based on a definitive idea at USAID that capacity building was needed at the organizational level for the organizations to become fully capable of achieving their development tasks, sustainable to be confident about their futures and to strongly focus on the HIV/AIDS needs of Ugandan people. As capacity building was the primarily concern of ACE, the project approached capacity building in a performance-driven mode, customizing response to the needs of each organization. Thus, the project's strategy aimed to assess "the resident or existing capacities of target organizations develop capacity-building plans to address identified gaps through technical assistance and skill building and monitor and document progress made in improving the operational efficiencies".

Galbraith developed the "Star Model" for analyzing business organizations in the 1960s. The model consists of a series of design policies that are controllable by management and can influence employee behavior. The policies are actually "the tools with which management must become skilled in order to shape the decisions and behaviors of their organizations effectively."

In the model (as illustrated in Figure 1), design policies fall into five categories: strategy policy determining direction; structure policy determining the site of decision-making power; processes policy determining the flow of information; rewards providing motivation and incentives for desired behavior; and human resource policy defining the selection and development of the right people. All these allow the organization to operate at maximum efficiency.

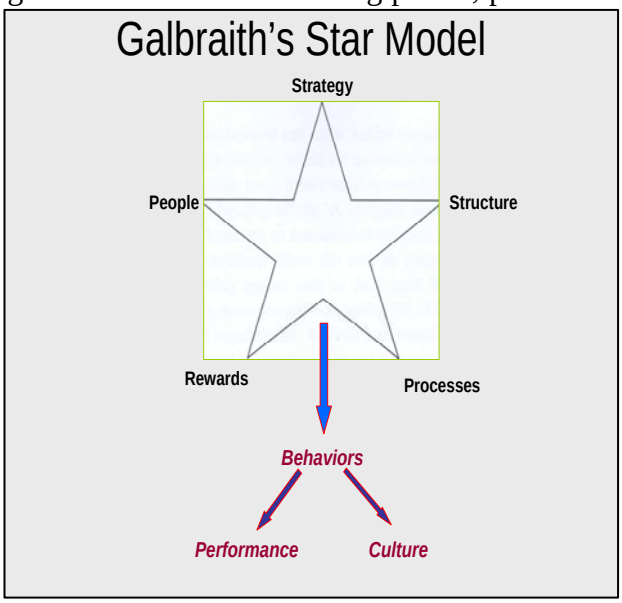


Figure 2: Galbraith's Star Model

The model illustrates the mechanisms managers can control and that can affect employee behavior. By choosing the desired behavior, managers can influence the organization's performance as well as its culture.

The Star Model fits well with Galbraith Management Consultants' clientele primarily, manufacturing companies to large global firms operating in several countries, where most of their clients are CEO's, presidents of business units, or heads of regional or global sales forces, who use the Star Model to assess their organizational practices[4].

Thus, in this corporate model, individual behaviors and culture are essentially products of the managers' actions and control, a view significantly different from the basic philosophy for NGO development, which although not always present, strives for a participatory approach to organization building.

The business approach adopted by the ACE Project greatly limited the project scope in the following respects:

- Made the project unable to focus on the organizational characteristics of the NGOs;
- Prevented ACE staff from thinking about people as the center of capacity building;

[4] Galbraith Management Consultant claims extensive experience in most major industries throughout North America, South America, Europe, and Asia. Their map, however, excludes Africa, and it is not involvement in nonprofit organization. Their expertise centers in Technology, Telecommunications, Health Care, Financial Services, Manufacturing, Energy (Oil, Gas, Nuclear), Airlines, Aerospace, Automobiles, Consumer Goods, Beverages, Engineering and Construction, Management Consulting, Diversified Conglomerates, Real Estate, Hospitality, Chemicals, Logistics and Distribution, Pharmaceuticals

- Hindered the prospects for intervening in the organizations as a whole and, instead, focusing on the top level from where changes could trickle down to the base;
- Dramatically limited the chance of the project to work with the cultures of the NGOs as a way to increase the learning processes and the practices of the organizations; and
- Restricted the interventions to the most discrete sections of implementation; that is, to support systems, believing that capacity building could happen through importing technology, such as software, database, IT, and websites.

It appears that from the beginning there was an unclear characterization of what the client and the contractor meant by *capacity building*. This lack of clarity was compounded by the unstable start of the project and the need to replace the COP shortly after start up. Due to this situation, the substantive focus on capacity building was to some extent replaced by the idea of *support systems,* which provided an easier path to define and operationalize interventions. This, combined with the early fielding of organizational assessments that were not able to provide the bases for defining an intervention package that contradicting the initial commitment to "customizing needs of each organization" revolved around three main areas: finance management, management information system, and monitoring and evaluation. Most of the interventions were then centered on these three components consuming 95% of direct expenditures.

There is no doubt that these three areas could have been woven into a significant capacity building effort. However, a subsequent step prevented the project from achieving this. That was the decision to concentrate on these three interventions an in electronic form. Thus, finance management turned into the selection and installation of finance software in the four NGOs; MIS became the development of databases, LAN applications and website design; and M&E morphed into databases and some software applications.

Nonetheless, there was not a clear and parsimonious description of the connection between software application and database design and the building of organizational capacity. In a sense, the project had become a computer system development enterprise. This brought about a situation that would further decrease the emphasis on capacity building; that is, interventions in the area of organizational development were severely neglected with only 5% of the budget allocated directly to this area.

Additionally, the significant investment in IT related interventions were not that successful. At the end of the project, ACE left several 'systems' unfinished or incompletely installed, databases unused, unworkable software and more significantly, people in the organizations who are unfamiliar with the products and probable results. That is, little progress was made in building capacity.

4. Results: Achievements and Challenges

This section reflects on the attainments and challenges of the ACE Project. Indeed, the project had a hard task to accomplish: to assist the capacity development of two public sector organizations and four NGOs in the field of HIV/AIDS sector in order for them to better strengthen the AIDS response in the country and to provide more and better services. Capacity building is a difficult area of intervention and achieving results requires the intertwining of different and sometimes complex activities. In addition, despite the emphasis on the importance of NGOs capacity building, the field still lacks a shared definition of the term and there is little information about what works and what does not in building capacity in NGOs. We seem to know little about what works and what does not work. While the benefits of improved capacity are undeniable, the effort of building capacity can seem daunting. Almost everything about building capacity in NGOs takes longer and is more complicated than one would expect. The need for developing new capacities is not always apparent to staff, volunteers, board members, and donors.

The results from the ACE capacity building interventions need to be analyzed in light of this difficult and demanding context. For this reason, we have taken this assignment with utmost openness, with total understanding of the challenges ACE faced in implementing its interventions and full appreciation for the hard work ACE executed over four years.

The two following tables depict the manner in which the ACE project organized its interventions and tasks. First, it organized them in five thematic areas Monitoring and Evaluation (M&E), Information Technology/Health Management Information System (IT/HMIS), Finance, Organizational Development and Communication—targeting the six partner organizations.

Table 3: ACE Direct Expenditures on Six Institutions by Thematic Areas of Interventions

Area/Org	MOH/RC	UAC	JCRC	IRCU	UWESO	HAU	TOTAL	TOTAL US$	%US$
M&E		2,872,780,464	58,698,200	586,509,000	68,067,800	126,380,685	3,712,436,149	**2,065,333**	**39%**
IT/HMISS	2,047,629,626		557,485,144	32,924,000	11,904,000	56,336,200	2,706,278,970	**1,505,579**	**28%**
FINANCE			1,309,201,296	879,921,493	176,656,600	193,748,800	2,559,528,189	**1,423,938**	**27%**
OD/HR			140,580,844	165,287,550	91,728,360	105,308,903 Two of	502,905,657	**279,781**	**5%**
Communication					14,845,380	111,504,499	126,349,879	**70,292**	**1%**
TOTAL	2,047,629,626	2,872,780,464	2,065,965,484	1,664,642,043	363,202,140	593,279,087	9,607,498,844	**5,344,923**	**100%**
TOTAL US$	**1,139,154**	**1,598,209**	**1,149,355**	**926,087**	**202,060**	**330,058**	**5,344,923**		
% US$	21%	30%	22%	17%	4%	6%	100%		

The table above shows that 51% of the direct expenditures of $5.4 million were allocated to the two organizations in the public sector, namely the MOH/RC and UAC for activities related to HMIS and M&E for a total of $2.8 million.

Also this table indicates that two NGOs captured $2.1 million, a significant proportion of direct expenditures, representing around 40% percent of this money. These four organizations capture 90% of all the direct expenditures while two smaller NGOs (UWESO and HAU) only obtained 10% of the entire direct investment.

Ninety-four percent of the direct expenditure was directed to the area of electronic and computer applications -IT/HMIS (39%), M&E (28%) and Finance/Navision (27%) while only 60% was spent on Organizational Development and Communications.

The table below shows that 75% of the total of direct expenditure ($5,344,923) was dedicated to subcontractors, 18% to training and 6% to equipment.

Table 4: ACE Direct Expenditures in Percentages on Six Institutions by Specific Interventions

	Subcontracts	STTA	Equipment	Training	Total (US$)
MOH/RC	64%	1%	20%	15%	1,139,154
UAC	57%	0	4%	38%	1,598,209
JCRC	94%	1%	0	5%	1,149,355
IRCU	64%	3%	1%	33%	926,087
Hospice	89%	0.4%	3.6%	7%	202,060
UWESO	68%	0	7%	25%	330,058
Total	**75%**	**1%**	**6%**	**18%**	**5,344,923**

Note: In addition, there was approximately $100,000 support to PEPFAR meetings through UAC.

These two tables provide the focus for our attention when reviewing the achievements of the ACE Project.

4.1. Organizational Development, Human Resources and Communications Interventions

The areas of Communication[5] and OD/HR/L&M only received 6% of the entire capacity building budget. And yet *Leadership* is the area of organizational life that encompasses how the overall direction of the organization is determined and how senior leadership and the board guide the organization. These challenges were identified during the ACE diagnostic studies - lack of clarity in the respective responsibilities of the staff and board; issues surrounding permission to take risks and make mistakes; and general questions about the Executive Director's ability to raise funds, motivate people, make decisions, encourage collaboration, and communicate. Yet, this area received less attention under the ACE Project despite its high significance to the ultimate achievement of organizational outcomes. Leadership is the cornerstone of effective organizations. This is an issue that could be addressed in the future capacity enhancement interventions.

Whereas communication is significant to organizational effectiveness the interventions by ACE were not budgeted for commensurately. Public relations, proactive and reactive influence on public policy hinge on the communication abilities of organizations. In the field of HIV and AIDS services, policy influence has been less impacted by the ACE partners. None of the interventions under the communication thematic area is complete or operational.

[5] 67% of the budget in Communication was dedicated to IT developments (website designs)

The gap in this sector was that ACE interventions concentrated in developing communication deliverables such as a communication strategy, brochures, fliers etc, but did less in developing skills to participate in policy discussions, engaging the decision- makers at the political level or participating in the political space to influence outcomes of decisions for policy development. Even the websites that were upgraded still did not show the inter-activeness required but they frequently updated to make them more marketable.

Table 5: Specific OD, HR and Communication Activities Undertaken by ACE[6]

Focus/ Organization	JCRC	IRCU	HAU	UWESO	UAC
Organizational Development	Strategic plan Organizational structure design Coached TREAT Coordinator Planning & mangmt. Workshops	Streamlined governance & management Team building Coached the S.G	Board policy procedures Organizational structure review Establishment of board Committees Coached Ex. Dir	Coached Ex. Dir. (unfinished)	Senior staff L&M workshop Coordination meetings Development National Strategic Plan
Finance	Manuals in Finance, procurement and asset inventory	Finance manual Grants management	Finance policy developed Chart of accounts	Training in budgeting	
Human Resource	HR manual revised Recruitment plan developed Job Descriptions completed	HR manual & SPA tools Operations tools	HR manual Supported recruitment of key personnel HR Orientation workshops	Standard Operating Procedures	
Communication		Annual report Communication products	Trained in communication, advocacy and documentation skills Website upgrade Brochures development	Communication materials LAN upgrade	National level communication strategy development

4.2. Management Information Systems Interventions

Information Technology was the main tool or, at least, an important platform for the overall improvement in organizational functioning – communication, data and information management (financial, Program M&E, HR Management, inventory, etc.). The development of Management Information Systems (MIS) was a critical part in the development of monitoring and evaluation; but not sufficient on its own to constitute a fully functional M&E system.

Improvement to Information and Communication Technology (ICT) was the sole ACE intervention for MOH-RC (HMIS); JCRC, HAU and UWESO as is clear from some of the outcome indicators as stated in their Performance Monitoring Plan (PMP). In addition, ICT was

[6] No intervention of this type was developed for MOH/RC

relevant as a part of M&E at UAC and all NGO interventions (IRCU, TCRC, HAU, and UWESO and in improving financial systems for all the NGOs.

The Annual Reports of ACE and those from some of the supported institutions (e.g. HAU and UWESO) highlight the ICT-related achievements, alongside other interventions in the ACE project. Progress in IT interventions was also discussed in the ACE PMP Update Report of September 2008, and the Review Report of the ICT and MIS Components of ACE of July 2009. Both reports were reviewed by the evaluation team. All these reports emphasize the fact that the bulk of ACE support to ICT focused on software development and training some staff in applying the software in regular program and management functions. They recognize the investment in IT 'hardware' (e.g. computers, LAN, etc.) in some settings (e.g., in MOH-RC, UWESO); but also note that inadequate computers constrained the full realization of the ACE interventions, especially in the field (e.g., in UWESO and HAU).

In most of the reviewed reports, the ICT-related outputs are reported as largely attained. To the extent that planned hardware and software was procured and installed, and staff were trained to utilize them, this in time. However, they acknowledge that most of these interventions were at the Headquarters of the targeted organizations with limited evidence of 'trickle-down' to the regional offices (e.g. in UWESO and JCRC), or to the service delivery sites (e.g. to IRCU's Implementing Partners). The reports noted that effective and sustained utilization of the IT installations requires on-going training and technical support beyond the ACE project period. They noted the effort to provide for this through training people within the supported organizations (e.g. in MOH-RC and HAU). Also mentioned in this regard was the opportunity to access external support from the local consultants that were hired by ACE to develop the IT systems.

Our fieldwork uncovered the following achievements at the Ministry of Health/Resource Center. The MOH-RC has received an extensive IT upgrade, including: fully functional and high capacity server systems, LAN for the entire MOH head office, development of the web-enabled HMIS, website modifications, and digitization of the MOH library – scanning the hard copy documents and making them available as soft copies on the website. The main change in IT capacity in the districts that was directly attributed to ACE was installation of the wHMIS onto existing computers.

All districts visited had challenges with internet connections that were installed but not functioning, promised installations but not yet realized, no installation yet planned, or available some distance away from the DHO – as a commercial service). While districts visited had a number of computers, none had inter-computer connectivity (LAN).

The MOH respondents gave enthusiastic reports of 'extensive training' for Ministry of Health Resource Center (MOH-RC) and District Teams. It was indicated that MOH-RC staff had been trained in setting up, operation and troubleshooting/maintenance of the systems on site. Some staff (e.g., in the library) indicated that they have full capacity and confidence to operate and troubleshoot their system without needing external help.

District teams have received 'introductory training' in two one-week residential sessions that covered theoretical instruction and hands-on practice. The training focused on data entry and basic report generation but paid little attention to troubleshooting and fixing problems in the

system, mechanisms to check accuracy of data entered, or on analysis of the data to generate information for use at the district and lower levels.

Some MOH-RC staff and selected HMIS staff in a few districts have been trained as trainers, to expand and continue training for district and lower level (Health sub-district and health facilities) staff. Effort was reported especially at MOH-RC levels to make a range of training resources available such as CDs and printed manuals. However, some of the people reported to have such training did not exhibit confidence in using the system well in their own setting (e.g. Masaka District). None of the district HMIS persons interviewed demonstrated good evidence that the training resources provided were in regular use.

The training done appears to have focused only on those staff that operate the system (MOH-RC team, district HMIS teams), with little or no involvement of the people with the greatest need interest and in using the data (MOH Program Leaders, DHOs, Health Facility leaders). For most of the districts visited (5 out of 8), the persons on the HMIS team (and therefore those trained) are Records Assistants or Clerks, often those who have worked for a long time and have progressively taken on such new roles. Many of them have limited formal education, low motivation to learn new skills and inadequate time to consistently practice the application of such skills.

The main evaluation finding here is that the HMIS system is largely used as a mechanism for 'first-level data entry' at both the district and MOH-RC levels. The district HMIS team receives manually completed monthly reports from health facilities which are entered into the wHMIS as they come in without systematic checks on the quality of data on the forms. There is also no systematic or consistent approach to checking on the quality of data entry done. Only one of the 8 districts visited indicated that the system was able to generate 'complete' reports that have been submitted to MOH-RC. The wHMIS system in Kabale district was able to generate 4 monthly reports – April to July 2009.

None of the other districts had submitted a report to MOH-RC generated from the wHMIS. Instead they were reporting based on entries into data systems in place before the ACE intervention (EPI-INFO or Microsoft Excel). All reports from districts whether from EPI-INFO, Excel or wHMIS, to MOH-RC are received and entered afresh into the wHMIS system at this central level. There appears to be no gain at this stage from the data processing done at district level to ease the process at central level.

Respondents at MOH-RC indicated that data from the system has been used in developing the RC Strategic Plan (Vision 2012), and has influenced some health programs to invest in expanding its introduction into more districts. None of the districts visited indicated that they had put to use data from the new wHMIS at district or lower levels.

There was a sense of dissatisfaction across the districts visited about the benefits so far gained from the new wHMIS. Efforts to start using the system have not been successful and capacity to address problems in use is very limited or none at all within the districts. The process of reporting problems to MOH-RC or the consultants who undertook the installation is not streamlined. Responses to address reported problems was said to be delayed, many times not forthcoming, or coming but not resolving the problem. Most districts reported that they have reverted fully to the systems in use before the ACE intervention.

Findings indicate that the team that developed the wHMIS was not the one that designed the migration tools. Many things kept changing on the system, to extent that the trained staff could not cope with managing the database. It was reported that the system installed at MOH-RC only managed to function for three months before it finally gave way. It has contributed to delays in reporting from the districts where some have reverted to EpiInfo while others have gone manual. Even the MoH RC has gone back to using EpiInfo software despite its limitations.

The MOH-RC respondents reported that university students and interns are using the new ICT system installed by ACE for training purpose. However, it appears that the potential problem-solving opportunity in this practical training process has not yet been fully exploited.

Evaluation interviews with UAC staff indicate that the MIS developed by ACE for the national AIDS response at UAC head office is aligned with the wHMIS at MOH-RC with respect to indicators measured and functional compatibility. However, it was also noted that some of the AIDS program indicators (e.g., use of specific ARVs in treatment and PMTCT programs) that are important for UAC monitoring are not included in the wHMIS. Such indicators are reported from implementing organizations through the district and MOH a reporting mechanism that is not integrated into the current HMIS.

It was also acknowledged at UAC and in some of the districts visited (e.g. Kabale, Jinja) that the information systems in the other sectors contributing to the AIDS response (e.g. prevention programs through schools, and OVC support as an integral element in social development sector) are not yet sufficiently developed to capture and report on the relevant AIDS indicators. This results in data gaps at national level in the respective sectors and at district level in the district planning unit; the coordination point for data most used in district development planning. However, this was not a responsibility of the ACE project although it constitutes a key weakness of the HIV/AIDS overall program in the country.

All supported NGOs - HAU, JCRC, UWESO and IRCU - acknowledge improvements in IT installation and application in finance management and in M&E. The Navision package was upgraded and its use diversified to include finance, human resource and supplies management in JCRC headquarters. The same software package is installed and in use in finance and human resource management at the head offices of UWESO and IRCU. HAU gained an upgrade of the existing Tally Accounting System package, from Tally 7.2 to Tally 9.

In all ACE-supported NGOs, the software installations and applications are present at the Kampala offices, but not in the field offices. Inadequate computer capacity was pointed out as the main limiting factor in HAU and UWESO. In HAU, procurement of the necessary computer installations has been resolved with the current USAID grant. The situation in UWESO is less definite, because there is no committed funding to support the needed equipment.

4.3. Monitoring and Evaluation Interventions

Monitoring and Evaluation (M&E) constituted the most relevant, single intervention of the ACE project. It consumed almost 40% of the expenditures and touched all the institutions and NGOs. Initially, the objective of these interventions was to develop an M&E system that would help the organizations. There is no doubt that, there is an important need for developing urgent capacity

in the area of M&E in the HIV/AIDS services environment in Uganda. However, it seems that this need was not the principal motivating factor to launching this line of intervention. The contractor has recognized that an important factor in developing this approach was the need to improve the reporting capacity of the organizations receiving support from USAID. However, the true grounds for developing comprehensive and substantive M&E systems should be centered on the needs of health service delivery organization to know the volume and the quality of the services they are producing. It seems that this focus was not properly considered.

IT consultants were recruited to undertake two tasks: first, the design of databases to contain the information the organization would collect, and second, the design of forms to collect the data. Both tasks were advanced without much regard for the actual reality of the data collection processes already functioning at the service delivery level in the organizations. Although these systems may have had serious weakness, they were known by the people operating them and they may have represented a significant opportunity in the development of the new 'systems'. Unfortunately, the project missed the opportunity by neglecting the value of building on 'existing capacity, even if flawed. On the contrary, to some extent, the designs were guided by the donors' data requirements (i.e. the indicators required by PEPFAR.) In fact, no serious assessments of the operation of these existing M&E systems were conducted. Thus, the development of the new 'systems' was rather top-down and mechanical.

Perhaps the key weakness of ACE regarding M&E was the total absence of a comprehensive conceptual framework for M&E which left the field open to the development and promotion of 'tools' as 'systems.' In fact, this was emphasized by the fact that the project was thinly staffed in M&E with just an M&E capacity building manager who was more familiar with MIS than public health or social science research. This contributed to the absence of the linkages between M&E interventions and the service delivery level. To date, no organization has fully introduced the developed M&E system in the management of their service delivery. No effort was made to develop the need for monitoring and evaluating services among the health providers. This task was very difficult due to the absence of a comprehensive conceptual framework for M&E.

Table 6: Status and Cost of M&E Systems by Organization

	MOH/RC[7]	UAC	JCRC	IRCU	UWESO	HAU	Total
System	Not fully operational	Unfinished	Not fully operational	Not fully operational	Not operational	Not operational	
# Contracts[8]	18	3	3	8	3	3	36
US$ Value	1,900,000	2,400,000	182,000	389,000	39,000	72,000	4,982,000

[7] Including the investment in MOH/RC defined as MIS but which is the base for the MOH M&E system.

[8] Consultants and consultancy firms were: Peter Paul Wakabi (2), Icon Afrika Consult (8), Spidd-Com (U) Ltd (3), DEPLANCO (5), Business Synergies (1), Health Training Consult Ltd (1), Health Consult Inc. (6),InfoTronics Business System Ltd (6), Creative Research Center (CRC) (1), Jimmy Sevume (1), Informatics Developers Ltd, Information Science foundation for East Africa (ISFEA), MFI Office Solutions (U) Ltd, Informatics Developers Ltd (2), WRAD Comms, and Data Care (U) Ltd

With this, the possibilities of determining any measure of impact from the services also almost entirely disappeared, calling into serious question the sustainability of the interventions directly or indirectly associated with M&E such as the MOHRC wHMIS that is not fully operational, the UAC national M&E "system" that remains unfinished and the NGOs' MIS/M&E 'systems' that are questionable from an impact point of view.

At the closing of the project, ACE has left M&E systems of different levels of complexity and configuration in the six partner organization. Their development was supported by 36 contracts in total for a total M&E intervention cost of $5 million. The current status of each 'system' is described in the table below. Our review indicates that none of the six M&E "systems" is fully functional and that the two most important ones (MOH/RC and UAC) will require a significant level of effort to finalize and make them fully operational.

4.4. Financial Management Interventions

This section of the report focuses on the specific Intermediate Results that aimed at strengthening the financial management systems in IRCU, JCRC, HAU and UWESO as outlined in Table 7 below. The ACE Project identified financial management as one of the gaps constraining service delivery and considered it as an essential building block in organizational capacity strengthening for improved HIV/AIDS services delivery. ACE developed a set of outcome indicators that defined the expected improvements in capacity expected in each area. For each organization, accomplishment of the full set of outcome indicators would mean they had significantly improved their institutional capacity and therefore delivery of improved services to their clients. Assessment of these four result areas forms the backdrop against which Q*uestion Two* of this evaluation's Scope of Work is premised.

Assessment of this task focused on each organization under the respective result areas and the indicators of measure. The main approaches used by ACE in strengthening financial management systems were the introduction of Navision software where it did not exist, upgrading the same software where a lower version was in use or upgrading the existing financial accounting software.

Table 7: **Outcome Indicators for Financial Management System Strengthening**

Project Deliverables/ Intermediate Results	Outcome Indicators
Strengthened capacity of the IRCU in financial management; governance/ strategic leadership of its program; monitoring, analysis, and reporting on program impact; and improvements in the application of quality standards and best practices to its grantees' programs	IRCU using an improved financial system to generate quality and timely financial management, grants, and human resource reports
	IRCU effectively manages its HIV/AIDS grants program
Strengthened capacity of JCRC through improved systems in planning, finance, M&E, and ICT as well as an updated organizational structure	Financial systems at JCRC headquarters and regional centers ensure better tracking and use of resources through the implementation of the Navision system, updated policies and procedures, and skills development among staff
Strengthened capacity of HAU through improved financial, M&E, communications and human resources systems, and improved governance structures and practices	HAU financial systems and staff ensure better tracking and use of resources through updated financial policy and procedures, skills development in financial management, and an upgraded financial system
Strengthened capacity of UWESO through	UWESO financial systems at both the headquarters and regional offices

Project Deliverables/ Intermediate Results	Outcome Indicators
improved finance, M&E, and communications systems	ensure better tracking and use of resources through skills development in financial management and an upgraded financial system

In conclusion, we can indicate that the introduction or upgrading of Navision software was done without a thorough analysis of the organizations' culture and capacities to utilize it. This undermined institutional its use and leaves in question the sustainability of the application of the software. The fact that the systems are still based at the headquarters of the different institutions and staff still grapple to use it efficiently at the time of the ACE project close out undermines the essence of intervention.

4.4.1 Joint Clinic Research Center

The interventions included development of a strategic plan and refining an organizational structure; planning and management sessions and finally the individualized coaching of the TREAT coordinator.

At the reporting lines are very clear is an evident outcome of the support rendered. The management team seemed to be inspiring and energetic and visibly committed to the organization and its vision, especially at the headquarters. At the headquarters, this intervention has been helpful in that there is a coherent strategy which is linked to the mission and vision and is known to all staff. There are signs that the strategic plan guides day-to-day management.

The shortcoming in this area is the assumption of a "trickle down" of this intervention to the Regional Centers of Excellence (RCEs). Anecdotal evidence shows that some key decisions that could be handled at RCE level still have to wait for approval from Kampala. A case in point is the leave roster, which is prepared centrally and any person due for leave has to wait for approval from Kampala while the procedures are already in place and well articulated.

With respect to human resources, the development of the Human Resource Manual has enabled some of the critical HR challenges to be addressed. Many staffing positions have been filled.

With respect to Finance, strengthening of Navision because it existed before the ACE intervention has enabled JCRC at the headquarters level to produce accurate and timely reports with ease but the Navision financial system is only functional at the headquarters. The RCEs still report manually.

4.4.2 Inter-Religious Council of Uganda

The interventions cut across both at governance and management level. The governance issues of every organization lies in the hands of the board and at IRCU it is in the Council of Presidents and an Executive Board on which ACE interventions have focused. A number of the trainings and interventions have been directed to these structures and evidently, the organogram of IRCU was reviewed and reporting lines are clear despite the complexities therein.

Being a faith- based, the interventions have focused on IRCU and constituent bodies of the Regional Coordinating Bodies have not been supported however, they provide the leadership that provides guidance and advice to the IRCU.

Both Human Resource and Finance systems have been supported and policies and procedures put in place. However, with respect to Finance the Navision finance accounting software has been installed at Headquarters leaving the Implementing Partners to reporting manually. Consequently efficiency and effectiveness at the lower levels was not evident.

The findings reveal that feasibility and viability assessment' were not undertaken as the basis for the installation of Navision finance and accounting software. The analysis from the budget allocations show that a substantial amount of funds were invested in this area and the outcomes in terms of operational efficiency and effectiveness both at headquarters and in the field are not commensurate.

4.4.3 Hospice Africa-Uganda and UWESO

The interventions in all areas seem to have been embraced by the governance and management structures. Organizational Development, Finance, Human resources, communication were the main interventions of ACE. HAU has made efforts to adopt advice in management to make improvements in organizational effectiveness.

However, again the ACE interventions only impacted significantly on the management at the headquarters and less visibly at the branches or sites in the field.

However, the shortcoming is that some of the interventions, especially in Finance, were not grounded in a realistic needs assessment of the existing operational capacities of the organizations. For example UWESO a fairly small learning and growing organization, could not absorb a financial software like Navision which puts a lot of stress on the existing organizational resources. HAU opted to upgrade the Tally Accounting System 7.2 to the Tally 9 version which in our opinion was justifiable.

4.5. Achievement of Results for each Organization Supported by ACE

In all cases, the consultants engaged by ACE appeared to have limited competencies to train staff in running the Navision software. Most of the institutions surveyed could not ably use all the functions of the software even when they needed specific reports that the system was capable of generating. Institution-specific constraining factors are outlined hereunder.

4.5 1 Inter-Religious Council of Uganda

Interventions: The main interventions were the installation of Navision accounting software at IRCU head offices and the training of 15 staff in its application. Staffs from the implementing partners were also trained in financial management and reporting. The interventions were expected to improve system so that generated quality and timely financial management, grants, and human resource reports and more effective HIV/AIDS grants program management.

Improved financial management systems: The evaluation established improved competencies among IRCU finance staff in operating the Navision system to detect and track errors in performing reconciliations and to, generate routine financial management practices e.g. variance

analysis reports and human resource reports for internal management and reporting purposes. IRCU is able to undertake analyses about grant transactions such as allocations amongst program areas, disbursements, and liquidations. The staff were unable to prepare the payroll in Navision, the leave register was prepared manually and the fixed asset register and debtors' register are still in Excel.

Effective management of HIV/AIDS grants program: All 81 IRCU sub-grantees had their finance staff trained in finance management and reporting. Their role was to generate financial reports in Excel format for onward submission to IRCU. These reports were entered into Navision to generate financial reports. In effect, there was an improvement in managing the HIV/AIDS grants at IRCU which resulted in an increase in the organization's funding from development partners.

The ***facilitating factors*** were in this case the existence of trainable staff in the Finance Department who were receptive to the intervention. This was in addition to the already existing PEPFAR-funded programme for HIV/AIDS where IRCU had to routinely submit electronic financial reports for its operations at the headquarter with from the implementing partners.

***Constraining Factors*:** The main constraining factors were the large number of implementing partners (IPs) that limited the spread of the Navision accounting package to the different institutions. This was further compounded by the limited skills and lack of computers at Implementing Partner (IP) level. The cost of installing and maintaining Navision and internet connection was equally prohibitive, especially for the small numerous IPs.

***Remaining Gaps/Weaknesses in Systems Support*:** In IRCU, the major gap lies in the capacity of staff to utilize all the required functions of Navision to guide and facilitate operations.

4.5.2 Joint Clinical Research Center

Interventions: These involved strengthening the financial systems of JCRC, reviewing and operationalizing the finance policies and procedures and orienting JCRC managers to financial and accounting policies and procedures. Forty two staff both at headquarters and in the Regional Centers of Excellence (RCE) were trained in financial management systems and reporting using Navision. The software was upgraded to a higher version. ACE also supported the design of the Navision import function for JCRC's RCEs, trained finance staff in running the systems and systems design and a support team was trained in troubleshooting the system. A performance review and improvement workshop for JCRC finance staff was conducted and the Navision database at JCRC was improved. All these were expected to result in improved systems in planning, finance, M&E, and ICT.

Improved systems in planning, finance, M&E, and ICT: Financial systems at JCRC headquarters and regional centers ensure better tracking and use of resources through the implementation of the Navision system, updated policies and procedures, and skills development among staff

The outcomes observed included: improvement in error detection on performing bank reconciliations and casting errors were detected when posting transactions by the accountant. There are authorization controls at different levels of responsibility where journal entries are

prepared by an accounts clerk and reviewed by the accountant and upon approval by the accountant, the journal is returned to the accounts clerk for posting. This ensures accuracy in producing reliable and accurate financial reports.

Ability to process the payroll using Navision could not be verified through reports generated since the Human Resources Manager was on leave, clearly showing lack of sustainable capacity to manage the system. Since the payroll could not be obtained for verification, a screen of the payroll module was printed and it was observed that the fields for deductions were active.

The leave register is prepared manually but the fixed asset register is processed using Navision. A sample updated fixed asset register report was queried and printed out for verification. The debtors' listings are processed with Navision. A sample updated debtor's age analysis was printed out. Three selected debtors were traced to the respective detailed ledger balance for accuracy of verification. One outstanding invoice per debtor selected was traced to the age category per debtor's age analysis for accuracy and no exceptions were noted. Sample monthly reports of June 2009 were requested and verified for consistency with the submissions of the systems accountant. The procurement process is done through Navision. A file for order notes was requested and a processed order of Paper Line Stationers for UG 2,549,752.50 # su000027 was selected. The order was checked for proper authorization, traced to the goods received note (GRN) and the invoice was matched to the order and GRN. An audit file could not be availed for verification. According to the Chief Accountant, the current year audit report is not yet available. A draft report and its corresponding management letter were not provided. The server provided by ACE had insufficient capacity to run the system but the back-up of data was being done on site.

JCRC staff follows approved revised accounting policies and procedures in handling financial transactions. Navision is mainly used at JCRC Headquarters to record and analyze accounting, procurement, inventory, and laboratory transactions. The RCEs use Excel spreadsheets to manage their accounts. In all cases, there was improved knowledge and skills in finance and accounting both at the headquarters and at the RCEs as the part of the finance and accounting staff.

***Facilitating factors*:** JCRC was already a beneficiary of input by a USAID grant and had to meet the reporting requirements on PEPFAR indicators. This provided a portal of entry for ACE to support the electronic database for finance management, logistics, human resource and clinical services. JCRC already had an earlier version of Navision which facilitated upgrading and reorienting the existing staff in its management.

Constraining factors: Some of the limitations faced here were the extensive and complex nature of services provided by JCRC and its Regional Centers of Excellence. In addition, the staff was too busy to allocate adequate time to internalize management of the system.

***Remaining Gaps/Weaknesses in Systems Support*:** The same applies to JCRC which is yet to strengthen the Navision accounting system in its Regional Centers of Excellence.

4.5.3 Hospice Africa Uganda

Interventions: ACE supported HAU to upgrade the Tally Accounting System from version 7.2 to version 9 and train users. Financial management training for non-financial Managers was conducted and the fixed assets register was designed and technical assistance provided in operation of the Tally Accounting System. The expected results were better tracking and use of resources through updated financial policy and procedures, skills development in financial management.

Improved financial management: HAU staff now appreciate the different levels of financial authorizations for different managers and the basic financial controls (e.g., financial statements, etc.). They have information on the budgets available and are clear on how to follow their expenditures and budgets. The finance staff are able to use the Tally Accounting System to generate financial reports but could not use it to prepare the payroll due to lack of the relevant module.

Facilitating Factors: Hospice was also a beneficiary of USAID funds but its system for monitoring PEPFAR indicators was weak. They already had the Tally Accounting System which was upgraded with support from ACE to cater for its increased operations which were at a small scale that did not necessitate migration to Navision.

Gaps and /Weaknesses in Systems Support: The gap that remains is the full operationalization of Tally financial and accounting package. Issues of on-going support from the soft ware supplier need to be addressed since the original company contracted closed shop in Kampala .In addition, the two sites (Hoima and Mbarara) are yet to fully use the Tally system and internet connectivity needs to be upgraded to handle queries and other reports in real time**.**

4.5.4 Uganda Women's Effort to Save Orphans

Interventions: ACE supported UWESO in procuring MS Dynamics 5.0 Navision accounting system and also provided technical assistance through training of staff in its operation. ACE facilitated trainings for improvement of financial management skills of the non-financial managers with emphasis in budget administration and monitoring, documentation of financial transactions, financial reports and internal auditing. The expected result was improved financial management systems.

Financial management systems: UWESO's financial systems at both the headquarters and regional offices ensure better tracking and use of resources through skills development in financial management and an upgraded financial system. The finance staff are able to use the Tally financial accounting system to detect errors in posting on performing bank reconciliations and casting errors are detected when posting transactions by the accountants. The journal entries are prepared by accounts clerks, checked and posted by the accountant who compares the entry with supporting documentation, and then reviewed by the financial controller. The financial controller is responsible for reporting and is able to produce variance analysis reports. A sample of a variance report of period covering January 1st, 2009 to July 31st, 2009 was requested and printed. Actual figures were compared with balances per detailed ledgers, and variance figures were re-computed for accuracy verification. The payroll module is not fully utilized and the

payroll is prepared manually. This also applies to the leave register. The fixed asset register is being prepared on Excel and debtors are maintained in an Excel format system. Submitted imported data by the centers for the month of June 2009 consisting of the income and expenditures for the month were verified for consistency with submissions by the financial controller. The function is utilized as far as generating purchases vouchers.

Facilitating Factors: This organization came on board at a later stage and with weak financial management and M&E systems. ACE interventions were occasioned by the need to improve financial management and M&E. The organization had finance department staff who were readily available to undertake training in the Navision accounting package.

Constraining Factors: This institution was constrained by the short time within which the different capacity building components had to be implemented. ACE introduced Navision without considering the institutional culture and capabilities to manage and maintain the system.

Remaining Gaps/Weaknesses in Systems Support: The same gaps/weaknesses in HAU above apply to UWESO as well.

4.6. Specific Challenges to Capacity Building

- Planning and execution of the capacity enhancement activities did not take cognizance of the peculiar operating circumstances of the field offices and therefore nothing was tailored to meet the challenges that management of the organizations faced. A case in point is the organizational capacities of the field offices in terms of equipment some partners like HAU and UWESO to accommodate upgraded financial and accounting software e.g. Navision needed robust and updated computers which were not there at the time the installation was being done. In addition, poor internet connectivity made sharing of information in a timely manner difficult. Even where the internet is installed, it's slow due to limited bandwidth.

- Support visits from the Headquarters to follow up on how the implementation of the capacity building interventions was ad hoc and erratic. Even on- going support from the service providers was not effective. The partners of ACE did not have direct control over the local consultants especially regarding the timeliness of delivering the expected deliverables. The project has ended with some systems not being functional. Partners had no input into the contract of the subcontractors' management and therefore could not press for expediting of the deliverables.

- The ability of an organization to make an impact on its chosen area of work depends largely on how it can manage its internal and external dynamics of growth and development. This covers areas such as an organization's structure, staff development, governance, management, financial management, administrative systems, evaluation mechanisms, networking capacities and fundraising opportunities. These are challenges that all local organizations face. ACE's partner organizations work in an environment which makes their work even more challenging, given funding uncertainty and economic decline. Therefore the continuity of the benefits of the capacity enhancement interventions is uncertain. The depth and breadth of capacity building in itself was

challenging, when is capacity built to allow the intervention to phase out. This was a challenge to the ACE project.

5. Cost-Effectiveness of ACE's Interventions

5.1. Study approach and methods

The scaling approach was adopted to depict the outcomes expected and actual. The Goal Attainment Scaling Approach (GAS) was customized to apply it in evaluating the effectiveness of an intervention for each organization for each thematic basis. Expected outcomes were determined at a scale of zero as a basis of what would be the expected level of outcome given the nature, timing and extent of the intervention. Actual outcomes were then scored in relation to the results upon verification of relevant documents and key informant interviews per thematic area of strengthened capacity with reference to the baseline expected outcome used as a reference point.

Goal Attainment Scaling (GAS)

The analysis used Kirusek and Sherman[1]'s (1968) method for assessing outcomes in mental health settings. It is a method of scoring adopted for this evaluation exercise to depict the extent to which thematic outcomes were achieved. Each thematic area had outcome measures which were scored in a standardized way to allow statistical analysis.

Rating on GAS

GAS was conducted using a 5-point measure, with the degree of attainment captured for each thematic area. An important part of GAS is the establishment of the outcome that is viewed as 'successful' on an *a priori* basis (i.e. before the intervention starts). If an organization achieved the expected level, this was scored at 0. If it achieved a ***better*** than expected outcome this was scored at: ***+1 (Somewhat better)*** and ***+2 (much better).*** If it achieved a ***worse*** than expected outcome this was scored at: ***-1 (Somewhat worse)*** or ***-2 (much worse).*** Although not in the original method described by Kirusek and Sherman, outcomes were weighted to take account of the relative importance of the outcomes.

5.2. Cost Data Limitations

The costs of interventions for each thematic area for each organization were collected retrospectively from their financial and operational records. Only the direct costs of the intervention were considered as the determination of indirect costs for a total cost determination was impossible given the time allowed.

The absence of baseline information on relevant indicators deprived this evaluation of strict computation of values for ranking cost effectiveness. Subjective baseline outcome values were used based on information provided by key informants and what was observed during data collection. To this end, the levels of cost-effectiveness portrayed in this section should be considered with caution.

5.3. Findings:

Introduction

Often times, evaluations analyze capacity building interventions to determine which approach produce the largest improvements. More intensive interventions with hands on ongoing support and more resources often lead to better outcomes than less intensive programs. Where more resources are spent, they are expected to yield more results. This leads to a very important question: How does one decide whether spending more on something – different components of organizational systems – is worth it? Specifically, what is the incremental gain in organizational performance from spending on one program or program component relative to another? Answering such questions is extremely important in any cost effectiveness analysis.

From this evaluation, it was realized that ACE interventions were not cost effective when summed up. Largely, the incremental gains in organizational performance following ACE project support were minimal and the following factors provide an undertone to the possible causes:

- The facilitation competencies of consultants engaged to strengthen capacities of different institutions was questionable in as far as their ability to pass on skills to organizational staff even when they had the knowledge in their specific subject matter. Because of this limitation, they spent more time than necessary in implementing interventions and therefore incurring more costs yet with limited results.
- In some cases, ACE engaged different consulting team for assignments which seemed to link to one another. This resulted in a disjoint in terms of flow and consistency of support to the organizations. It is important to note that each of the consulting team was paid separately even where one competent firm would have been engaged to handle the different tasks at a lower lump sum cost. This would have enabled achievement of results at a lower cost.
- ACE's capacity to technically monitor the consulting teams was limited to the extent that they signed off contracts even when there were no tangible results to show. The concept of cost effectiveness of interventions was even not clear to ACE both at project design and implementation level. It was therefore not in their line of duty to ensure cost effectiveness tracking of interventions. This was compounded by absence of cost effectiveness milestones or indicators to guide the project in tracking performance and take corrective action in time.
- The organizations which were expected to improve capacity for HIV and AIDS interventions as a result of ACE support were by end of the project still unable to use some of the systems introduced yet money was spent and contracts closed out. The non functional products in place are not commensurate with the amount of money invested. In essence, a lot of resources were spent for minimal results which were even not sustainable.

The detailed analyses of assessment of cost effectiveness for individual organizational interventions by the ACE project are discussed below.

5.3.1 Hospice Africa Uganda

The Finance function achieved the least outputs across the thematic areas resulting in a negative 80% level of achievement relative to the expected outputs. ACE updated the Tally Accounting system from version 7.2 to version 9 so that efficiency would be achieved in reporting through all accounting activities contributing to financial reports, including processing of the payroll, to leave register, procurement and updating of the fixed asset register within the Tally system. However most of these processes are still being done manually. Data for a periodic financial reporting purpose is exported into Excel for editing so as to suit specific multi donor reporting requirements formats.

Communication and M&E had negative 55% level of achievement compared to the expected outcomes. Costs per actual outcome were much lower because, for communication a strategy was developed but not implemented, and no trainings or outreach programmes were conducted. An Advocacy Officer to lead the activities is yet to be employed. M&E is not yet functional as data is yet to be uploaded into the new database. They are awaiting integration of the database with the Hoima and Mbarara centers. No training in the use of data collection tools and the application of the database was done for either of the two centers.

MIS and OD/HR areas achieved more outputs than expected resulting in a lower computed cost per output and ultimately a higher percentage level of achievement. The strengthened MIS system has seen cost savings in distribution of study modules of the HAU Diploma in Palliative of $14,960 per current 30 students per 18 months of the programme whilst OD/HR has managed to retain competent staff through performance incentives of ' Best Employee of the Year' and ' Best Employee of the Year per Department'.

5.3.2 Joint Clinical Research Center

Outputs for M&E and MIS were at par with expected units of output. The percentage level of achievement remained constant showing neither an indication of cost-effectiveness nor ineffectiveness in relation to baseline cost per output. The roll-out of the M&E database to 21 clinical sites on an integration basis with the Head Office has resulted in complete capture of relevant data which produces accurate reports informed decision- making. However training in the appropriate use and application of the tools and database needs to be rolled out to community-based volunteers for accurate data capture at source.

As observed before, strengthening of the Navision system by ACE, raised reversing journals were high but these have now been reduced by approximately 60%. Data capture was inaccurate when using the manual process. The Intranet as a benchmark output for the MIS which can enable communication internally and posting of important materials such as Vision, Mission Statement, policies and required procedures, updates on new information has not been installed. A non-existent record of error fixed complaints failed the benchmark test. However the data captured back log is nearing completion and the 6 data entry staff employed to assist the systems accountant has since been redeployed to other tasks, resulting in salary savings.

The level of achieving cost-effectiveness per output compared to baseline data was a negative 22% for ***OD/HR*** and -10% for ***Finance***. Ineffectiveness to a high output is to a greater extent due to the absence of an organizational structure, a high staff turnover of 16 key staff since January 2009 and the absence of closely monitored performance reviews. This reveals the level of dissent among employees which hinders the achievement of high output levels. A lack of hands-on training of accounting staff affects achievement of the outputs for the Finance section.

5.3.3 Uganda AIDS Commission

Communication and M&E had negative 36% level of achievement relative to benchmark outcomes. A draft communication framework is in place awaiting approval by the Board. No clear and agreed definition of short and long term objectives is in place. Outreach programmes to sensitize stakeholders about their participation in UAC's interventions have not been spelt out. M&E is not yet functional as data is yet to be uploaded into the new database. There are no performance indicators since the results of a survey in this respect are not yet ready. Data collection tools have been developed but not yet in use. Trainings on the Performance Measurement and Management Plan dissemination have been conducted in the regions where 516 senior persons were oriented versus the planned 720. 2,496 stakeholders were oriented in the NSP and PMMP versus the planned 3,200.

5.3.4 Uganda Women's Effort to Save Orphans (UWESO)

Outcomes for ***communication*** were at par with benchmark outcomes. Cost-effectiveness was achieved in producing expected outcomes at a breakeven level of expected level of achievement. Six proposals with budget lines for communication and advocacy programmes have been submitted but are still waiting feedback for all proposals from the prospective donors. Promotional materials to sensitize communities about the UWESO programmes have been developed and disseminated to 20 school clubs in Oyam and Apac Districts. A Civil Society Fund to raise awareness on child protection has been set up and IEC materials for 6 sub-counties of Kiruhura District have been developed. Guidelines have been developed, approved by the Board and circulated to all employees.

On ***finance management systems***, the level of achievement to expected outcomes fell short by 55% non- cost-effectiveness. Control on journals lacking as some are posted and processed without approval or checking for validity and accuracy by a senior official. Payroll computations, the leave register and the fixed asset register are prepared manually irrespective of the training provided in Navision use by ACE.

Outcomes for ***M&E*** failed to tally with the benchmark resulting in a cost-ineffectiveness of negative 36%. Standard operating procedures providing written guidelines for implementing activities have been developed but there is a data backlog which was due to the incomplete registration exercise whereby all beneficiaries in communities are listed and volunteers requested. This has hindered the production of trend reports due to incomplete data. No training on the use of M&E tools was conducted for staff.

Outcomes for ***MIS*** were at par with the benchmark outcomes. Cost-effectiveness was achieved in producing expected outcomes to breakeven level of cost per outcome. With the redesigned

website, Masulita Children's Village, one of the Orphanages under UWESO's assistance received new donors from the US who made their pledge after visiting the website. Hill Top High School is now providing school fees to 12 orphans for are year. Costs of USD100 per year have been saved in maintenance contracts due to the redesigned website. However no trainings in end-user maintenance of IT equipment were conducted by the systems administrator.

ACE strengthened the capacity of UWESO in ***organizational development*** by providing training in leadership and management to senior managers, but however there was high staff turnover and of the 5 senior managers trained in leadership and management, 4 have since left the organization. The skills acquired by trained staff were not passed on to others leading to capacity gaps on their departure. The chart which clearly defines the organizational structure and responsibilities is not in place. This has fueled internal conflicts among staff which has affected morale and levels of productivity of staff. A policy to review performance through appraisal is in place but since 2008 no appraisals have been done. The CEO established the internal audit department which took stock of the status of affairs before she joined and after she joined. This is expected to inform the future direction.

5.3.5 Ministry of Health Resource Center

The level of achieving cost effectiveness per output compared to baseline data was a positive 8%. The observed positive score was a result of outcomes from the functional e-library and internet system at the RC and the strengthened supply chain management system used to implement all sales order management, procurement, inventory management, distribution, and procurement-related financial management functions.

The non-functionality of the web-enabled reporting system both at the resource center and in the districts contributed to the low score of cost-effectiveness. This reporting system was supposed to facilitate migration from a system of a large client-server–based set of reports to a system with a smaller set of more flexible web-based reports where users can choose their own report parameters, a on a web page. In the long term, this approach was expected to add value by having reports generated on one platform and being accessed by other user groups. The new web-based reporting system operates with multi-level identity management for controlling user access. From observation, the web-enabled system is unable to all these functions.

5.3.6 Inter Religious Council of Uganda

Finance had a negative 80% level of achieving cost-effectiveness per output to benchmark units of output. Journals can be posted or reversed by the Accountant and/or the Finance Manager without approval from the senior official contributing to a greater risk of validity and authenticity ultimately affecting the accuracy of reports produced. Payroll computations, the leave register and the fixed asset register are all being done manually, irrespective of the training provided in Navision use by ACE thereby resulted in inefficiency.

Training in ***M&E tools*** was supported by ACE but it requires the presence of the IT Expert and M&E Specialist to produce reports. This is a weakness in their capacity building approach which focused on individuals rather than the institution. Training in data collection was done for sub-

grantees enabling capture of all relevant data at the primary source to enable query-based reporting.

The results for ***OD/HR*** show that outputs produced were at par with the benchmark results therefore no incremental cost-effectiveness was achieved. On predetermined outcomes, analyzing the management's philosophy and operating style and commitment to competence, communication and enforcement of integrity and ethical values, responsibilities defined by job descriptions, evidence of performance reviews by the Board, expected results were all achieved in these areas of analysis except that there is no substantive Human Resources function enacted which resulted in staff related issues taking a long time to be resolved

5.4. Conclusions

Overall, ACE interventions were not cost-effective in delivering the desired outcomes. Most of the capacity building endeavors focused on processes and stopped at the output level to the extent that they precluded determination of outcomes. The lack of a framework at project design deprived ACE of the opportunity to guide processes that would have facilitated monitoring the cost-effectiveness of capacity building interventions. For example, the absence of baseline parameters for subsequent quantification of outcomes and the use of subjective variables for estimation of benchmarks limited the rational analysis of cost-effectiveness of the interventions. In addition, there were no milestones to assess progress towards the achievement of cost-effectiveness along the project result chain (input, processes, outputs and outcomes). In effect, subjecting the ACE project to a cost-effectiveness analysis at the end-of-term evaluation when it was not part of the design is unfair.

The study concludes that ACE project was implemented as planned. As an intervention, it was relevant and appropriate to improving HIV and AIDS Service. The OD interventions triggered positive developments in some organizations for capacity development at their headquarters. Furthermore, some capacity building interventions contributed to reshaping the organizations to better position themselves for resource leveraging in order to expand services.

In terms of results, ACE supported interventions through the introduction of tools for data gathering and analysis that brought about increased interest in activity monitoring and impact evaluation. Systems support either in terms of hard or software and development tools are seen as the tangible outputs. Most of the ACE capacity building interventions (95% of direct expenditure) focused on three components: finance management, management information systems, and monitoring and evaluation

The evaluation team concludes that imprecise results at the end of the life span of the project indicate that the ACE-supported interventions lacked an appropriate capacity building framework to guide the interventions. Even in major and critical interventions such as M&E, no framework existed.

In addition, little attention was paid to organizational development, resource development, community linkages, programming and services. Limited involvement of the organizations in the leadership of the program triggered inadequate absorptive capacity on their part.

The evaluation team observed that outsourcing most of the assistance to local consultants was an attractive strategy that did not produce the expected results. Local consultancy firms and consultants were largely recruited from the field of IT with marginal effort made to contract personnel from the public health or medical sciences sectors creating a severe gap in communication between the client organizations and the consultants.

It can be observed further that ACE interventions were not cost-effective in delivering the desired outcomes. Most of the capacity building endeavors focused on processes and stopped at the output level to the extent that they precluded determination of outcomes. Lack of a framework at project design level deprived ACE of the opportunity to guide processes that would have facilitated monitoring the cost-effectiveness of the capacity building interventions.

Some capacity building interventions contributed to reshape the organizations to position themselves for resource leveraging to expand services. This seems to have been the case with HAU with its significant effort to make palliative care more visible and acceptable and the case with UWESO with its new fund raising initiatives.

The introduction of tools for data gathering and analysis brought about some interest in activity monitoring and impact evaluation. Staffs are more sensitized, at least at the headquarters level, about results and their analysis. Perhaps progress in M&E interventions were minor but it may have trigger some openness for changes in the future. Thus, improvements in some of the organizations could constitute the future base for capacity building in service expansion.

To implement a powerful Capacity Building Program it is necessary to focus on the entire organization and not only on the individuals who are part of the organization. This sometimes leads to equating capacity building with training but capacity building is not just training. More often than desired, the focus of the main intervention in capacity building is training and, indeed, training is an important input but it's not capacity development. The most critical aspect of capacity building is the use of new information on the job and team building.

The ACE intervention further brought out the need and opportunities for linking capacity building processes for different organizations active in the same geographical or thematic area, to enhance cross-learning and integration in the AIDS services.

There is need for more Capacity Building with an appropriate operational approach. The organizations need to focus on building the capacity of their entire body if they want to maximize their social impact. Interventions putting the emphasis on the headquarters usually miss the need to develop capacity at regional levels, particularly for coordination, supervisions and timely supply, and at the service delivery level where, usually, people are in urgent need of new skills and knowledge to better organize services and plan service delivery strategies. Of course, to neglect the central level it would also a serious mistake.

The capacity building approach that focuses on strengthening elements in existing organizational capacity is likely to be more sustainable in the long run. ACE support to develop M&E systems (e.g., in UWESO) was based on existing program focus and data collection tools, synthesizing them into a common toolkit that is applicable to the different program elements that are funded by different donors. In HAU, the strengthening of financial management built on the existing finance and accounting software, and upgraded it from Tally 7.2 to Tally 9. The high cost of

running Navision (the software taken on for the other NGOs), and adequacy of the Tally software for the current and future program and management needs of HAU were the main basis for this decision.

The connection between increased capacity and increased impact is hard to measure and to quantify. However, the experience of few successful experiences clearly indicates that one does lead to the other. Furthermore, for the NGO sector to achieve a greater social impact, more organizations must address their gaps or weaknesses in organizational capacity. After perfecting and streamlining their program, necessarily they need to invest in building their organizational capacity to deliver programs more effectively and efficiently or to replicate their success in other locations and among other sister organizations. Unless they invest in capacity building, they will be incapable of fully sharing in the promise to control the HIV/AIDS epidemic in the country. Strengthened monitoring and evaluation must be directly connected to improving and expanding service delivery. NGOs tend to focus on their programs; their leadership and staff need to devote attention to capacity building – to think early and often about strengthening the organization simultaneously with implementing programs. One of the most discouraging barriers hindering the ability of NGOs to engage in capacity building is the sometime unhelpful funding environment. Every NGO knows that a majority of donors prefer to allocate their contributions to support particular projects or programs. Maybe, in this context, USAID has become a most welcome exception. Though these barriers may seem formidable, the interaction of NGOs with a performance based more and more demanding environment will continue to advance the NGO culture toward a more open view on capacity building. As more organizations begin to address capacity building systematically, better information and improved measures will surface to make a more convincing connection between capacity building initiatives and social impact.

Notwithstanding the above, the evaluation team concludes that the ACE project was a well intended intervention. However, given the shortcomings at the design stage and within the implementation phase, the intended results were not achieved.

5.5. Recommendations

In future, USAID should clearly elaborate the cost-effectiveness concept. This can be in the form of a framework with defined approaches and clear variables of the measurements along the results chain for monitoring cost-effectiveness. This will facilitate assessment of value-for-money analysis both on an ongoing basis and at midterm and end of term evaluations.

6. Summary of Results and Lessons Learned

6.1. Overall Results

Most of the ACE capacity building interventions that consumed 95% of direct expenditure centered on three components: finance management, management information systems, and monitoring and evaluation. ACE support in these areas was dominated by interventions in electronic applications installation and introductory training in the use of selected software; development of databases and websites; and procurement of basic computer hardware (servers and accessories) to host the databases.

The ACE investment in organizational development was relatively modest at only 5% of the total direct expenditure, but it stimulated major organizational change, especially in some of the targeted NGOs. This is perhaps indicative of the level of readiness of the organizations to undergo through organizational changes in order to improve the delivery of their programs.

6.2. Project Achievements

- OD interventions triggered positive developments in some organizations for capacity development at their headquarters level. Non-profit organizations are committed to genuine improvements and are able to absorb changes. Thus, the potential for benefiting from ACE's support was based on the culture of the organizations. The two organizations benefiting most from ACE's efforts are HAU and IRCU. The key characteristics of these organizations were the participatory character of the organization, their focus on their target populations, democratic leadership, and an authentic sense of relative independence.

- Some capacity building interventions contributed to reshaping the organizations in order to position them for resource leveraging to expand services. This seems to have been the case with HAU with its significant effort to make palliative care more visible and acceptable and with UWESO with its new fundraising initiatives.

- The introduction of tools for data gathering and analysis brought about increased interest in activity monitoring and impact evaluation. Staffs are more sensitized, at least at the headquarters level, about results and their analysis of these results progress in M&E interventions were minor but it may have triggered some openness for changes in the future. Thus, improvements in some of the organizations could constitute the future base for capacity building in service expansion.

6.3. Areas for strengthening in the ACE Capacity Building interventions

- The project lacked an appropriate capacity building framework to guide the interventions. This facilitated the remarkable shift toward computer application technology interventions.

- Little attention was paid to organizational development, resource development, community linkages, programming and services.

- Excessive emphasis on technology and computer applications, thereby missing the opportunity to develop people's skills which could then be applied to their organizational tasks. Now, organizations have new electronic resources, sometimes incomplete ones, but that the institutions will need to absorb, use and sustain. To do this, they will need to develop some specific capacities.

- Emphasis on central offices without attention to the field/service delivery, thereby hindering potential capacity building in the organizations

- Absence of a comprehensive conceptual framework for M&E promoted the development of 'tools' as 'systems.' No linkages between interventions and the service delivery level. Therefore, it is impossible to determine any measure of impact.

- Training was extensively emphasized with little attention to the methodological aspects, evaluation and follow-up of its application by the trainees. For example, in 2008 ACE reported that had provided a lot of skills development through training to later indicate that the organizations would "need further support in transferring knowledge gained in trainings/workshops into the successful use and management of improved systems"[9]. The problem with this is that the task was not only centered on 'skills development' but on creating the capacity to use this knowledge. That is, capacity building.

- Outsourcing most of the assistance to local consultants (57% of the contract), an attractive strategy that did not produce the expected results. Local consultancy firms and consultants were largely recruited from the field of IT with marginal effort in contracting personnel from public health of medical sciences, creating a severe gap in communication between the client organizations and the consultants. Further analysis of this approach is warranted to identify specific lessons learned.

- ACE was thinly staffed, particularly in the areas of OD, IT and M&E.

- Limited involvement of the organizations in the leadership of the program triggered an inadequate absorptive capacity.

- A limited and imprecise M&E Plan for the project and insufficient early organizational diagnosis. Indicators were "soft" and often quantitatively immeasurable.

- Sustainability of the ACE results constitutes a tremendous challenge for the near future.

6.4. Lessons Learned

The discussion under this section is based on responses of evaluation respondents to a specific question about lessons gained from the ACE intervention and from analysis by the evaluation team on the different components of the ACE program.

[9] AIDS CAPACITY ENHANCEMENT (ACE) PROJECT, PERFORMANCE AGAINST UPDATED PERFORMANCE MONITORING PLAN INDICATORS. September 2008

Lesson 1: The imperative of a comprehensive and appropriate capacity building framework

The process of effectively developing capacity for organizations in the national AIDS response requires an evidence-based framework as a basis for deciding the key elements of capacity to focus on and the action steps to prioritize. Such a framework also provides the theoretical model for connecting changes in specific organizational capacities to the ultimate desired change in the national AIDS response, namely more and better quality AIDS services. The ACE capacity building intervention was based on the Star model[10], a framework for analyzing organizations developed in the 1960s which is actually a model for organization design in the corporate world. The capacity building framework preferred by the evaluation team is the McKinsey's prepared for venture philanthropy partners[11]. In addition, the evaluation design drew from the framework on areas for evaluation in organizational capacity building (Mayer, 2002)[12].

In taking on organizational capacity building, it is critical that the chosen framework is applied consistently and to its completion in all targeted organizations. Necessary adaptations if the framework to fit in the unique contexts of each organization should be made. The lesson from the ACE intervention is that such a comprehensive process must be based on an in-depth assessment of existing capacity and the gaps there-in; commitment from all stakeholders in the organization (staff, volunteers, board members and donors); and the necessary resources to take it to completion. It requires patient and repeated negotiation within the organization to fit with the routine service activities and other elements in organizational functioning. Respondents on the ACE Leadership Team (e.g., M&E Manager) and among the beneficiary organizations (e.g., IRCU) indicated that many of the ACE intervention activities often took longer than initially planned for, at times twice as long and even more.

Lesson 2: Need for Strengthening Project M&E Systems

The future of M&E in the AIDS response in Uganda both for the MOH and NGOs should be tightly connected to all the forms of HIV/AIDS services with the objective to determine the level of the results and particularly the impact on the target population. The key focus of an M&E system should be the continuity in delivery of services (monitoring) and the actual impact of those services on the target population and the factors determining the given impact (evaluation.) The primary data feeding an M&E system revolves around the interaction between a health service provider and the patient. It is the result of this interaction that we need to record and, and then later, to process and to analyze. The idea of a national M&E system from the UAC is a good idea but we need to be sure that the information flowing from the service level is of high quality.

This calls for the development of a rigorous and substantive M&E framework for HIV/AIDS interventions in Uganda. One that should be framed around the body of knowledge and practices that inform HIV/AIDS with particular attention paid to the available strategies for service

[10] Emphasizes 5 main elements of the organization: Strategy, Structure, People, Process and Rewards as the main determinants of behaviour in the organization; the basis of performance and culture. See details: http://www.jaygalbraith.com/services/starmodel html.

[11] McKinskey and Co. (2001) Effective Capacity Building in Non-Profit Organizations. Venture Philanthropy Partners.

[12] Steven E. Mayer (2002) Organizational Capacity Building: Areas for Evaluation. Effective Communities Project www.efectivecommunities.com

delivery among the different segments of the target population and for sub-areas of coverage (PLWA, HIV+ pregnant women, HIV+ children, NGOs, public sector, urban/rural areas, etc.) These would constitute the project/program activities (interventions) to achieve the goals and objectives and their connection to specific expected results. Supported by this body of knowledge and practices, and keeping in mind the project/program goals and objectives and their connections to impact, the contractor should develop a map of the theoretical interactions involved, clearly defining the final outcome from the service system. That is, the result or dependent variable, the proximate determinants of this results, and other factors playing a significant role in the outcome. An example of this process would be as follows:

Program	Dependent Variable	Proximate Determinants	Other independent factors
PMTCT	Rate of infection among new born from HIV+ mothers	Enrollment of HIV+ pregnant women in PMTCT program Enrollment in PNC program Assisted delivery with PMTCT support ART new born treatment	Drugs supply system Quality of counseling of HIV+ pregnant women Follow up of HIV+ women enrolled in PMTCT Psychosocial support

Figure 3: Mapping of Variables for an M&E System

This modeling calls for appropriate data for monitoring and evaluating the intervention's results. The following Graph depicts a way how to guide the planning of data collection and how to connect objectives and results, starting with programmatic goals and impact (at the opposite end), project objectives and results and, in the middle of the Graph are the interventions, with their corresponding inputs and outputs:

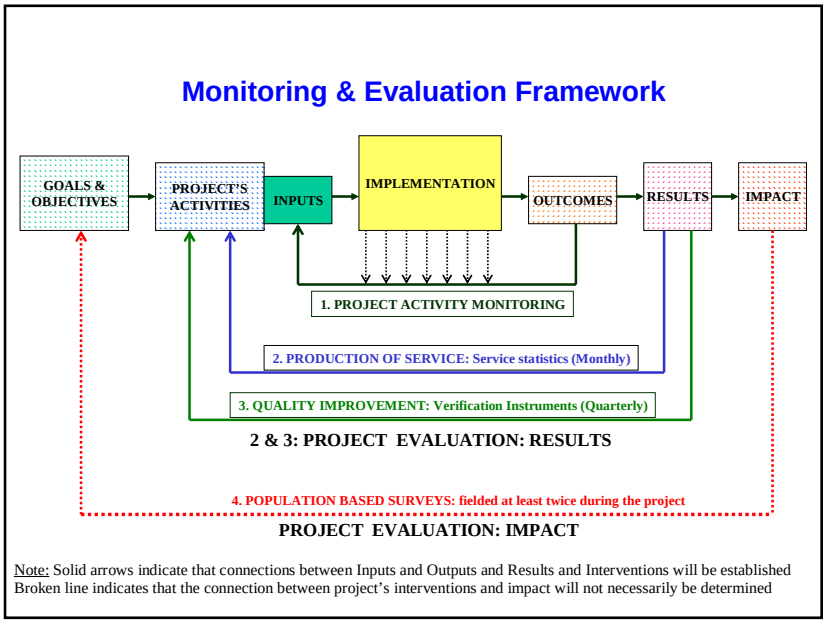


Figure 4: A model M&E Framework

To complete the tasks, it would be necessary to cover the following tasks:

1. A substantively sound and empirically supported methodological selection of indicators that closely relate to the objectives of the program in order to be able to 'describe' the level of working of the health service delivery system. Develop this matrix of indicators including the design for data collection and data processing.

2. Design an activity monitoring model including expected results following the indicators.

3. Development of specific evaluation pathways to assist in the analysis of results and analysis of impact, production of services and quality of services.

4. Define and design the appropriate data processing routines to be followed to fulfill the requirements of the different pathways.

5. Design data processing tools and select appropriate statistical analysis to support program analysis.

6. Identify the audience for the produced information and customize reports for different segments of the audience: community-based health workers and other community groups, SDP, health service providers, DHO level and regional NGO offices, national level, and donors.

Lesson 3: Capacity building for an improved national AIDS response requires to be connected across the multiple stakeholders and levels of action

To implement a powerful capacity building program it is necessary to focus on the entire organization and not only on the individuals who are part of the organization. More often than desired, the focus of the main intervention in capacity building is training and, indeed, training is an important input but it is not capacity development. The most critical aspects of capacity building are the use of new information on the job and team building.

The ACE intervention illustrates very well the need to focus on multiple stakeholders in the national AIDS response, including the government-led multi-sectoral coordination function embodied in UAC; government sectors and their operation at different levels as represented in MHO-RC; non-Governmental service providers such as UWESO, HAU and JCRC, and faith-based institutions as service providers and program coordinators as exemplified in IRCU. The ACE intervention also demonstrates the importance of addressing capacity building needs at the different levels of the national AIDS response, beginning from the service delivery level, through the sub-national/district coordination level, to the central leadership function at national level (see illustration below).

The ACE intervention further brought out the need and opportunities for linking capacity building processes for different organizations active in the same geographical or thematic area, to enhance cross-learning and integration in the AIDS services. Examples include:

- Connecting JCRC and IRCU in developing strategies to strengthen the role of FBO health facilities in AIDS Treatment/ART;
- Linking HAU and IRCU in strategies to enhance effectiveness of FBOs as the primary providers of Palliative Care – in health facilities, congregations and home-based care and support;
- Linkages between UWESO and IRCU to strengthen the capacity of FBOs in OVC care and support; and
- Strengthening decentralized coordination and management of a scaled up AIDS response (focused on the district and service levels), e.g., in integrated data and information systems, joint planning and review processes, lesson learning and sharing

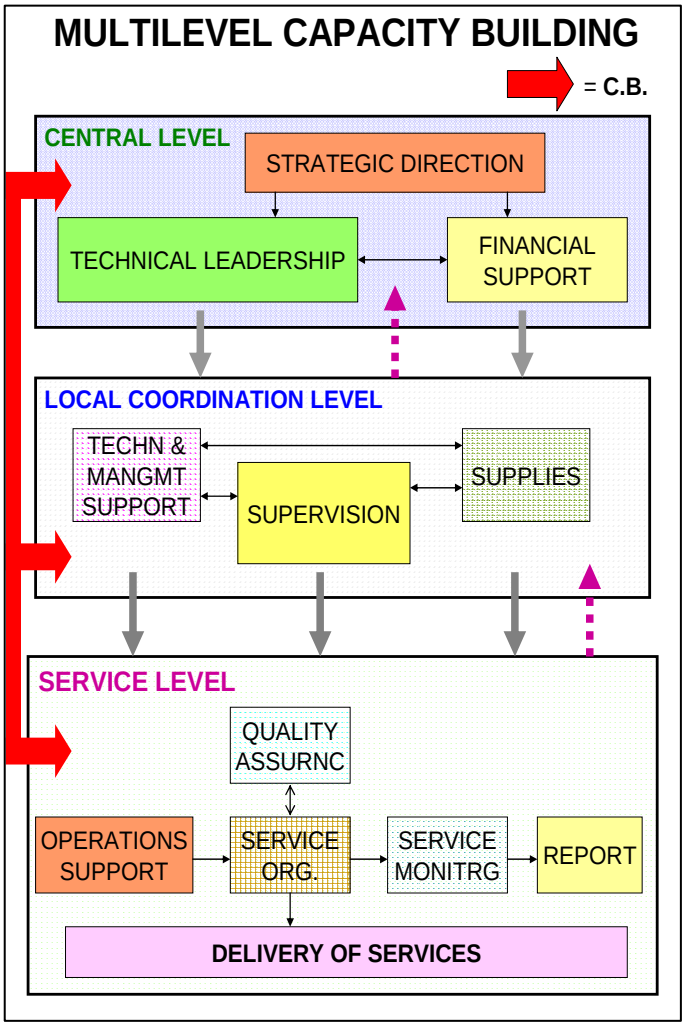
There is need for more capacity building with an appropriate operational approach. The organizations need to focus on building the capacity of their entire organisation if they want to maximize their social impact. Interventions putting the emphasis on the headquarters usually miss the need to develop capacity at regional levels, particularly for coordination, supervisions and timely supply, and at the service delivery level where, usually, people are in urgent need of new skills and knowledge to better organize services and plan service delivery strategies. Of course, to neglect the central level it would also be a serious mistake.

Thus, there is a great need to develop capacity building interventions that apply to all the levels of an organization. Taking into consideration the different needs, priorities and requirements at different level can a congruent and noteworthy development of capacities throughout the organization.

The illustration in figure 4 depicts an example of such a venture. In the figure we can identify three level of an organization dedicate to provide health services.

At the top level or central level, we can identify three key areas of needs for new capacities: strategic direction, technical leadership and financial support. At the mid -level, we can recognize three different key needs: technical and management support, supervision and supply. Finally, at the service delivery level, we can distinguish five areas in need of

Figure 5: A Model of Multi-level Capacity Building



capacity: quality assurance; operations support; organization of services; service monitoring; and reporting.

All these areas are directly supporting the delivery of service, thus, capacity building in any of these areas will enhance the progress in the delivery of health services both in quantity and quality. For this to be possible, nonprofit organizations will need to move capacity building upto a similar level of importance as program; that is, to strengthen the NGO simultaneously with implementing strong programs.

Lesson 4: The opportunity and value in building on 'existing capacity'

The capacity building approach that focuses on strengthening elements in existing organizational capacity is likely to be more sustainable in the long run. ACE support to develop M&E systems (e.g., in UWESO) was based on an existing program focus and data collection tools, synthesizing them into a common toolkit that is applicable to the different program elements that are funded by different donors.

In HAU, the strengthening of financial management built on the existing finance and accounting software, and upgraded it from Tally 7.2 to Tally 9. The high cost of running Navision (the software provided to the other NGOs), and adequacy of the Tally software for the current and future program and management needs of HAU were the main bases for this decision.

Capacity building that introduced more radical changes to existing approaches (e.g. financial management using Navision software) also demanded more investment in computer hardware and staff skills to operate the system across the organization, and longer periods of on-going technical support. On one hand, some of supported agencies (e.g. UWESO) acknowledged that they do not have the possibility to make the necessary HR changes for optimum utilization of Navision. In addition, the necessary on-going Technical Assistance in Navision application for financial and HR management was not available from the consultants hired to promote it. Their expertise was more in marketing and installation, rather than application, and the fee rates they charge are relatively high.

Lesson 5: Strengthened Monitoring and evaluation must be focused on and applied to improving service delivery particularly service coverage

The connection between increased capacity and increased impact is hard to measure and to quantify. However, the experience of few successful experiences clearly indicates that one does lead to the other. Furthermore, for the NGO sector to achieve a greater social impact, more organizations must address their gaps or weaknesses in organizational capacity. After perfecting and streamlining their program, necessarily they need to invest in building their organizational capacity to deliver programs more effectively and efficiently or to replicate their success in other locations and among other sister organizations. Unless they invest in capacity building, they will be incapable of fully sharing in the promise to control the HIV/AIDS epidemic in the country. Strengthened monitoring and evaluation must be directly connected to improving and expanding service delivery.

The interactions of the evaluation teams with district health offices and service delivery points in the field highlighted the service improvement benefit that can result from strengthening M&E

capacity. Field teams that have participated in M&E training and/or received the necessary support from strengthened headquarters in Kampala demonstrated several examples of improved application of M&E data to local service review and planning. Examples include:

- AIDS service planning in Kabale District, based on ART data from JCRU's RCE, and data from general AIDS care experiences in public health facilities and NGO, coordinated through quarterly service review and planning at the DHO.
- Routine service planning and joint learning sessions in the services of HAU in Mbarara, based on the strengthened M&E system (introduced M&E framework, hired M&E staff, simple and easy to use database – MS Access).

Lesson 6: Application of the strengthened organizational capacity to improve services depends on available resources for programs

NGOs tend to focus on their programs but their leadership and staff need to devote attention to capacity building – and to think early and often about strengthening the organization simultaneously with implementing programs. One of the most discouraging barriers hindering the ability of NGOs to engage in capacity building is the sometime unhelpful funding environment. Every NGO knows that a majority of donors prefer to allocate their contributions to support particular projects or programs. Maybe, in this context, USAID has become a most welcome exception. Though these barriers seem formidable, the interaction of NGOs with a demanding performance-based environment will continue to advance the NGO culture toward a more open view on capacity building. As more organizations begin to address capacity building concerns systematically, better information and improved measures will surface to make a more convincing connection between capacity building initiatives and social impact.

It therefore rests with donors, founders, organization leaders and staff to support NGO's efforts to build organizational capacity. Coincidently, donors have become more and more committed to support the NGO organizational capacity. In addition, non-profit organizations need leaders who are committed to taking the initiative to make capacity building happen and are willing to "own" it and drive it down through the organization.' Strengthened organizational capacity to improve services depends on available resources for program development.

Building the capacity of AIDS service organizations will most probably result in a sustained change in program management and service delivery practices if it is aligned with donor priorities. For example, donors that insist on unique monitoring and reporting practices will constrain efforts to apply generic M&E systems for the entire organization.

Similarly, sustained government funding for AIDS programs is likely to result in effective and continued application of the capacity developed especially where there the capacity building process and government priorities for the national AIDS response are aligned.

APPENDICES

APPENDIX A: SCOPE OF WORK FOR END OF PROJECT EVALUATION OF THE AIDS ENHANCEMENT CAPACITY PROJECT (ACE) – July 20, 2009

I. Background

ACE is a four-year project designed to build the capacities of selected Ugandan institutions to improve program outcomes in HIV/AIDS prevention, care and treatment. The project is 100% PEPFAR funded through a contract with USAID/Uganda, and is implemented by Chemonics International. The project began in November 2005 and is scheduled to end in September 2009 with a total budget of $9,439,323.

ACE provides technical assistance, training, and material support to the Uganda AIDS Commission (UAC), the Inter-religious Council of Uganda (IRCU) and its network of faith-based organizations, the Ministry of Health Resource Centre (MOH/RC), the Joint Clinical Research Center (JCRC), Hospice Africa-Uganda (HAU) and the Uganda Women's Effort to Save Orphans (UWESO). ACE assists these organizations in five thematic areas: organizational development, M&E, Health Management Information System (HMIS), finance and communications.

The project also provides facilitation and coordination of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) team. ACE provides technical services that support the U.S. government team to plan, coordinate and manage its HIV/AIDS program in Uganda, including supporting achievement of the "three ones" - one national coordinating body for HIV/AIDS, one M&E framework and one national strategic plan for HIV/AIDS.

The ACE project's approach to capacity building is performance-driven and is customized to the needs of each organization. The project's strategy is to assess the resident or existing capacities of target organizations, develop capacity-building plans to address identified gaps through technical assistance and skill building and monitor and document progress made in improving the operational efficiencies. The following deliverables for the initial three-years were the following:

- Strengthened capacity of the UAC to provide strategic leadership to Uganda's HIV/AIDS program; to direct the formulation of one national monitoring and evaluation framework for HIV/AIDS, and to coordinate the overall HIV/AIDS response.
- Strengthened capacity of the IRCU in financial management; governance/strategic leadership of its program; monitoring, analysis, and reporting on program impact; and improvements in the application of quality standards and best practices to its grantees' programs.

- Strengthened capacity of the IRCU grantees to monitor, analyze, and report on program impact; improved quality of the grantees' HIV/AIDS prevention, care, and treatment services.
- Strengthened capacity of selected national NGOs in specific targeted areas that lead to improved efficiencies and program outcomes. Specifically:
  - Strengthened capacity of JCRC through improved systems in planning, finance, monitoring and evaluation, and ICT as well as an updated organizational structure.
  - Strengthened capacity of HAU through improved financial, M&E, communications and human resources systems, and improved governance structures and practices.
  - Strengthened capacity of UWESO through improved finance, M&E, and communications systems.
- Strengthened capacity of the MOH/RC to collect data, monitor, analyze, and report on key HIV/AIDS indicators that will be part of the national HIV/AIDS M&E framework.
- Support given to selected HIV/AIDS policies and strategies such as the National Strategic Plan and the palliative care advocacy strategy that contribute an improved policy environment.

At the conclusion of the project base period in September 2008, ACE received a one year extension to continue working with the same client organizations. Under each deliverable, ACE committed to achieving an additional set of results that are listed below.

1) Strengthened capacity of the Ugandan AIDS Commission (UAC) to provide strategic leadership to Uganda's HIV/AIDS program; to direct the formulation of one national monitoring and evaluation framework for HIV/AIDS; and to coordinate the overall HIV/AIDS response.

Results:
- UAC staff using a database and able to generate reports and perform data analysis that will inform HIV/AIDS stakeholders about the status of the epidemic in years not covered by the Demographic and Health Survey or Sero-Behavioral Survey.
- UAC collecting data for the National Performance Measurement and Monitoring Plan on a quarterly basis to track progress of the national response.

2) Strengthened capacity of the Inter-religious Council of Uganda (IRCU) in financial management; and governance/strategic leadership of its program.

Results:
- Resource mobilization strategy developed and IRCU has approved funding from at least two new sources such as the Civil Society Fund and faith-based donors.
- IRCU leaders taking more active role in raising IRCU's public profile and discussing issues related to HIV/AIDS work.
- IRCU leadership providing strategic vision to the organization, motivation to staff and linkages to external partners.
- Managers at ICRU better able to prioritize their work respond to program changes, complete key tasks on time and advance the program.
- IRCU using national standards in quality assurance for all their core program areas to implement supervision plan for the grantees that support quality service delivery.

3) Strengthened capacity of the IRCU grantees to monitor, analyze and report on program impact; improved quality of the grantees' OVC and HIV/AIDS prevention, care and treatment services.

Results:

- At least 55 of the IRCU grantees receiving supervision from IRCU Secretariat and following national quality assurance guidelines for their program area.
- Electronic reporting system developed for selected implementing partners to facilitate rapid reporting and easier data analysis.
- At least 50 grantees receive training on program management and are better able to plan and develop their programs, have strong administration skills and improve their timely reporting.
- Technical assistance provided in financial management and compliance as needed and in conjunction with IRCU staff.

4) Strengthened capacity of the Joint Clinical Research Center (JCRC) through improved systems in planning, finance, monitoring and evaluation and ICT as well as an updated organizational structure.

Results:

- JCRC able to integrate data from their databases at headquarters, Regional Centers of Excellence and satellite sites to generate quality reports for internal program use and reporting to partners.
- Regional Centers of Excellence is organizational and leadership structures strengthened through a restructuring exercise and management trainings.
- Financial systems at Regional Centers of Excellence improved by using Navision software to track inventory, procurement, laboratory transitions and accounting and human resources; thereby making patient services and the drug supply chain more efficient and reliable.
- Regional Centers of Excellence and satellite sites improve their data analysis for program improvements.

5) Strengthened capacity of Hospice Africa-Uganda (HAU) through improved financial, M&E, communications and human resources systems and improved governance structures and practices.

Results:

- HAU broadening the number and type of palliative care courses available to increase the number of health care providers with palliative care information and training; thereby increasing demand and improving the frequency of technical updates for these services.
- HAU improving fund-raising skills and diversifying sources of funding to add at least two new donors.
- Managers at HAU better able to prioritize their work respond to program changes, complete key tasks on time and advance the program.
- IT systems at HAU supporting the monitoring and evaluation, communications and finance functions for improved reporting that leads to better programming.

6) Strengthened capacity of the Ministry of Health Resource Centre (MOH/RC) to collect data, monitor, analyze and report on key HIV/AIDS indicators that will be part of the National HIV/AIDS M&E Framework - pending the results of the USG-supported assessment.

Results:

- Web-enabled HMIS system rolled out to 15 new districts.
- At least 55 districts reporting HMIS data electronically (including the 15 above).
- District Ministry of Health workers using reports from the HMIS for decision making at the district level.
- Data warehouse supporting the HMIS, health infrastructure database, HRIS routine reporting systems and other electronic systems in one platform.
- Resource Centre staff able to effectively manage HMIS data to generate reports and analysis that districts access and use for disease surveillance, planning and health care delivery response.

7) Strengthened capacity of Uganda Women's Effort to Save Orphans (UWESO) through improved finance, M&E and communications systems.

Results:

- Managers at UWESO better able to prioritize their work respond to program changes, complete key tasks on time and advance the program.
- Regional offices have improved program reporting and data analysis.
- Improved accounting, bookkeeping and reporting at the UWESO regional offices.
- Communications strategy implemented by UWESO.
- UWESO able to expand its funding base to new donors through an established fund-raising strategy.

8) Coordination and planning for PEPFAR Country Team.

Results:

- FY10 PEPFAR planning achieved.
- Stakeholder meeting facilitated.

I. Purpose of Evaluation and Key Questions

The Automated Directive System (ADS) 203.3.6.1 requires that an evaluation is conducted when there is a distinct and clear management need to address an issue. The primary purpose of this review is to critically examine the overall project to:

- Determine if the ACE approach for capacity building to each client organization was appropriate
- Determine if the ACE project achieved the specific results identified for each client organization and examine what factors facilitated and/or hindered its achievement of planned results

- Determine to what extent the capacity building provided by ACE contributed to the client organizations' overall performance in delivery of HIV/AIDS programs
- Identify remaining gaps/weaknesses in systems support for each organization
- Determine if the ACE approach for capacity building was cost-effective
- Determine lessons learned that will assist USAID, Government of Uganda and other implementing partners with future capacity building programs in Uganda and elsewhere

Key evaluation questions that the evaluation should address are:

7) How appropriate was the ACE approach for capacity building to each client organization?

8) To what extent has ACE achieved its intended results for each client organization? What factors facilitated and/or hindered its achievement of planned results? What are the remaining gaps/weaknesses in systems support for each organization?

9) To what extent has the capacity building provided by ACE contributed to the client organizations' overall performance in delivery of HIV/AIDS programs?

10) How cost-effective were the ACE interventions?

11) What are the key lessons learned for capacity building programs in Uganda and elsewhere?

12) Has ACE had any positive or negative unintended results? What factors can such unintended results be attributed to?

I. Performance Period

1. The evaluation will begin on or before August 16, 2009 and will require approximately 30 working days of effort: 7 days for preparation and document reviews; 11 days field work; and 17 days for data analysis, debriefs with USAID and other stakeholders and report writing. In addition to time in the ACE offices in Kampala, it is proposed that team members will spend time with each client organization at their headquarters, and where appropriate, at selected field sites throughout the country. A draft report will be submitted to USAID prior to the departure of the evaluation team leader and a final report provided to USAID no later than September 16, 2009.

II. Existing Information Sources

The following information documents and sources are available and relevant to the review:

GOU: National frameworks, policies and implementation guidelines from Uganda AIDS Commission and Ministries of Health and Gender

USAID: Original Request for Proposal, Emergency Plan documentation, USAID program and financial reporting requirements, The Role of Evaluation in USAID

ACE:

- Contract and other amendments
- Annual and quarterly reports
- Annual work plans and PMPs
- Tools, training materials, guidelines, etc.
- Internal assessments and reviews
- Individual contracts and agreements between USAID and client organizations
- Other

I. Evaluation Methodology

The evaluation team will be required to propose a clear methodology to answer all the evaluation questions. With regard to data quality, the evaluation team is expected to be familiar with USAID data quality standards for objectivity, validity, reliability, precision, utility and integrity and be able to apply them in the final report, by identifying such data limitations as may exist with respect to these standards (ADS 78.3.4.2 - http://www.usaid.gov/policy/ads//500/578.pdf) and ADS 203.3.5.1- http://www.usaid.gov/policy/ads/200/203.pdf)

II. Evaluation Team Composition

The evaluation team will be comprised of one international and three national experts. The team will have prior organizational capacity building experience that focuses on the five thematic areas of the ACE project: organizational development, M&E, Health Management Information System (HMIS), finance and communications. One staff member from USAID/Uganda will also participate. The team should possess the skills and experiences below:

Team Leader

- Demonstrated experience (10 years) in HIV/AIDS program evaluation in Africa. Uganda experience is highly preferred.
- Solid experience in organizational capacity building in developing countries covering the following thematic areas: organizational development, M&E, Health Management Information System (HMIS), finance and communications.
- Solid understanding of HIV/AIDS and health service delivery.
- USAID programming experience is desirable.

National Experts

- Solid experience in organizational capacity building in developing countries covering the following thematic areas: organizational development, M&E, Health Management Information System (HMIS), finance and communications.
- Solid understanding of HIV/AIDS and health service delivery.
- Sustainable development
- Experience in program/project cost-effectiveness analysis

I. Deliverables

The evaluation team is expected to deliver the following outputs to USAID/Uganda:

Deliverable	Week Due
1. An inception report to be reviewed by USAID. The report will include: ▪ A detailed work plan showing a timeline for each evaluation activity to be undertaken, including field work ▪ Methodology detailing client organizations and field sites to be visited	First
2. Oral debriefing to USAID to present methodology, data collection instruments and plan.	Second
3. Oral debriefing to USAID, ACE and selected partners to present key findings prior to submission of draft report.	Third
4. Draft evaluation report in both hard copies (2) and one electronic copy for review by USAID.	Fourth
5. Final evaluation report in both hard copies (5) and one electronic copy incorporating feedback from USAID.	Sixth

I. Roles and Responsibilities

UMEMS roles and responsibilities:

- Select and contract the evaluators
- Have full time USAID staff member to participate in the evaluation if possible
- Manage the evaluation process
- Provide briefing to team
- Provide logistical support for the evaluation team including office space and transport
- Submit evaluation report to USAID/PPC/CDIE

USAID's roles and responsibilities:

- Review inception and draft evaluation reports and provide feedback
- Sign off on final report

ACE's roles and responsibilities

- Participate in final review of inception report
- Provide relevant documents as needed
- Provide assistance with setting up meetings and interviews

ILLUSTRATIVE REPORT OUTLINE

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

Preface or Acknowledgements (Optional)

Table of Contents

List of Acronyms

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

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

Main Part of the Report

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

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

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

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

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

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

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 B: LIST OF RESPONDENTS INTERVIEWED FOR ACE EVALUATION

Name	Role/Position	Contacts
ACE Team		
Anne Fidler	Chief of Party	0772-755330
Festus Kibuuka	OD Manager	0772-212420
Moses Atwine	M&E Manager	0772-472788
Ismail Wadembere		0772-472922
UAC HQ Team		
John Rwomushana		
Charles Nkolo	M&E Coordinator	0782 472489
Rose Nalwadda	Director Planning	0772 490132
Elizabeth Mushabe	Partnership coordinator	0772 959 032
Edward Were	Data Manager	
Enosh Bizimana	M&E officer	
MOH-RC		
Dr. Eddie Mukooyo	Assistant Commissioner - MoH/RC	0772400641
Ruth Magoola	MoH/RC Databank Manager	712321806
Martin Kiyingi	MoH/RC System Administrator	772906361
Mr. Amos Nzabanita	MoH/RC Principal Biostatistician	772605870
Juliet Nansonga	MoH/RC Senior Information Scientist	772522331
Moses Doka	Senior Librarian	
DHO Teams		
Tumwesigye Enock	Senior Clinical Officer – District Surveillance Focal Person Kabale	0752-836600
Twikirize Pross	Records Assistant – Kabale	0772-568546
Paul Lyagoba	Assistant DHO/Environmental Health – Mubende	
Ssenzizi Darlington	HMIS Focal Point Person – Mubende	0782-525330
Isingoma Diana	HMIS Focal Person – Wakiso	
Nimukama Anthony	Acting District Biostatistician - Bushenyi	
Kasande Peace	Records Assistant – Mbarara	
Dr Musisi	DDHS Masaka	
M/s Fatuma	Focal Person HMIS	0712-319489
IRCU Team		
Joshua Kitakule	Secretary General	0782 551108
John Byarugaba	Coordinator HIV/AIDS	0772 658889
Johnson Matsiko	Director HIV/AIDS Program	
Agness Nabawanuka	Finance manager	0712 502701
Allan Mugisha	Grants officer	0772 502438
Charles Serwanja	M&E officer	0772 694941
Sunday Edward Mazinga		
Stephen Kunya		
IRCU-RCBs		
IRCU-IPs		

Hajat Aisha Senyonga	Coordinator Lyatonde Muslim Health Centre	0772-643783
Dr Birungi Denise	Kisiizi COU Hospital	
Roland Bakunda	Coordinator	
Kevin Akumpurira	Records Assistant – HMIS Focal person	
Dr Anguyo	Director KIHEFO Muslim Affiliated HC	
Byamukama Geoffrey	Expert Client Counsellor KIHEFO	
M/s Kyampaire Caroline	Coordinator KIHEFO	
Ngabirano Martin	Finance/Accounts department	
KIHEFO		
Dr. Anguyo Geoffrey	Director	
Byamukama Geoffrey	Expert Client Counselor	
Kyampiire Caroline	Regional Coordinator	
Ngabirano Martin	Finance Controller	
Kisiizi Hospital		
Dr. Birungi Denise	HIV and AIDS Coordinator	
Roland Mbakunda	Project Officer	
Kelvin Akampura	Records Assistant	
Ishaka Hospital		
Dr. Isagani Manuel	Medical Director	
Dr. Victor Valenzuela	HIV and AIDS Coordinator	
Begumisa Enock	Programme Manager	
Barbara Akampwera	M&E Officer	
Lyantonde Muslim Health Centre		
Hajjati Aisha Senyonga	Programme Director	
JCRC HQ Team		
Dr Samson Kibende	Deputy Director Administration	
Micheal Kabugo	Programme Director	
David Muhumuza	M&E Officer	
Brian Munaura	Senior Accountant	
Herbert Bitwire	Human Resource Manager	
Dr. Kibende Samson	Deputy Director Administration	
Micheal Kabugo	Programme Director	
Ms Atine Margaret	Systems Accountant	
JCRC-RCEs		
Zziwa Richard	RCE Manager – Mubende	
Annet Namara	Finance and Administration – Mubende	
Richard Mugumya	Data Assistant – Mubende	
Ssebutinde Peter	RCE Manager – Mbarara	
Jackie Ndigumanawe	Accounts Assistant – Mbarara	
Emilly Ninsima	Laboratory Technologist	
Segawa Kevin	Data Manager – Mbarara	
Tapson Sekindi	Locum	
Claire Kizito	Accounts Assistant – Mbale	
Henry Ntanda	Data Manager – Mbale	
Mary Abwola	RCE Manager – Mbale	
Daniel Kizito	Laboratory Manager – Mbale	

Alima Hillary	RCE Manager – Kabale	0772-412910
Nassali Janet Annet	Regional Data Manager Kabale	0772-909056
Margaret Atine	Systems Accountant	
Ann Nakirija	Training Coordinator	
Simon Atwine	IT Supervisor	
HAU HQ Team		
Nina Shalita	Executive Director	0772-500769
Martin Othieno Radooli	Programme Director	0772-602007
Saloma Nakazzi	Director Finance & Administration	0752-407378
Flavia Bakundana	Director Education	0782-920405
Mariam Siriri	Communication	0772-350882
Jane Sengooba	Clincal Director	
Andrew Sentunmbwe	Finance Mananger	
Rosette Kamanyi	M&E Officer	
Milly Nabakoza	Human Resource Manager	
Phillip Mugisa	IT Manager	
Harriet Bwogero	IT Officer	
HAU – Mobile Hospice Mbarara		
Jackson Mucunguzi	Administrator	0753-065345
Martha Rabwoni	Clinical Services Team Leader	0772-568111
Samalie	Data Manager	0753-065511
UWESO HQ Team		
Noami Watiti	Executive Director	0392 777448
Martha Mukasa	Financial Controller	0752 624444
GW Bagandanswa	Head of Operations & Administration	
Baker Sserwambala	System Administrator/ M&E	0772 547471
Carol Namagembe	Communication	0772 570427
Bosco Epila	Programme Director	
UWESO Regional Offices		
Ian Nshana	Regional Manager – Mbarara	0772-602821
Eddie Wambewo	Regional Manager – Mbale	
David Werikhe	Accountant – Mbale	
Musinguzi Robert	Regional Manager – Masaka	0782-837838
Martha Naomi	Finance and Administration	
ACE Consultants		
Coach Africa		
Norah Bwaya		
Victoria Nabukenya		

APPENDIX C: SELECTED LIST OF DOCUMENTS REVIEWED

1. ACE Contract Statement of Work
2. ACE Final Y1-Y3 Anual Reports
3. ACE PMPs
4. ACE 2009 Q1-Q3 Reports
5. ACE FY09 PEPFAR Targets
6. ACE Work plans Y1-Y4
7. ACE Technical Assistance Trip Reports
8. List of ACE activities 2006 -9
9. Partners locations/sites for ART, Palliative Care, OVCs & wHMIS
10. JCRC TREAT Annual Reports for 2006, 2007 & 2008
11. HAU Final work plan submitted to USAID
12. IRCU Work plans and narratives

APPENDIX D: EVALUATION QUESTIONS

Evaluation Question

ACE	PARTNERS
SOW Question 1. How appropriate was the ACE approach for capacity building to each client organization?	
Which activities were pursued to strengthen the partners' Mission, Vision and Overarching Goals? And which one were implemented associated to Action and Programs aimed to fulfill the organizations' overarching goals? There was a continuous monitoring of Organizational Skills of the partners? How was this monitoring process defined and operationalized? What interventions were implemented to reinforced Human resources, particularly, regarding Collective Capabilities, Experiences, Potential and commitment of management team, staff and volunteers? Regarding Systems, what have been the interventions associated to Planning, Decision Making, Knowledge Management, and Administrative Systems? What improvements have been gained in the physical and technological assets that support the organizations? Considering the Organizational Structure development, what actions have taken with regards to Governance, Organizational design, Inter-functional coordination and job descriptions? What interventions have been pursue to sustain or further develop the organizations' Culture, particularly in regards to shared values and practices, behavioral norms and organizations' orientation toward performance. Has Capacity Building interventions affected the centralization or decentralization of the organizations? How? Has Capacity Building interventions promoted or discouraged participation of all levels? How?	1.1 What are your perspective of capacity building that targets an organization like IRCU/RCBs/IPs and their delivery of HIV/AIDS programs? *Probe about the elements to address, the process to develop and implement the intervention,* 1.2 What elements of capacity building were addressed in the ACE intervention for IRCU/RCBs/IPs? • At the level of aspirations and strategy (vision, mission, goals, etc.); • At the level of organizational structure, systems and how they operate; • The different categories of people involved in the work of the organization; • At the level of people connecting and bonding so as to work together effectively as linked units or teams 1.3 How has the ACE intervention affected decision making in IRCU/RCBs and IPs at the different levels of operation?

SOW Question 2. To what extent has ACE achieved its intended results for each client organization? What factors facilitated and/or hindered its achievement of planned results? What are the remaining gaps/weaknesses in systems support for each organization?	
1. STRENGTHENED CAPACITY OF UAC. **HIV/AIDS M&E: (National database)** What is the concept of the ACE's M&E Capacity Building Process? What is the current status (functionality) of the National database for tracking response? What organization/institutions are using it, with what quality and timing? What is the training approach for the M&E database? What are the organizational characteristic of the system's 'installation'? Specific reports generated by the HIV/AIDS database and their use by level (local, regional, national levels)? **PMMP** What are the key specific objectives of the PMMP? What specific organizational changes have been observed in association to the implementation of the PMMP? What is PMMP parsimonious relationship to service production? **COMMUNICATION** What have been the specific results from the dissemination of messages to HIV/AIDS partners of the NCCS? **2. STRENGTHENED CAPACITY OF IRCU.** **LEADERSHIP** What is the model of leadership pursued by the capacity building strengthening venture? Approach to governance across and by levels?	2.1 What are the main organizational elements of IRCU, RCBs and IPs that were the focus of the ACE intervention? • Please explain the specific targets under each of the elements of focus **A: Lets explore the following elements in IRCU and how they were changed through the ACE intervention** **Governance and organizational oversight:** 2.2 What are the main elements in the governance of IRCU? How do they work together to enhance effectiveness in supporting IRCU? 2.3 What aspects of governance does IRCU use to measure effectiveness (indicators of good governance) 2.4 What elements of governance did the ACE intervention address? What change has IRCU realized on these elements as a result of the ACE intervention? 2.5 What other interventions has IRCU received or undertaken to strengthen governance (before the ACE intervention; alongside the ACE intervention) 2.6 What is the current governance relationship between IRCU and the RCBs (that constitute it)? How has this changed as a result of the ACE intervention? What other factors have affected the evolution of this governance relationship? **Organizational structure:** 2.7 Please describe the main components of the IRCU organizational structure, and how they relate/ connect to each other (organogram illustration may help, if available) 2.8 What characteristics of an organizational structure would you consider to be essential in a streamlined structure? Please comment about those specific elements in the IRCU organizational structure? How has the ACE interventions affected those elements? 2.9 What are the main lines of authority (centres for decision making) in the IRCU structure? What is their current functional status? How has the ACE intervention changed/influenced this aspect in IRCU? 2.10 What are the main reporting channels in the IRCU operations (especially with reference to the HIV/AIDS program? What is their current functional status? How has the ACE intervention

What are the indicators of good governance? Does the capacity building consider the objective to decentralize the 'management' of the network? To what extent has the centralized coordinating structure have an effect on the quality of the grantees' service delivery? What is the participatory approach for the organizational development of this network? What role has been assigned to the communities and small NGOs in this network? Only as beneficiaries of grants? **FINANCE** What have been the outcomes in service delivery as a product of the finance TA to the partners? What are the results from the improved financial systems in terms audits results, grants improvements and timing? What is ACE's operational definition of financial transparency use by ACE? And its application to the case of IRCU? **M&E and MIS** To what extent the M&E and MIS training permeated toward the IPs in this network? Why? **SUPERVISION** To what extent the supervisory efforts of IRCU have ensured the delivery of quality services? **3. IRCU GRANTEES (80+)** **DATA COLLECTION** *Review the M&E data collection system among grantees (3-5) to observe quality, timing, reporting and use of data. Analyze the use of the data transferred at grantee level and transfer to IRCU's HQ.* **FINANCIAL MANAGEMENT**	changed/influenced this aspect in IRCU? **Financial Management:** 2.11 What are the main elements/components of the IRCU Financial Management System? 2.12 What are the main products generated fro the system to guide management and decision making (especially with respect to the HIV/AIDS program)? What is the expected frequency/timing of generating the different products? *Probe specifically for Financial Management, Grants Management and Human Resource Management reports/products if these are not discussed without prompting* 2.13 What is the current functional status of the IRCU Finance Management System? How has the ACE intervention changed/influenced this aspect of IRCU? **Grants Management:** 2.14 Please describe the approach used in IRCU to manage the HIV/AIDS grants program. What other grants does IRCU manage? Please describe any differences between the management of the HIV/AIDS grants program, and that for the other grants. 2.15 What is the current effectiveness of the IRCU approaches in managing the HIV/AIDS grants program? What factors have enhanced or constrained/ inhibited this? 2.16 How has the ACE intervention changed/influenced this aspect of IRCU? 2.17 What is the IRCU perspective of Financial Transparency (its definition, the strategies used to promote it; current status of this element in the HIV/AIDS program of IRCU)? **Monitoring and Evaluation:** 2.18 Please describe the key elements in the IRCU M&E System. *Probe for aspects of the M&E system for data collection, reporting, and using M&E to make/ influence program improvements* 2.19 What is current functional status of the M&E system; especially with respect to the HIV/AIDS grants program? *Probe for the downstream M&E functioning in the HIV/AIDS grants program (to RCBs, IPs)* 2.20 How has the ACE intervention changed/influenced this aspect of IRCU? *Probe for specific influence on key aspects of data collection (e.g., tools, people involved and their data collection skills/experiences, data quality check, etc.); reporting (e.g., is it timely, comprehensive, targeted/reaching the right audiences, etc.); and use of M&E in program improvement (e.g., by who, to make what decision, etc.)*

What is ACE's operational definition of financial transparency use by ACE at grantee level? And its application to the case of IRCU's grantees? Methodology to connect Finance TA to the increased transparency? **4. STRENGTHENED CAPACITY OF NGOs** **<u>JCRC.</u>** **LEADERSHIP & MANAGEMENT** What is the approach utilized to promote leadership & management improvement? What are the main objectives for the implementation of the revised organizational structure? To what extent this L&M program has produced changes in the potential and commitment of management, staff and volunteers? **FINANCIAL SYSTEM** What are the direct effects of the financial interventions in the work of the organization and particularly in service delivery? **ICT ASSETS** To what extent the ICT developments have improved communication and participation in the organization? **DATABASE INTEGRATION** What are the programmatic effects of the integrated database on the delivery of services (number and quality)? **<u>HAU.</u>** **MANAGEMENT & LEADERSHIP** What is the approach utilized to promote leadership & management improvement?	**National quality standards for core HIV/AIDS program areas:** 2.21 Please tell me the core program areas that the IRCU HIV/AIDS program is focused on. 2.22 What are the national quality standards that IRCU is aware about, for the different core program areas of the HIV/AIDS Program? *Ask for copies of the quality standards documents available to IRCU* 2.23 What approaches does IRCU use to support IPs in quality HIV/AIDS service delivery? *Probe about quality inclusion in IRCU supervision, in RFP process, in Toolkit provision, etc.* 2.24 What is your assessment of the current IRCU support to IPs in quality assurance for HIV/AIDS services? What is the status of quality in the HIV/AIDS services of the IPs? 2.25 How has the ACE intervention changed/influenced this aspect of IRCU? **IRCU source of funding:** 2.26 What are the different sources of funding for IRCU program activities? *Probe for sources before 2006; and sources for 2006-2009; new/additional sources already committed for future funding.* 2.27 What is your opinion about the current range of funding sources for IRCU programs? 2.28 What specific support has the ACE intervention provided to IRCU to increase diversification in sources of IRCU funding? **IRCU leadership and management practices:** 2.29 What changes have you noticed in the IRCU leadership and management practices over the last four years? Probe for specific changes in planning, management of staff, Board relations 2.30 What role has the ACE intervention played in these changes? **Factors that have facilitated/enhanced positive change:** 2.31 On the above aspects of IRCU (or handling each of the elements separately); what factors have facilitated achievement of planned results? *Probe for factors inside IRCU, factors in the RCBs; factors in the broader context* **Factors that have hindered/reduced positive change:** 2.32 On the above aspects of IRCU (or handling each of the elements separately); what factors have hindered/ constrained/ reduced achievement of planned results? *Probe for factors inside*

What are the main objectives for the implementation of the revised organizational structure? To what extent this L&M program has produced changes in the potential and commitment of management, staff and volunteers? **M&E SYSTEM** What is the current status (functionality) of the National database for tracking response? What are the improvement in health services as a product of installing and using the M&E System: What quality and timing of the M&E outputs? What is the training approach for the M&E database? **IT SYSTEM** To what extent the IT developments have improved communication, information sharing and participation in the organization? **FINANCIAL SYSTEM** What are the direct effects of the financial interventions in the work of the organization and particularly in service delivery? **<u>UWESO</u>** **FINANCIAL SYSTEM** What are the direct effects of the financial interventions in the work of the organization and particularly in service delivery? **M&E SYSTEM** What is the current status (functionality) of the National database for tracking response? What are the improvement in health services as a product of installing and using the M&E System: What quality and timing of the M&E outputs? What is the training approach for the M&E database? **COMMUNICATION** What have been the specific effects of communication interventions in	*IRCU, factors in the RCBs; factors in the broader context* **Remaining gaps/weaknesses:** 2.33 What are the remaining gaps/weaknesses in systems support for IRCU? *Probe for areas that are important but were not addressed in the ACE intervention; areas that were included in ACE but were not addressed to the extent necessary.* 2.34 What suggestions do have for action/support to address the remaining gaps/weaknesses? *Probe for action that IRCU should take; action by RCBs; action by IPs; needed external support – what, by who* **B: Lets now turn our attention to IRCU grantees, and how their HIV/AIDS services have been changed by the ACE intervention** (Responses expected from IRCU, RCBs and sampled IPs) **Financial Management:** 2.35 What forms of Technical Assistance in Financial Management does IRCU provide for IPs? *Probe for direct TA from the IRCU Secretariat; Indirect TA (e.g., through RCBs, contracted agents, etc.)* 2.36 What other sources of Technical Assistance are available to IPs in the area of Financial Management? 2.37 What is your opinion about the accuracy and transparency in IP accounting practices; especially with regard to HIV/AIDS programs? *Probe for examples of IPs that are doing well, IPs that are not doing so well; what explains the differences; any differences in accounting for different programs/religious ministry areas* 2.38 How did the ACE intervention change/influence the IRCU practices with respect to provision of Technical Assistance to IPs in Financial Management? *Probe about how this has translated into benefit/change at the level of IPs and their HIV/AIDS programs* **Monitoring and Evaluation:** 2.39 What is your opinion about the M&E operations in the HIV/AIDS programs of IRCU IPs? *Probe for key element of M&E systems that are well developed; elements that are not so well developed; elements that are lacking; ask about examples of M&E good practice among IPs; IPs with particular problems in M&E. Probe about data collection tools; quality of M&E reports, use of data for program analysis – if these are not discussed without prompting* 2.40 What support does IRCU provide to IPs to improve M&E practices? *Probe for forms and*

increasing awareness on the services to OVCs? **MANAGEMENT** How the managers improved capacity has positively affected better OVC services? **5. STRENGTHENED CAPACITY OF MOH/RC** **SYSTEMS CONSOLIDATION & IMPLEMENTATION** To what extent the investment in IT at the MOH/RC has produced effective results in the organization and quality of service delivery? What is the training approach for the MIS System? What is the current status (functionality) of the National MIS System for tracking response at district level? What are the improvement in health services as a product of installing and using the M&E System: What quality and timing of the MIS outputs? What is ACE approach to MIS integration? **DISTRICTS ELECTRONIC REPORTING** Detailed description of the functioning of the system at district level. **COORDINATION** Explore use of information by district managers: data/report for planning and organization of services, assessments, etc.	*depth of M&E support by IRCU before 2006 and since 2006; M&E support that is directly provided from the IRCU Secretariat; indirect support (e.g., through RCBs, contracted agents, etc.)* 2.41 What other sources of M&E support are available to IRCU IPs? *Probe for support sources available to IPs in different parts of the country – Kampala, large/regional towns, small towns/remote-rural areas* 2.42 What are the different ways in which IRCU IPs put M&E products to use? *Probe for use of data at different levels of operation, processing of data to generate meaning, writing of reports for sending to different audiences, etc. Ask about M&E specific to HIV/AIDS programs, and M&E for other programs/ religious ministries* 2.45 How did the ACE intervention change/influence the IRCU practices with respect to provision of Technical Assistance to IPs in M&E? *Probe about how this has translated into benefit/change at the level of IPs and their HIV/AIDS programs* **Program planning, implementation and reporting by IPs:** 2.46 What is your opinion about the practices of IRCU IPs with respect to HIV/AIDS program planning, implementation and reporting? *Probe about any differences in practice with respect to other programs (non-HIV/AIDS), and in religious ministry activities* 2.47 How does IRCU provide support to IPs to improve HIV/AIDS program planning, implementation and reporting? *Probe for forms and depth of support by IRCU in HIV/AIDS program planning, implementation and reporting before 2006 and since 2006; support that is directly provided from the IRCU Secretariat; indirect support (e.g., through RCBs, contracted agents, etc.)* 2.48 What other sources of support in HIV/AIDS program planning, implementation and reporting are available to IRCU IPs? *Probe for support sources available to IPs in different parts of the country – Kampala, large/regional towns, small towns/remote-rural areas* 2.49 How did the ACE intervention change/influence the IRCU practices with respect to provision of Technical Assistance to IPs in HIV/AIDS program planning, implementation and reporting? *Probe about how this has translated into benefit/change at the level of IPs and their HIV/AIDS programs* **Factors that have facilitated/enhanced positive change:** 2.50 On the above aspects of IRCU IPs (or handling each of the elements separately); what factors have facilitated achievement of planned results? *Probe for factors inside IRCU, factors in the*

	RCBs; factors in the broader context where the IP operates **Factors that have hindered/reduced positive change:** 2.51 On the above aspects of IRCU IPs (or handling each of the elements separately); what factors have hindered/ constrained/ reduced achievement of planned results? *Probe for factors inside IRCU, factors in the RCBs; factors in the broader context where the IP operates* **Remaining gaps/weaknesses:** 2.52 What are the remaining gaps/weaknesses in systems and program management support for IRCU IPs? *Probe for areas that are important but were not addressed in the ACE intervention; areas that were included in ACE but were not addressed to the extent necessary.* 2.53 What suggestions do have for action/support to address the remaining gaps/weaknesses? *Probe for action that IRCU should take; action by RCBs; action by IPs; needed external support – what, by who*
SOW Question 3. To what extent has the capacity building provided by ACE contributed to the client organizations' overall performance in delivery of HIV/AIDS programs?	
What estimated direct or indirect quantitative connection could be established between the M&E component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect quantitative connection could be established between the IT component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect quantitative connection could be established between the Finance component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect quantitative connection could be established between the Communication component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect quantitative connection could be established between the L&M component and the number and quality of HIV/AIDS services delivered or supported by the partners?	3.1 What do you see as the overall impact of the ACE intervention on the performance of IRCU with respect to HIV/AIDS programs? Please explain your answer **Let us now focus on each of the elements of the ACE support to IRCU and how it has influenced the IRCU HIV/AIDS program** 3.2 What would you say is the estimated direct or indirect influence of the ACE support on governance and organizational oversight on the quality of the IRCU HIV/AIDS program? 3.3 What would you say is the estimated direct or indirect influence of the ACE support on the IRCU organizational structure on the quality of the IRCU HIV/AIDS program? 3.4 What would you say is the estimated direct or indirect influence of the ACE support on financial management on the quality of the IRCU HIV/AIDS program? • How has the ACE support in this area trickled down to the RCBs, IPs and the quality of HIV/AIDS services they deliver? 3.5 What would you say is the estimated direct or indirect influence of the ACE support on grants management on the quality of the IRCU HIV/AIDS program? 3.6 What would you say is the estimated direct or indirect influence of the ACE support on M&E on the quality of the IRCU HIV/AIDS program? • How has the ACE support in this area trickled down to the RCBs, IPs and the quality of HIV/AIDS services they deliver?

	3.7 What would you say is the estimated direct or indirect influence of the ACE support on applying national quality standards on the quality of the IRCU HIV/AIDS program? 3.8 What would you say is the estimated direct or indirect influence of the ACE support on diversifying IRCU funding sources on the quality of the IRCU HIV/AIDS program? 3.9 What would you say is the estimated direct or indirect influence of the ACE support on leadership and management on the quality of the IRCU HIV/AIDS program? 3.10 What would you say is the estimated direct or indirect influence of the ACE support on program planning, implementation and reporting on the quality of the HIV/AIDS services delivered by IRCU IPs?
SOW Question 4. How cost-effective were the ACE interventions?	
What estimated direct or indirect cost-effectiveness association could be established between the M&E component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect cost-effectiveness association could be established between the IT component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect cost-effectiveness association could be established between the Finance component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect cost-effectiveness association could be established between the Communication component and the number and quality of HIV/AIDS services delivered or supported by the partners? What estimated direct or indirect cost-effectiveness c association could be established between the L&M component and the number and quality of HIV/AIDS services delivered or supported by the partners?	4.1 Would you say that the ACE intervention in IRCU has been worth the investments made (by the funding source, by the ACE implementing agency, and by IRCU? Please explain your answer. *Probe for the characteristics of the program that show that it is good value for money; cost effective* 4.2 What factors have contributed to making the ACE intervention cost effective? 4.3 What factors in the ACE intervention hindered cost effectiveness?
SOW Question 5. What are the key lessons learned for capacity building programs in Uganda and elsewhere?	
Is the Capacity Building approach applied Comprehensive (involving all elements of the organization) versus Narrow (focus in one or two areas.) Capacity Building approach facilitates/precludes to walk toward a participatory organization.	5.1 From your knowledge and experience of the ACE intervention, would you say that it had a clear strategy for planned lesson learning as an integral part of its implementation? Please explain your answer 5.2 What would you say are the main lessons learnt by IRCU, RCBs and IPs from the ACE intervention and its implementation? *Probe for lessons about capacity building approaches,*

Capacity Building approach defines Accountability and Transparency as organizationally or systemically supported. Capacity Building approach includes/excludes beneficiaries of HIV/AIDS services, families and communities. Capacity Building approach strongly/weakly connected to empowering all segments of the organization.	*lessons about the critical components/ functions in an organization that influence its programs; lessons about good practices in IRCU, RCBs and IPs that were not well appreciated before then; lessons about/from the other agencies targeted by the ACE intervention (was there any opportunity to know each other and interact?)* 5.3 Are there any examples of lessons learned in IRCU, RCBs and/or IPs from/ through the ACE intervention that have been documented and shared? Ask for samples of such lessons learned documentation. • Please suggest any such lessons learned that you would propose for documentation and sharing. Ask about the preferred documentation methods, and the audiences to target in sharing
SOW Question 6. Has ACE had any positive or negative unintended results? What factors can such unintended results be attributed to?	
Positive or negative unintended results in the area of Mission, Vision or Overarching Goals in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Actions and Programs to fulfill Overarching Goals in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Capabilities (performance measurements, planning, resource management) in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Human Resources (collective capabilities, experiences, and commitment of leaders, staff and volunteers) in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Mission, Vision or Overarching Goals in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Systems and Infrastructure (Planning, Decision Making, Knowledge Management, Administrative systems, physical and technological assets) in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Organizational Structure	6.1 Has the ACE intervention contributed to any other positive changes in the work of IRCU, RCBs or IPs beyond the specific elements included in the planned results (as discussed already under section 2)? Please explain your answer. *Probe for IT systems development and how it related to the direct result areas; about communication systems and practice; about relations among different RCBs in the country; about local collaboration among IPs and other AIDS service organization; etc.* 6.2 Has the ACE intervention contributed to any negative experiences in the work of IRCU, RCBs or IPs? Please explain your answer. *Probe for experiences in the working relationship between IRCU, RCBs and IPs; in relations between the IRCU-related actors and other AIDS service or development organizations; in relations with government at different levels, etc.*

(Governance, Organizational design, Inter-functional coordination, job description) in any Partner? What factors can these unintended results be attributed to? Positive or negative unintended results in the area of Organizational Culture (relational mechanisms: shared values and practices, behavioral norms, orientation to performance)? What factors can these unintended results be attributed to?	

The Evaluation will be based on Description/Comparison	
Method	(*Data Source*)
Document & Record Reviews/Interviews	(*Reports/Records/Key Informant Interviews/Observations*)
System appraisal	(*System*)
Purposeful Sampling	

APPENDIX E: EVALUATION METHODOLOGY AND WORK PLAN

Purpose and Objectives of the Evaluation

The ACE project is completing its fourth year of implementation. The Automated Directive System (ADS) 203.3.6.1 requires that an evaluation is conducted when there is a distinct and clear management need to address an issue. The primary purpose of this review is to critically examine the overall project to:

13) How appropriate was the ACE approach for capacity-building to each client organization?

14) To what extent has ACE achieved its intended results for each client organization? What factors facilitated and/or hindered its achievement of planned results? What are the remaining gaps/weaknesses in systems support for each organization?

15) To what extent has the capacity-building provided by ACE contributed to the client organizations' overall performance in delivery of HIV/AIDS programs?

16) How cost-effective were the ACE interventions? *

17) What are the key lessons learned for capacity-building programs in Uganda and elsewhere?

18) Has ACE had any positive or negative unintended results? What factors can such unintended results be attributed to?

The evaluation will closely follow these key questions requested by the Mission.

The evaluation is led by Dr. Jaime Benavente, independent consultant. Team members include Dr. Nathan Nshakira, independent consultant, Dr. Hizaamu Ramadhan, independent consultant, Mr. Henry Emoi Gidudu, independent consultant, and Mr. James Tapera, independent consultant.

B. Methodology

This evaluation will use multiple sources of evidence to obtain a comprehensive and in-depth understanding of complex, diverse and multiple phenomena present in ACE's assistance, control the errors implicit in any chosen research method, support sound analyses, arrive at practical conclusions, and make accurate inferences.

- **Instruments for Data Collection and Key informant interviews**

The primary means of data collection include document and systems review, individual interviews, group interviews, and observations. Instruments were developed in Kampala by the Evaluation Team to guide interviews and observations. The Program activities include various groups of people whose actions significantly affect the final results of the interventions. At the core of the project, although unreachable, is the target population who are the beneficiaries of project interventions: People at risk of AIDS, PLWA, OVC and their families. Second, we have the Implementing Partners that are key to the implementation of activities and to achieving results. Third, we have the health managers at local, district and region levels. Fourth, we have the country level managers directly involved in guiding project interventions and operations. Finally, there is the ACE's management and staff who have been key in the implementation of the overall enhancement capacity efforts and USAID.

- **Review of relevant documents.**

Many publications were consulted and reviewed in order to obtain a comprehensive understanding of the HIV/AIDS circumstances in Uganda as well as the USAID Mission goals. They include: project annual reports, and other reports, financial documentation, monitoring reports and accompanying databases, research reports and accompanying databases, training reports, curricula, protocols, as well as BCC materials, and other materials. An Appendix will contain a list of documents collected and reviewed. The list will be complemented by the References section listing technical documents consulted during the assignment.

- **Design and preparation**

The agenda and protocol as well as evaluation instruments were developed in Kampala before the start of data collection field trips. The detailed agenda of visits to various sites was prepared and it is included in the work plan. Instruments, schedule and interviewee criteria were also developed by the evaluation team.

- **Field Work**

This assignment is scheduled from August 24 to October 2, 2009. The evaluation team will spend a week (August 26 and September 1) organizing the evaluation, and it will spend another week (September 3 and 7) interviewing ACE managers, NGO leaders and staff as well as visiting Program sites in Kampala area. In addition, the team will spend two weeks (September 7 to 18) visiting Programs offices sites and interviewing regional and district managers and local NGOs in ten districts (Kampala, jinja, Iganga, Mbale, Mubende, Wakiso, Kabale, Mbarara, Lyantonde and, Masaka.

Organization and Sites to Be Visited

Week 2	Week 3	Week 4
ACE: General ACE: M&E ACE: Finance PEPFAR ACE: L&M ACE: ICT ACE-Evaluation Team: debriefing UAC IRCU RCB Catholic RCB Muslim ACE: Cost-Effectiveness	IRCU: Jinja (AOET, Bugembe) MOH/RC: Jinja (Ref. Hospital) JCRC: Jinja-Iganga (Hospitals) UWESO: MBale (Regional OVC site) MOH/RC: Mubende (DHO/HC) JCRC: Mubende (Hospital) IRCU: Wakiso (RCB- Orthodox) MOH/RC: Wakiso (DHO/HC) JCRC: Kampala Eagle-Nest IRCU: Kampala (RCB Anglican Namirenbe)	IRCU Kabale: (IP-KIHEFO) MOH/RC Kabale: DHO-HC JCRC Kabale (Hospital) JCRC: Mbarara (Hospital) UWESO: Mbarara HAU: Mbarara (Hospice) IRCU: Mbarara (Catholic KAMUKUZI) MOH/RC: Mbarara (Hospital) IRCU: Lyantonde Muslim HC JCRC: Masaka (Treat Center) UWESO: Masaka (Reg. Off. OVC site) MOH/RC: Masaka (Referral Hospital)

The team will spend the two next weeks (September 21 to October 1st) reviewing project data, reports and records, writing draft report and briefing managers and partners on the preliminary results and recommendation.

In summary, the Evaluation Methodology to answer the evaluation questions is a combination of the following qualitative techniques:

- **Review** of relevant program documents;
- **Key informant interviews** with relevant staff of USG/Uganda, ACE and other key stakeholders
- **In-Depth Interviews** with ACE's clients that have been supported by the project

- **Application of a standardized tool** to assess capacity in the six partner organizations and a sample of their branches/centers/regional offices.

The proposed data collection methodologies are primarily qualitative in nature although the review of project documentation will examine closely reported results related to performance indicators from the ACE Project's Performance Management Plan.

The Document Review will encompass review of ACE's Statement of Work, modifications thereto, their Performance Management Plan, baseline data, quarterly and annual reports and work plans. The Evaluation Team will analyze the results achieved against the targets and benchmarks set. ACE itself has conducted capacity assessments of its institutional partners and these, together with their data collection tools, will also be reviewed by the Evaluation Team. Other documents to be reviewed include more general contextual sectoral data to be obtained on the status of HIV/AIDS capacity-building in the health sector from the GOU, USAID and other donors. These include *inter alia* the Government of Uganda's National frameworks, policies and implementation guidelines from the Uganda AIDS Commission and the Ministries of Health and Gender.

- **Key Informant Interviews** will be held early in the evaluation process with the technical and management staff of the relevant USG agencies and the ACE project so that the Evaluation Team fully understands the project**.**

- The Evaluation Team will visit each of the six partners at which **in-depth interviews** will be held with a senior staff and a review of the current status of the organizations' capacity undertaken using the tools developed by the Team. Each visit will require approximately one-half day with the full Evaluation Team working at each site with the exception of the visit to the MOH Resource Center which can be undertaken by the M&E/HMIS Specialist alone **(six organizational visits).**

The Evaluation Team will then select approximately 15-20 branches/regional centers/sub-grantees of the six partners to visit around the country for further in-depth interviews using the assessment tool **(15-20 organizational visits).**

WORK PLAN

First Week						
Monday 24	Tuesday 25	Wednesday 26	Thursday 27	Friday 28	Saturday 29	Sunday 30
Material review	Material review	Evaluation Team Briefing Material review	Material review **Briefing with USAID**	Inception Report Preparation (Methodology & Work Plan)	Inception Report Preparation (Methodology & Work Plan)	
ACE: Value-for-Money Analysis JT						
			Assessment of the Day	Assessment of the Day	Assessment of the Week	

Second Week						
Monday 31	Tuesday 1	Wednesday 2	Thursday 3	Friday 4	Saturday 5	Sunday 6
Work-plan Preparation	Preparation & submission of inception report Presentation USAID: **Oral Debriefing**	ACE: General ACE: M&E HR-NN ACE: Finance JT-HG PEPFAR JB-NN	ACE: L&M JB-HR ACE: ICT HG-NN ACE-Evaluation Team: debriefing	UAC HG-NN IRCU JB-HR RCB Catholic JB-HR RCB Muslim HG-NN	Review of Collected Data Organization of Field Trip	
ACE: Value-for-Money Analysis JT						
Assessment of the Day	Assessment of Inception Meeting	Assessment of the Day	Assessment of the Day	Assessment of the Day	Assessment of the Week	

Third Week						
Monday 7	Tuesday 8	Wednesday 9	Thursday 10	Friday 11	Saturday 11	Sunday13
IRCU: Jinja (AOET, Bugembe)	JCRC: Jinja-Iganga (Hospitals)	MOH/RC: Mubende	IRCU: Wakiso (RCB- Orthodox)	Debriefing	Assessment of the Week	

NN-JB MOH/RC: Jinja (Ref. Hospital) HR-HG	NN-HR UWESO: MBale (Regional OVC site) JB-HG	(DHO/HC) HG-HR JCRC: Mubende (Hospital) JB-NN	JB-NN MOH/RC: Wakiso (DHO/HC) HR-HG JCRC: Kampala Eagle-Nest NN-HR IRCU: Kampala (RCB Anglican Namirenbe) HG-JB	Preparation **Oral Debriefing USAID**	Review Notes Integrate Notes Preparation of Weekly Summary	**Trip to SW**
Assessment of the Day	Assessment of the Day	Assessment of the Day	Assessment of the Day	Assessment of the Day		

Fourth Week						
Monday 14	Tuesday 15	Wednesday 16	Thursday 17	Friday 18	Saturday 25	Sunday 26
IRCU Kabale: (IP-KIHEFO) NN-JB MOH/RC Kabale: DHO-HC HG-HR JCRC Kabale (Hospital) HG-HR-NN-JB	JCRC: Mbarara (Hospital) JB-HR UWESO: Mbarara HG-JB HAU: Mbarara (Hospice) HG-NN-JB	IRCU: Mbarara (Catholic KAMUKUZI) NN-HR MOH/RC: Mbarara (Hospital) JB-HG IRCU: LYANTONDE MUSLIM HC HG-HR-NN-JB	JCRC: Masaka (Treat Center) HG-HR UWESO: Masaka (Reg. Off. OVC site) NN-JB MOH/RC: Masaka (Referral Hospital) HG-HR-NN-JB	Data Organization & Analysis	Data Analysis Assessment of the Week	
Assessment of the Day	Assessment of the Day	Assessment of the Day	Assessment of the Day	Assessment of the Day		

Fifth Week

Monday 27	Tuesday 28	Wednesday 29	Thursday 30	Friday 1	Saturday 2	Sunday 3
Data Analysis & Drafting Report	Data Analysis & Drafting Report	Data Analysis & Drafting Report	Drafting Report	Drafting Report **Submission Draft evaluation report for review by USAID.**	Debriefing with MG	
Assessment of the Day	Assessment of Inception Meeting	Assessment of the Day	Assessment of the Day			

Dr. Jaime Benavente JB
Dr. Nathan Nshakira NN
Dr. Hizaamu Ramadhan HR
Mr. Henry Emoi Gidudu HG
Mr. James Tapera JT

APPENDIX F: THE COST-EFFECTIVENESS ANALYSIS

Introduction

This section presents an analysis to 'determine if the ACE approach to capacity building was cost-effective' in cognizance of the interventions to selected organizations in different thematic. The evaluation was addressing the question' How cost-effective were the ACE interventions'

In addressing the question approach adopted was to analyze the performance by the organizations in impact created after receiving assistance. Scores of outcomes were analyzed and rated to units of outcomes relative to a predetermined benchmark of set outcomes drawn up responsively to the nature, extent and timing of interventions using the Goal Attainment Score line approach.

In quest to strengthen the capacities of the organizations, ACE carried a needs assessment to identify gaps for potential strengthening. An intervention was affected based on the condition of the thematic. It was from this condition that objectives were drawn up and outcomes determined.

Study Approach and Methods

Background

Measuring the cost effectiveness of an intervention within implementing organizations encountered limitations due to the absence of definitive baseline information or rate of the condition at intervention level which would have made it easier to compute the incremental rate of effectiveness in actual outcome relative to condition before intervention. Capacity strengthened thematic are mostly of supportive administrative roles to final objectives hence performance indicator as set were focused on end result rather than behind the scenes operational tasks. An inventory of benchmarks per organization in lieu of the nature, timing and extent of assistance were correspondingly developed to measure cost effectiveness as a result of the ACE interventions.

Approach Customization

Based on the above submission, we customized the Goal attainment scaling approach to apply it in evaluating the effectiveness of an intervention per organization per thematic basis. The scaling approach was adopted to depict the outcomes (expected and actual). Expected outcomes were determined at a scale of zero (0) as a basis of what would be the expected level of outcome given the nature, timing and extent of the intervention. Actual outcome was then scored in relation to the exact results upon verification of relevant documents and key informant interviews per thematic area of strengthened capacity with reference to the baseline expected outcome as a reference point.

Goal attainment scaling (GAS)

Measurement through GAS was first introduced in 1968 by Kirusek and Sherman[1] for assessing outcomes in mental health settings. Since then it has been modified and applied in many other areas.
GAS is a method of scoring adopted for this evaluation exercise to depict the extent to which thematic outcomes were achieved in the course of intervention. In effect, each thematic has own outcome measure but this is scored in a standardized a way as to allow statistical analysis.

[1]Kiresuk T, Sherman R. Goal attainment scaling: a general method of evaluating comprehensive mental health programs. Community Mental Health Journal 1968; 4:443-453.

Rating on GAS

GAS is essentially conducted on a 5-point measure, with the degree of attainment captured for each thematic area. An important part of GAS is the establishment of the outcome that is viewed as 'successful' on *a prior* basis (i.e. before the intervention starts).
If an organization achieved the expected level, this was scored at 0.
If it achieved a ***better*** than expected outcome this was scored at:

+1 (Somewhat better)

+2 (much better)

If it achieved a ***worse*** than expected outcome this was scored at:

-1 (Somewhat worse) or
-2 (much worse)

Although not in the original method described by Kirusek and Sherman, outcomes were weighted to take account of the relative importance.

Cost collection

Costs of intervention per thematic area per organization were collected retrospectively from financial and operational records kept by ACE. Only direct costs of intervention were considered for the purpose of the evaluation. Determination of indirect costs for a total cost determinant was impossible given the time frame of the evaluation study.

HAU

Table 1:

Thematic area	cost	conversion	cost in	Actual	expected	cost per	cost per	% achieved
	UGX	rate to USD	USD	outcomes	outcomes	actual outcomes	expected outcomes	
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
Communication	111,504,499	2,000	55,752.25	32.22	50.00	1,730.24	1,115.04	(55)
Finance	193,748,800	2,000	96,874.40	27.78	50.00	3,487.48	1,937.49	(80)
M&E	126,380,685	2,000	63,190.34	32.22	50.00	1,961.08	1,263.81	(55)
MIS	163,216,800	2,000	81,608.40	54.44	50.00	1,498.93	1,632.17	8
OD/HR	117,814,063	2,000	58,907.03	54.44	50.00	1,081.97	1,178.14	8.16
Total	**712,664,847**	2,000	**356,332.42**	**201.11111**	**250**	**9,759.70**	**7,126.65**	**(174)**

Figure 1

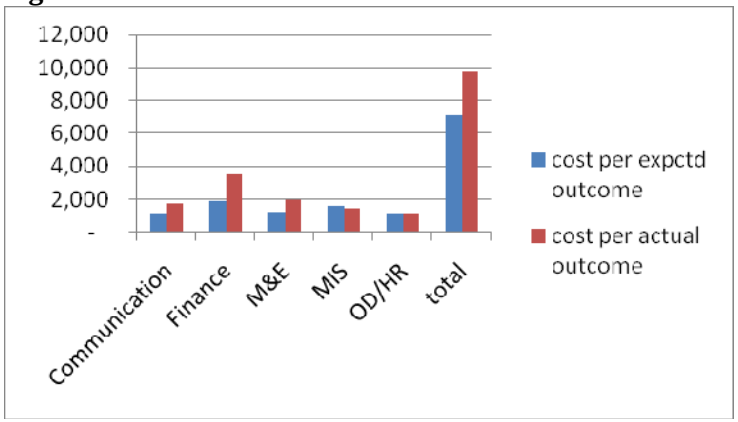
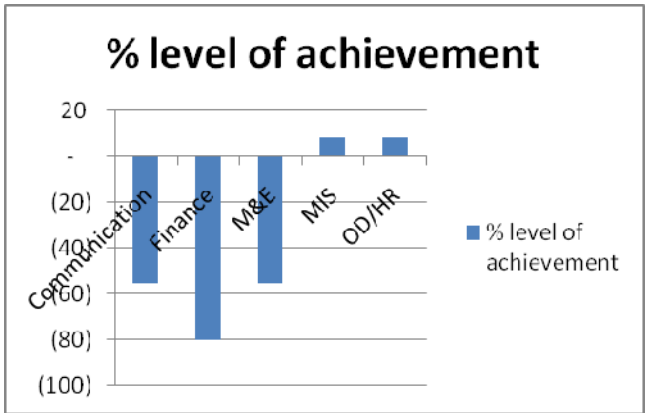


Figure 2



Findings

- The finance function achieved the least outputs across the thematic areas resulting in a negative 80% level of achievement relative to the expected outputs. ACE updated the Tally accounting system from version 7.2 to version 9 so that efficiency would be achieved in reporting through all round accounting activities contributing to financial reports, these include processing of the payroll to include leave register, procurement and updating of the fixed asset register within the Tally system. However most of these processes are still being done manually.

- Data for a periodic financial reporting purpose is exported into excel for editing so as to suit specific multi donor reporting requirements formats.

- Communication and M & E had negative 55% level of achievement expected. Cost per actual outcome for were much lower because, for communication a strategy was developed but not implemented, no trainings or outreach programs have been initiated to date. An advocacy officer supposedly to lead the activities is yet to be employed. M&E is not yet functional as data is yet to be uploaded into the new database. They are waiting for integration of the database with Hoima and Mbarara centers. No trainings in use of data collection tools and application of the database have been done to date for the two centers.

- MIS and OD/HR areas achieved more outputs than expected resulting in a lower computed cost per output as depicted by Figure 1 and ultimately a higher percentage level of achievement, refer figure 2. The strengthened MIS system has seen cost savings in distribution of study modules of the HAU Diploma in Palliative of $14,960 per current 30 students per 18 months of the program whilst OD/HR has managed to retain competent staff through performance incentives of ‘ Best employee of the year’ and ‘ Best employee of the year per department’.

Benchmark outcomes summary

Finance
- handling of the procurement process from initiation and authorization, recording and processing in the system, through to disclosure and presentation in the Navision system since the system supports the computer generated vouchers, authorization access levels and GRNotes
- Audit reports related finance issues
- Accurate produced reports with balances corresponding to detailed ledgers
- Payable and Receivables transactions functionality processed in the Navision and Tally systems
- updating the fixed asset registers within the Navision and Tally systems
- Payroll processing, all statutory deductions and employee NSSF benefits implemented within the Navision and Tally system.
- Error detection in transaction processing
- Authorization controls to alter and access data before final reports at different levels of responsibility

Joint Clinical Research Centre (JCRC)

Table 2:

Thematic area	cost	conversion	cost in	Actual	Expctd	cost per	cost per	% achieved
	UGX	rate to USD	USD	outcomes	outcomes	actual outcomes	xpctd outcomes	
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
Finance	310,759,500	2,000	155,380	46	50	3,411	3,108	(10)
M&E	299,103,700	2,000	149,552	50	50	2,991	2,991	-
MIS	356,687,728	2,000	178,344	50	50	3,567	3,567	-
OD/HR	293,574,660	2,000	146,787	41	50	3,571	2,936	(22)
Total	**1,260,125,588**	2,000	**630,063**	**187**	**200**	**13,539**	**12,601**	**(31)**

Figure 3

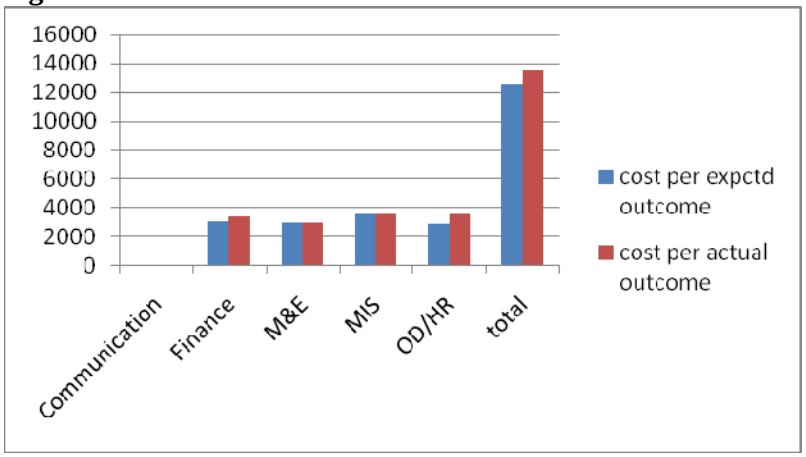
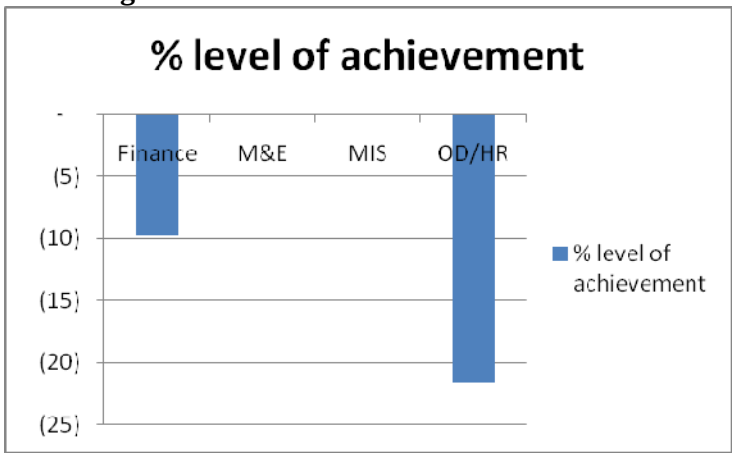


Figure 4



Findings

- Outputs for M & E and MIS were at par with expected units of output. The percentage level of achievement remained constant entailing no indication of cost effectiveness or ineffectiveness in relation to baseline cost per output. The roll out of the M & E database to 21 clinical sites on an integration basis with the Head Office has resulted in a complete capturing of relevant data which produces accurate reports informed decision making. However training in appropriate use and application of the tools and database needs to be rolled out to community based volunteers for accurate data capturing at source.

Benchmark outcomes summary

M&E

-achievement of program performance indicators
- Electronic data management to enable accurate and reliable reporting on the status of the program by the aid of graphical and trend analysis
- Number of peripheral staff in districts trained on how to use the M&E database.
- improved programming of program activities and budgeting as performance in prior periods per information in the database is used as a benchmark.
- Progress reports from new M & E system on program implementation.

- As observed before strengthening of the Navision system by ACE raised reversing journals were high but however these has been reduced by approximated 60%. Data capturing was inaccurate by the manual process. Intranet as a benchmark output for the MIS which can enable communication internally and posting of important material such as Vision, Mission Statement, policies and required procedures, updates on new information has not been installed. A non existing record of error fixed complaints failed the benchmark test. However the data captured back log is nearing completion and the 6 data entry staff employed to assist the systems accountant has since been redeployed to other scope of work resulting in salary savings.

- As depicted by Figure 4, the level of achieving cost effectiveness per output compared to baseline data was a negative 22% for OD/HR and negative 10% for finance. Ineffectiveness to a high output is to a greater extent due to the absence of an organizational structure, a high staff turnover of 16 key staff since January 2009 and no closely monitored performance reviews. This reveals the level of dissent among employees which hinders the achievement of high output levels. A lack of hands on training of accounting staff affects achievement of outputs for finance section. The accounts server is low on capacity putting processed data at risk.

UAC

Table 3:

Thematic area	cost	conversion	cost in	Actual	xpctd	cost per	cost per	% achieved
	UGX	rate to USD	USD	outcomes	outcomes	actual outcomes	xpctd outcomes	
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
Communication	14,845,380	2,000	7,423	37	50	202	148	(36)
M&E	86,869,000	2,000	43,435	37	50	1,185	869	(36)
Total	**101,714,380**	2,000	**50,857**	**73**	**100**	**1,387**	**1,017**	**(73)**

Figure 5

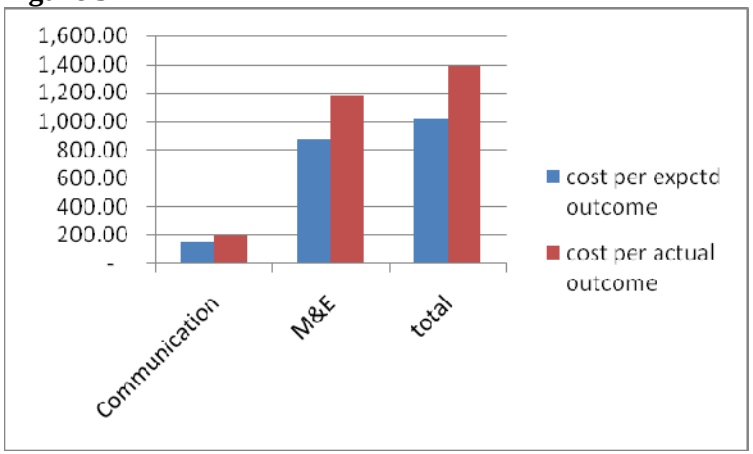
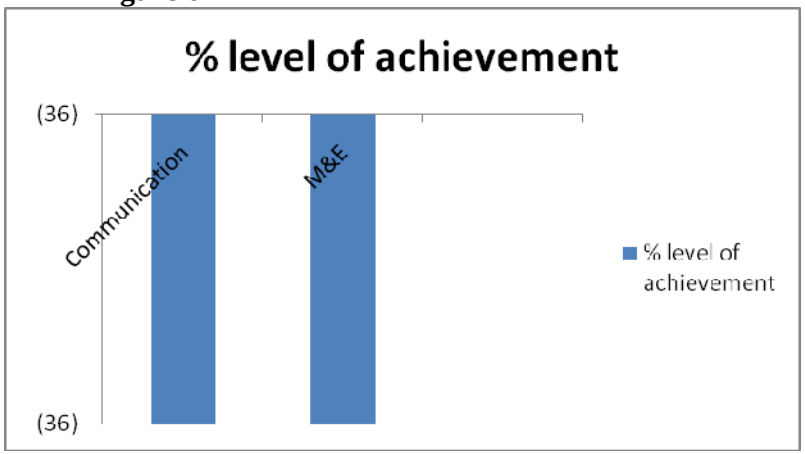


Figure 6



Findings

- Communication and M & E had negative 36% level of achievement to benchmark outcomes. A draft communication framework is in place awaiting approval by the Board. No clear and agreed definition of short and long term objectives has been put in place. Outreach programs to conscientise the publics about UAC's planned activities and how them the public as stakeholders are to be involved has not been spelt out. M&E is not yet functional as data is yet to be uploaded into the new database. No report yet on Performance Indicators as the results of AIDS indicator surveys not obtained were to be used for obtaining indicator values. Data collection tools have been developed but not yet put into use for results. On a positive note trainings on the PMMP dissemination have been conducted in the district regional sessions where 516 senior persons were oriented versus the planned 720. 2,496 stakeholders were oriented in the NSP and PMMP versus the

Benchmark outcomes summary

MIS

- Payable and Receivables transactions functionality implemented.
- Purchase order cost allocations used by the procurement unit for all procurement activities.
- Website framework and design, search capabilities, and content management system.
- Intranet with updated internal information
- Stock level reports to indicate replenishment period.
- Reduced error rate in data processing
- Reduced rate of fixing end users complaints by the IT administrators
- Existence of IT policy manuals circulated to all employees
- Training to staff on IT hardware and software maintenance procedures.
- Data warehouse supporting the HMIS, health infrastructure database

UWESO

Table 4:

Thematic area	cost	conversion	cost in	Actual	xpctd	cost per	cost per	% achieved
	UGX	rate to USD	USD	outcomes	outcomes	actual outcomes	xpctd outcomes	
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
Communication	55,587,000	2,000	27,794	50	50	556	556	-
Finance	127,111,020	2,000	63,556	32	50	1,972	1,271	(55)
M&E	91,728,360	2,000	45,864	37	50	1,251	917	(36)
MIS	48,940,000	2,000	24,470	50	50	489	489	-
OD/HR	14,055,000	2,000	7,028	37	50	192	141	(36)
Total	**337,421,380**	2,000	**168,711**	**206**	**250**	**4,460**	**3,374**	**(128)**

Figure 7

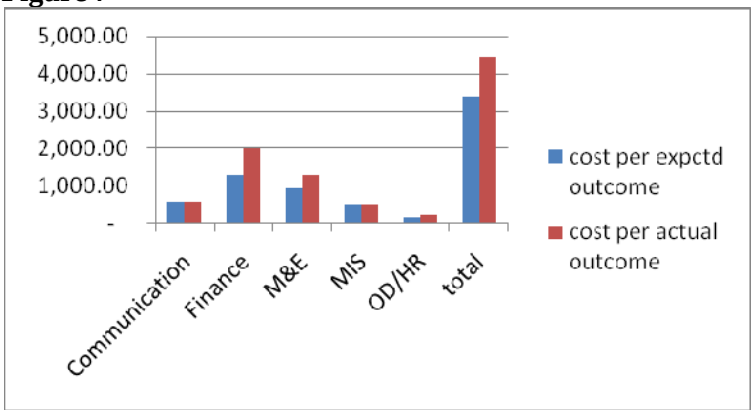
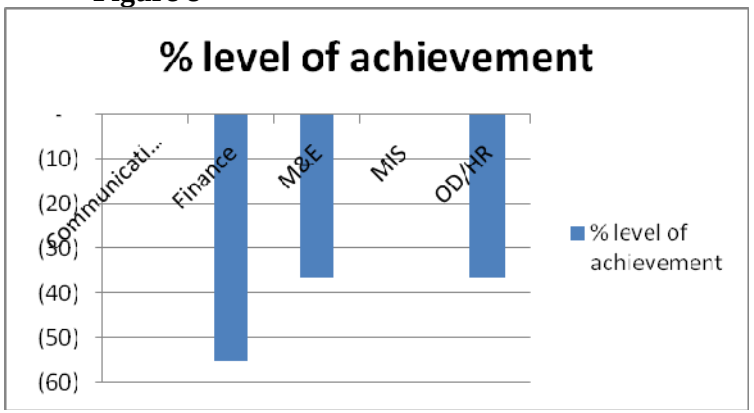


Figure 8



Findings

- As shown by Figure 7 and 8 outcomes for communication were at par with benchmark outcomes. Cost effectiveness was achieved in producing expected outcomes at a breakeven level of expected level of achievement. 6 proposals with budget lines for communication and advocacy programs have been submitted, still waiting for feedback for all proposals from the prospective donors. Promotional materials to sensitize communities about the UWESO programs have been developed and disseminated to 20 school clubs of Oyam and APAC. A civil society fund to raise awareness on child protection has been set up IEC materials for 6 sub counties of Kiruhura district have been developed. Guidelines have been developed and have already been approved by the Board and circulated to all employees for their awareness.

Benchmark outcomes summary

OD/HR

- Established Human resources functional department
- Performance monitoring systems
- Responsibilities defined by job descriptions
- Increased staff motivation indicated by low staff turn over
- Organizational structure showing assignment of authority and responsibility
- Communication and enforcement of integrity and ethical values
- Management's philosophy and operating style and commitment to competence

- The level of achievement to expected outcomes came short by 55% entailing non cost effectiveness as Figure 8 shows. Control on Journals are lacking as some are posted and processed to reports without approval or checking for validity and accuracy by a senior official. As noted a payment voucher # PET 0801 (UGSh 20,000) for fuel payment was prepared by Isaac never reviewed by any senior official but payment processed. Also a payment voucher # UOP 00306 (1,075,076) for personnel expenses was prepared by Isaac, never reviewed by any senior official for accuracy, but payment was processed. . Payroll computations, leave register and fixed asset register are all being done manually irrespective of the training provided in Navision use by ACE thereby resulted in inefficiency.

- Outcomes for M & E as per Figure 8 failed to tally with the benchmark resulting in a cost ineffectiveness of negative 36%. Standard operating procedures providing written guidelines for implementing activities have been developed but there is a data backlog which was said to be due to incomplete registration exercise listing all beneficiaries in communities and also the register of volunteers. This has hindered production of trend reports due to incomplete captured information. No training on the use of M & E tools was observed to have been conducted yet.

- As depicted by Figure 8 outcomes for MIS were at par with benchmark outcomes. Cost effectiveness was achieved in producing expected outcomes to breakeven level of cost per outcome. With the redesigned website Masulita Children's Village one of the Orphanages under UWESO's assistance got new donors from US who made their pledge after visiting the website. Hill top High School is now providing school fees to 12 orphans for a year.

Costs of USD 100 per year have been saved in maintenance contracts due to the redesigned website. However no trainings in end user maintenance of IT equipment have been conducted by the systems administrator.

- ACE strengthened the capacity of UWESO in organizational development by provision of training in leadership and management to senior managers, but however there was a high staff turnover and of the 5 senior managers trained in leadership and management 4 have since left the organization. No dissemination of the skills gained was imparted to other staff. In house squabbles of top management have hindered morale of staff. A policy to review performance through appraisal is in place but as observed since starting 2008 no review has been done. No organogram exists in which the organization structure responsibilities are clearly defined. However the CEO also spearheaded inception of internal audit department which took stock of the status of affairs before she joined and after she joined.

MOH/RC

Table 5:

Thematic area	cost	conversion	cost in	Actual	expected	cost per	cost per	% achieved
	UGX	rate to USD	USD	outcomes	outcomes	actual outcomes	expected outcomes	
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
MIS	799,865,038	2,000	399,933	46	50	8,779	7,999	(10)
Total	**799,865,038**	2,000	**399,933**	**46**	**50**	**8,779**	**7,999**	**(10)**

Figure 9

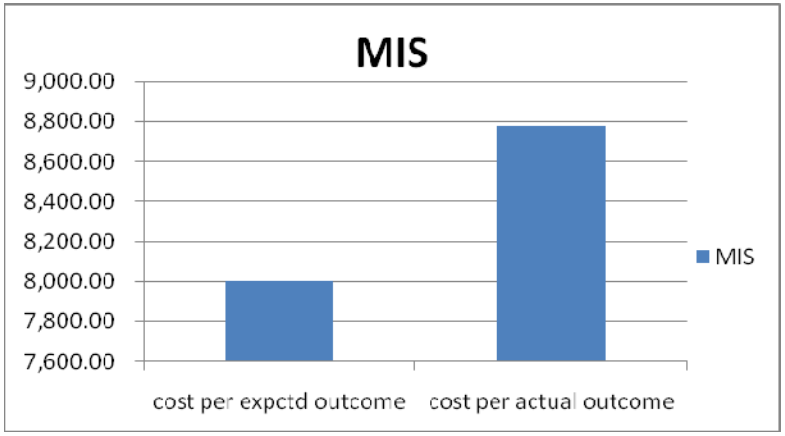
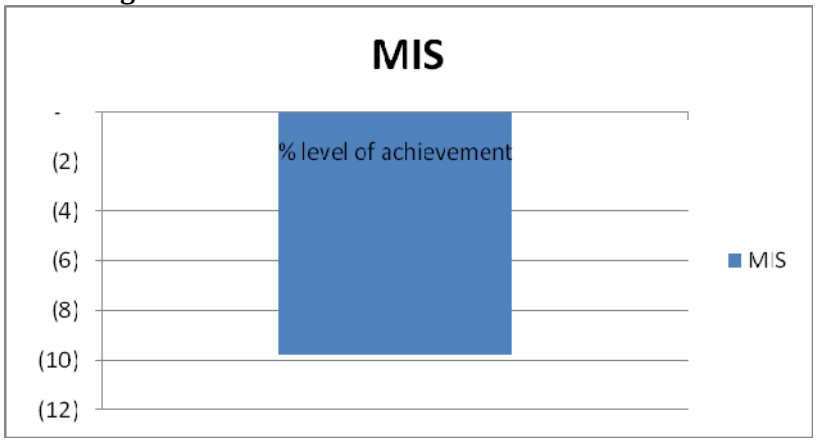


Figure 10



Findings

As depicted by Figure 10, the level of achieving cost effectiveness per output compared to baseline data was a negative 10%.
After the strengthening of the capacity by ACE, the supply chain management system is now used to implement all sales order management, procurement, inventory management, distribution, and procurement-related financial management functions

The level of achieving cost effectiveness per output compared to baseline data was a negative 10%. The observed score was aided by a result of outcomes from the functional e-library and internet system at the RC and the strengthened supply chain management system used to implement all sales order management, procurement, inventory management, distribution, and procurement-related financial management functions. The non functionality of the web enabled reporting system both at the resource centre and in the districts contributed to the low score of cost effectiveness. This reporting system was supposed to facilitate migration from a system of a large client-server–based set of reports to a system with a smaller set of more flexible web-based reports, where users can choose their own report parameters using selectors on a web page. In the long term, this approach was expected to add value by having reports generated on one platform and being accessed by other user groups. The new web-based reporting system operates with multi-level identity management for controlling user access. From observation, the web enabled system is unable to do all these functions.

Benchmark outcomes summary

Communication

- Trainings conducted to conscientise employees and/or stakeholders about the values of the organization and how to share the same values
- Partners identified in preparation to fund communication and advocacy components in budgets
- Developed guidelines on information dissemination
- Achievement of short term set objectives and performance communications strategy
- Awareness of the communications strategy by all

On line support is now offered to end users on impromptu fault queries and follow up technical training support has been carried out in 35 districts were the web based MIS was rolled out.

IRCU

Table 6:

Thematic area	cost UGX	conversion rate to USD	cost in USD	Actual outcomes	xpctd outcomes	cost per actual outcomes	cost per xpctd outcomes	% achieved
	a	b	c =a/b	d	e	f = c/d	g = c/e	h = (g-f)/g
Finance	216,185,186.0	2,000.0	108,092.6	27.8	50.0	3,891.3	2,161.9	(80)
M&E	641,508,100.0	2,000.0	320,754.1	45.6	50.0	7,040.9	6,415.1	(10)
OD/HR	119,405,120.0	2,000.0	59,702.6	50.0	50.0	1,194.1	1,194.1	-
Total	**977,098,406.0**	2,000.0	**488,549.2**	**123.3**	**150.0**	**12,126.3**	**9,771.0**	**(90)**

Figure 11

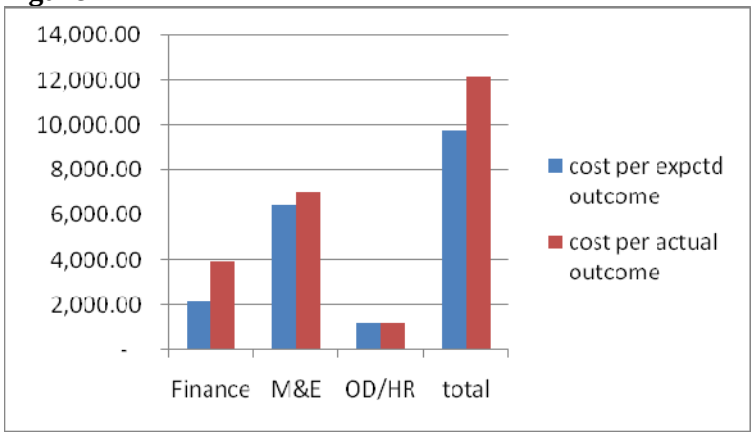
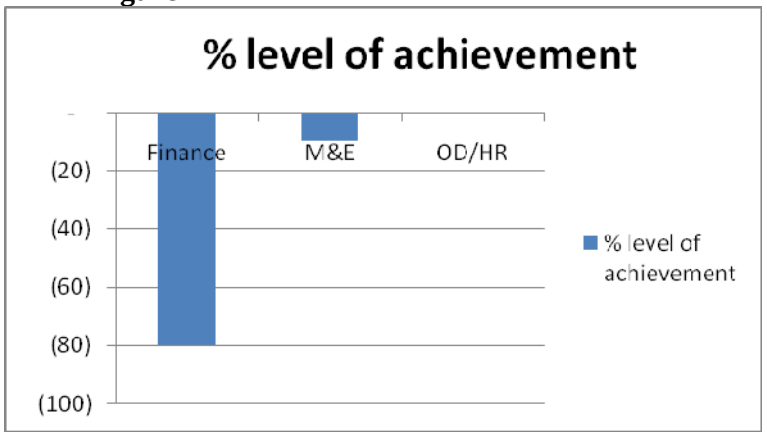


Figure 12



Findings

- As shown by Figure 12, finance had a negative 80% level of achieving cost effectiveness per output to benchmark units of output. Journals can be posted or reversed by the accountant and/or the Finance manager without approval from the senior official that gives rise to risk of validity and authenticity ultimately affecting the accuracy of reports produced. Payroll computations, leave register and fixed asset register are all being done manually irrespective of the training provided in Navision use by ACE thereby resulted in inefficiency.

- Training in M & E tools was administered by ACE but however it only requires the presence of the IT expert and M & E specialist to produce reports. However training in data collection has been done for sub grantees enabling capturing of all relevant data at primary source to enable query based reporting.
- The results for OD/ HR as shown on Figure 11 and 12 shows that outputs produced were at par with the benchmark results therefore no incremental cost effectiveness was achieved. On a predetermined outcomes analyzing the management's philosophy and operating style and commitment to competence, communication and enforcement of integrity and ethical values, responsibilities defined by job descriptions, evidence of performance reviews by the Board, expected results were all achieved in these areas of analysis except that there is no substantive Human resources function enacted which resulted in staff related issues taking long to be solved

Figure 13: Communication

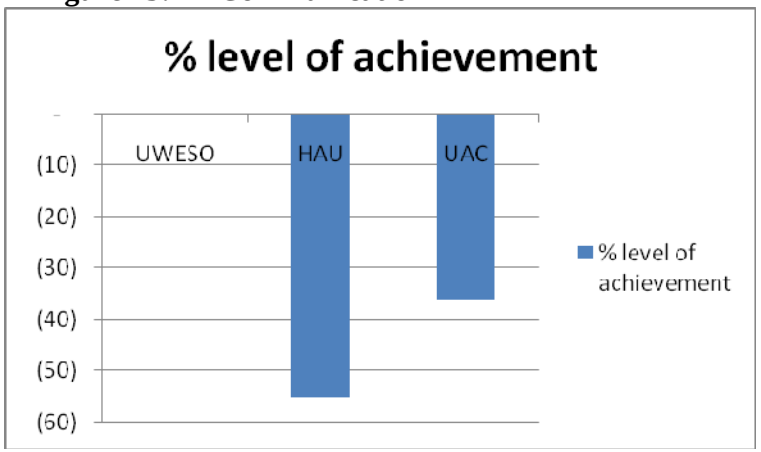


Figure 14: OD/HR

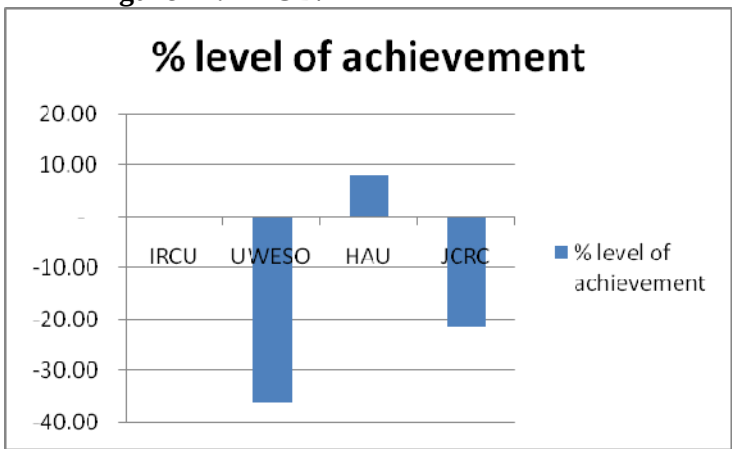


Figure 15: Finance

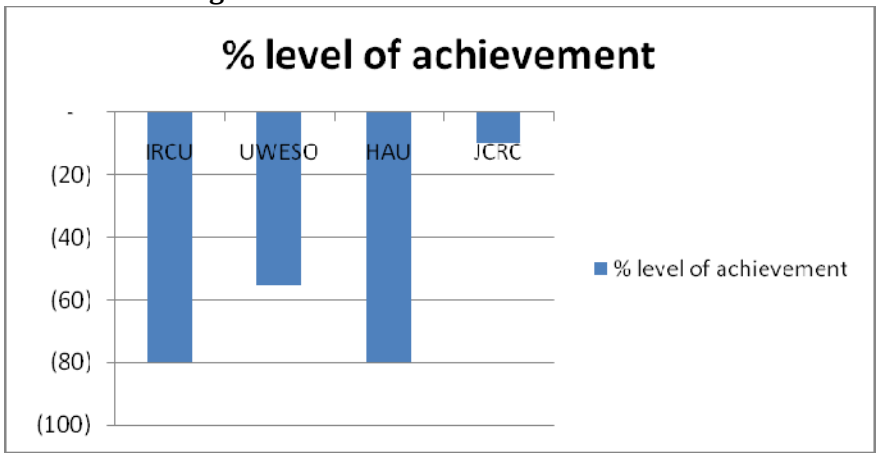


Figure 16: M & E

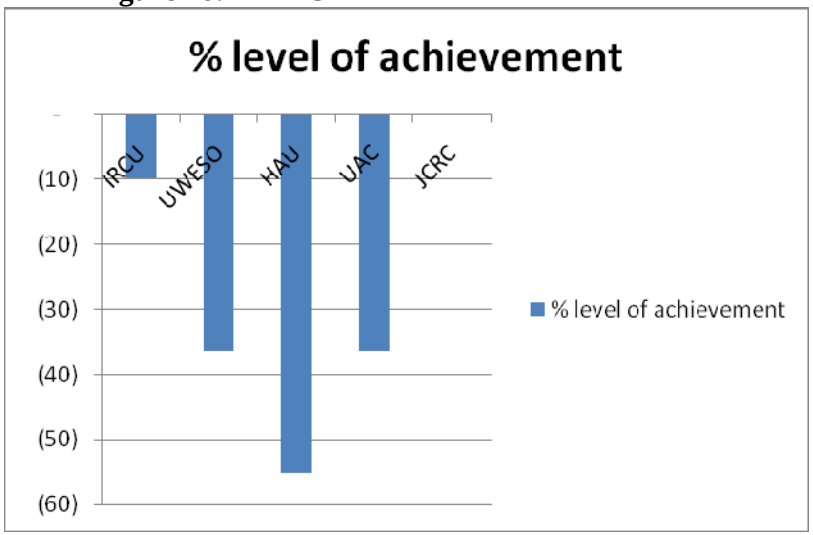
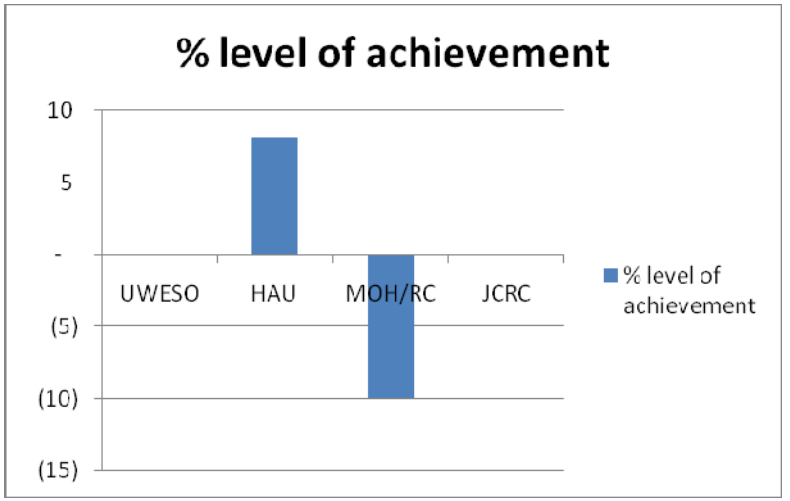


Figure 17: MIS



Conclusions

ACE strengthened the capacities of organizations across the five thematic of MIS, OD/HR, M & E, Finance and Communication on the basis of gaps identified per the needs capacity assessment. On this backdrop ACE contributed responsively, however achieving effectiveness to the cost of intervention by producing outcomes as expected per strengthened capacity was a prerogative of the organizations.

The development and launch of the MIS across the organizations has met a number of challenges to cost effectiveness, but however it is this thematic to have produced the most cost effective results.

Dismal results have been produced by Finance as staff has failed to utilize the systems provided into efficiency. Though training has been followed up in all instances after development or upgrading of the accounting system, staff are virtually operating semi manually on activities that are supposed to be computer assisted, for instance procurement and receivables management system to track overdue receivables so as not to give allowance to potential bad debts.

Communication and M & E would need an accelerated and concerted effort from the senior management and those bestowed with the responsibility to ensure that outcomes are achieved. On paper strategies and performance indicators have been developed but not much has been done by most organizations to put theory into practice and utilizing ammunition to victory. In some instances in the case of UAC, ACE assistance was received towards end of its project, which gave little time to enable an execution phase to produce outcomes. This is case scenario of M & E and communication where the capacities were strengthened in April 2009. In some time is still needed under monitoring to ensure performance outcomes are achieved.

In-house squabbles have hindered performance of UWESO resulting in a non achievement of outcomes for OD/HR. Lowered morale within the organization has seen resignation of key staff who should have been instrumental in spearheading the organization's developmental programs. The discord could have spilt loss of direction to other thematic like M& E and communication which have a direct link to the tone set on top. JCRC also had a performance under par in OD/HR. The turnover of staff indicates that staff morale might have been at its lowest, and this to a certain extent in the long run can have a multiplier effect to the other thematic if it is to continue unabated.

Managing expectations: Based on the observations on evaluation, organizations need to exert much more by effecting change management in operational, understand that ACE was there to ensure viability and sustainability of projects, to strengthen organizational capacities in proposal writing so that these organizations would be able to bid or solicit for funds through well crafted proposals. Success of the proposals entailing going concern and sustainability of the donor dependant organizations.

Recommendations

While organizations must continually adapt to their competitive environments, there are certain core ideals that remain relatively steady and provide guidance in the process of strategic decision

making. These unchanging ideals form the business vision. Given the fact that ACE lifespan has ended, it is imperative that management's philosophy and operating style be committed to competence in pursuit of performance outcomes in all thematic. This being said it follows that where ACE support has fallen short of expectations, for instance further training in proficiency of Navision use, it is now a prerogative of the organization's management to set aside funds through their budgets for enhancing a strengthened capacity. For advocacy programs to be a success there ought to be full time advocacy officers who spearhead implementation of strategies through support and involvement of senior management.

Organizations privileged to own Navision software and offered training in its use should capitalize on the abilities of the accounting system to have customized reports tailor suited to the organizational preferences, to run the procurement system from initiation and authorization through to recording and processing, process payroll computations within the supported module, monitor receivables ageing analysis so as to curtail potential bad debts as supported by the module and processing fixed asset registers in its supported modules as this would enhance efficiency and accuracy of reporting since automated systems if programmed well are free from human error and efficient.
An insight into the needs of staff to prop up morale and avoid staff turnover, a case of JCRC and UWESO would be needed as the effect has a multiplier effect into performance of other functional departments.

Formulas to determine units of outcomes score line

Computation of the overall scores

Overall outcome Attainment Scores were calculated by applying a formula:

$$\text{Overall GAS} = 50 + \frac{10\,\Sigma(w_i\,x_i)}{[(1-\rho)\,\Sigma w_i^2 + \rho(\,\Sigma(w_i)^2]^{\frac{1}{2}}}$$

Where:
w_i = the weight assigned to the *i*th goal (if equal weights, $w_i = 1$)
x_i = the numerical value achieved (between –2 and + 2)
. . the expected correlation of the goal scales
For practical purposes per literature . is usually taken as 0.3. In which case the equation simplifies to:

$$\text{Overall GAS} = 50 + \frac{10\,\Sigma(w_i\,x_i)}{\text{sq root}\,(0.7\,\Sigma w_i^2 + 0.3(\Sigma w_i)^2)}$$

In effect, therefore the composite GAS (the sum of the attainment levels x the relative weights for each goal) is transformed into a standardized measure with a mean of 50 and standard deviation of 10.
However if all the scores are weighted equally so that all the w_i are set equal to 1, then the equation above can be written as:

$$T = 50 + \frac{10\ x_i}{[n-n_{\,.} + n^2 p\,]^{\text{square root}}}$$

where n is the number of scales on the outcome attainment

NB* scores per thematic were seen to be of equal weighting therefore, the equation as above was adopted throughout the outcome determination evaluation exercise

Procedure for Goal/Outcome Attainment Scoring

Identify the goals

- Interview the Implementing Partners' staff and also review ACE assessment reports before interventions to identify the main problem areas (condition before intervention) and objectives on intervention.
- Establish an agreed set of priority outcome areas (with the help of the team) for achievement by the period of evaluation.

Weight the goals

Assign a weight to each outcome
Rushton and colleagues[2] used the following method:
Weight = importance x difficulty
Importance and difficulty are each rated on a 5 point scale

Importance	**Difficulty**
0 = not at all (important)	0 = not at all (difficult)
1 = a little (important)	1 = a little (difficult)
2 = moderately (important)	2 = moderately (difficult)
3 = very (important)	3 = very (difficult)

Define expected outcome

The 'expected outcome' is the most probably result if the organization achieves the desired outcome at the expected levels given the nature of intervention and period in use of a strengthened capacity up to the date of evaluation.

Define also the levels for

- 'somewhat less' and 'much less'
- 'somewhat more' and 'much more'

These were defined by the team, to be ***as objective and observable as possible***

Score baseline

This is usually rated –1, unless the organization in the thematic area is as bad as they could be in that particular goal/outcome area, in which case the baseline rate is –2.

Outcome Attainment scoring

Rate the outcome scores.
Calculate the outcomes by applying the formula as above.

[2]Rushton PW, Miller WC. Goal attainment scaling in the rehabilitation of patients with lower-extremity amputations: a pilot study. Archives of Physical Medicine & Rehabilitation. 2002;83(6):771-5.

APPENDIX G: CHEMONICS RESPONSE TO THE ACE EVALUATION

February 12, 2010

Elise Ayers
USAID/Uganda
Kampala, Uganda

Subject: Chemonics response to the End-of Project Evaluation of the AIDS Capacity Enhancement (ACE) Program: Final Evaluation Report

Dear Ms. Ayers:

Chemonics appreciates the opportunity to respond to the End-of Project Evaluation of the ACE Program submitted by the Mitchell Group in September 2009. In light of the project's achievements vis-à-vis the contracted scope of work, we were concerned to find critiques outside the realm of the project's scope of work, misrepresentations of ACE's work, and many factual errors. Below, we have listed the six areas where we found the findings most problematic in terms of what lessons USAID and partners can draw from the project. In addition, we have provided a table with a list of factual errors and our corrections as well as corrected budget figures.

1. The framework for measuring project results

We were disappointed that the ACE project's contract scope of work, deliverables, and baseline data were not included in the framework for evaluating the project. As demonstrated in our final report, the ACE project achieved all of its contract deliverables as they were agreed upon with USAID. Indeed, the overarching goal of the project—to build capacity of targeted Ugandan institutions for improved program outcomes and the sustained capacity to deliver results in regards to HIV/AIDS prevention, care and treatment—was achieved. The client organizations have all increased the size of their operations, and as a result increased the number of HIV/AIDS-affected people reached, enhanced the quality of services provided, and expanded their outreach and services. Some examples of the remarkable progress made by client organizations as a result of the ACE Project include:

- The Inter-Religious Council of Uganda (IRCU), by its own admission, could not have increased their grants portfolio to more than 80 grantees around the country without the direct support from ACE in grants and financial management supervision.
- Hospice Africa Uganda (HAU) expanded its palliative care programs, increasing both its service delivery and palliative care education program. ACE's support to HAU in governance, organizational restructuring, and strategic planning was the foundation for this growth.
- The Joint Clinical Research Centre (JCRC) is positioned to win a substantial follow-on project with increased funding for their service delivery due in large part to their improved reporting of the Timetable for Regional Expansion of ART (TREAT) project results and financial management practices.

In addition to those more direct results, ACE's support to government partners Uganda AIDS Commission (UAC) and Ministry of Health Resource Centre (MOH RC) was targeted to developing and implementing national monitoring and evaluation (M&E) plans. In both cases, significant progress was made though the project and USAID ultimately invested the ownership of those systems in the institutions themselves for complete implementation.

While the evaluators' capacity building model is interesting, there is no compelling reason given that the project could not have been evaluated against the capacity building deliverables detailed in the project's scope of work. The evaluation devotes significant time to the star model, which is simply one graphical representation used in the proposal to demonstrate the importance of the inter-related elements of capacity building. However, the framework around which the project was organized was always a results-based system whereby the project's overall deliverables were broken down into sub-results for each organization. Ignoring for the most part the 'big picture' accomplishments of the project including any comparison with the baseline data collected and evaluating the project against the evaluators' own ideas of how it should have been designed, may help readers broaden their understanding of capacity building, but does not provide a fair or adequate framework for evaluating the project as it was established.

2. Emphasis on organizational development (OD) interventions

We would like to take this opportunity to provide USAID and the evaluators with correct budget figures (versus those provided in section 4.1) and respectfully assert that ACE did focus sufficiently on organizational development as evidenced by budget expenditures. An updated budget is provided at the bottom of this letter. Organizational development interventions were the foundation for successful systems change at IRCU, JCRC, and HAU in particular. The work in restructuring, board development, strategic planning, etc. accounted for 15.5 percent of the Strategic Activities Fund (SAF) expenditures versus the 5 percent cited. In addition, because the project valued OD interventions so highly, local consulting resources accessed through the SAF were regularly supported by US subcontractor Training Resources Group (TRG). With TRG's inputs (approximately $350,000 over the life of the project for OD interventions) added to the SAF portion allocated to OD ($545,942), the total spent on OD is $895,942 compared to the evaluation finding of $279,781. In addition, ACE deliberately sequenced many of the

interventions so that OD work in things like restructuring was the foundation for subsequent support to finance, information technology (IT), or M&E departments within organizations.

3. Usefulness of electronic systems

In the evaluation sections about finance, M&E, and management information systems (MIS), the evaluators criticize the reliance on electronic systems. These systems played a supportive role in ACE's comprehensive capacity building approach, and were developed to meet critical needs in not only donor reporting but also for an organization's own program expansion. Systems were developed in collaboration with organizations who preferred to move from small scale paper systems to larger more professional operations. The project always followed a protocol of user feedback during the design and testing phase with continuously updates to make systems more user-friendly. While we appreciate that the evaluators witnessed several challenges with these systems, we have recently documented much more positive results than the evaluators found (15 TREAT sites reporting electronically to JCRC; IRCU M&E database functional; HAU Clinical department using M&E database, among others). We would also point out that the evaluation report in several cases details many positive functions of the system, but declares it a failure over one functionality not being used. While fair to point out failures, the evaluation takes an overly negative tone given where the organizations came from four years ago.

The largest electronic investment by the project, the Health Managament Information System (HMIS) for the Ministry of Health (MOH), needs to be understood as part of USAID and ACE's long term investment in country ownership—in this case the MOH specifically requested a web-enabled SQL-based system. The MOH was part of the design at every step and ACE spent three years constantly improving and updating it by adapting it to non-internet environments, adding modules to help the government report to other partners, designing CD ROMS to help data entrants understand its use, and training both HMIS staff and higher level staff at the MOH such as District Health Officers and others at the MOH headquarters. According to the last HMIS monthly submission report, Isingiro, Kabale, Kabarole, Mbale, Mbarara, Bugiri, Wakiso, Kibale, and Bukedea districts reported using the HMIS. This is admittedly fewer districts than the project set out as a target but shows the system can work and work well when supported. Ultimately, this system belongs to the MOH and they will be the ones to continue to provide support and trouble shooting. Following all of ACE's support, the MOH staff has the full capacity to do this and will need to take the lead on maintaining this system which was so crucial to their own vision of the future.

4. Use of local consultants

Contrary to the evaluators' findings in Section 5.3, we believe that use of local consultants was not only effective in serving the local partners, but also contributed to long-term capacity building of the Ugandan development community. The local firms were examined through a rigorous evaluation process, supervised at every step by both ACE staff and the client organizations, and where necessary, supplemented with international technical assistance. These firms did effective work in a number of technical areas and applied their relevant Ugandan experience and knowledge of the organizations working context. Contrary to the evaluators assertion that they were not supervised, the local firms had to have all deliverables approved by

both ACE and the client organization, making their work highly responsive to the organizations' needs. This meant the consultants frequently revised and reworked their products until the client organization and ACE project team were fully satisfied, taking as long as was necessary- a luxury that would not have been possible with expatriate consultants. During the life of the project, consulting firm capacities increased in both their technical abilities and in their client service. The greatest benefit however has been their long-term presence in Uganda. HAU, MOH RC, and JCRC confirmed that they still contact the local firms who worked with them to trouble-shoot problems or provide additional support. In many cases, the local firms are still providing this service at no additional cost to the client organization. This approach is more sustainable and cost-effective than using international staff that would have done short expensive interventions without the ability to follow up. It is also more sustainable as ACE has provided the list of firms to many other USAID projects who have been successfully using many of the same firms and reaping the benefits of their experience and training from ACE.

5. Emphasis on organizations headquarters versus regional offices

The criticism raised in the Executive Summary and financial section that the project paid insufficient attention to regional offices demonstrates a misunderstanding of the project's scope of work (SOW), resources, and the correct sequencing of capacity building. Naturally, a capacity building project must strengthen the headquarters through improved systems and stronger governing bodies in order to lay the foundation for effective change throughout the organization. ACE's SOW, in agreement with USAID, was focused on the headquarters first, and our recommendation in our final report was that additional capacity building at lower levels would be the logical next step.

Several ACE interventions did however reach lower levels and were tailored to those sites' specific needs. Examples include the M&E database for TREAT sites; the finance, grants, and M&E recording tools for IRCU grantees; and the financial and accounting tools for the Uganda Women's Effort to Save Orphans (UWESO) UWESO, HAU, and JCRC. These interventions were tailored to the needs of those sites and hence were more effective than, as the evaluators suggest, replicating a central system regionally like Navision. Simple excel tools for lower level sites were linked into the main system at headquarters, which was more appropriate, user-friendly, and cost-effective.

6. Project monitoring and evaluation approaches

Contrary to the evaluator's assertions in section 4.3 on Monitoring and Evaluation, the project did have an M&E framework which was documented in detail in our final report. We also took a holistic approach to the beneficiary organizations' M&E approaches, looking beyond the simple requirements of USAID. JCRC's M&E framework and plan encompassed all aspects of the organizations work and were designed using an intensive consultation process with all departments in the organization. Similarly, IRCU's M&E tools were not only developed with input from the grantees but continuously improved and modified according to the feedback received. It is possible the consultants found no system 'complete' because the project approached M&E as a continuous process that is constantly being updated and improved upon by the organization.

In conclusion, we are disappointed that the evaluation failed to document or acknowledge the project's significant accomplishments, critiqued the project based on factors outside of project's scope of work, misrepresented elements of the project's work, and included factual errors. Chemonics did try to correct some errors during the process but found the evaluators unwilling to modify their established understanding. Finally, it is worth mentioning that two other evaluations have been conducted on this project (one direct, one indirect) and both of them have come to strikingly different conclusions.

We thank you again for your consideration of our perspective on this important matter. We welcome the opportunity to discuss any of these points further.

Sincerely,

Joanne Moore
Senior Vice President, Africa Region

Factual Errors in the Evaluation Report

Evaluation Claim	Correction
Training on HMIS was not done for those who would use the data (MOH Program leaders, DHOs, Health facility leaders).	MOH Program leaders and DHOs both received training on the system. Health facilities are not yet using the system so were not relevant.
IT consultants work in designing databases did take take into account the reality of data collection already functioning.	All assignments began with an assessment of the data collection functioning and built on existing successful practices where practical. Assessment reports are available for review.
Navision was introduced without a thorough analysis of the organizations' culture and capacities.	Assessments were completed in each organization prior to any financial management intervention and options were presented to the organizations for their review and consultation. Assessment reports are available for review.
ACE assumed a 'trickle down' approach to support to headquarters.	No such assumption existed. Finance and M&E tools were tailored to regional branches or grantees. Other interventions were determined to not be appropriate yet.
Planning and execution of the activities did not take cognizance of the peculiar operating circumstances of the field offices and nothing was tailored to meet the challenges such as not considering state of equipment.	Upgraded computers were purchased for UWESO and HAU.
Partners of ACE didn't have control of local consultants and ACE signed off on deliverables	Consultants were not paid until both the organization and ACE had signed off on their deliverables. This was strictly enforced.
ACE engaged different consulting teams for assignments that linked to one another.	This was extremely rare and only done when one firm was too busy or over extended to handle multiple tasks in a timely way.
Training was not followed up with support.	In many instances, training was followed up with regular one on one consultations.
Local consultants had mostly IT skills and not public health and medicine.	A review of CVs would reveal all consulting teams except those doing only IT work included public health specialists and those specializing in the technical area of the assignment (M&E, organizational development, HIV Prevention, other).
Limited involvement by organizations in the leadership of the program.	ACE's COP consultanted with organizational heads monthly if not more frequently. Organizaions consulted annually as part of work planning. Organization staff contributed to scopes of work, work plan documents, and assignment evaluations.
Unmet need for rigorous and substantive M&E framework for HIV/AIDS interventions in Uganda.	The Performance Measurement and Management Plan (PMMP) developed by ACE with UAC is an example of where this was done.
Unmet need to link HAU and IRCU in strategies to enhance effectiveness of FBOs and providers of palliative care.	This was done- not by ACE- but it is a link that has been made.

Correct Budget Figures for the Special Activities Fund
(does not include US subcontractor support)

Special Activities Fund Expenditures by Technical Area	
Finance	16.44%
ME	31%
MIS	32.70%
OD/HR	15.52%
Communication	4.38%
Total	**100%**

Special Activities Fund Expenditures by Organization	
HAU	13%
IRCU	26.10%
JCRC	23.60%
MOH/RC	20.20%
UAC	6.80%
UWESO	8%
Other	2.30%
Total	**100%**