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SUPPORTING PUBLIC SECTOR WORKPLACE TO EXPAND ACTION AND RESPONSES AGAINST HIV/AIDS (SPEAR)

MID TERM EVALUATION

FINAL REPORT

23rd February 2012

The Republic of Uganda

Mid Term Evaluation REPORT

SUPPORTING PUBLIC SECTOR WORKPLACE TO EXPAND ACTION AND RESPONSES AGAINST HIV/AIDS (SPEAR) PROGRAM

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Evaluation Team

Team Leader : Rose Azuba (roseazuba@gmail.com

Team members: Denis Nabembezi (nabembezidennis@yahoo.co.uk)

Max Ddiba Bwetunge (maxbwetunge@yahoo.com)

Fred Wajje (yoweriwajje@yahoo.co.uk)

MULTIPLE MANAGEMENT CONSULT

mmc@ymail.com

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Acronyms and Abbreviations

ACP	AIDS Control Program
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retrovirals
BCA	Behavior Change Agent
BCC	Behavior Change Communication
BTVET	Basic Training and Vocational Education Training Institute
CSO	Civil Society Organizations
FPPs	Focal Point Persons
GIK	Gift in Kind
HCP	Health Communication Partnerships
HCT	HIV Counseling and Testing
IDI	Infectious Diseases Institute
IEC	Information, Education and Communication
IGA	Income Generating Activity
IGP	Inspector General of Police
ILO	International Labor Organization
IR	Intermediate Result
M&E	Monitoring & Evaluation
MJAP	Mulago Mbarara Joint AIDS Project
MJAP	Mulago-Mbarara Joint AIDS Program
MMC	Medical Male Circumcision
MoES	Ministry of Education and Sports
MOH	Ministry of Health
MoIA	Ministry of Internal Affairs
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MoU	Memorandum of Understanding
NCDC	National Curriculum Development Center
NUMAT	Northern Uganda Malaria, AIDS and TB Program
PAC	Project Advisory Committee
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
POSHNET	Police Support and Help Network
PHA	People Having AIDS
PLHIV	Persons Living with HIV/AIDS
PSW	Public Sector Workers
RHSP	Rakai Health Sciences Program
RTI	Research Training Institute International
S&D	Stigma and Discrimination
SDS	Strengthening Decentralization Systems
SMC	Safe Male Circumcision
STAR	Strengthening TB & AIDS Response
TAAG	Teachers Anti AIDS Group
TASO	The AIDS Support Organization
TNA	Training Needs Assessment
TWG	Technical Working Group
UAC	Uganda AIDS Commission

UNATU	Uganda National Teachers Union
UNEB	Uganda National Examination Board
UPS	Uganda Prisons Service
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VHT	Village Health Teams
WV	World Vision
YEAH	Young Empowered and Healthy

Executive Summary

The Supporting **P**ublic sector workplaces to **E**xpand **A**ction and **R**esponses against HIV/AIDS, (SPEAR) project (Agreement *No.617-A-00-08-00015-00)* is a five-year (June 20, 2008 to June, 19 2013), USAID/PEPFAR funded initiative to support the Ministries of Internal Affairs (MoIA), Local Government (MoLG) and Education and Sports (MoES) in Uganda to enhance HIV/AIDS prevention, care and treatment of public sector workers for selected workplaces.

USAID sanctioned a Mid Term review with a rationale to evaluate and contextually assess continued relevance of the SPEAR project and its effectiveness in approach since inception and establish lessons learned and good practices that will inform implementation of ongoing and future programs by USAID and Government of Uganda. Four local consultants was hired to undertake an evaluation assignment between November 23rd 2011 and 23rd February 2012. Participatory methods took precedence against the extractive methods using both quantitative and qualitative methods. The evaluation covered 16 districts, selected in a consultative process based on an inclusion and exclusion criteria (Table 1). The respondent population included USAID, SPEAR, RTI staff, District Local Government officials, PHA groups, target ministries and autonomous departments and institutions like Uganda Prison Services (UPS) and Uganda Prison Force (UPF), Teachers' Anti Aids Group (TAAGs), Public Sector Workers (PSWs) and key civil society partners and beneficiaries (spouses and immediate family members of PSWs).

The program so far has made very significant contributions in terms of responsiveness to HIV/AIDS prevention and access to care, treatment and support at the work place for public sector workers. Generally the project is on track and on average 80% of the targets set for year 1-3 have been met with exception of providing spouses and immediate family members of PSW access to services, enhancing access to wrap around services, and disseminating policies to the lower levels of the public sector.

In spite of challenges, SPEAR has established political, social and institutional sustainability through top leadership support. This was achieved by: drumming up stakeholder interest through participation in consultative dialogues and workshops at national and country wide launches of the HIV/AIDS policy at the work place; institutionalizing a training component within the curriculum of all 3 key institutions of police, prisons and PTCs; and establishing and supporting PHA networks such as TAAGS, POSHNET(Police Support and Help Network) and Drama groups to sensitize and fight stigma about HIV/AIDS among public sector works and initiate Income Generating Activities (IGAs).

SPEAR has established efficient approaches and strategies to achieve the project objectives through a well- selected project team represented by technical expertise in each of the project objective areas. Regional field hubs have been established to handle operations at the district level. The project works with National structures aligning with existing institutions like the ACPs and autonomous departments at target Ministries. SPEAR has set up performance based contracts and MOUs with select partners to solicit specialized services where an additional partner is more appropriate. By design, the project scaled down the number of target districts, a spot-

on design efficiency given the thin staff (high staff to workload ratio) at the SPEAR office and the need to ensure direct participation and 'buy- in' by stakeholders despite the existing challenges.

The total project overheads still lie over 30% compared to the direct costs. Although there is no agreed to benchmark or best practice with regard to the ratio of administrative costs to direct project costs, 25% is commonly accepted as a reasonable threshold and in this case, this cost is well over the reasonable thresholds.

On access to HIV/AIDS prevention, care and treatment, SPEAR is synonymous with mobilizing PSW's to undertake Voluntary Counseling and Testing (VCT) services. Although with limited success, it has attempted to link people that tested HIV positive to other HIV and AIDS care providers. Clients are referred to USG funded partners with complementary services like STAR-E, EC, SW, NUMAT, TASO, AIC, URCS, ICOBI, PACE, MJAP and JHUCCP, etc. SPEAR's services also included capacity building of service providers to offer additional services for a complete wrap around package. The latter services include: SMC; production and dissemination of HIV/AIDS related IEC materials; condom use education; and supply of materials like HIV testing kits and condoms.

SPEAR's uniqueness stems from targeting public sector workplaces to develop and implement HIV/AIDS work place policies tailored to address concerns and issues of the unique groups of highly mobile and hard to reach professionals at risk: majorly prison officers; police; and guard services. The policies are designed to guide rules and regulations in target Ministries to ensure that their staff have access to and are encouraged to use voluntary HIV testing services and the clinical referral system for care and treatment. Though the system is not yet functioning well, the concept is appreciated.

Ineffective partnership arrangements; un-signed performance based contracts; staff overloads; unexpected delays in preparing policy operational guidelines; weak monitoring and quality assurance systems; and ineffective coordination among IPs are some of the impediments that may hold up the program results if not sufficiently addressed.

As **short and immediate term measures**, the evaluation team recommends the program to : -i) effect outstanding performance based contracts with concerned service providers and partners ii) integrate biomedical interventions like PMTCT and SMC in all prevention strategies, iii) support operationalization of HIV /AIDS policies, iv) augment support of PHAs under the linkage referral system and in their PHA groups. For long term measures, support SPEAR to work with the Ministry of Health to harmonize and establish a tracking systems for HIV and AIDS care clients nationally for easy follow up and monitoring.

CHAPTER ONE: - INTRODUCTION

1.1 BACKGROUND

The Supporting **P**ublic sector workplaces to **E**xpand **A**ction and **R**esponses against HIV/AIDS, (SPEAR) project (Agreement *No.617-A-00-08-00015-00)* is a five-year (June 20, 2008 to June, 19 2013), USAID/PEPFAR funded initiative to support the Ministries of Internal Affairs (MoIA), Local Government (MoLG) and Education and Sports (MoES) in Uganda. The project is implemented by World Vision (WV) and Research Training Institute International (RTI) in the Central, Eastern, Western, Northern and Southern regions of Uganda. With an overall strategic objective to enhance HIV/AIDS prevention, care and treatment of public sector workers for selected workplaces, the project is implemented through a multi-dimensional HIV/AIDS workplace intervention.

The 3 strategic objectives targeting policy development, institutional capacity building, behavioral change and access to and utilization of HCT and wrap around services contribute to USAID Uganda I.R 8.1 towards a final impact of effective use of social sector services through the following key results:-

R1 Supported public sectors have policies, plans and activities that assure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees

- IR 1.1 Public sector workplaces supported to develop adopt/adapt disseminate policies and practices that improve employees' access to high quality HIV-related services
- IR 1.2 Target workplaces and partner service providers equipped with HIV-related technical and institutional capacity to mainstream and implement HIV/AIDS prevention, care and treatment programs

R2 Increased access of quality HIV/AIDS prevention, care and treatment services by target public sector workers and their families, with a focus on identifying HIV-positive individuals and facilitating access to networked care and treatment services

- IR 2.1 Demand created for utilization of HIV prevention, care and support services
- IR 2.1.1. Effective stigma and discrimination reduction programs developed and implemented in target public sector workplaces
- IR 2.2 Increased availability of HCT services for target public sector workers and their families
- IR 2.3 Improved linkage to palliative care, treatment services, and psychosocial support services for HIV-positive public sector workers and their families

R3 Improved utilization of wrap-around services by target public sector workers living with HIV/AIDS (PHA) and their families through effective partnerships with USG and non-USG supported programs

- IR 3.1 Increased number of target public sector workers and their families accessing wrap-around services through effective referrals and linkages
- IR 31.1.Improved public sector worker's awareness of wrap-around services available and accessible
- IR 3.2 Effective referral and tracking system for HIV/AIDS prevention and support services in target workplaces strengthened

1.2 Rationale for Evaluation

Having ended the 3rd year of implementation, USAID sanctioned a Mid Term review of the 5 yr program with a prime rationale to evaluate and contextually assess continued relevance of the SPEAR project and its effectiveness in approach since inception. This is aimed at guiding the stakeholders especially the implementing and funding agency on current status, underscoring what is working and what is not working well. The evaluation was also to document effectiveness towards the original design purpose; major achievements so far,

missed opportunities and good practices as well as limitations and challenges encountered. It is also designed to establish lessons learned and good practices that will inform implementation of ongoing and future program work by USAID and Government of Uganda.

1.3 scope and methodological approach

The evaluation entailed a comprehensive review of the SPEAR project since inception from 2009 to 2011 assessing design, implementation and achievements so far. In the inception phase an in-depth review appraised the project objectives, strategies undertaken, implementation and monitoring through project documents and studies undertaken. The methodology, evaluation design, sampling tools and work schedule were refined with consultation of USAID task managers and SPEAR implementing agency staff.

The field phase comprised the main component in which data was gathered through interface with various stakeholders at the targeted institutions of: MoIA headquarters, local police, prisons, immigration, community services, guard services; MoLG headquarters and associated institutions at the districts; MoES headquarters, and her affiliated bodies and educational institutions both nationally and at the districts. Others consulted included the different collaborators and partners at national level. Discussion and meetings were held with different project beneficiaries and local government officers. All activities were carried out in representative districts from the 5 regions (Table 1). A desk phase for in-depth analysis of the evaluation findings, interpretation, and report preparations ensued.

To guarantee a high degree of stakeholder participation and emphasize a learning process, participatory rather than extractive methods were employed using USAID evaluation guidelines and applying international principles of evaluation. Both quantitative and qualitative data has been used for interpretation of the findings.

A purposive multi-stage sampling procedure was adopted and used to select 16 districts. Respondents and key informants were identified in consultation with the SPEAR technical staff. The inclusion and exclusion criteria of the selected districts endeavored to attain a mix based on: regional representation, HIV/AIDS sero-prevalence rates (high, medium, low), district accessibility for service delivery (Easy Vs Hard to Reach), monitoring performance indicators, intensity of SPEAR activities, and the intervention sector distribution (Police, Local Government, Prison Services, Immigration, Education and Private security).

To maximize time and resources, following a collective consultation in the central region, the evaluation team spilt into 2 groups and carried out simultaneous activities with multiple stakeholders groups. Whereas 100 % coverage of districts and regions selected was achieved there were several instances where the persons and officials targeted especially in government were not available due to other various ongoing activities. In most cases, a representative was delegated and in a few of such cases, the officers delegated had limited information on the subject matter. Where possible, consultations by emails and telephones was undertaken to fill the gaps. The Personnel consulted included but not limited to: Directors, HIV/IADS focal persons, Community service Dept officers, Senior Immigration Officers, ACP Commissioners Personnel in the 3 key ministries. At the districts, persons consulted included Regional SPEAR Coordinators, District HIV/AIDS personnel, district leadership e.g. CAO, Chairpersons or their assistants, Members of TAAGS, Leadership and Officers from Prison and Police services and family members especially spouses. At national

level, members of PAC and other INGOs, and NGO partners and /or their representatives who were active in the project were also consulted.

Table 1: Criteria for District selection

Regional	Districts	Prevalence	Reach	Performance[1]	Data Sources
Central	1.1.1 Kampala[2]	High	Easy	High	Kampala Line Ministries • HIV/AIDS personnel • Top Management • ToTs • Policy Champions • Staff (PHAs and other selected employees s) • Documents Partners NGO, FBOs, Hospitals and documents People to be consulted • SPEAR and WVI Staff • HIV/AIDS focal person • TAAG • Local Government leaders • Policy Champions • Prison , police workers • Families (police and prisons) • Private security firms
	Jinja	High	Easy	High	
	Bugiri	Moderate	Hard	Moderate	
	Kiboga	Low	Hard	Low	
Eastern	Mbale	High	Easy	High	
	Soroti	Low	Hard	Moderate	
	Katakwi	Low	Hard	Low	
Northern	Apac	Low	Hard	Low	
	Gulu	High	Easy	High	
	Arua	Low	Hard	Moderate	
Western	Hoima	Low	Hard	Low	
	Masindi	Moderate	Hard	Moderate	
	Kabarole	High	Moderate	High	
Southern	Masaka	High	Easy	High	
	Mbarara	High	Moderate	High	
	Kabale	Low	Hard	Moderate	

A mix of methods including reconstruction of cause and effect correlations, FGDs, KIIs, and Direct Observations, were used to gather both qualitative and quantitative data. Evaluation focused on the six evaluation questions whose themes are summarized in Box 1 below (*details in Annex TORs*). Interpretations employed standard evaluative criteria of relevance, effectiveness, efficiency, sustainability and responsiveness. Sample tools for data collection are included among the Annexes.

Box 1: Themes for Key Evaluation Questions

- Effectiveness vs. national partnership
- Ownership and sustainability
- Efficiency of strategies and approaches
- Linkages and value addition
- Risk factors

1.4 Organization of the Report

Included in Chapter one of the document is an introduction that gives a brief background to the projects, the rationale and purpose for evaluation, and a brief of the methods adopted in

[1] MoH Performance Service Delivery Indicators, 2009/2010

[2] Kampala is central but was selected mainly because of its centrality in administration

executing the project. Chapter two highlights all findings presented in a narrative and statistical form (tables) with information from all data sources corroborated to enhance better interpretation and understanding to the readers. Judgments and interpretation of the findings are based on data gathered against the specific performance indicators in the PMP. The findings are presented in alignment to the key evaluative questions specified in the ToRs. The lessons learnt, best practices, recommendations and a conclusion are mentioned at appropriate sections and summarized in Chapter 3. The ToRs, list of respondents and other data is annexed id the section that follow thereafter.

CHAPTER TOW: MAIN FINDINGS

2.1 Program Effectiveness

How effective has the program been in achieving the planned results to date? This will include amongst others a review of the effectiveness and contribution of the partnership between World Vision Inc. and the national level partners to achieve shared program objectives and results?.

The project effectiveness has been discussed in consideration of the 3 strategic objectives set out by the project namely: - to i) Develop, avail and integrate utilization of HIV/AIDS policy at work place, ii) Improve access to and utilization of Quality HIV/AIDS prevention, care and support and iii) Improve access and use of wrap around services (nutritional, water and sanitation, Family planning, Malaria Prevention , OVC) .

2.1.1 Policy Formulation, Implementation and Monitoring

The policy strategy was designed to provide a framework to guide the key actors of the selected public sector workplace to plan and implement the HIV/AIDS policy and ensure that i) there is continued integration, access and utilization of sustainable and high quality services and ii) that institutions are equipped with adequate technical and institutional development skills to integrate and utilize prevention, care and treatment services for HIV/AIDS.

All the 3 Line Ministries (MOES, MoIA and MoLG) have developed their HIV/AIDS policies . Using the existing institutional establishments, efforts have been made to disseminate them for implementation by staff at different levels through training and imparting dissemination skills to policy champions. Of the three, only the Ministry of Education and Sports had developed operational guidelines for the policy by the time of this evaluation exercise.

Planned Results

- **Employees at work place access high quality HIV/AIDS related services**
- **Workplace and partners service providers are equipped with HIV related technical and institutional development skills to implement sustainable strategic plans and operational activities**
- **Stigma and discrimination at workplace is reduced**

Key Activities

- **Develop HIV/AIDS policy and present it in a user friendly package to all beneficiaries**
- **Disseminate policy widely to all beneficiaries**
- **Training of Policy Champions to support and sustain implementation**
- **Develop policy guidelines, and plans to customize and operationalize policy at different levels**
- **Develop framework for monitoring policy progress**

2.1.2 Dissemination

The exercise revealed that HIV/AIDS policy is available and its existence is officially recognized in all 3 ministries. Both senior and middle officials are aware of the policy, with some in possession of the policy booklets which were printed and disseminated in large numbers. Key stakeholders at the work place (WP) and policy champions were sensitized through policy training, launches and inaugurations. The latter strategically ensured the participation of politicians and top institutional leaders. While their presence was spot on and of high impact at that moment, it was short lived. Many of these higher ranked senior officers are busy people, always with changing priorities and have therefore not been able to carry on policy championing activities as expected. Delegating the responsibility of policy championing to officers who are most strategically placed to carry out these activities, such as the HIV focal persons, District health educators and District education officers ensured buy in but was also on one hand an indication of commitment .

MoES published 20,000 policy booklets and disseminated 20,000 charts, MoLG 11,000 policy booklets and disseminated 4,500 charts while MoIA only published 9,500 and no charts. Given the number of stakeholders who are direct users and beneficiaries from the policy, these numbers are insufficient. By the time of the evaluation, the policy was therefore yet to be officially adapted for practice by many of the institutions. Although reports mentioned that MoES and MoIA had prepared policy implementation guidelines, the consultations affirmed that only MoES has operational guidelines at the final drafting stage. Whereas MoES had the advantage of having initiated the policy formulation during the ESWAPI project, it is true that the policy process has been slow. It is also conceivable the process of consultation coupled with delegation to lower cadre staff that have less mandate on making key decisions, partly contributed to the delay in drafting guidelines.

Table 2: Policy achievements

Planned	LOP Targets	3 yr Targets	Mid Term achievement (MTA)	MTA vs. LOP
1. Policy documents (3 line ministries	100%	3/3	(3/3) 100%	100%
2. Mainstreaming HIV/AIDS workplace policy in ongoing programs	100%	40%	40%	40%
3. # of sectoral outlets/districts supported to develop HIV/AIDS at workplace	90	77	69 (90%)	85%
4. # of individuals trained workplace HIV related policy development	150	133	137 (>100%)	91%
5. # of individuals trained in operationalizing policy and plans	400	350	238 (60%)	60%
6. # of individuals trained in workplace HIV related institutional capacity building	90	105	154 (150%)	171%
7. # of points of operation supported with institutional capacity building for workplace implementation and costed work plans	150	110	86 (78%)	57%

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Even in the absence of the guidelines, at least 14 of the 35 districts have attempted to customize and adapt the HIV/AIDS policy to their environment for practical application. These are:- Bugiri, Mayuge, Jinja, Mpigi, Masaka, Kasese, Mbarara, Apac, Nebbi, Ibanda, Soroti, Mbale and Tororo.

2.1.3 Institutional Capacity Building

A total of 392 policy champions have been trained as part of the technical and institutional skill development. Of these, 238 were trained to operationalize the policy while 154 were equipped with capacity building skills. Having realized these large numbers, there was an agreement between SPEAR and USAID to cap further training of the policy champions and instead integrate policy issues into existing activities at the workplace instead of making it a stand-alone. MoEs has gone an extra mile to hold a policy implementation review and discuss plans and activities to integrate the policy into the education curricular, and some of the education institutions have developed customized guidelines for implementation of the policy. The capacity has thus been built to operationalize and sustain the policy. Despite the large number of Policy Champions trained (1107 BCAs, 132 policy champions and 1207 anti S&D) operationalization of the policy only lies at 60% of the planned 3 yr targets and the skills within the different policy champion categories are still fragmented, besides there being no monitoring framework to follow up progress on roll down and adoption activities.

2.1.4 Policy adoption and Practice

In a few districts, the policy stipulations are already being applied even without guidelines. Although the policy booklets and communication materials were fairly well disseminated among the mentioned groups, ironically there are direct beneficiaries who have neither seen nor read the policy booklets. Whereas the element of poor reading culture is undeniable, in some it is lack of commitment and laxity to put the policy into practice.. Some junior officers mentioned that their seniors had casually referred to the contents of the policy and nothing beyond that. E.g. at one Gulu police FGD with 28 officers, only 5 attested to having knowledge of the policy, while in an Arua PHA FGD, 7 of 7 maintained that they had no knowledge of policy and had not seen the policy handbook. A similar observation applies in other districts visited like Katakwi, Soroti, Kabarole and Kabale.

There was evidence however, that the policy has been adopted and is being applied by some officials even before guidelines are in place. For example, testimonies of PHA staff benefitting from the policy by having differed deployment and transfers were attested to in various police, prison and teachers' institutions in Kibuli , Mbale, Soroti, Arua and Bugiri. The PHAs who have presented their status to their superiors and supervisors are given special consideration and not transferred to where they cannot access ARVs and/or given or posted to less stressful work in their daily routine. This specification which is an HIV.AIDS policy stipulation, is yet to be systematically applied and is still seemingly at the discretion of the supervisor.

Cases are reported where senior officials or supervisors at district institutions although aware of the policy requirements have declined to give special consideration of staying or selective transfers in spite of the PHA pleas. This was often blamed on a perpetual manpower shortage, but in some cases, respondents reported that supervisors felt that as a command institution, there should be no negotiation to commands irrespective of this policy. These attitudes reflect limited knowledge or deliberate denial of the existence of policies and guidelines, and point to strong degrees of stigma and discrimination that have yet to be addressed.

2.1.5 National level Partnership

Over the 3 years, the project has developed and nurtured partnerships with government, CSOs INGOs and PHA networks to varying degrees of engagement at planning and implementation. The partnerships were stronger with the government ministries, weaker at the districts and least functional with other NGOs and CSOs. The project held partnerships formalized by performance-based and fee-for-service contracts with key service provider institutions like AIC and MJAP while with others they were loosely structured based predominantly on activities undertaken by one party rather than being strategic. However, loose as they were, they were not devoid of positive results although we believe much more could have been achieved with full commitments dedicated to continued care and treatment of PHAs. It is commendable, that at the national level, partnerships were established with senior level officers. The national partnerships with the line Ministries served as useful entry points into the districts especially where MoUs with WV Inc did not exist as yet. Liaison was mainly through the HIV/AIDS focal persons at the ministries, districts or agencies. Through these (Prison HIV/AIDS focal person, Prison and Police medical services, District HIV/AIDS focal persons) the project was able to solicit for and mobilize effective participation of the officers at workplaces and to a limited extent their families.

The future of the partnerships especially with CSOs and NGOs is uncertain. First it will depend on whether more clear partnership strategies and synergies are developed with implementing partners and then secondly depend on the capacity of the implementing partners. Information shows that some new care programs like SUSTAIN, The STARs, Mildmay, Baylor and MJAP are likely to expand operations having secured new grants with their development partners while on one hand others like PACE and JCRC, NULife and NUMAT are scaling down as their grants come to an end. This will certainly affect their support and collaboration with the SPEAR program especially the PHA's care and treatment which is critically needed in the next phase.

2.1.6 Key challenges and Limitations

i) Large resources were spent on sensitizing, training and preparing policy champions whose enthusiasm seemed to have waned with time, as a result of a strategic change to stop separate standalone policy champion activities. Resumption of activities is likely to be costly in terms of time and resources needed to refocus people whose priorities and duties may have changed. In some Ministries like MoLG, there have been several changes including the transfer of key officers dealing with HIV/AIDS and hence dis-continuity.
ii) Transfers and redeployment of staff within these key institutions is a big challenge to the successful implementation of the project as it currently is. Some of such decisions are sensitive administrative matters complicated in part by a general ban on recruitments within GoU civil service. In consequence, many public institutions have skeleton HR structures that even with a good will and commitment to the needs of PHAs, transfers would seem inevitable as explained by some senior officers. Both PHAs and BCA have been transferred or redeployed to areas where there is neither access to HCT and VCT services nor operational SPEAR programs. In such cases the PHAs are dis-advantaged and the BCA training is turned redundant most especially when not supported to disseminate the information. Conversely, some of the policy champions who are

redeployed continue to be active in their new areas when supported to do so. For example evidence was found where officers transferred from MoLG to MoPFED and MoWE and a number of redeployed police officers have continued to champion the policy at the new workplaces.

iii) At the moment, policy interpretation is over simplified and seemingly narrowed to a limited perception of staff welfare, addressing only staff transfers, redeployment, sick leave, and retirement. This is because these issues are the ones that employees, especially PHAs, are most concerned about. Missing the broader picture of defining roles and responsibilities, funding, and legal implications and any such issues that affect the implementation of the policy for example PSW don't know the legal implication of contravening the law.

iv) The project was defined around staff at three line ministries, the RFA, and thus, implementation was narrowed to a scope of staff at only these 3 ministries and their associated institutions such as UPS, UPF, Immigration, Community Service, private guard services, Ugandan local authorities association, Urban Authorities Associations and educational institutions. Major education institutions like public universities which are high risk groups were not considered in the RFA. Equally significant, but not included also are the private schools which constitute a big component of the Education Sector .Strategies to ensure that they benefit from the efforts already put in by public school teachers are needed.

Box 2: Strategic Action points - Policy

1. **Integrate policy champion, S&D champions and BCAs' skills into a complete package of skills given to one individual instead of having separate individuals with these specialized skills and support them to roll down their activities.**
2. **Review activities to further roll down the policy to ensure adoption through sector road maps plans specifying indicators for monitor progress on policy dissemination and practice adoption**
3. **Plan and conduct regular round table discussions to share lessons and discuss policy dilemmas within and between stakeholder groups**

2.2 Access to and Utilization of Services

This component majorly focuses on i) access to and utilization of HIV/AIDS prevention, care and support services including palliative care, treatment and psychosocial support and ii) improve /increase perception of risk.

The 'SPEAR' program is synonymous with mobilization of public sector workers and autonomous department to undertaken VCT and HCT sessions. The project distributed 375,247 IEC materials, supported 74,274 voluntary testing and HCT services, and supplied 41 PHA groups with home based care and hygiene kits and IGAs.

2.2.1 Stigma and Discrimination

There is substantial evidence showing a significant reduction of stigma and discrimination in workplaces where the SPEAR project is implemented. The targeted numbers of BCAs trained to reach out with messages on sexual prevention in HIV/AIDS was 5,469 which is 79% of the 3 yr target and 54.7 % of the LOP target (Table 3). There is similarity to targets for messages of evidence based prevention which were 80% and 52% respectively. For stigma and anti discrimination messages, 2,999 persons were trained, a number that not only surpassed the 3 yr target by 77% but also the LOP target by 20%. The outputs are comparable since targets of people reached with anti S&D messages were also surpassed (170% 3 yr target and 101% LOP target). These achievements are regardless of having organized only 19 % of originally planned events, in the wake of which a change in strategy after consultations with USAID was adopted to integrate S&D into existing events instead of having stand-alone S&D events. The anti S&D messages contributed to reduce S&D with a net increase of confidence for testing and status disclosure in all 3 key ministries. Consequently 41 PHA groups were formed known as POSH, UPRO and TAAGS. The groups have continued to disseminate and reach out with anti –S&D messages through official and non official gatherings like parades and regular PHA meetings supported by various activities like drama groups.

Several personnel benefitted from in-service training and they extended services through HCT outlets and outreach programs. Both public sector employees and communities attested to the effectiveness of the services and appreciated the services getting nearer to people and especially the hard to reach communities. In every institution, BCAs were trained and there is evidence that they undertook several activities to sensitize public workers and sometimes their spouse and /or families.

2.2.2 Risk prevention and Provision of HCT Services

The training generated sufficient knowledge and skills to elicit positive behavior change among communities where they operated. Avoiding multiple partners, transactional sex, alcohol, indiscriminate drug use and promoting use of condoms crowned by voluntary testing and counseling were some of the key messages and practices elicited. Supported with information on benefits of adoption of health precautions, the messages reached a number of people in all selected districts especially the under-served who would normally miss the opportunity by nature of their work. From the services of the BCAs, those that accessed T&C services and received their test results were only 48% of the number targeted due to nationwide scarcity of testing kits. Other indirect unexpected positive benefits are linked to increased demand of other laboratory services immediately following the SPEAR outreach programs as attested to and observed by laboratory data in Arua prison laboratory.

All districts visited attested to having received specialized services (HCT and VCT) and facilities like circumcision beds, condom supplies, and testing kits. Unfortunately, the enthusiasm of some BCAs has waned over time with slowing down of activities in some districts. Reasons cited include: - lack of or inadequate facilitation, delayed and irregular report pick-up by coordinators which became a dis-incentive to continue working, transfer of sector coordinators and insufficient supervision of the BCAs from new coordinators.

Table 3: Utilization of Care and Treatment Services				
Planned	LOP Targets	3 yr Target (Fy2009-11)	Mid Term achievement (MTA)	MTA vs LOP
# successfully trained In-service training program in Sexual Prevention of HIV/AIDS during the reporting period.	10,000	6,900	5469 (79%)	54.7% %
# of targeted population reached with HIV prevention interventions evidence based or meeting minimum standards required (ABC clients & AB clients)	350,000 (adjusted)	230,000	183,891 (80%)	52%
# of individuals trained in HIV-related stigma reduction	2500	1750	2999 (171%)	120%
# of Stigma & Discrimination work-based events organized and or supported	37[3]	37	37 (100%)	100%
# of people reached with anti-stigma and reduction messages	10000	7523	20,258 (268%)	202%
# of individuals trained in workplace HIV-related community mobilization for prevention, care and/or treatment	2500	1052	812 (77%)	32%
# of Service outlets supported to provide Testing and Counseling (T&C)	100	150	144 (96%)	150%
# of individuals who received T&C services for HIV and received their test results	116,667	128,600	74,274 (58%)	112%

2.3 Utilization of wrap around services

Following voluntary testing and counseling, those who had tested positive were supposed to receive Psychosocial support, treatment for opportunistic infections and benefit from referral centers and services from partner services linked to disease control. Partners were to provide basic health care services including treatment packages and continue with the psychosocial support where needed. Although the value addition concept of wrap around services and referral –linkage program in support of PHAs was appreciated, there was limited success in this component.

2.3.1 Referral and linkage program

Skills development for undertaking wrap around services was done with 89% achievement on the number to be trained for this purpose. However, only 6,226 persons out of the targeted 15,000 received wrap around services and of the 100 projected partner MoUs to be signed, so far only 13 have been signed. With the exception of AIC, PACE and Nulife no other performance based contracts had been signed with direct service providers at both national and district level. However PACE and Nulife made substantial coverage each of 15-17 districts across the country.

[3] This is the new target after strategic change. Initially LOP was 200 and 3 yrs targeted 193.

Failure to have hit the target is also attributed to various reasons. While it is accepted that the number that receive wrap around services, depends on the number that choose to disclose status after testing positive. It is however also true that disclosing status at that stage also depends on the actual anticipated benefits and value usually based on information available, experiences learnt from others and /or simply the individuals' perception.

On one hand, some PHAs who went through the referral system, complained that the project did not offer sufficient psycho-social services and where they were referred, the care and treatment was neither satisfactory nor and was the environment conducive. Issues like long distances, long waiting or repeated visits with frequent failures to access anticipated services were common. On the other hand, the SPEAR project implementers maintained that once the beneficiary (PHA) was referred and linked to another partners organization, they did not get feedback from the referred beneficiaries and thus was the furthest they would go. Some of the partners talked to were of strong views that, it was a poor assumption in the design for the SPEAR project to have believed that i) implementing partner service outlets would always **readily avail** care and treatment services without anticipating resource constraints and ii) the program would work easily with limited joint planning and coordination since all those involved are USG partners.

For services like psychosocial assistance which were overly lacking, the evaluation found that BCAs were not in position to handle specialized psycho social support and they were not technically competent to do so as the task required specialized skills which cannot be developed within such a short time that BCAs were trained. In consideration of all the above, it can be deduced that this particular component has not performed to the expectations of the project.

2.3.2 PHAs beneficiary groups

Over 41 groups of PHAs have been formed and group formation, we observed is to a great extent reliant on the active support of the Regional Coordinator . In some districts visited like Arua, UPS, the PHAs who have openly disclosed their status have not yet been assisted to form groups and yet in a not so far away neighborhood there exists a very strong UPF PHA group. Group cohesion is wedged on tangible benefits like IGA, & access to wrap around services as well as groups leadership and regular meetings. Most PHAs have received support in form of an agriculture enterprise like good quality cereal seeds (Arua UPS), Apiculture enterprise (Hoima), and poultry farming (Jinja and Mbarara). The groups also received sewing machines which were rejected by some groups which because of lacking electricity power felt they were not about to use them in the near future.

Gifts in Kind (GIKs) in form of Home Based and Hygiene Kits were also provided to all, albeit the several complaints that arose of inequitable and poor supervision during distribution. Three main complaints that i) non PHAs received kits, where PHAs missed, ii) kits had some expired items like drugs at the time of distribution, iii) that kits were very limited and not enough for each PHA and spouse to have a kit. Information from PHA FGD in Arua, was that the kits were so highly valued that some people PHAs who had previously withheld information on their status did so in order to secure a kit once it was mentioned that the kits were meant for PHAs only. The flip side was that some PHAs felt that the colour had a stigma and discriminatory connotation for it was easy to conclude that whoever was seen with the 'blue bag' was HIV positive. This in our view however was not by design and was

beyond the project for the simple reason that gifts are wrapped. It nevertheless sends message about how some PHAs feel even when they have disclosed their status.

2.3.3 Communities and family benefits

The program was designed to reach out to both PSW and their immediate families. The activities targeting them were to have included sensitization and training of spouses, and selecting BCAs from among who would in turn reach out to other spouses and people in the communities surrounding them. In over 30 FGDs held for spouses and families within the police and prison quarters, , information gathered from the evaluation exercise showed that there was limited systematic programs designed directly to reach out to them although there were records of outreach activities for the surrounding communities.

2.4 Key concerns and challenges

2.4.1 Access to and utilization of services

i) Dis-incentives such as lack of privacy at venues selected for conducting VCT, difficult to physically access hard to reach areas were mentioned as some of the reasons for non-utilization of services. The beneficiaries also maintained that inconsistence in access of services e.g. In Soroti where some beneficiaries said the HCT services were only availed once in 3 years although records from SPEAR mention that there were 5 outreaches per year in Soroti and Katakwi. In another incidence in Gulu, there were claims of un-ethical behavior where some nurses and assistants failed to maintain confidentiality of client results

ii) Limited referral and linkage services for PHAs and failure to offer specialized psychosocial services (PSS) was also noted have a negative effect and remains a challenge to be addressed. *Citing one PHA,* [*'This, is a gross dis-incentive to disclose status'*, said one PHA. *"People don't feel like there is value to test after all when one finds that she is positive, she has nowhere to run ……..']*

iii) Whereas some groups have been linked to existing PLHIV groups, there is still stigma leading to discomfort of uniformed services mixing with a civilian population or high ranking officers mixing with subordinates. Some districts have supported special 'windows" for care of the public sector workers a case for Hoima and Kaberamaido and in some others like Kaberamaido, Soroti, Mubende and Mbarara, district local governments have provided office space for PLHIV.

iv) There is limited accomplishment in harmonizing and integrating the HIV workplace policy or its activities with other existing policies at the Districts. In some districts, it was expressed that SPEAR regional coordinators are rarely participating in meetings held to discuss HIV/AIDS activities while coordinators say time to attend is one of the constraints

v) Although districts have limited and constrained budgets, there appears to have been no deliberate effort to secure any additional funding for any of the SPEAR activities beyond what the project offers in the district.

2.4.2 Existing PHAs groups formed

There is still an overwhelming need for psychosocial assistance for PHAs and people that test positive and the activities in the last 3 yrs have been inadequate to address these needs. Some of the PHAs interviewed by the evaluation team, although supported to engage in IGAs, lack business skills and some have hardly any knowledge of simple group dynamics. Note worthy is the concern of presenting to them sewing machines when none of the group members has knowledge or is willing to invest in tailoring skills. Although SPEAR has of late started addressing this concern by encouraging PHAs to submit their own concepts or IGA strategies, many of the concepts are hampered with the ceiling of 1 million Uganda shilling. While variations existed between districts on the amount of IGA cash given to PHA groups depending
on the concept submitted, the upper ceiling of I million for IGAs per group is prohibitive for any meaningful small enterprise in Uganda at the current inflation rates. The groups also need skills in writing proposals and conceptualization

Box 3: Strategic Action points- Improve Access to Services

i) Increase the seed capital for the PHA groups IGAs and support them with skills in business management, proposal writing, resource mobilization, group dynamics and formation through regular learning and sharing activities like exchange visits within and across districts.
ii) Review referral strategies and follow up for the continued care and treatment services. Psychosocial services are in great demand and donors and implementing partners must find a way to offer more berths and increase quality of PSS to PHAs.

2.5 Sustainability and ownership

To what Extent is SPEAR strengthening ownership and sustainability of HIV related change process within the public Work place institutions?

Ownership of the project at the workplace would ensure that benefits are sustained after the project has come to an end.

2.5.1 Political ownership:

This has been registered through top leadership support majorly by drumming up stakeholder interest through participation in consultative dialogues and workshops at national and country wide launches of the HIV/AIDS policy at the work place. In each line Ministry, an HIV/AIDS focal person is charged with liaising with SPEAR on preparing and ensuring work plans are integrated within the line Ministry's schedule. In some, the top leadership continues to actively participate in the project activities whereas in others participation is predominantly by delegation of lower officials. This has a tacit implication and has in some cases been construed as lack of support from leadership.

2.5.2 Institutionally

Several activities have been undertaken which indirectly indicate ownership and affirm possible sustainability of the benefits. Institutionalizing a training component within the curricular of all 3 key institutions of police , prisons and PTCs and in police as an example, discussing HIV/AIDS at police parades is a good indicator for ownership. The trained BCAs within every institution will also augment the capacity to continue to provide support to ensure that some needs are addressed. As far as the other institutions are concerned, we find most of the existing linkages and partnerships loose and not effective enough to sustain what has been initiated.

2.5.3 Social, economic and financial sustainability:

The PHAs networks when strengthened with income generation and committed to regular social sharing between and within groups, will be the nexus for cohesion and continuity. At the moment, not all PHAs have appreciable knowledge of the HIV/AIDS policy and /or the adoption practices. Their needs are many including psycho social care, ARV and support drugs, laboratory and even livelihood support. Since many of these are through linkages to other implementing partners and beyond the mandate of SPEAR, they need to be explored beyond SPEAR through other donor and government support opportunities. Some groups of PHAs have already benefitted from other sources of funds as a result of firming up their position as registered community based groups with a constitution, clear objectives and a functional leadership. Such groups are the minority. Well managed savings and credit schemes used by such groups to manage their small business have been tested as viable support components in Uganda and such capacity development can be extended to SPEAR PHA groups.

2.5.4 Challenges to ownership and sustainability

- The political and institutional leadership is being judged by the apparent superficial participation and more importantly commitment to expedite and ensure that guidelines are both in place and being systematically implemented. Furthermore, inadequate monitoring, quality assurance and facilitation[4] of activities by BCAs, ToTs and anti-S&D champions are interpreted as lack of ownership.
- At district level, BCAs, ToTs and other Champions have no forum that brings together all 3 ministries for sharing experiences, lessons and challenges nor learning or harmonizing strategies and work plans for handling HIV/AIDS policy and related activities.
- Some champions like BCAs maintained that the IEC materials like handbooks used are not language user friendly (strong English) making it difficult to unpack and communicate the information contained therein. The IEC materials would have achieved maximum benefit if they were supplemented with visual aids especially for special groups like youth and families. Whilst agreeing that this is critical and significant, it further affirms that joint planning and coordination between partners is lacking since other partners have these facilities and they can be shared.

Box 4: Strategic Action Points - ownership and sustainability

i) Strengthen partnership agreements, defining clear roles and responsibilities for planning, implementation, funding and monitoring. SPEAR to systematically and gradually dis –engage from or reduce active services while enhancing partnership involvement.

ii) Design and implement activities to engage stakeholders in more strategic round table discussion for strategic planning and support functionality of district networks beyond simple regular meetings

[4] The facilitation fee of Ushs 10,000 per 3 months given to BCAs is little compared to other organizations like Red Cross and AMREF working within the same area who give that same amount per person per month

2.6 Efficiency

How efficient are the strategies and approaches implemented by SPEAR in achieving intended outputs and outcomes.

This evaluation looks at strategic efficiency in terms of implementation and cost efficiency.

In doing so, the evaluation has sought answers to the following questions:

- Have the results been achieved strategically with minimum resources (time, funds, human resource and logistics)?
- Could the same results have been achieved with fewer resources?
- Could more of the same results have been produced with the same resources?

In attempt to answer the above questions, the evaluators have considered the questions of whether the project administration structure is the most appropriate for promoting efficiency in its operations, whether activities have been implemented in a timely manner, whether the strategies employed and the activities conducted are the most cost-effective for achievement of the stated objectives, the ratio of administrative overheads to project costs and whether or not the activities have been conducted within the planned budgets versus the actual obligated budget.

2.6.1 Administrative Structure efficiency

The SPEAR project team was carefully selected to represent technical expertise in response to the project objectives namely: - Executive leadership as Chief of Party, Policy expertise, communication and HIV/AIDS prevention specialist, Finance team, M&E, program manager, person in charge of care and treatment and ICB experts supported by a research team at RTI. In addition the program has regional field hubs for handling operations at the district level for the central, eastern, western and northern regions each with a regional coordinator and a recently recruited technical assistant. The team is also supported by a Project Advisory Committee.

2.6.2 Design and implementation efficiency

The project was designed to work with National Structures at the line Ministries in alignment with already existing institutional structures like HIV/AIDS Control programs in the ministries and autonomous departments in the three target ministries. They include structures in UAC, ACP national program, DAAC at the districts and SACC at the sub countries. This was a sound strategy given the thin staff (high staff to workload ratio) at the SPEAR office and the need to ensure direct participation and 'buy- in' by stakeholders.

In addition, the implementation was designed with a sub –contractual approach in mind where organizations and other private sector firms or partners may be sub-granted to offer

various services under contractual or MoU arrangements which leverages resources like time, human resources and brings together a pool expertise. For example SPEAR is working with Local and government hospitals like Gulu independent hospital, Lacor hospital, Mulago and Mbarara government hospitals to offer various HIV/AIDS related services to PSWs, while prison and police medical services, and Rakai Health Sciences offer support in VCT, HCT and SMC services. This became more effective but not without challenges which are mentioned further on. It is also true that increased demand for and uptake of HCT by PSWs is attributed to the work of active BCAs whose efforts have simplified the task of mobilizing PSWs to receive embrace and utilize services. Some of key design issues are below highlighted:-

The project design envisaged addressing HIV/AIDS response in all districts of the country. The assumption was that entry and implementing partnership would be easier in districts where WV Inc is operating. It was assumed that no additional MoUs would be required for such districts and that WV staff on ground would mobilize the support that would be a springboard. This did not work as WV Inc has MoUs with only 29 of the 58 SPEAR districts and even then in each district, only operates in one or two sub counties. Re visiting this approach to a more effective one delayed the project entry and initiation within the districts.

The program efficiency was further constrained by the exponential multiplication of districts. Instead of spreading the already constrained resources thin, the project made a positive critical administrative decision to work in only 58 districts. While this appears to have worked better than the previous approach, it is in essence still not effective especially with the low intensity of district activities in the 58 districts and limited coordination at the district level.

Thirdly, implementation efficiency is also affected by delays in accountability from district beneficiaries which is further complicated by the un –friendly cash advance systems at SPEAR office set at a maximum cash of Ush1,500,000/= per person per advance request and yet tagged to accountabilities. This working amount effectively between the Regional Coordinator and Technical Assistant becomes a total of Uganda shillings 3,000,000 in cash that can be advanced per request, which is low given the activity loads in each district.

Elucidating on the gravity of the workload, it was observed that all planned outputs and outcomes cannot be achieved efficiently at the regional level given workload of the Coordinators in the absence of a non functional partnership arrangement as was earlier assumed in the proposal document. Each is assigned between 10-15 districts, assisted by the Technical Associates and a Driver who literally facilitates all processes while World Vision ADP support is concentrated on the accounting function, administration, employee benefits like processing payroll and office support.

The operational structure is such that the Regional Coordinator's physical presence is required in almost all districts and at all activities especially where money disbursements are to take place such as transport refund and facilitation. Whenever they are undertaking a bulk activity in one district, the activities in other districts are literally at standstill. These tasks are too heavy for only three staff to handle and it therefore hampers effective delivery of services. Furthermore, the work overload for the coordinators limited the effective time that was spent on lessons learning and adopting changes for better practices. Whereas the

coordinators received lots of useful information, there was hardly time to analyze the data and use it for effective planning.

The situation was aggravated by having failed to effect MoUs and performance based service contracts with partners who may otherwise alleviate the workload. Subsequently, the Coordinators have found themselves taking over the workloads designed to have been addressed by partners such as supervision and monitoring of BCA activities through sector coordinators. The entire situation has a negative effect on the operational efficiency and may be reflected in subsequent delays and /or failures to achieve some of the anticipated project outcomes if not addressed.

The remuneration package of the staff, we observed may have silent effect on the implementation efficiency since comparably other organizations working in similar regions have higher packages than those of SPEAR staff. Not surprising therefore is the high turnover and replacement delays in some of SPEARs establishment. For example, records show that the Mid Western region spent over 6 months without a permanent regional coordinator, the position of the COP has had three different occupants, the M&E position has also changed hands for more than three times. .

2.6.3 Financial efficiency

In assessing resource utilization by the project, the evaluators have in the first instance, analyzed its cost structure and the following are observations from table 4 on cost efficiency:-

Table 4: Costs and Expenditure structure

	Actual Costs			**% costs**		
	Fy 2009	Fy 2010	FY2011	**Fy 2009**	Fy 2010	FY2011
Program and administrative Salary and benefits costs *	**4,571**	485,109	395,323	31.5%	34.04%	27%
Program and administrative Overheads**	**402,875**	221,165	157,768	20.7%	15.52%	11%
Direct Project Costs						
1. Policy	**154,628**	112,641	169,517	7.93%	7.90%	12%
2. Institutional capacity building	**66,269**	168,962	174,502	3.40%	11.86%	12%
3. Behavioral Change Communication	**308,881**	143,285	104,076	15.84%	10.05%	7%
4. HCT and VCT services	**22,253**	**51,923**	128,426	1.14%	3.64%	9%
5. Care & Treatment	**2,132**	3,947	22,360	0.11%	0.28%	2%
6. Wrap around services	**378,522**	238,000	294,321	19.41%	16.70%	20%
	1,950,131	**1,425,031**	**1,446,293**	**100%**	**100%**	100%

Staffing and administration costs have ranged from 52% in 2009, reducing slightly to 49.5 % in 2010 and standing at 38% in 2011. While there is no agreed to benchmark or best practice with regard to the ratio of administrative costs to direct project costs, 25% is commonly accepted as a reasonable threshold and yet in this case, the total project overheads at 38% which is still well over the reasonable thresholds[5].

[5] **Although the evaluators feel strongly about this point, the implementers did not agree with this statement**

The overall project budget apportioned to the direct project costs in comparison to the administrative and program cost is low for example for care and treatment. While it is appreciated that this was a function of the referral and linkage program and allotted to partners with a critical assumption that partnerships will be effective and efficient, and it did not work. Strategic decisions should have been made to effectively increase the number of new care and treatment patient slots, going by the priority it holds as a key expressed need for the PHAs. Likewise, the numbers of HIV positive PSWs who receive wrap-around services are function-dependent on the number of PSW who test positive for HIV; this line was at 20% of the budget by 2011, but the number of people accessing services did not seem to match with the planned funding.

There were several stock outs of HIV testing kits, reagents and drugs like septrin and ARVs which were critically needed in the health centers. Although SPEAR's mandate does not allow procurement of reagents, ARVs, or testing kits, a one-time only approval was sought for and sanctioned to purchase testing kits. In similar, deficiencies within care and treatment services e.g. specialized laboratory services like chest X-rays, liver function test, renal function test, and CD4 and cell blood counts, it was presumed that the partners within the referral and linkage program would do the same but this did not happen.

Several other effective strategic changes in implementation and funding approaches included:- i) Change in workshop modules and categories of participants to improve stakeholder buy-in, ii) facilitating the building capacity planning activities initially not provided for, iii) using existing MoH experts to train people in various activities instead of BCAs whose capacity was limited. iv) Supplementing costs for reproduction of existing IEC materials created by other implementing partners. Most of the changes although more value efficient had a higher monetary and/or time implications.

Some of the other strategic approaches that worked also at a cost in terms of time and financial resources were:-

- Shifting to home-based and weekend HCT outreach services to ensure couple counseling services where couples worked in different workplaces
- A re-focus to BCAs and champions in the higher ranks of the Public sector workers to reach out to senior officials or PHA groups in police to reach out to barracks
- Sustaining motivation and commitment of the trained volunteers to continue offering services amidst delays and institutional changes
- A shift from private service providers for commodities like test kits to autonomous bodies like national medical stores to enhance their supplies to accredited units charged with procurement and distribution of test kits. The approaches addressed the needs but time delays because of these national stock outs negatively affected the uptake of VCT services.

Box 5: Action points- financial efficiency

i) The budget support must be revised to meet new changes that were previously not included like support for PMTCs, SMC and related activities

ii) Explore all possible opportunities of engaging the ministries and districts to increase participation and commit budget lines on activities for HIV/AIDS policy implementation and services in addition to funds from SPEAR.
iii) Support financial resource mobilization capacity of PHAs to meet their other needs that are not met by SPEAR

2.7 Linkages and value addition

How well is SPEAR activities linked with other activities pursuing similar results? What unique or value adding features does SPEAR bring to the basket and how is this utilized to leverage specific program results and overall USG development results

2.7.1 Linkages

In the recent past there are many organizations INGOs, NGOs and other CSOs contributing to the national HIV /AIDs responses in the country all engaged in similar themes on prevention, care, treatment for purposes of reducing new infections and ensuring access to services. Most of the services are integrated covering structural prevention, behavioral change and biomedical interventions ranging from general education using designed IEC materials to organizing and mobilizing communities for HCT/VCT services and followed with psychosocial support for those that need it. For continued holistic care and treatment, SPEAR clients are linked and referred to other partners with complementary services who are USG funded like STAR-E, EC, SW, NUMAT, TASO,. AIC, URCS, ICOBI, PACE, MJAP and JHUCCP etc. Others are part of the broader care and treatment programs funded by CDC like Mild May International and Baylor. SPEAR's services are extended to capacity building of service providers to offer additional services like SMC, prevention of risk like condom education and supplying physical materials like HIV testing kits, condoms, and other safe practices code named wrap services. Using Home based programs, MARPS, and outreach programs to reach the hard –to –reach communities are all shared approaches which make the link effective as all partners will be familiar them.

The missing linkage with SPEAR is their absence from the service provider networks where information is often shared. At such fora information and joint planning is undertaken and discussions often focus on synergies to maximize time and financial resources as well as sharing available facilities. One organization mentioned that at one point SPEAR utilized services of BCAs that had already been trained by another organization, thereby leveraging existing resources. Some beneficiaries felt that SPEAR lacked synergies for communication and yet approaches like use of T-shirts, HIV experts, organized talk shows and use of community radios are proven communication approaches that work jointly in the communities. In addition, SPEAR has not explored approaches for sustainability like specifying user fees, or token training fee contributions that other organizations have employed. While it may be an organizational policy not to charge user fees, it is a policy that differs from what others do. Most PHA groups under SPEAR do compel their members to pay a token membership fee. While, this appears non prohibitive with an apparent

'opportunity for all' approach, it is superficial and neither promotes ownership nor long term sustainability.

2.7.2 UNIQUE qualities or value addition from SPEAR PROJECT

Unique to this project is the targeting of the public sector workplace of line ministries with institutions with people who are always at risk and yet by default always miss out on HIV/AIDS sensitization. Its strength lies in the following:

i) Addressing concerns and issues of the unique groups of people at risk, the officers in prison, police and guard services who are always on the move and therefore underserved and hard- to- reach. Assisting them to benefit from HIV/AIDS, and form self support structures like PHA groups is unique to this program,
ii) although these institutions operate under 'command', the program attempts to introduce a national policy which is above their commands structure,
iii) SPEAR has to an extent overcome a degree of stigma and discrimination in the public sector where, public figures such as teachers, police, prison guards, local government officials placed in authoritative positions endure barriers to health seeking behaviors at their risk and peril. As such, disclosing their status has always been seen as a risk not only to their relationships with family, friends and neighbors, but to their careers. The project has successfully convinced all teachers in project area to undertake voluntary HIV testing and has reached MARP categories (CSWs, IDUs, MSM) through building trust
iv) SPEAR contributes to measurable development results, such as public sector workers who are part of PEPFAR targets in prevention, or number of health workers trained in SMC, and refers them to partners who report on PEPFAR care and treatment targets, PMTCT targets, FP/RH targets, etc.
v) Sometimes SPEAR leverages practical immediate assistance that impacts the lives of PLHIVs. For example in 2009, during a period of septrin scarcity, the only sources available in the country was a GIK from a SPEAR private partner in the pharmaceutical industry
vi) The referral and linkage program though not yet functioning to satisfactorily provides a good leverage for attainment of US development results on effective use of social sector services towards improving human capacity.

2.8 Key risk factors

What are the key risk factors against SPEAR's ability to achieve expected results?

The following risks will affect the project results if not addressed:

- Failure to effect performance based contracts, and fee for service contracts with implementing partners and service providers in replacement of MoUs. Such agreements shall clearly define roles and responsibilities; implementation arrangements; operational time frame and funding clarity.
- Un exploited mutual trust with district leaderships to enhance buy-in, commitment, and effective integration and supervision of activities within the existing district structures addressing HIV/AIDS
- Un addressed workload of the regional Coordinators compromising their availability to regularly visit the districts under their operational jurisdiction, tracking progress of BCAs and other activities, ineffective quality assurance and failing to utilize the feedback in time to advice management beyond routine quarterly review meetings, success stories and required reporting. Lack of timely changes in downstream activities, will negatively affect timely achievement of the long term outcomes and eventual impact
- Non scheduled delays in preparing policy guidelines risk the policy component slowly running off track. Once not institutionally grounded, could be exacerbated by changes in political and policy environment. Delays affect resources, and thus operational efficiency Cost overruns, optimism bias, and high stakeholder expectations if disregarded will results in low buy –in and reduced participation.
- Failure to strengthen systems including securing strategic alliances, active participation and synergy with districts, CSOs and networks offering similar and /or related services is an implementation risk which is critical at this stage. Ineffective coordination which may result in duplication of efforts or failure to focus on activities may endanger stakeholder interest in the program.

CHAPTER 3: BEST PRACTICES, LESSONS LEARNT AND CONCLUSIONS

The project has offered not only challenges but best practices and lessons from the implementation so far. Some of the key highlights are mentioned here

3.1 Best practices and lessons learnt

3.1.1. Implementation approaches

- With adequate capacity building, multiple national institutions could work together to implement projects with minimized and shared resources only if, functional partnership arrangements are in place, with harmonized and well coordinated action plans including effective monitoring systems.

- While Multi level support and involvement of stakeholders is fundamental and will ensure sustainability in the long run, involvement of national government especially at district level is indispensable, irrespective of the challenges. One can only learn how to effectively deal with such. Activities at the districts are best undertaken by the district officials themselves but with functional arrangements that clearly define transparent financial mechanisms, work plans, and quality assurance systems. Implementation of work plans developed by the beneficiaries themselves increases ownership and the existing working groups will provide the best entry points

- The workplace is an ideal site to increase access to HIV prevention and care services since we know that most busy people who work spend perhaps more time at the workplace than in their residential areas.

3.1.2 Policy

- Whereas departments with organized chains of command like the Uganda Police Force and the Uganda Prisons Service act on agreed tasks faster due to command lines of communication. they can equally be a challenge where subordinates are commanded to obey orders e.g. accepting transfers and re-deployment without entering into plea. As such, success becomes subjective and dependent on the senior officials in charge. Mobilization and rapport with top public officials is a therefore a key ingredient in success making it worthwhile to spend resources to secure their buy-in.

- As far as private guards are concerned, much as they are part of command services, the environment and conditions under which they operate are different. They operate under private entities which are business focused and only engage employees under contractual basis, which contracts hardly include health packages. Mobilizing them for testing is not easy but achievable. They are however still facing serious stigma issues and employees who test positive are likely to be dismissed or otherwise end up in un affordable legal wrangles.

- Because many wrap-around services are provided through NGO/CBO-based efforts, more focus needs to be targeted towards strengthening linkages and referrals to assure that clients access a full continuum of needed HIV/AIDS services.

3.1.3 Institutional capacity building

- Although with challenges, by being part of the target communities, the services of BCAs, were undeniably responsible for increased uptake of HCT services among the target population. They have a significant effect on peers within the communities but have limitations where their superiors are concerned. They are also limited in terms of communication, technical and psychosocial skills.

- District mobilization to participate is more effective if done with the support of the respective Ministry headquarters. Better attendance and commitment from the participants was seen in districts where the ministries were directly involved in mobilization activities.

- Engagement of health sector or institutional health personnel such as police or prison nurses in VCT and HCT activities provides a more effective mechanism for both mobilization and follow-up with those that have been identified as positive. Ethical observance is nevertheless a pre-requisite

- Facilitation in whatever form, monetary incentives or benefits like bicycles are unfortunately inevitable. Negotiations to make them realistic without compromising desired results is the challenge

3.1.4 Wrap around services

- While beneficiaries appreciated the free HCT and VCT services, they still measure success according to tangible benefits which is addressing personal felt needs and priorities which in the case of PHAs is care and treatment (ARVS, prophylactic treatment etc). As long as these are not met, the project will have measured below their expectations irrespective of the sources and who provides since the process started with SPEAR.

- Although the supply of home based care kits, in the form of WV gifts in kind program, was irregular due to reasons cited earlier, this small incentive elicited a strong response and in some areas a number of PSWs who had tested positive and had not yet revealed, disclosed their status so that they could access the packages. This is evidence of the power of tangible /physical benefits and how much they are appreciated and valued by the communities.

- The use of positive living groups plays a big role in giving hope to the PHAs. And the PHA experts on the other hand are also very effective in relaying messages and sharing their experiences with other PHAs. They however need motivation to do this however small the facilitation may be.

3.2 Summary and conclusions

3.2.1 Summary and key recommendations

	Evaluative Question	Status Overview	Key Recommendations
1.	How effective has the program been in achieving the planned results to date? This will include amongst others a review of the effectiveness and contribution of the partnership between World Vision Inc. and the national level partners to achieve shared program objectives	1.1 HIV/AIDS policies in 3 Line Ministries on track 1.2 Operational guidelines in only Ministry 1.3 Capacity of building of policy champions effected 1.4 Capacity of health units and staff insufficient 1.5 Referral linkage program not functional 1.6 Wrap around services inadequate	National level: support MoIA and MOLG to finalize Policy implementation guidelines District level : support ▪ 21 districts to prepare district specific plans for policy adaption ▪ 21 districts initiation policy dialogue and subsequent plans for operationalization Review & improve referral linkage program
2.	To what extent is SPEAR strengthening ownership and sustainability of HIV related change processes within the public workplace institutions?	2.1 Political support was strong but waning 2.2 Institutional sustainability in place especially for policy champions 2.3 Social economic sustainability strong with PHA networks in police, prisons and education and weak with private guard services 2.4 Ownership with districts insufficient	i) Support the ACP to supervise and monitor performance of PSW trained policy champion institution ii) Develop and implement mechanisms to track PLHIV access to care and treatment services iii) Support dialogue with districts to promote integrated joint planning with other district teams
3.	How efficient are the strategies and approaches implemented by SPEAR in achieving intended outputs and outcomes.	3.1 Technical efficiency at WV offices is strong and working through existing national structures 3.2 Staff overload at regional centers 3.3 Financial and logistical support sufficient to achieve desired outputs	i) Focus on couple testing and counseling within UPF& UPS immediate and surrounding communities. ii) Scale up practices like condom distribution, SMC and PMTCs promotions
4.	Is SPEAR's design and implementation still relevant and consistent with the needs of public sector workers…, How well is SPEAR integrated and working in harmony with other USG-funded activities?	4.1 Project still relevant after creating PHLIV networks in the key institutions 4.2 Disease prevention and Behavior change insufficiently addressed in surrounding 4.3 Integration with other USG funded activities not complete for intended results and outcomes	i)Effect all pending MoUs and /or contract based performance agreements with clearly defined roles and responsibilities ii) USAID to cause a Strategic intervention meeting to support joint planning, learning and sharing in wake of DTBs
5.	How well are SPEAR activities linked with other activities pursuing similar results?	5.1 SPEAR inked and referred clients to several USG funded partners and other government facilities 5.2 Systems for participation and sharing not well streamlined	i) Support institutional capacity development (HR and facilities) at police &prison HUs through ACP program to improve facilities for better quality prevention care and treatment services
6.	What unique or value adding features does SPEAR bring to the basket and how is this utilized to leverage specific program results and overall USG development results? What are the key risk factors against SPEAR's ability to achieve expected results?	6.1 Uniqueness and value addition ▪ Mobilizing PSWs from hard to reach areas and institutions to undertake VCT and HCT ▪ Complimenting the PHAs and their groups with wrap around services including referrals and linkages to other prevention, care and treatment agencies ▪ Targeting Public Sector Workers	Address following risks: i) failure to effect performance based contracts and alliance with strategic partners ii)Un exploited mutual trust with district leaderships to buy-in and commitment iii)Un addressed workload of the regional Coordinators iv)Weak and /or non functional M&E systems v)Incomplete prevention and care services for PHAs and introducing IGAs with no livelihood management skills

3.2.2 Conclusions

The SPEAR program has so far has made very significant contributions in terms of responsiveness to HIV/AIDS at the work place and the overall national development priorities The project is generally on track and on average 80% of the targets set for yr 1-3 have been met.

Learning from challenges, evidently sufficient attempt was made to apply approaches which are participatory and inclusive in order to secure buy-in from the beneficiaries. Whereas this was successful at political, institution and community (beneficiaries) level, the buy-in from implementing partners has been slow and not without effect on the efficiency and progress of the project.

On project effectiveness, the project made positive strides towards achievement of the 3 main goals on policy, institutional capacity building, access to and utilization of services. HIV/AIDs policies are in place for the 3 key line ministries of MoEs, MoIA and MoLG. They have although not adequately been disseminated to the key stakeholders, information on the policies has been unpacked for the utilization by the beneficiaries and in waiting are the operational guidelines and strategies to roll down the policy to a level of full adoption.

On access to and utilization of HIV/AIDS services, the project has many documented successes towards beneficiaries within UPS, UPF and public teaching institutions in the operational areas, SPEAR is synonymous with mobilizing for HIV/AIDS VCT and HCT services. Most attributes are to the anti S&D messages which consequently secured confidence among PSWs in the key institutions to undertake voluntary testing which many had not ventured into before. PHA groups were formed among those that tested positives and they have been supported by SPEAR to start engaging in IGAs to help them meet their needs. Only a few of the linkage and referral activities were undertaken.

Whilst political ownership was secured through the high powered launches at the project initiation phase, the 3 key specialized institutions of UPS, UPF and tertiary education institutions also embraced the project. There are varied successes in engaging partners in complementary implementation especially of the linkages and referral activities in the care and treatment component.

The efficiency of the strategies and approaches used by SPEAR were measured according to budget performance and outputs /outcomes achieved. Funding affected the implementation efficiency of the project. Resources initially spread thin due to an expanded geographical coverage which was later narrowed. Other factors that affected the efficiency included high start up administrative costs, costs outrun due to changed work plans and high workload of the regional coordinators.

On linkages with other activities pursuing similar results, SPEAR works by providing services up to VCT and HCT and linking the rest of the components for care and treatment to other USG funded partners like STAR-E, EC, SW, NUMAT, TASO,. AIC, URCS, ICOBI, PACE, MJAP and JHUCC and government health facilities like health centers or hospitals. For most of these, the partnership has been informal and/or loose and still needs to be strengthened to maximize achievement of planed outputs and outcomes. They all have shared

goals and use similar and /or familiar approaches like capacity building, and services provision through outreaches and home based care. Most uniquely, SPEAR has addressed concerns and issues of a unique group at risk which is usually hard to reach at the work place.

This target group of officers in prison, police, guard services and teaching institution has a unique feature in that they always miss out on HIV/AIDS information and services. Those that test positive qualify for continued holistic care and treatment services through client linkages and referrals to other partners with complementary services who are USG funded like STAR-E, EC, SW, NUMAT, TASO,. AIC, URCS, ICOBI, PACE, MJAP and JHUCCP etc. Others are part of the broader care and treatment programs funded by CDC like Mild May International and Baylor. SPEAR's services are extended to capacity building of service providers to offer additional services like SMC, prevention of risk like condom education and supplying physical materials like HIV testing kits, condoms, and other safe practices code named wrap services. Using Home based programs, MARPS, and outreach programs to reach the hard –to –reach communities are all shared approaches which make the link effective as all partners will be familiar them.

The project has faced several challenges which are institutional like high and over expectations of stakeholders, delayed buy –in of stakeholders, lack of effective partnership arrangements beyond performance based and declining interest of some key stakeholders which may have collectively or individually affected achievement of certain results. The project is nonetheless on track.

ANNEX 1: STATEMENT OF WORK

BACKGROUND

Uganda has a population of 28 million people, with 85 percent of the population living in rural areas. The country has had considerable success in reducing prevalence of HIV/AIDS over the past 15 years from a national average of around 18 percent (up to 30 percent in selected urban antenatal clinics) to the current level of 6.4 percent. However, despite initial successes of the late 1980s and early 1990s, the decline in prevalence has stagnated over the past five years and no longer shows a downward tendency. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in the conflict regions are the most severely affected. Approximately 1.1 million Ugandans are HIV positive, of which approximately 100,000 are children under the age of 18. Forty percent of those who are HIV positive have an HIV negative spouse.

Increasingly, data from Uganda and other countries in the region show that new cases of HIV are being transmitted within the adult population. Programmatically, the emphasis of prevention activities has centered on the population of young people, both in and out of school. Programmatic approaches that address risk factors, risky behaviors, and perception of risk among the adult population need to be developed and scaled up. The inclusion of the public sector workforce in HIV/AIDS prevention programs falls within the focus on adults. People enrolled in the uniformed services (e.g., guard services, police, prisons) are often mobile or away from home, may have increased opportunities for casual encounters with house girls, sex workers and barmaids, and may have several sexual partners thus increasing their likelihood of contracting or transmitting HIV'. In addition, local governments employ the majority of the work force at the district level. Many of these employees are the providers of key HIV/AIDS prevention, care and treatment services, but they are unable to access the same services they provide because they are working. There are very few efforts to address their special needs in prevention, care and treatment.

Through the process of mainstreaming AIDS throughout the national development process, the causes and effects of AIDS will be addressed in an effective and sustained manner.[6] In Uganda, the concept of mainstreaming has been applied to national efforts to implement a multisectoral response. In doing so, the emphasis, in part, is on mainstreaming HIV/AIDS across all line ministries. Under the guidance of Uganda AIDS Commission, with support from the Partnership Forum, public sector line ministries have been supported to hold joint reviews, develop work plans and streamline HIV/AIDS within their respective sectors. Despite these and other efforts however, activities have not extended beyond the development of sector specific HIV/AIDS workplace policies.

On June 18, 2008, USAID Uganda signed a $10,000,000 Cooperative Agreement (CA) with World Vision, Inc. to implement a program in partnership with the ministries of Education and Sports (MoES), Local Government (MoLG) and Internal Affairs (MoIA) focusing on HIV/AIDS in the three sectors. The public sector workplace program named Supporting Public Sector Workplace to Expand Action and Responses against HIV/AIDS (SPEAR) program, works at the national level and, initially, in all districts to:

- Support public sector to develop and implement HIV/AIDS policies that ensure availability, integration and utilization of sustainable HIV prevention, care and treatment services for their employees and dependants.
- Increase access to quality HIV/AIDS prevention, care and support services by targeting

[6] Support to Mainstreaming AIDS in Development, UNAIDS Secretariat Strategy Note and Action Framework 2004 – 2005. UNAIDS.

public sector employees, with a focus on identifying HIV positive individuals and facilitating access to networked care and treatment services.

- Improve access to use and utilization of wrap around services by target public sector employees living with HIV/AIDS and their families through effective partnerships with other USG and non-USG supported programs.

SPEAR's Key Intermediate Result areas:

- IR 1.1 Enhanced capacity of public sector workplaces to adopt/adapt policies and practices that improve employees' access to high quality HIV –related services
- IR 1.2: Target workplaces and partner service providers equipped with HIV related technical and institutional development skills to develop and implement sustainable strategic plans and operational activities.
- IR 2.1 : Increased personal perception of risk of HIV infection/transmission and utilization of prevention services through aggressive targeted behavior change programs
- IR 2.2 : Increased access to and utilization of HCT services by target public sector workers and their families
- IR 2.3 : Improved access to and utilization of palliative care, treatment services and psychosocial support services for HIV positive public sector workers and their families

The SPEAR Project is using a network model that facilitates the acquisition of positive attitudes, personal skills, and knowledge of HIV protective behaviors. The assumption was that this model would contribute to the reduction of HIV infection among Public sector workers and their families within each of the three target ministries. Targeted institutions include: MoIA: headquarters, local police, prisons, immigration, community services, guard services; MoLG: headquarters, Uganda Local Authorities Association (ULAA) staff, Urban Authorities Association of Uganda (UAAU) and districts; MoES: headquarters (including the affiliated bodies/educational institutions), national teachers colleges (NTC), primary teachers colleges PTC), Basic Tertiary and Vocational Education Technical (BTVET) institutions, secondary schools, district education offices (DEO) and primary schools.

In summary SPEAR is expected to:

1. Consolidate activities for Years 1 and 2, and implement Year 3 activities around a needs-driven, transformational development approach, with participatory and inclusive decision-making at all levels in order to achieve program objectives while engaging the public sector workforce in project implementation, monitoring and evaluation.
2. Ensure sustainability of its interventions by strategically mobilizing political and popular support through coalitions building, engagement and networking with governments, institutions, donors, USG-funded NGOs/local NGOs, CBOs and key stakeholders.
3. Generate creative and appropriate HIV/AIDS workplace interventions to build institutional capacity and a policy and advocacy environment that will engender a cultural shift at all levels of governance on the importance of protecting the lives of the public sector workforce.
4. In Year 3, to continue implementing interventions in the areas of comprehensive Behavior Change Communication (BCC); counseling and testing; linkages and referrals to care and wrap-around services. Cross cutting themes will consist of evidence based action and responses and reaching rural and hard to reach areas; and gender and disability sensitivity and meaningful involvement of PLHIV.
5. Focus on cross cutting issues in the design, implementation and reporting of its program activities.

I. PURPOSE OF THE EVALUATION

USAID Uganda is commissioning this midterm evaluation to assess the relevance of the SPEAR project and effectiveness of its approach in reference to contextual and programmatic changes since its inception. The evaluation will recommend ways to increase SPEAR's contribution to HIV Prevention in the current environment. The evaluation will document major achievements (what is working well) and opportunities (what could have been done better), limitations and challenges; and establish lessons learned and good practices to inform implementation of ongoing and future program work by USAID and Government of Uganda.

II. KEY EVALUATION QUESTIONS

The evaluation should answer the following questions: How effective has the program been in achieving the planned results to date? This will include amongst others a review of the effectiveness and contribution of the partnership between World Vision Inc. and the national level partners to achieve shared program objectives and results.

1. To what extent is SPEAR strengthening ownership and sustainability of HIV related change processes within the public workplace institutions-
2. How efficient are the strategies and approaches implemented by SPEAR in achieving intended outputs and outcomes.
3. Is SPEAR's design and implementation still relevant and consistent with the needs of public sector workers, current understanding of Uganda's HIV epidemic, other interventions and other socio-political changes in Uganda? How well is SPEAR integrated and working in harmony with other USG-funded activities?
4. How well are SPEAR activities linked with other activities pursuing similar results? What unique or value adding features does SPEAR bring to the basket and how is this utilized to leverage specific program results and overall USG development results?
5. What are the key risk factors against SPEAR's ability to achieve expected results?

III. PROJECT INFORMATION AND DOCUMENTS

The following information documents and sources shall be available and relevant to the evaluation:

USAID:

- Original Request for Proposal
- USAID program and financial reporting requirements

SPEAR:

- Agreement and other amendments/modifications
- Annual and quarterly reports
- Annual work plans and Performance Management Plans
- Baseline survey report
- Relevant training and activity reports
- Internal assessments and reviews

Sector Specific Information:

- HIV work place policies (Sector specific)
- Work plans to implement with SPEAR project
- Minutes of National Steering Committee meetings

IV. EVALUATION METHODOLOGY

The offerer may propose a mix of qualitative and quantitative methods to conduct an evaluation that meets the stated purpose and responds to all the evaluation questions listed above. Proposed methodology should bear in mind the wide coverage and diverse group of stakeholders and show clearly how reliable and meaningful information will be collected in an efficient manner. Proposal should include a sampling methodology and analytical plan. Initial findings of the evaluation will be shared within the Mission and with the Implementing Partners. This report will form the basis for subsequent design and planning meetings between USAID and World Vision to incorporate lessons learned and proposed recommendations for improvement. The final report will be shared with the Government of Uganda, other development partners and USAID's Development Experience Clearing House

V. DELIVERABLES

1. In Briefing: Introduction of the evaluation team, discussion of the SOW and initial presentation of the proposed evaluation work plan.
2. An Inception report detailing the Contractor's interpretations of the assignment, an evaluation design and methodology, analytical plans, sampling, tools and work schedule
3. Weekly Progress Reports: Brief informal reports summarizing progress, challenges and constraints and describing evaluation team's response
4. Oral Presentation: Power Point presentation (including hand outs). The oral presentation should, at a minimum, cover the major findings, conclusions, recommendations, and key lessons. The evaluation team will liaise with the mission to agree on the dates, audience, venue and other logistical arrangements for this briefing.
5. Draft Evaluation Report: The report should comply with the USAID's Evaluation Report standards set out in Annex 1.
6. Final Draft Report: Complete report incorporating comments from USAID and other stakeholders.
7. Final Report: The contractor will submit a final report incorporating final edits for wider sharing

*All reports should be provided in five (5) hard copies and one (1) electronic copy.

VI. DURATION OF THE ASSIGNMENT

VII. The assignment is expected to start towards the end of September and be concluded by mid-November 2011.

VIII. LOCATION OF ASSIGNMENT

SPEAR office(s), USAID and site visits conducted in the different institutions currently covered by the SPEAR program.

IX. MANAGEMENT ROLES AND RESPONSIBILITIES

The USAID Senior Strategic Information Advisor (SSIA) for the Health, HIV and Education Team will have primary administrative and technical responsibility of the evaluation process. This also includes making the necessary arrangements for USAID inputs and briefings. The Contractor will liaise closely with the Agreement Officer's technical representative (AOTR) for SPEAR and Program office M&E Specialist on coordination and clarification of USAID requirements and standards. World Vision will contribute to the design and planning of the evaluation, provide logistics for implementation (documents, meetings, interviews), participate in the oral presentation and review the draft and final reports. GoU institutions will participate in the review of proposals, facilitate interviews and participate in the oral presentation and review of the draft and final reports.

ANNEX 2: LIST OF PEOPLE CONSULTED AND RESPONDED

	Name	Designation	Contact where Possible
	Joseph Mwangi	Senior Strategic Information Advisor	USAID
	Rhobinah Ssempebwa	Sen HIV/AIDS Information Advisor	USAID
	May Mwaka	Mission Evaluation Officer	USAID
	Catherine Muwanga	OVC Specialists	USAID
	Andrew Kyambadde	HIV/AIDS Information Advisor	USAID
	Rudo Kwaramba	National Director ,	WV Inc
	Lawrence Tiyoy	Programmes Director	WV Inc
	Jesca H N Sserwanga	HR and HIV/AIDS focal person	MoES (PAC)
	Dr Ndiwalana Bernard	Police Medical services	MoIA (PAC)
	Edward Walugembe	Ass Comm M&E	MoPS (PAC)
	Edward Mujimba	Commissioner Equal Opportunities	MoL
	Godwin Tugume	PAC Member	MoLG
	Biddemu Charles	AS Police	MoIA (PAC)
	Kisakye Julius	PAC	MoES
	Dr. Ndiwalana	Surgeon Uganda Police HQs	Luzira HU
	Paul Bogere	Asst. Comm. HRM,	MoPS
	Dr. Edward Walugembe	Inspectorate, M&E MoPs	PAC
	Hephi Kyamuyondo	Secretary	MoES
	Dr. Joseph Andowa	Medical Sup. Staff clinic	Luzira
	Margret Ondongwen	Senior Nursing Officer	Murchison Bay
	Milly Nabulayi	NO-incharge of ART clinic	Luzira
	Alex Dragule	BCA Prison Dta	Luzira
	Mweru Olive	Nursing Asst. Asst.AIDS Counsellor	Murchison Bay Prison
	Catherine Achilo	ASA, Wife to an officer	0772318117
	Sophie Muhindo	SNO, Trainer	
	Jack Sibointole	Health Educator Program	Prison Luzira
	Maria	Programmes Development Director	WV SPEAR TEAM
	Wise Besigye	Finance Manager	WV SPEAR TEAM
	Derreck Musooka	M&E Specialists	WV SPEAR TEAM
	Warren Tumwekwatse	Program Manager	WV SPEAR TEAM
	Joseph Lubwama	ICB Specialist-RTI	WV SPEAR TEAM
	Caroline Odongo	Prevention/Communication Specialist	WV SPEAR TEAM
	Lillian Ayebale	MaSPH CDC-HIV Fellow with SPEAR	WV SPEAR TEAM
	George Luboobi –	Policy Specialist -RTI	WV SPEAR TEAM
	Erasmus Tanga	SPEAR Chief party	WV SPEAR TEAM
	George William Ebulu	ROM /QA Director	WV SPEAR TEAM
	Brain Assimwe	Ag SPEAR Central Region Coordinator	WV SPEAR TEAM
	Sharon Nakanwagi RC	Regional Coordintor Southern	WV SPEAR TEAM
	Jane Tushabe Mpiima	Regional Coordintor Eastern	WV SPEAR TEAM
	Shiela Kyobutungi –	Regional Coordintor Western	WV SPEAR TEAM
	Majorie Lagen	Regional Coordintor Northern	WV SPEAR TEAM
	Alfred Mubangizi	Care & Treatment Specialist	WV SPEAR TEAM
	Mr. Katungye	Director Administration UPS	MoIA
	Kettie Bagamba, ,	UPS	MoIA
	Jack Siboitole	UPS	MoIA
	Mbabazi, sophie	UPS	MoIA
	Muhindo	UPS	MoIA
	Charse Bidemu	ASP-UPS	MoIA
	Mr. Ziraba Charles –	PP0	MoIA
	Ms. Winnifred Sande	FPP-Community Service Dept.	MoIA
	Mr. Marshal Alenyo	Senior Immigration Officer / DC & IC	MoIA
	Mr Mutabwire	Director of Administration	MoIA
	Mr Ssonko	currently transferred to MoPED	MoIA
	Leofrida Oyella,	Formerly HIV/AIDs Focal person	MoTWC
	Mr. Opio Okiror	Assist. Commissioner Personnel -	MoES
	Jesca Naluzze,	Departmental HIV Focal Point Person	MoES
	Juliet Wajega	Project Coordinator UNATU	Affiliated to MoES

APAC – District			
	Dragule Alex	Data Entry Clerk	APAC District
	Domara Charles	DPC Apac (Police)	APAC District
	Beruga Henry	OIC Prison farm	APAC District
	Lunyoro Justine	Prison Officer	APAC District
	Omara George	Prison Officer	APAC District
	Ochen Jonana	Prison Officer	APAC District
	Kidega David	Prison Officer	APAC District
	Ochom Patrick	Prison Officer	APAC District
	Abinduga Sebastian	Prison Officer	APAC District
	Amil Salim	Prison Officer	APAC District
	Poro Geofry	Prison Officer	APAC District
	Omase James	Prison Officer	APAC District
	Opeyo Simon Peter	Prison Officer	APAC District
	Tegu Emanuel	Prison Officer	APAC District
	Okumu Richard	Prison Officer	APAC District
	Luwa John Charles	HIV/AIDS focal person	Apac District
	Ogweng Denis	Prison Officer	APAC District
	Acon Mary	Spouses of officers	APAC District
	Acen Mercy	Prison Officer	APAC District
	Akello Susan	Spouse of officer	APAC District
	Bakitta Kawomba	"	APAC District
	Ongom Sarah	"	APAC District
	Okwir Goretti	"	APAC District
	Asagai Norah	"	APAC District
	Acom Josephine	"	APAC District
	Imede Salin	"	APAC District
	Alum Liberty	"	APAC District
	Lameck Mwesigwa	"	APAC District
	Aciro Betty	"	APAC District
	Mwiru Olive	Nurse	APAC District
Gulu District			
	James Owal	HIV/AIDS coordinator	Gulu District
	Aziku Zota Tom	RPC	Gulu District
	Apolot Agnes	Regional Police Coordinator HIV/AIDS	Gulu District
	Joyce Akello	OC/CID Gulu	Gulu District
	Zaake	DPC	Gulu District
	Madrama Charles	Dr./Police surgeon-ASP	Gulu District
	Apunyu Cyprian	Clinical officer- IP	Gulu District
	Watulo Steven		Gulu District
	Lacaa Judith	Enrolled Nurse- WAIP	Gulu District
	Oyo Richard Oscar	Police Officer PC	Gulu District
	Opiro Jolly Joe	Theatre Asst AIP	Gulu District
	Obung William	Police Officer ASP	Gulu District
	Orena Emmanuel	Police Officer AIP	Gulu District
	Amai Bonny	Police Officer SGT	Gulu District
	Nyeko Patrick Dennis	Police Officer D/CPL	Gulu District
	Inenu Pamellah	Police Officer D/w/CPL	Gulu District
	Akwero Alice	Police Officer D/w/SGT	Gulu District
	Muwonge Robert	Police Officer PC	Gulu District
	Oyet D'Aquinas	Police Officer IP	Gulu District
	Obwang Augustine	Police Officer CPC	Gulu District
	Apolo David	Police Officer PC	Gulu District
	Uwmanich	Police Officer PC	Gulu District
	Abua Caroline	Police Officer WCPL	Gulu District
	Kilama Joel	Police Officer PC	Gulu District
	Akello Lilian Rose	Police Officer PC	Gulu District
	Onek Christopher	Police Officer 2nd SGT	Gulu District
	Odokonyero Moris	Police Officer AIP	Gulu District

	Tukamwesiga Nicholas	Police Officer AIP	Gulu District
	Okello Tonny	Police Officer CPL	Gulu District
	Okello Jacob	Police Officer - A/c (BCA)	Gulu District
	Emuron Richard	Police Officer CPC	Gulu District
	OkirorGeorge	Police Officer PC	Gulu District
	Obote George Bulish	Police Officer SGT	Gulu District
	Oyella Innocent	Police Officer –(BCA)	Gulu District
	Anenorwot Stella Hope	Spouse of Police officer	Gulu District
	Christine Anywar	"	Gulu District
	Olum Hilder	"	Gulu District
	Akelo Christine	"	Gulu District
	Aliga Mariam	"	Gulu District
	Magret Oneka	"	Gulu District
	Josephine Nyeko	"	Gulu District
	Akello Patricia	"	Gulu District
	Janet Onekgiu	"	Gulu District
	Jono Irene	Nurse /BCA, councilor	Gulu District
	Okwolalo Esther	Custodian and Counsellor .	Gulu District
	Agola Lilian	Prison Staff and trained BCA	Gulu District
	Ayet Joyce	Prison Staff and BCA	Gulu District
	Ocang	Nursing Officer , BCA	Gulu District
	Auma Jane	Prison staff	Gulu District
	Aciru Rose	Staff	Gulu District
	Obuku James	Staff and beneficiary	Gulu District
	Magalo William	Prison Officer and BCA	Gulu District
	Odubire Franscis	BCA	Gulu District
	Musubika Monica	Clinical Officer and BCA	Gulu District
	Akello Margaret	Staff	Gulu District
	Dawa Catherine	Health worker	Gulu District
	Otim James	Chief of Party NUMAT	Northern Region
Arua District			
	Masiga Patrick	Regional Prisons Commander	
	Waleera	Assistant Regional Police commander	ARUA District
	Iwanve Robert	OC Prison Arua	ARUA District
	Rita Dranziru	Social Worker Arua Prison	ARUA District
	Aremi Peter	CPL	ARUA District
	Dr. Anguzu Patrick	DHO	ARUA District
	Sr Esatu Angela Edami	Police Clinic Nursing Officer in charge	ARUA District
	Sr Kareo Rose	ASP Arua nurse	ARUA District
	Andezu Keezi	Midwife Arua	ARUA District
	Abima Justo	CPL	ARUA District
	Aiiorwoth Onen Beatrice	Asst. Matron	ARUA District
	Chandia Beatrice	In charge Wards	ARUA District
	Nyakuni Nazarene	IP- Chairperson TAJIKU	ARUA District
	Andezu Kezzi Blick	Police officer	ARUA District
	Ngamta Flavia	Police constable	ARUA District
	Anguzu R Francis	PC	ARUA District
	Bako Lilian	Police officer/BCA	ARUA District
	Kareo Rose	AIP/BCA	ARUA District
	Amaruma John Bosco	CPL/BCA	ARUA District
	Alonzi Phillian Samuel	Sgt/BCA	ARUA District
	Ocita Yona	AIP/BCA	ARUA District
	Ocokoru Grace	AIP/BCA	ARUA District
	Drati Fredrick	D/AIP/BCA chairperson	ARUA District
	Oyoma A Florence	W/PC/BCA	ARUA District
	Anguyo Candiru Solome	BCA	ARUA District
	Abuko Gladys	Deputy Principle	ARUA District
	Tabeya Harriet	Spouse	ARUA District
	Letaru Christine	"	ARUA District

	Likicho Mary	"	ARUA District
	Linda Christine	"	ARUA District
	Achan Sharon sheillah	"	ARUA District
	Nabatanzi Judith	"	ARUA District
	Kanyunyuzi Diana	"	ARUA District
	Kamuli Beatrice	"	ARUA District
	Mutesi Diana	"	ARUA District
	Tayebwa Agnes	"	ARUA District
	Candiru Caroline	"	ARUA District
	OyellaJannet	"	ARUA District
	Aciro Eunice	"	ARUA District

JINJA DISTRICT			
	ASP Omara	Clinical Officer,	Jinja Police
	Grace Obeti	Clinical Officer Kirinya Prison	0712862224
	Emmanuel Kafeero	AIC, Jinja	Jinja District
	Kim Bwayo	D/CAO Jinja	0776597365
	Namutosi Sarah	BCA Police	Jinja District
	Epila Eunice	BCA Police	Jinja District
	Aje Mary	BCA Police	Jinja District
	Namboze Precious Sanyu	BCA Police	Jinja District
	Edema Jane	BCA Police	Jinja District
	Akenda Simon	BCA Police	0773840053
	Amuge Agnes	BCA Police	Jinja District
	Namulinda Irene	BCA Police	Jinja District
	Asimo Caroline	BCA Police	0785839375
	Anyait Janet	BCA Police	0784258583
	Achen Miriam	BCA Police	0778232126
	Nambogo Veronica	BCA Police	Jinja District
	Chebotibin Violet	BCA Police	Jinja District
	Nakirya Eva	BCA Police	Jinja District
	Swaha Martin	BCA Police	Jinja District
	Agwaya Samuel	BCA Police	Jinja District
	Adamba Jacinta	BCA Police	Jinja District
	Kozaala Livingstone	BCA Police	Jinja District
	Mugala Petwa	BCA Police	Jinja District
	Acen Grace	BCA/VHT/Peer Educator Police	Jinja District
	Agwang Marion	BCA Police	Jinja District
	Kakande Agnes	BCA Police	Jinja District
	Omiel Susan	BCA Police	Jinja District
	Naluyima Hadijah Mutyaba	BCA Prison	Jinja District
	Niwamanya Ivan	S&D Champion Prison	Jinja District
	Kushemererwa Owen	BCA Prison	Jinja District
	Ssentongo Joseph	BCA/S&D Champion	Prison
	Natukunda Judith	BCA	Prison
	Emuget Charles Ojackol	BCA/ S&D champion	Prison
	Okullu Martin	BCA	Prison
	Odyew Pius	BCA	Prison
	Amajo Pauline	BCA	Prison
	Omviru Florence	BCA/S&D Champion	Prison
	Iwutung Robinah	BCA/ S&D Champion	Prison
	Olupot Samuel	S&D Champion	Prison
	Kamaala Ngobi Herbert	member	TAAG
	Namusisi N.Joan	member	TAAG
	Kitakule N. Hassan	Chairman	TAAG
	Nambi Caroline	Secretary	TAAG
	Abalirya David W	member	TAAG
	Musubika Vicencia	member	TAAG

BUGIRI DISTRICT			
	Cpl Wanjala Sam Obwete	Staff, BCA	Police
	AIP Mungecha HM	CLO/ BCA	Police
	Oketcho Dedderio	I/C outpost / BCA	Police
	Najjuko Juliet	Staff, BCA	Police
	AIP Namuyonga Judith	CID /BCA	Police
	Amali Florence	STAFF/MCB	Police
	W/AIP Nabirye Christine	Ass/ OC Medical	Police
	SP Magooba Annet	Sector Coordinator	Police 0772413059
	D/AIP Igodobe Paul	Member PHA	Police
	D/W/CPL Namutosi Rachel	Anti-corruption/ BCA	Police
	Rose Mutesi	OC Prison	Prison / 0772872671
	Mwerero Abdul	Staff/ BCA	Prison
	Komugaso Jolly	BCA	Prison
	Naigaga Christine	BCA	Prison
	Baliraine Abdu	BCA	Prison
	Masiga Samuel	BCA	Prison
	Namukwana Florence	BCA	Prison
	Mutesi Joy	Staff/ BCA	Prison
	Chief Ilweku Elisha	Staff/ BCA	Prison
	Okware James	D/OC Prison/BCA	Prison
	Nyuliyedi Juliet Betty	Child	Prison
	Kwagala Rachel	Child	Prison
	Mutesi Alice	housewife	Prison
	Namukwana	housewife	Prison
	Omusudutu		Prison
	Ninsiima Anna	housewife	Prison
	Nalongo Lucy	housewife	Prison
	Ssanyu Rachel	child	Prison
	Namulondo	housewife	Prison
	Tasumba Barbra	housewife	Prison
	Philip		Prison
	Esther		Prison
	Omoding		Prison
	Kampi Catherine	housewife	Prison
	Emenyu C	Staff/ BCA	Police
	Nabalayo E	Housewife/ BCA	Police
	Magara Dominic	Staff/BCA	Police
	ASP Kalikolaki Amisi	Staff/ BCA	Police
	d/cpl Wanyama S.Charles	Staff/ BCA	Police 0772330934
	Naigaga Mariah	Spouse/ BCA	Police
	W/SGT Nakaweke Monica	Staff/ BCA	Police/ 0772430023
	Muteguya Benjamin	Staff/ BCA	Police/ 0774885437
	Nampala K.Simon	Staff/BCA	Police
	Dr Nakendo Abubakeri	Ag MS, Bugiri Hospital	
	Butanda Shafiq	Focalpoint person	0701510051
	Dr Kiirya Stephen Bulolo	DHO, Bugiri	0772432918
	Mubballeh Ally Abdallah	Sec Mobilisation	TAAG
	Nandutu Esther M	Chairperson	"
	ARIOKT Mary Awoori	member	"
	Basirika Sarah	treasurer	"
	Hasahya Mary	member	"
	Nabwire Were Beatrice	coordinator	"
	Luvaluka Irene	member	"
MBALE DISTRICT			
	Wandwasi Robert	Focalpoint person	0772639774
	Wamburu David	A/CAO	
	Sam Wananda	Branch Manager AIC	0772622040
	Rhoda Buyinza	Clinical Officer	Prison 0782006378

	Amusolo Faith Norah	Student, Community Mob	Prison
	Achiro Josephine	BCA/ CM	Prison
	Akoko Florence	CM	Prison
	Kajoina Rose	CM	Prison
	Mono Kevin	CM	Prison
	Nakombe Aidah	CM	Prison
	Mugide Jesca	CM	Prison
	Ukija Clara	CM/ BCA	Prison
	Akol Gilbert	S&D Champion	Prison
	Dr Francis Abwaimo	SDS Programme	0772415913
	Simon Zabwe	Star East, Mbale	0782 356612
	Lucy Amango	TASO	
	Ocheng Ronald	TASO	
	Jane Tushabe Mpiima	RC Eastern, SPEAR	0392 946073
	Francis Oundo	Technical Associate, SPEAR	
	Mudukoya Augustine	Regional Manager, Eastern	Saracen 0777 341264
	Beatrice Khanakwa Mutenyo	secretary	TAAG
	Nabwire Teopista	treasurer	TAAG
	Busiku Patrick	member	TAAG
	Wataka James	PHA Coordinator	TAAG
SOROTI DISTRICT			
	Amodoi Martin	DHE/ Focalpoint person	0772591788
	Aupal Dominic	DHI	
	Sam Alutya	Ass Counselling Coordinator	TASO
	Ojera Morris	Staff/ BCA	Prison
	Ocen Peter	Staff	Prison
	Abala Camilo Don Charles	Staff	Prison
	Akurut Joyce Mary Agoda	Staff	Prison
	Akonyu Ketty	Staff/ BCA	Prison
	Christine Ejolu	BCA /Nurse	Prison
	Cherukut Leonard	Staff /BCA	Prison
	Ogwal William	Staff /BCA	Prison
	Harriet Ojera (mrs)	Housewife	Prison
	Apolot catherine Rose	Staff/ BCA	Prison
	Aluko Zaitun	Sec Mobilisation	TAAG
	Apio Anne Mercy	member	TAAG
	Apedun Agnes	Member	TAAG / 0775226152
	Opiane Sam	Assistant Chairman	TAAG
	Amongin Jenifer	member	TAAG
	Olinga Micheal	member	TAAG
	Ilenyot Jennifer	Ag DIS	TAAG
	Akalo H.Barbara	Chairperson	TAAG
	Aruto Angela	Sec	TAAG
	Apolot Alice Olinga	member	TAAG
	Apuret DD	Member	TAAG
	D/IP Egwang Micheal	Chairman PHA/ BCA	Police
	D/SGT Apiso Susan	BCA	Police
	D/SGT Othira Stella	BCA	Police
	W/IP Adong Florence	BCA	Police
	W/AIP Ayoro Joyce	BCA	Police
	Ililaip Idoto	BCA	Police
	Peter Ewadu	P/O BCA	Police barracks
	Akello eatrice	D/O BCA	"
	Amuso Regina	P/O BCA	"
	Joseph Asiat	Wife/ P/O	"
	Nantume Naume	P/O PMTCT	"
KATAKWI DISTRICT			
	Amecu Francis	DHE/ Focalpoint person	Katakwi District
	Andrew Adakun	D/ OC Prison	

	Walimbwa	Clinical Officer, ASTU	0772 524673
	Thomson Ogole	Commandant, FFU	
	ARIOKOT Juiet	member TAAG	/ 0787252285
	Adome James	MEMBER TAAG	07734922
	Apiny Florence	Member TAAG	0775166534 / 075151453
	Achieng Carolyn	Member TAAG	0773086152
	Iripoit Stella	Member TAAG	0772987664
	Atuko Jane Frances	Member TAAG	0759661814
	Arukol Mary	Member TAAG	0781733710
	Omugur Gelasio	Member TAAG	0774020742
	Olinga John	Member TAAG	0782254916
	Apuda Emmanuel	Member TAAG	0712048275
	Odokocan E.R	Member TAAG	0775975558
	Iningo Alfred	Member TAAG	0753456548
	Ateria Micheal	Member TAAG	0782492937
MASAKA DISTRICT			
	Juliet Mayanja	Ag D/CAO	Masaka District
	Baptista Mulindwa	HM representing DEO	Masaka District
	Miwanda Jamil	Sec Social services	Masaka District
	Nakanwagi Olivia	Focalpoint person	0772641594
	George Oriokot	Centre Coordinating Tutor	Kalungu 0772938652
	Nabwire Daisy	Clinical Officer I/C South	Prison 0779222129
	Kamya Joshua	Medical staff (N/O/P)	Prison
	Wansadha A.B. Simon	OC	Prison
	Nakanwagi Betty	Receptionist	Prison
	Nkamwesiga Frank	BCA	Prison
	Kibuule Gerald	BCA	Prison
	Musa Muwonge	Clinical Officer I/C South	Police 0772337301
	Jackson Wafula	ROM Southern, WVU	Masaka
	Sheila Kyobulungi	Ag RC SPEAR Southern	0772309003
	Migadde Vincent	Member TAAG	Education Masaka
	David Akamuha	Member TAAG	Education Masaka
	Nandawula Kigongo	Member TAAG	Education Masaka
	Kaate Matovu Theopista	Member TAAG	Education Masaka
	Mutebi Charles	Member TAAG	Education Masaka
	Nakitto Jesca	Member TAAG	Education Masaka
	Ssekandi Ronald	Member TAAG	Education Masaka
	Nabulya Maurice	Member TAAG	Education Masaka
	Naula Juliet	Member TAAG	Education Masaka
	Nakalema Rosemary	Member TAAG	Education Masaka
	Nakuya Lucy	Member TAAG	Education Masaka
	Odoch John Odongtoo	Lab Ass / Police Clinic	Masaka District
	Bazibu Joseph	Police Officer (P/O)	Masaka District
	Muwonge Musa	P/O MCO	Masaka District
	Kamya Paul	Office clerk	Masaka District
	Ocha George	Training Officer	Masaka District
	Bwayiga Milly Grace	Registered Nurse	Masaka District
	Musiime Julius	CLO asaka CPS	Masaka District
	Obua Tonn Blair		Masaka District
	Opio Alfred		Masaka District
	Ssekiwunga John Bosco	New Ug Guard	Masaka District
	Amisi Mutegeki	Supervisor New Ug Guard	Masaka District
	Madaya Micheal	Supervisor New Ug Guard	Masaka District
	Ocen Jimmy	Supervisor New Ug Guard	Masaka District
	Nalugya Jessica	P/O	Masaka District
	NSEREKO John Paul	P/O	Masaka District
	Ssemanda Godfrey	P/O	Masaka District
	Oleru Hellen	P/O	Masaka District

	Okiranyang Emmanuel		Masaka District
	Opira Allex	New Ug Guard	Masaka District
	Twinamatsiko Bosco	Police Officer	
MBARARA DISTRICT			
	Umar Maseruka	DHI/ Focalpoint person	Mbarara District
	Mbabazi Edward	DEO	Mbarara District
	Tusimireyo Johnson	DP	Mbarara District
	Tindisimwa Silva	Sen Distict Planner	Mbarara District
	Jack Masamba	HR	Mbarara District
	Okuku Francis	Chairman BCA	Prison
	Victoria Nahiyema	I/C Clinic	Prison
	ASP Namakuye Harriet	OC Women Prison	Prison
	Teddy Namakula	Sen Clinical Officer	Prison
	Conkal Betty	Staff/BCA	Prison
	Okumu Hellen	Housewife	Prison
	Ochwo Betty	Housewife	Prison
	Nerima Ritah	Staff/ BCA	Prison
	Kyomugisha Medius	Staff/ BCA	Prison
	Bainomugisha Mary		Prison
	ASP Polly Namaye		Police
	Nerima Jesca	Staff / S&D champion	Police
	Byabagambi Norah (mrs)	Midwife	Police
	Petwa Mwesigwa (mrs)	wife	Police
	George Mwesigwa	Staff	Police
	Asiimwe Jane	Staff	Police
	Musinguzi		Police
	Nyanda Erick	P/O	Police
	Cate Mwesigye	Wife	
	Ndyanabangi Steven	Staff	Police
	Nalongo	Staff	Police
	Prasidia Owembabazi	Clinical Officer MJAP	
KABALE DISTRICT			
	Besigye K Patrick	C/M LC V	Kabale District
	Nalongo R Kampereza	Sec Health	Kabale District
	Kalama Ali	Sec Works	Kabale District
	Mary Bebaziba	V/ CM	Kabale District
	Maurice	HIV Focal point person	Kabale District
	Kanagizi Flavia	Dep Speaker	Kabale District
	Nzirimana	DEO	Kabale District
	Pastoli Twinomuhangi	District Speaker	Kabale District
	Byamugisha Geoffrey	Sec Education	Kabale District
	Twesigye Flora	Teacher / TAAG	Kabale District
	Arigye Ambrose	Teacher / TAAG	Kabale District
	Turyamusiima Sam	Teacher / TAAG	Kabale District
	Tusimomwe Teddy	Teacher / TAAG	Kabale District
	Kijunguri Silvertoris	Teacher / TAAG	Kabale District
	Asiimwe Alfred	Teacher / TAAG	Kabale District
	Barugahare Moses William	Teacher / TAAG	Kabale District
	Tussime Allan	Teacher / TAAG	Kabale District
	Tumuhairwe Pelly	Teacher / TAAG	Kabale District
	Mugarura Hudson	Teacher / TAAG	Kabale District
	Tugume Juliet	Midwife/ BCA	Prison
	Sanyu Agatha	BCA	Prison
	Isingoma Peter	Staff/ BCA	Prison
	Kugonza Adolf	Staff/ BCA	Prison
	Turyahikayo Ambrose	Staff/ BCA	Prison
	Adong Susan	Staff/ BCA	Prison

	Ajalo Joyce	Staff/ BCA	Prison
	Anna Tumwebaze	Staff/ BCA	Prison
	Mutaka James Dennis	Staff/ BCA	Prison
	Owomugisha Vivian	CHILD	Prison
	Turyakira Frank	HIV / AIDS	Police
	Katumwijukye Alex	Coordinator	Police
	Twinomuhwezi G		Police
	KaanaWilly	P/O BCA	Police
	Agaba Hardrick	BCA	Police
	Abihire Frank	BCA	Police
	Tukirina W	BCA	Police
	Mbabazi Hexisty	BCA	Police
KABAROLE DISTRICT			
	Kwanya Wilson	RPC Western, Police	Kabarole District
	Dr Richard Mugahi	DHO	Kabarole District
	Bagambaki Peter	D/ CAO	Kabarole District
	Tumuhimbise Gervase	OC representing RPC	Kabarole District
	Moses Ikagobya	Sec Health LC V	Kabarole District
	Mpuga Hosea	DHE/ focalpoint person	Kabarole District
	Kunihira Janepher	Secretary TAAG	Kabarole District
	Nakyeyune Grace	member TAAG	Kabarole District
	Kobusingye Harriet	Member TAAG	Kabarole District
	Muhumuza Francis	Member TAAG	Kabarole District
	Komuhancu Sylvia	Member TAAG	Kabarole District
	Namazzi Gertrude	Mobiliser TAAG	Kabarole District
	Baguma John	vice c/person TAAG	Kabarole District
	Muhumuza Edward	Mobiliser TAAG	Kabarole District
	Kemigisha Rose	Member TAAG	Kabarole District
	Manyindo Benburn	Member TAAG	Kabarole District
	Mbabazi Edith	secretary finance TAAG	Kabarole District
	Kihamba Joseph	DPC, Police	Kabarole District
	Kabayaga Beatrice	Clinical Officer/ Coordinator HU	Prison
	Katusabe Jacintah	CM	Prison
	Karungi Sarah	CM	Prison
	Nkamushaba Mercy	CM	Prison
	Ateo Chrisine	CM	Prison
	Angwech Winnie	CM	Prison
	Mbabazi Mable		Prison
	Kayumba Mary	CM	Prison
	Musinguzi Evassy	CM	Prison
	Beitasya Dorothy	BCA/ Teacher	Prison
	Ondoa Florence	CM	Prison
	Grace Idaa	CM	Prison
	Driwaru Scovia	CM	Prison
	Mwanga Issa	BCA	Prison
	Laker Jackline	BCA	Prison
	Sharon Nakanwagi	RC Western, SPEAR	WVU
	Arinaitwe Annalet	BCA	Police
	Namyalo Hadija	BCA	Police
	Mulawa Abdu	OC Station Kabarole	Police
	Kamugisha Joseph	Secretary / BCA	Police
	Ciriku Kanisto	BCA	Police
Kiboga District			
	Ms. Rhoda Nyakato	Prog. Manager	WV-Kiboga
	Scovia Nankabirwa	Prog. Asst	WV- Kiboga
	Lwamasaka Prosper	DEOprosperlw@gmail.com	0772456706,
	Mr. Nsubuga Patrick	PSWO, Sector Coordinator	Kiboga
	Ssebigaju John Jelly	Ag. PPO	Kiboga/0783258338
	Bigirwa Kaliisa Samuel	DCAO	0772659563

	Natunga Harriet	Police officer	0789349878
	Monday Florence	Police officer	
	Namisi Isaac	Police officer	0782516268
	Aliga Zachary	Police officer	Prisons/0772960893
	Kwikiriza William	Police officer	Prisons/0759941198
	Wandera Kennedy	Teacher	Kagobe p/s /0779762607
	Nakalema Mariam	Teacher	Lwamata SSS/0700445838
	Ssendege Moses	Teacher	p/s/0782911535
	Baagala Sarah	Teacher	0782896483
	Nakkazi Sarah	Teacher	0782311841
	Tuhaise Harriet Byakora	Teacher	Kagobe p/s/0777963047
	Kakooza Martin	Teacher	St. Andrews/0782122124
	Wamala Ivan	Teacher	St. Andrews/0773689473
	Namono Sarah	Teacher	Bamusuuta p/s/
	Oyuku George	Tutor	Bamusuuta p/s
	Mbaale John Patrick	Teacher	Kiboga DAS/0782689026
Hoima District			
	Mr. Ntulume	CAO – Hoima	Hoima District
	Nabwire Flavia	ACAO	Hoima District
	Byaruhanga Samuel	TAAG	Hoima District
	Ms. Nansiiti Rebecca	TAAG	Hoima District
	Mufumu Christopher	TAAG	Hoima District
	Ms. Abigaba Jackline	TAAG	Hoima District
	Ms. Kaahwa Flora	TAAG	Hoima District
	Ms. Nyamahunge Margret	TAAG	Hoima District
	Kunihira Julius	TAAG	Hoima District
	Tumusiime Janepher	TAAG	Hoima District
	Bigirwa Betty	TAAG	Hoima District
	Nakanwagi Sharon	Coordinator	sharonnakanwagi@yahoo.com
	Zondera Amon	District. Sports Officer	Hoima District
	Augustine Kasangahi	DPC Hoima	Hoima District
	Matua Alfred Otokira	Police officer	Hoima District
	Kyomuhendo Alice	Police officer	Hoima District
	Kalungi Blandibah	Police officer	Hoima District
	Ponji Dorothy	Police officer	Hoima District
	Katusiime Oliver	Police officer	Hoima District
	Matubua Avinzo Charles	Police officer	Hoima District
	Byenkya Fred	Police officer	Hoima District
	Kanyunyuzi Annet	Police officer	Hoima District
	Ayuru Grace	Police officer	Hoima District
	Nyakabandwa Beatrice	Police officer	Hoima District
	Mukaanga	Police officer	Hoima District
	Anena Betty	Officer/wife	Hoima District
	Kaseke John	Officer/wife	Hoima District
	Nagawa Samalie	Wife to officer	Prison/ 0714760709
	Tuhaise Everse	Student	
	Apiyo Jennipher	Housewife	0774596283
	Akao Susan Ongom	House wife	Prison
	Nuwabiine Provia	Officer/wife	0782349010
	Agondwa Lucas	Police Sector Coordinator	0782941551

ANNEX 3 : DETAILED BUDGET PERFORMANCES

Table 5 Budget Performance Summary Fy 2009

	Budget		Variance	
	Planned	**Expenditure**	Actual	%
Administrative Salaries	**593,932**	**614,571**	(20,639)	-3.46
Administrative Overheads	**459,308**	**402,875**	56,433	12.29
Direct Project Costs				
Policy	**61,765**	**154,628**	(92,863)	-150.35
Institutional capacity building	**27,794**	**66,269**	(38,475)	-138.43
Behavioral Change Communication	**318,235**	**308,881**	9,354	2.93
HCT and VCT services	**126,471**	**22,253**	104,218	82.4
Care & Treatment	**40,000**	**2,132**	37,868	94.7
Wrap around services	**450,000**	**378,522**	71,478	15.88

Table 6 : Budget Performance Summary Fy 2010

			Variance	
	Planned	Actual	Actual	%
Administrative Salaries	668,389	485,109	183,280	27.42
Administrative Overheads	371,621	221,165	150,456	12.29
Direct Project Costs				
Policy	176,638	112,641	63,997	36.23
Institutional capacity building	124,022	168,962	(44,940)	-36.24
Behavioral Change Communication	285,682	143,285	142,397	49.84
HCT and VCT services	**81,005**	**51,923**	29,082	35.90
Care & Treatment	53,995	3,947	50,048	92.69
Wrap around services	350,000	238,000	112,000	32.00
	2,111,352	**1,425,031**	**686,320**	32.51

	Fy 2010		Variances	
	Planned	Actual	Planned	Actual
Administrative Salaries	465,307	395,323	69,984	15.04
Administrative Overheads	284,653	157,768	126,885	12.29
Direct Project Costs				
Policy	176,638	169,517	7,121	4.03
Institutional capacity building	124,022	174,502	(50,480)	-40.70
Behavioral Change Communication	192,797	104,076	88,721	46.02
HCT and VCT services	146,480	128,426	18,054	12.33
Care & Treatment	58,400	22,360	36,040	61.71
Wrap around services	378,800	294,321	84,479	22.30
	1,827,097	**1,446,293**	**380,804**	20.84

ANNEX 4: SOME OF THE KEY DOCUMENTS CONSULTED

1. USAID Evaluation Standard guidelines
2. SPEAR Annual Report Fy 2008 to USAID
3. FINAL REPORT to USAID 2009
4. SPEAR Annual Report Fy 2010 to USAID
5. SPEAR Annual Report Fy 2011 to USAID
6. Formative Evaluation Report in Uganda Police Force
7. SPEAR Fy2010 report to USAID
8. SPEAR Q3 Report 2010
9. SPEAR Fy2010 report to USAID
10. SPEAR Quarterly Report Oct-Dec 2008
11. SPEAR Report Jan –March 2010
12. SPEAR Quarterly Report Jan –March 2009
13. SPEAR Quarterly Report Oct-Dec 2008
14. SPEAR Q3 Report
15. SPEAR Quarter 2 Jan –March Report 2011
16. 617 A 00-08-00015 Public sector Services
17. RFA 617 08-005 Public Sector HIV Services
18. Approved Workplans 11.2409
19. RFA
20. Public Sector Award
21. SPEAR FY 2011 Revised Work plans 2011 approved
22. SPEAR Q1 Report 2011
23. Report Oct-Dec 2008
24. SPEAR 3rd Quarter (April –June) 2011
25. Baseline Report
26. Formative Evaluation
27. Performance Monitoring Plan
28. USAID program and Financial reporting requirements
29. HIV/AIDS Work Place Policy , Government of Uganda, Ministry of Education and Sports
30. HIV/AIDS Work Place Policy , Government of Uganda, Ministry of Internal Affairs
31. HIV /AIDS Work Place Policy , Government of Uganda, Ministry of Local Government