UGANDA PROGRAM FOR HUMAN AND HOLISTIC DEVELOPMENT

UPHOLD

RAPID ASSESSMENT OF MONITORING AND EVALUATION NEEDS IN AIDS INFORMATION CENTER (AIC)

DRAFT REPORT

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Abbreviations

AIC	-	AIDS Information Center
ARV	-	Anti-Retroviral (Drugs)
CDC	-	Centers for Disease Control and Prevention
DDHS	-	District Director/Directorate of Health Services
FP	-	Family Planning
HIMS	-	Health Information Management System
M&E	-	Monitoring and Evaluation
MOH	-	Ministry of Health
PLI	-	Philly Lutaaya Initiative
PTC	-	Post Test Club
STD	-	Sexually Transmitted Disease
UPHOLD	-	Uganda Program for Human and Holistic Development
VCT	-	Voluntary Counseling and Testing

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Executive Summary

This report presents the results of a rapid assessment of the monitoring and evaluation (M&E) needs of AIDS Information center (AIC). The assessment aimed at establishing the current and future M&E needs in AIC that would have to be addressed to have a functional and effective M&E system. The assessment was conducted amongst staff of AIC at the headquarters and selected branches. Other participants included AIC partner organizations, districts, and staff of the health units supported by AIC to provide voluntary counseling and testing (VCT) services.

Key Findings

Overall, M&E in AIC is currently narrowly conceived in terms of routine data collection processing and analysis. The full application of the M&E function to the whole organization and to guiding decision-making and programming is still lacking. This however, should be understood in light of the fact that AIC has not been having an M&E department/unit and is still in the process of establishing one. Whereas AIC has a Strategic Plan, it lacks an M&E strategy or plan to guide monitoring and evaluation activities. In absence of this, AIC has no formal or documented M&E system.

The current M&E department in AIC has two staff in the positions of M&E Officer and Data Analyst. These work in close collaboration with Data Supervisors and Data Entry Clerks in branches. The existing capacity is inadequate both in terms of numbers and competences to fulfill the requirements of a fully functional M&E unit for an organization of AIC's type.

The key elements of AIC's M&E system include (i) a system of routine data collection on all services provide and all clients, (ii) monitoring and support supervision visits, (iii) quarterly review meetings, (iv) production of reports, (v) data feedback workshops, (vi) studies/surveys, (vii) and data bases.

The existing system for routine data collection in AIC has been functioning quite well and it has been providing much of the information that is required by AIC and its partners, especially on VCT. AIC has been able to produce regular reports about its work. A number of tools exist for purposes of collecting data on the various services provided. Most of the existing tools are quite comprehensive. There is concern about the length of the VCT client card, which is the most used tool. With about 60 questions under the registration and counseling sections of the card alone, most counselors find it time consuming and laborious to fill for every client, especially when they are very busy or when

they have many clients to see. This issue has been partly contributory to improper filling of the cards, especially in the indirect sites, watering down the quality of data collected.

There are other concerns about the system for routine data collection, processing and analysis. Processing of the collected data is characterized by a huge workload for data entry in branches that oversee many indirect sites. Coupled with delayed submission of data from the indirect sites, the process of centralized data entry translates in some delays in reporting and submission of data to headquarters. The system is not strongly linked to the government HIMS and tends to bypass the district, raising questions of local ownership and sustainability.

The other elements of M&E are generally good mechanisms, but they also have a number of limitations. Support supervision that were initially planned to be monthly have reduced in frequency and currently there seems to be no schedule for such visits. Whereas quarterly and annual reports are produced as scheduled, they are largely statistical (do you mean numeric?) and do not include sufficient analysis and interpretation (do you want to see more of a qualitative element in the reporting?) to guide programming. Some specific studies have been undertaken, but there is need for more of such studies to produce findings that cannot be captured through routine data collection. Feedback systems to the districts and sites exist mainly in form of annual data feedback workshops and copies of reports, but these are not sufficiently user-friendly. Quarterly review meetings are more focused on reporting progress, with little time to dissect issues that need action.

Incremental improvements have already been carried on this system especially with support from CDC, in areas of establishing the Local Area Network, refining data collection tools, creating data entry systems, training of laboratory staff, and developing guidelines. CDC is also to support development of online computer registration of clients.

Recommendations

Overall, the system needs to be more focused on linking the different components of the organization, and guiding programming. There is scope to improve AIC's M&E system by tackling the capacity of the M&E unit, improving the tools, translating data into meaningful reports, and promoting better use of information for planning and decision making at all levels.

The M&E system that AIC requires is one that will enable the organization to track the progress of its work, measure the impact, and utilize this knowledge to

inform and improve programming. Overall, AIC needs to move away from the narrow definition of M&E in terms of routine data collection, to a broad function of monitoring all the elements of the organization including the financial resources, human resources, service delivery to beneficiaries and capacity building of districts (Inputs, outputs, outcomes and impact evaluation). The process of building an effective and efficient M&E system should start by posing the question; "What information is needed and for what purpose?

The specific recommendations include the following:

Develop an M&E Plan – AIC should develop a monitoring and evaluation plan that sets out the M&E framework, including the activities, tools, indicators, and time schedules. The M&E plan should be in part of or at least in harmony with the strategic plan and should enable monitoring of the implementation of the strategic plan as a whole.

Identify/refine Indicators – AIC should revisit the indicators being monitored, categorise them according to their strength, and specify the time period by which they are to be measured. Indicators should capture both quantitative as well as qualitative measures. They should also capture broader aspects of AIC work such as building district capacity.

Build human capacity of M&E Department – The human capacity of the M&E department should be strengthened to meet the increasing needs for stronger M&E. The department needs to acquire more skills in specific aspects of M&E, such as report production, more rigorous interpretation of data, and application of monitoring and evaluation results to programming. This can be done through hiring a consultant/technical advisor to work with the M&E office for a period of time, recruiting at least one more staff with extensive experience in M&E issues, short-term training courses for M&E staff, exposure to the M&E systems of organizations involved in similar work, and contracting out specific M&E functions.

Pilot data entry at District/Site level in order to decentralize this process and build capacity – AIC should identify districts and sites that may be ready to take up data entry, and then support them to do it themselves – initially with close support supervision.

Improve Data Collection and Monitoring Tools – In view of the current problems in filling the VCT card in the indirect sites and the attendant problem of data quality, AIC should revisit the VCT data card to make it shorter, simple and more user-friendly. Options include using a shorter card (with fewer

variables) in the indirect sites, while the long card is maintained for the main branches. Another option is to use a shorter card in all the sites including branches, and then administer a longer card at certain intervals of the year to collect comprehensive data for research purposes.

There is need to adapt the existing tools to suit the various contexts in which VCT will be provided in future. There is also need to develop tools for monitoring and support supervision visits.

Re-orient service providers/data collectors – There is need to reorient service providers involved in data collection on the importance of accurate and timely data.

Feedback Mechanisms – AIC should put in place other feedback mechanisms to stakeholders in addition to the feedback workshops and quarterly reports. These could include summaries capturing key indicators and/or trends in key indicators produced on a monthly/quarterly basis per site/district.

Specific studies/surveys – AIC should provide for and build capacity for initiating and conducting specific studies on issues of interest such as following up people that have gone through the testing, KAP surveys, mid-term reviews, documentation of best practices, lessons and success stories, testing implementation strategies, evaluating performance of certain interventions, repeat testing and couple counseling.

Target/Support information Integration in the Medium/Long Term – UPHOLD and other funding partners should support efforts that can work towards integration and harmonization of the various information systems on HIV/AIDS used by different actors in the medium and long term. Such support may include financing and or providing joint technical assistance to MOH, AIC, UAC, TASO and other key actors in the area of VCT or HIV/AIDS in general.

Develop Systems for Monitoring Inputs – The use of inputs such as staff, financial resources, vehicles, and testing kits should be regularly documented and linked to the M&E function, such that their use is assessed against the outputs they help to produce.

Provide for on-going support to cater for emerging needs – In addition to actions that may be implemented once to improve the M&E system, there is need for continuous support to M&E responding to emerging needs and demands from the M&E personnel themselves. Such support has been

available to AIC from CDC. UPHOLD should work closely with CDC to ensure this type of support continues.

1 INTRODUCTION

1.1 Background

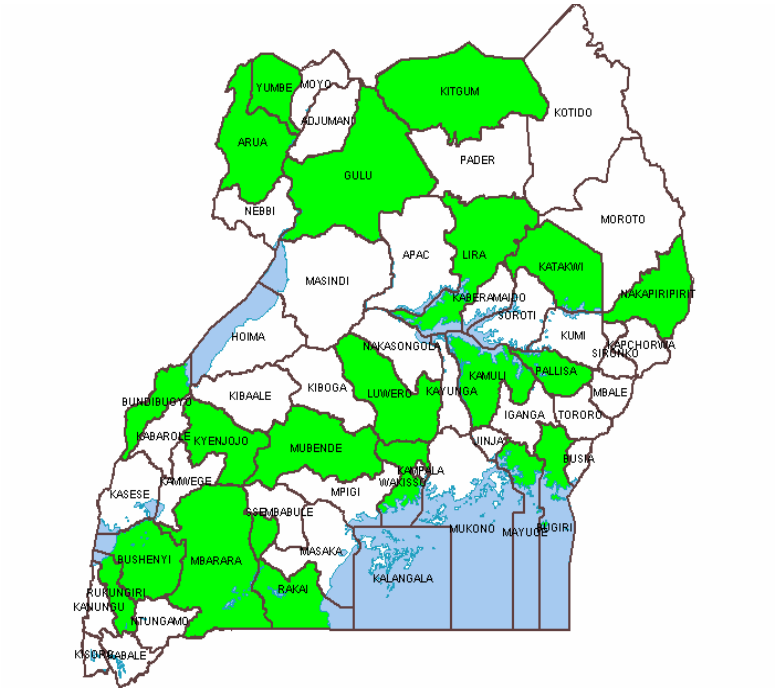
AIDS Information Centre (AIC) is a non-governmental organization established in Uganda in 1990 to provide Voluntary Counseling and Testing (VCT) services and general information on HIV/AIDS. AIC is currently one of the major providers of VCT services in Uganda and sub Saharan Africa. AIC is funded by a number of donors including USAID through The Uganda Program for Human and Holistic Development (UPHOLD).

UPHOLD is a 5-year (2003 – 2007) bilateral program funded by USAID under the Strategic objective 8 (SO8) results framework with the mandate to improve quality, utilization and sustainability of services delivered in three areas of Health, Education and HIV/AIDS in an integrated manner. Strategic behavior centered approaches including behavior change communication, quality assurance, and working with private sector represent cross cutting priority areas for UPHOLD for intervention in these service areas. UPHOLD has a mandate to oversee AIC operations including support in overall organizational development. UPHOLD through its Grant Strategy supports AIDS Information Centre (AIC) with an objective of expanding HIV/AIDS prevention, care and support services.

AIC provides voluntary counseling and testing for HIV/AIDS, and a number of related services, including syphilis testing and management of all sexually transmitted diseases (STDs), family planning, tuberculosis (TB) management, Post Test Club/Philly Lutaaya Initiative (PTC/PLI), and training of trainers and providers of in VCT and related services.

AIC offers VCT services through 8 main branches, selected hospitals, health centres, and antenatal clinics currently totaling up to 138 sites. Its operations reach 33 out of 56 districts (~ 60% coverage) in Uganda – a map showing these districts (see illustration below) could be a useful addition to this report AIC's branches include Kampala, Jinja, Mbale, Mbarara, Arua, Lira, Soroti and Kabale.

Figure 1: Map showing districts covered by AIC in Uganda (illustrative)



AIC has progressively been expanding its services both geographically and in terms of technical scope. It has recorded significant achievements in as far as contributing to national targets in VCT service delivery are concerned. In the course of this growth, AIC has also encountered a number of challenges, both real and potential, in as far as strengthening its institutional capacity is concerned. AIC collects, analyses and reports on different categories of data as reflected in the services that they offer. With the amount of work and organizational expansion that AIC is experiencing, it has become increasingly important for AIC to not only collect data for reporting but have an institutional mechanism for building staff capacity to manage and use data for better planning, decision making and sharing among stakeholders.

There was therefore need to establish the kind of needs that AIC might have to address in order to respond to its internal information needs as well as those of its different stakeholders/partners.

1.2 Purpose of the Needs Assessment

The purpose of this needs assessment was to establish current and future M & E needs in AIC that would have to be addressed to ensure a functional and effective M & E system in the organization. The assessment was intended to generate recommendations as an input into the process of enhancing AIC's M & E system,

and ultimately strengthen AIC's organizational efficiency and effectiveness. The results of this study are therefore to feed into a more detailed scope of work for establishing an M&E system for AIC.

1.2.1 Objectives

1) To describe strengths and weaknesses of the AIC M&E system
2) To make specific and practical recommendations for strengthening AIC's M & E system.

1.2.2 Specific Tasks

The following tasks were to be accomplished:

- Review relevant documents such as the strategic plan, the current AIC M&E strategy/plan, PWC report and Quarterly reports.
- Review and refine the existing tools and develop a schedule for assessing the M & E needs and discuss with UPHOLD/AIC through a participatory approach.
- Assess the M&E needs of AIC - including visiting at least 3 AIC branches and 3 indirect sites.
- Write a draft report emphasizing the current and future M & E needs, and providing recommendations for a more detailed scope of work for establishing an M & E system for AIC.
- Make a presentation to AIC, UPHOLD and other stakeholders.
- Compile final report based on the comments provided by stakeholders.

1.3 Study Process and Methodology

1.3.1 Overall Approach and Design

The assessment was conducted using a participatory rapid assessment approach. The methodology and tools were discussed with UPHOLD and AIC, and initial consultations were held with both organizations to reach a common understanding of the expected outcomes of the exercise. Data collection involved consultations with different categories of people that are in one way or another involved in AIC's monitoring and evaluation activities.

1.3.2 Study Sites and Study Participants

The assessment was carried out at AIC headquarters in Kampala, and the branches of Kampala, Jinja and Mbale. Three indirect sites under the Mbale region were also vited (Mukuju Health Centre IV, Busiu Health Centre IV and Pallisa Hospital), and two indirect sites under the Jinja region were visited (Kamuli Health Centre and Buwenge Health Centre IV). Partners of AIC including districts, the Ministry of Health, UAC, UPHOLD and CDC were also consulted. Could you please include some rationale on why these sites where chosen amongst all the other sites?

Participants in this assessment included the following:

- AIC staff at headquarters including the Executive Director and department heads,
- Branch staff in Kampala, Mbale and Jinja, including the Branch Managers, department heads, and service providers
- In Charges, site supervisors and service providers in the sample indirect sites
- District staff in Jinja, Mbale, and Pallisa, including the DDHS and District VCT Coordinators
- AIC Board members and members of the Regional Advisory Committees (RACs)
- Staff of partner organizations including UPHOLD, TASO, UAC, CDC and MOH

1.3.3 Data Collection

Data was collected using qualitative methodologies, which included unstructured interviews, documents reviews, and meetings with staff.

1.3.4 Data Processing and Analysis

Much of the data from this assessment was in textual form, resulting from interviews, meetings and document reviews. This data was manually processed and analyzed to bring together the key issues that address the objectives of the study. To go through this process, a framework of analysis was conceived, that involves the following considerations:

- Consideration of AIC's mandate, its mission and vision and the services it provides to fulfill its mandate
- The context in which AIC operates, including the government health system, government policy, the presence of other actors that provide similar services, and the position and influence of donors

- The attributes of AIC's current M&E system, including its major elements, strengths and weaknesses
- Analysis of AIC's current M&E system in terms of theoretical features of a good M&E system such as a functional M&E department; clear goals, strategies and guidelines; clear indicators; a system for data collection and analysis including tools; and a system for data use, feedback and dissemination (WHO et al, 2004).
- Consideration of emerging developments in the VCT sub-sector and AIC's future direction and implications thereof for M&E
- Identification of needs and drawing of recommendations for strengthening M&E in AIC

1.4 Scope and Limitations of the Study

The results of this assessment should be understood in light of its scope. This assessment was not intended to develop an M&E system for AIC, but to identify existing strengths, gaps and needs that should form a basis for building an M&E system. Secondly, this assessment did not attempt to do a full survey of all the AIC branches and sites. The assessment reached only a few branches and sites on the premise that most of the issues that the study was interested in could be adequately discerned from such a sample of sites and branches.

1.5 Organization of this Report

This report is organized into three sections. The first section has outlined the background, objectives and methodology of the assessment. The second section will discuss the results of the assessment, pointing out the identified strengths and weaknesses of the AIC M&E system. The third section makes recommendations for strengthening the M&E system.

2 FINDINGS OF THE NEEDS ASSESSMENT

2.1 Introduction

This section presents the results of the needs assessment which derive from the consultations and interviews held with different stakeholders and from the review of relevant documents. The section begins a brief context analysis and then proceeds to provide a description of the M&E system that currently exists in AIC, including its strengths, weaknesses and areas that need improvement.

2.2 The Mandate of AIC

The mandate of AIC as derived from its mission statement is 'to prevent the spread of HIV and mitigate its impact by being a model of excellence in the provision and expansion of voluntary counseling and testing, information and education, and the promotion of care and support'. AIC's vision is 'to have an environment in Uganda where individuals feel free to have VCT, can access the service promptly, and at an affordable cost'.

To fulfill this mandate, AIC provides a number of services which include the following:-

i) Voluntary Counseling and Testing (VCT for HIV/AIDS).
ii) Syphilis Testing and Management of all Sexually Transmitted Diseases (STDs)
iii) Family Planning
iv) Tuberculosis (TB) Management
v) Post Test Club/Philly Lutaaya Initiative
vi) Training in counseling, laboratory HIV/STD screening, PMCT, and drama

As will be pointed out later in this report, the scope of services provided by AIC is likely to change in future. The M&E needs of AIC must therefore be considered in terms of the current services provided, as well as those that may be provided in future.

2.3 The Context of AIC Work

Before discussing the M&E aspects of AIC's work, it is important to highlight some important elements about the context of AIC's operations. First, AIC is the leading provider of VCT services in the country. However, there are other providers, mainly consisting of NGOs, youth programmes, and government health units some currently supported by the AIDS/HIV Integrated Model District program (AIM). The MOH and the UAC are responsible for the overall coordination of all HIV/AIDS

interventions in the country, as well as aspects of overall monitoring and evaluation.

Secondly, much of the VCT provided by AIC takes place in health facilities that are not directly under the control of AIC. These are mainly government health units, under the responsibility of districts. The indirect sites number up to 138 compared to only 8 sites under the direct control of AIC.

Thirdly, AIC is facing increasing demand for VCT services. Many parts of the country are not accessible to a testing site, and even the existing sites are not adequate to cover the population in their current jurisdiction.

Fourthly, various changes are taking place in the provision of VCT, including introduction of new VCT models, such as home-to-home, the Mobile Van, and introduction of related services such as PMTCT and ARV administration. All these factors have a bearing on the M&E needs of AIC and its partners. These factors will be revisited in the discussion of the M&E system that follows.

AIC's activities are currently funded by a number of donors including USAID (through UPHOLD), European Union (EU), Centers for Disease Control and Prevention (CDC) and the UK Department for International Development (DFID). Funding from these partners constitutes more than 90% of AIC's total budget of between $ 5-6m per year. AIC raises some funds locally through cost-sharing and charges for services. Some of the funding partners, particularly CDC and UPHOLD have also provided technical and organizational support to AIC in addition to funding.

2.4 Description of the Current Monitoring and Evaluation System in AIC: Strengths and Weaknesses

2.4.1 The M&E Framework

The Strategic Plan (April 2004 to June 2006)

The strategic plan provides the broad framework within which all the activities of AIC are premised. From the strategic plan, annual work plans are formulated. The strategic plan also provides a basis against which funding is provided by the different funding partners. The strategic plan states the vision, mission, strategic goal, core values, priority issues, objectives, and strategies. In this way, the strategic plan should be an important framework for the monitoring and evaluation system, serving both as a basis for M&E but also articulating the M&E plan.

However, there are some gaps associated with the current strategic plan. Whereas the strategic plan is supposed to contain the monitoring and evaluation plan that outlines the procedures and processes that will be undertaken to track progress and measure change, this is missing in the current strategic plan document (Revised Strategic Plan April 2004 to June 2006). In addition, the strategic plan is supposed to have a logical framework that shows the planned activities against the indicators and inputs. This is also missing. Whereas some ideas on M&E and a log frame were included in the older version of the strategic plan, nevertheless, they were not sufficiently articulated. In absence of an M&E plan and a log frame, it is difficult to undertake systematic monitoring and evaluation. In addition, the strategic plan has not been fully utilized to guide implementation.

Related to the strategic plan are the annual work-plans. These also are not sufficiently based on previous performance and experience.

2.4.2 Key Elements of the M&E System in AIC

AIC's monitoring and evaluation system consists of the following elements:

(i) Routine collection, entry and analysis of data on different services provided by AIC
(ii) Monitoring and support supervision visits
(iii) Quarterly Review Meetings
(iv) Production of Reports (activity reports, quarterly reports and annual reports)
(v) Data Feedback Workshops
(vi) Studies/surveys
(vii) Data bank/data bases

These elements are elaborated below, highlighting their strengths and weaknesses:

Routine Data Collection and Analysis on Services Provided
AIC currently has a system for collecting, processing and analyzing data on the various activities undertaken. This is the most critical and visible element of AIC's M&E system. The process of data collection, entry and analysis involves different levels of the organization, including the health facility (indirect site) level, the branch level, and the headquarter level. Data is collected by the service providers (such as counselors, laboratory technicians, medical officers) and other staff (such as receptionists) in the indirect sites and branches. For every client served, a card is filled in. A number of tools are in place for this purpose. Much of the data

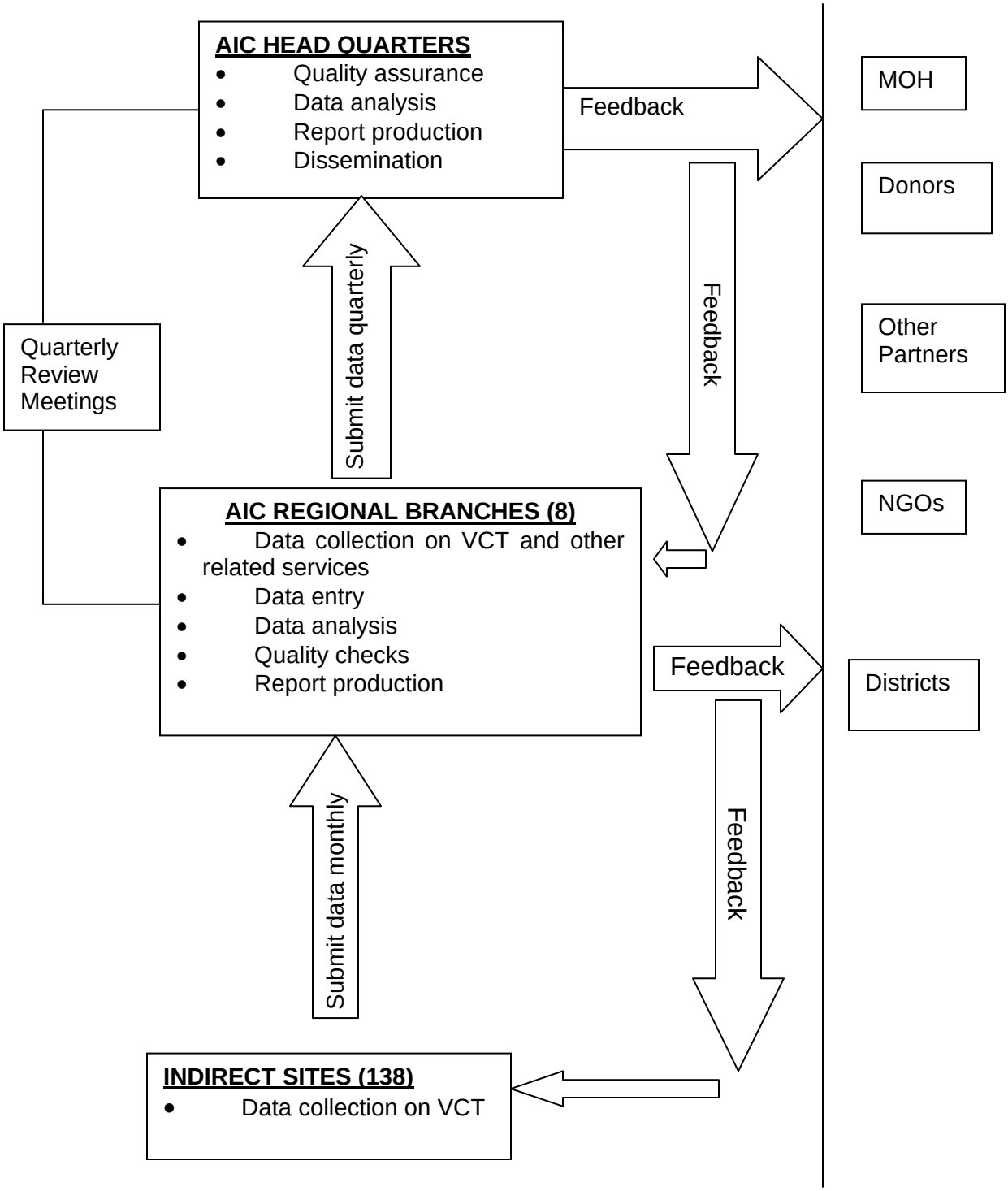
collection takes place in the branches and the indirect sites. The only data collected at Headquarters is for activities implemented at this level, such as training, and advocacy. It is also important to note that the data collected from the indirect sites is solely on VCT, because this is the only service supported by AIC in these sites, while the data collected at branch level includes VCT and other services such as family planning, STD management, TB management, and PTC. An exception to this is PTC/PLI data that is also generated from the district based PTC clubs that are also supported by AIC.

All the collected data form the indirect sites and the respective branches are entered into the computer at branch level. To do this, the VCT cards filled at the indirect sites are carried to the branch office at the end of each month for entry. In the past, AIC branch staff used to collect the VCT cards from the indirect sites, but this had its own problems in terms of costs and time, and the option of the staff of indirect sites bringing the cards was preferred. AIC refunds their transport expenses. The cards are returned to the health units at the end of the quarter.

After data entry, some data cleaning and other quality checks are done at this level. Some analysis is also done at this level and some reports are produced, mainly in form of branch quarterly reports.

Data is then sent to the headquarters by e-mail, where more quality checks take place, and more extensive and aggregated analysis is done. Data from branches is sent to the headquarters on a quarterly basis. The headquarters then produces quarterly reports and subsequently annual reports for the whole organization.

Figure 1: AIC Information System



This assessment identified some strengths of the above routine data collection system in AIC. First, the system has been successful in generating key data on a regular basis. This data has been used to produce regular reports. The data is also sometimes used to prepare papers for conferences. Secondly, the system has enabled collection of data on all services provided. Third, the structures and tools for data collection, processing, analysis and reporting are in place and fairly working.

However, this system was also found to have a number of limitations and challenges, which include the following:

- Incomplete/improperly filled data cards – Whereas there has been no problem with the data collected at the AIC managed sites (branches), the data cards from the indirect sites are sometimes improperly filled or incomplete. Yet given the distance between these sites and the place of data entry, it is difficult to crosscheck the data with the people who filled in the cards. Even where this has been done, sometimes completing the card requires re-interviewing the client, who will have already gone. This has often raised questions about the quality of data from the indirect sites. The problems in filling of VCT cards from the indirect sites is affected by a number of factors, including the following:
    - Staff of indirect sites have raised complaints that the card is too long and takes a lot of time to fill in. This is often problematic, especially when they are very busy or when there are few staff available and other clients are waiting to be served.
    - The setting conditions in which services are provided, e.g. in the outreaches is often not conducive for filling in lengthy forms. There may be no proper place to write from and the turn up of clients may be too big.
    - It was reported that some staff in the indirect sites expect to be paid for what they see as ‘extra work’ or ‘AIC work’. They are therefore not motivated to be accurate or to fulfill all the requirements.
    - In other cases, sites are understaffed. Some of the staff trained by AIC have been transferred or are no longer on their stations for various reasons. Although discussions have been held to the effect that such staff should not be transferred or should be transferred to sites that offer VCT, the problem is not fully solved, because others get transferred for unavoidable reasons.
    - It is also possible that some staff in the indirect sites lack adequate skills in filling in the cards. Others may not appreciate the need for the data to be accurate and complete. This also applies to the counselor attendants that fill in the PTC/PLI data in district PTC groups.

A combination of the above factors has led to poor quality data from the indirect sites. Sometimes, data from the indirect sites has not been entered or not included into the analyses due to problems of quality. One informant had this to say about the PTC/PLI data:

> *Since the time I knew PTC in AIC, data collection and management for this activity has been a challenge. We never have data to report adequately about our work. Whenever I want to make a presentation or a report, or whenever we are going for quarterly review meetings, we just have to make estimates of what we have done. Sometimes our data is not entered because the data entrants say the forms are not properly filled. Sometimes the data I report contradicts what the branch managers have. This is sometimes very frustrating (PTC/PLI Coordinator, AIC)*

- Length of tools (cards) – Some of the tools, especially the VCT card is indeed long, with many variables, requiring a lot of time to fill in. This is in light of the fact that the service providers are often very busy, having a big number of clients to see. The situation is worse in indirect sites where the same service providers are the same people providing all other services available at the health unit in addition to VCT.
- Delays in submission of data cards – data from the indirect sites sometimes does not come in on time to enable timely entry to meet reporting deadlines
- Huge workload associated with entry of data – in some branches, due to the big number of sites handled, they face a huge amount of work. In such cases, data entrants tend to give priority to VCT data, while other components are not entered in time. This puts the managers in charge of such components in a difficult position as far as reporting and tracking their progress is concerned.

  To deal with the huge workload, different branches have devised different coping mechanisms. Mbale branch sends some of the data cards to be entered at Mukujju Health Center, the only indirect site that has data entry facilities. In other branches, they hire sessional data entrants at peak times, such as end of the quarter to supplement the existing data entry staff.

  In collaboration with CDC, AIC is considering introducing online registration of clients. This would take away or at least reduce the workload associated with data entry and also quicken the time required for data processing.

- Lack of/Inadequate use of data at lower levels – the current data collection process is extractive, especially with respect to the indirect sites. Cards containing the data are carried away for entry at the AIC branch, and returned

at a later date after entry.[1] The sites collect the data because AIC demands it, not having an opportunity to use it at their own level, before submitting it to AIC. Although, they later receive summaries of analyzed data from AIC, this is seen as a separate procedure, not directly linked to the effort they put in data collection. Because of this, most service providers at indirect sites lack the motivation to fill in data comprehensively and accurately, since they are not putting it to immediate use. This is amounting to lack of ownership of the process by the sites. As one informant stated:

> *The information we collect is so good but it is not useful to us. Although we later get feedback, it doesn't cover all the information collected. So we wonder why we have to suffer with the long form, when the data is not useful to us (Informant, Pallisa District)*

In addition, the process of submitting data from the sites to AIC bypasses the normal hierarchy responsible for supervising these sites. For instance VCT data collected by government health units is submitted to AIC without passing through the DDHS, which further takes away the ownership from the district. It was however found out that AIC had at one time in the past tried to work through the districts, but this approach was abandoned due some constraints.

- Lack of integration with government HIMS (isn't it HMIS i.e., Health Management Information System?) – The AIC information system runs parallel to the government (MOH) health information system (HIMS). Although a few aspects of the VCT data are included in the HIMS, there is no mechanism for linking the two systems. It was also found that the Ministry is in the process of introducing a new tool to collect more extensive information on VCT and PMTCT. The use of multiple tools will no doubt increase the workload of the data collectors, but also duplicate effort. There is also concern that information systems that are not integrated or at least closely linked to the government system will not be sustainable in the long-term, for instance if AIC phases out of the sites. The existence of parallel systems also contradicts the "three ones" principle provided for in the National Strategic Framework for HIV/AIDS adopted by the Uganda AIDS Commission with respect to national HIV/AIDS programming. Under this principle, there should be one national monitoring and evaluation system. At national level, use of various data collection systems has the danger of leading to double counting.

[1] In addition to the cards, sites also keep record books which they use for reference in case the client comes for another visit in future

On the other hand, it is argued that the data collected through the government HIMS on VCT and related services is very limited and cannot be ready in time to meet the reporting needs of AIC or any other organization for that matter, whose more than 90% of its budget is funded by external donors.

The key question with regard to parallel information systems therefore is how can the drive to meet the data needs and reporting requirements of AIC be reconciled with the need for integration and harmonization? There is need to strike a balance between the two, by identifying indicators that should be collected in an integrated HIMs, and those that individual organizations have to follow up on their own. However, systems should strive to move as closer to integration as possible.

Monitoring and Supervision Visits

Monitoring and supervision visits are carried out by two levels, namely the headquarter staff visiting the branches and the branch staff visiting the indirect sites. During monitoring and supervision visits, staff would check on the progress of work, provide needed support, solve problems, check on quality of service delivery and data collection, and collect any filled forms. There are no tools for use during support supervision. Discussions with different staff indicated that ideally, each site is supposed to be visited at least once in a month. This schedule of visits was attempted in the past. This study found that such visits have become less frequent due to a combination of heavy workload of relevant supervisors and inadequate resources. The reduction in the frequency of supervision visits has resulted into limited opportunities for onsite quality control.

The major strengths of monitoring and support supervision visits are:

- It allows on-spot solving of problems, crosschecking and verifying information
- It enables supervisors to give support to service providers about proper service delivery and collection of information – ensured e.g. through sit in sessions
- The supervising staff use this opportunity to collect filled data cards, rather than waiting for the sites to bring them to the branch
- It is a motivation to the service providers – they feel they are not forgotten, and there is someone to attend to their problems
- It allows physical verification of work-in-progress

However, it also has some limitations

- High cost – Field visits involve a high cost in terms of transport. This is worsened by the fact that the responsible officers may not be found at their stations
- Less frequency – Frequency of visits to sites has reduced compared to the past. In addition, currently there seems to be no schedule of supervision.

- Time consuming – if the AIC branch staff were to visit each site regularly, they would not find time to do their work at the branch.

Quarterly Review Meetings

Review meetings are held on a quarterly basis (every 3 months), attended by headquarter technical heads and the branch managers and staff. The venues for the review meetings rotate in different branches. During these meetings, branches present the progress made during a given quarter and this forms a basis for discussing any emerging issues including achievements and constraints.

The strengths of quarterly review meetings are:

- Other stakeholders such as district officials are invited to the review meetings. This gives an opportunity to keep them updated and provide feedback
- It is an opportunity for keeping updated on progress, solving problems within a short time lag, and sharing experiences between branches
- They provide an opportunity to look at the data and use it in planning and decision-making

Limitations

- There is little time to pay enough attention to the data and its meaning. The meetings are characterized by presentations from each branch. As one informant put it:

> *By the time, the last branch presents, everyone is tired and there isn't enough time to exhaustively discuss the data that has been presented (Informant, AIC Headquarters).*

Production of Reports

Different types of reports are produced by individual staff, branches and the headquarters. For some activities such as training, activity reports are produced for every event that is concluded. Technical heads both at branch and headquarter level make monthly reports to their managers/supervisors. Monthly and quarterly reporting formats were designed and exist for this purpose. The branches produce quarterly reports which are submitted to the headquarters. In turn, the headquarters also produces quarterly and annual reports. These are approved by the Board of Trustees before being circulated to stakeholders. These different types of reports portray the progress made in achieving the set plans and targets. They also highlight the problems and the needed actions to resolve these problems. In the past, AIC produced different reports to meet the demands of different donors. Over the recent past, one report (quarterly or annual as the case may be) is produced and copies given to all donors and other partners.

Strengths

- Regular reporting has been institutionalized
- Reporting formats for departments have been standaridize, enabling easy reporting, reading and consolidation
- Tracking of some specific indicators, namely, number of clients tested by sex, age, and sero-status results
- Reporting to donors has been harmonized, such that a single report is produced and shared with all donors

Limitations

- Reports largely do not refer to the targets
- Reports are mainly statistical (what do you mean here? Don't you think numerical may be the right word?) and descriptive, with limited analysis of why certain things are the way they are
- The qualitative insights are lost due to lack of a mechanism for capturing and analyzing them

Data Feedback Workshops

Workshops are held annually by the respective branches to provide feedback to their respective district stakeholders. Participants in these workshops include the branch staff, the relevant district staff and politicians, and the staff from the supported sites.

Strengths

- Feedback is provided to stakeholders in the regions including district officials, NGOs, and health units.
- It is an opportunity to review progress, get views of stakeholders, compare with performance of previous years

Studies/Surveys

Some studies are carried out to find out or document specific aspects of AIC's work. The most common of these are the Client Satisfaction studies which are carried out annually. These utilize an exit poll approach and focus on issues of quality of service and client perspectives on the services provided. Some few other studies have been carried out, e.g. on PTC, on youth, and on laboratory testing algorithms in collaboration with CDC. UPHOLD also supported a study in 2004 on the feasibility of the Mobile van VCT service. In addition, an internal management review was conducted by an independent firm, Price WaterHouse Coopers. A mid-term review is planned for mid this year.

Strengths

- Client satisfaction studies are regularly done
- Some of the studies that have been done have been useful in improving service delivery. For instance, the youth study resulted into starting of Youth Corners to provide youth-friendly services.

Weaknesses

- No major monitoring and evaluation studies for the whole programme or for major components of the programme have been undertaken.
- The use of specific studies to do operational research on issues of interest has been limited

Data Bank/Data Base

AIC has several databases for each of the services provided. Occasionally, data from the data base is used to analyze trends in service provision/utilization which have been presented in conferences. The major limitation has been that such analyses have not been fully utilized to improve the organization's work. Provide more information about AICs Databases – what is the platform, is information easy to extract and upload into the databases of the funding organizations? Is there a central database, who manages it etc.

2.4.3 Structures and Resources for M&E

AIC has a Monitoring and Evaluation department at the Headquarters. This department was only recently uplifted to this level, having previously been a data department, manned by one person, a Data Analyst. Currently, two positions have been created, namely, that of M&E Officer and Data Analyst. The two staff are well qualified for these positions, with the M&E Officer having a degree in Statistics and a Masters in Economics, while the Data Analyst has a degree in Statistics. The M&E Officer also attended a 3-week course of monitoring and evaluation of HIV/AIDS programmes conducted by MEASURE Evaluation, an international M&E specialist group. However, these two will not be adequate to meet the requirements of a fully functional M&E department. Both in terms of numbers and in terms of the wide range of competencies required, more human capacity will be required – it will be great if you give an indication of how many more staff would be needed by AIC and in what capacities (i.e., the roles they will be playing and the level of qualification therefore required) as well as the deployment i.e., headquarters versus field.

At branch level, each branch has a Data Supervisor and Data Entrant(s). While each branch has only one Data Supervisor, the number of Data Entrants varies

depending on branch capacities and level of activities, with Kampala having 5, while others have between 1 and 3. The Data Supervisors are responsible for ensuring data quality and for data analysis.

One indirect site, namely Mukuju Health Center IV in Tororo district has facilities and staff for data entry, and therefore enter the data they generate. Sometimes, Mbale branch also takes the cards collected from other sites to be entered n Mukuju.

Data analysis staff have computers with appropriate software necessary for data entry and analysis (Epi Info 6/2000 and SPSS and SAS respectively).

There are some funds budgeted for M&E activities. The main budget items under this vote include per diems for monitoring and supervision visits, and client satisfaction studies.

Some improvements have also been undertaken to increase the efficiency of data management within the organization. With the support of CDC Entebbe, a Local Area Network (LAN) has been installed at the headquarters and Kampala branch. This is also being installed in the upcountry branches. This network enables different staff to instantly access information entered into any other computer that is on the same network. There are also plans to establish a Wide Area Network (WAN), which will enable all the branches and headquarters to be networked, easing information access, sharing ad management.

The key strengths of the system in terms of the structures is that each branch has some capacity for data entry and analysis. New innovations such as the LAN are also expected to make the system more efficient.

The major limitations include the following:

- In some branches, the number of data entry staff is inadequate to handle the volume of data that is generated, especially where they have many indirect sites. Such staff work under severe pressure, and sometimes, all the data cannot be entered in the required time.
- The second limitation is that the structures are centralized at the branches (regional level), with no capacity for data processing and analysis at the site or district level

2.4.4 Tools for M&E

Various data collection tools are used for the different services offered. In total, over 15 different forms are used for the various activities. The various tools are to be filled at the point of service provision. For some services, more than one tool exists. The table below summarizes the existing tools for different services:

Table 1: Data Collection Tools in AIC

Service/activity	Tools
VCT	Counseling and Testing Form
Family Planning	FP Client Form
PTC/PLI	PTC Member Visitation Register/Service Sheet
	PTC Counseling Form
	PTC Counseling Follow-Up Form
	Outreach /Orientation Seminar Data Card
TB	TB Prevention Programme Entry Form
	Active TB Follow-UP Register
	Follow-Up Chart
	Home Visit Form for Suspects/Active TB
	Locator Card
	Latent TB Treatment Discharge Certificate
	Request Form for SPUTUM Examination
	Follow UP for Clients stopped on IPT
	Home Visit Form
Training	
Drama	
Advocacy	
STDs	
?	Septrin Prophylaxis Card

The various tools have been developed and revised over time. As already discussed, most concern exists about the length of the VCT card, which most service providers feel its too long and consumes a lot of time to fill. Some informants described it as a “research tool” which should not be used for routine data collection from clients. Wasn’t there any concern from the health facilities you visited about the sheer number of tools that they have to fill in?

A look at the VCT card indicates that it is divided into various sections, namely; registration, counseling, client consent, bleeding, laboratory, results giving, referrals, behavior options agreed/planned, and programs agreed to join. The sections for registration and counseling alone cover a full page. The table below summarizes the contents of the VCT card:

Table 2: Variables and Questions on the VCT Client Card

Section	Variable	Number of questions under variable
Registration		
	Visit date	1
	Registration number	2
	Branch/site code	1
	Mother's name	2
	Date of birth	1
	Place of birth	3
	Sex	1
	Place of residence	4
	Employment	3
	Religion	1
	Education	1
	Tribe	1
	Languages	1
Sub-total	***13***	***22***
Counseling		
	Marital status	2
	Marital history	2
	Testing reasons	2
	Session type	2
	Source of information about AIC	3
	Previous testing	6
	Couple sex relations	5
	Sexual behavior	7
	Partner history	1
	Most recent partner	8
Sub-total	***10***	***38***
Client consent	7	7
Bleeding	8	8
Laboratory	7	7
Results giving	6	6
Referrals	5	5
Options agreed/planned	1	1
Programs agreed to join	2	2
Grand total	***59***	***96***

From the table above, a counselor would have to ask a total of 60 questions for under registration and counseling alone, before sending the client for bleeding. In addition, recording answers to these questions may require reading through several answer options to pick the appropriate one. It is therefore evident that the VCT card is no doubt too long for routine use.

Some of the questions are also suitable for research purposes, rather than immediate counseling purposes, take for example, questions on religion, tribe, source of information about AIC.

Problems also reflect in the filling of the card, especially at the indirect sites, whereby often the card may be left incomplete, some sections are not filled, or are improperly filled. Such problems affect data quality, but also make data entry tedious and slow.

There is therefore need and room to improve the VCT card to make it simpler and user-friendly for regular use.

2.4.5 Scope of M&E activities Undertaken

The M&E function in AIC is a relatively new one, being built onto the previously existing Data Analysis functions. As such the M&E activities are still limited in scope, mainly addressing routine data collection, analysis and reporting.

No major monitoring and evaluation studies and very few action-oriented/operational studies have ever been conducted apart from the yearly client satisfaction studies conducted through exit interviews. Similarly, no impact studies have ever been conducted.

2.4.6 Feedback

AIC branches conduct annual feedback workshops as the major mechanism through which feedback is provided to the stakeholders in the respective regions such as district administration staff, politicians, participating health units, NGOs and any other partners. This mechanism is hailed by many stakeholders talked to as a useful means of taking the results of AIC work back to the community.

However, the indirect sites and districts would benefit more from more user-friendly summaries of data that reflect their needs.

2.4.7 Data Use

Monitoring data should never be collected for its own sake but for use to improve service delivery. In AIC, the collected data is used by the branches and headquarters to track the progress of implementation, to address areas of weakness and to report to partners. Most heads of departments at branch and headquarters also reported that they use the data to see what is happening in their own departments. However, they agreed there is scope for making more use of data. Overall, there has been limited use of data to improve planning and programming. Some of the major policy and programmatic decisions have been based more on "national needs", rather than organizational needs identified through the collected data. For instance expansion of AIC services to more districts and sites seems to have been based on what are considered national needs.

The service providers, such as the counselors may have little or no time to look at the summaries of data they collect. Often times they may the lack the opportunity as well. Whereas the sites get copies of the summaries of the data, there is nothing to show that such data is used in anyway at this level. Data use at district level varies depending on the vigilance of the responsible district staff.

2.4.8 The Future of AIC and Emerging Developments

The future M&E needs of AIC are largely dependent on the future of AIC as an organization. Discussions with AIC managers and policy makers indicated that AIC is likely to move in the following directions in the near future:

i. AIC looks forward to phase out from most of the districts that it has supported for a long time, and move to a new set of districts. Although this is still complicated by lack of an alternative reliable source of testing kits for the districts, it is expected that it will be possible in future. Another possibility is for AIC to stop supplying kits as another actor takes over this role, while AIC continues to play the other roles such as training.
ii. As the number of actors in VCT and HIV/AIDS work in general increases, AIC plans to consolidate its services in few aspects where it has a comparative advantage. This would mean that some activities are left to other actors, and are accessed by AIC clients through an effective referral system.
iii. AIC plans to expand the scope of services provided by introducing and/or expanding related services such as CD4 count, TB management, ARV administration and medical services. So far, CD4 count is only carried out at the headquarters, while Medical Officers have been recruited in 4 out of the 8 branches. These developments are planned to move to all branches.

iv. AIC wishes to work more strongly with MOH on issues of quality control. Monitoring of quality of services therefore needs to be strongly reflected in the M&E system.
v. AIC wishes to build stronger relationships and networking with partner organizations, for instance those where their clients are referred.
vi. In addition to the above, new models of VCT are emerging that present a different setting from the traditional VCT. These include testing in homes, and testing of inpatients.

All the above have implications for the future monitoring and evaluation needs of AIC. The implications include the following:

First, expansion of the scope of activities will mean there are more activities and indicators to monitor. This may increase the workload of the people directly involved in data collection, processing and reporting.

Secondly, introduction of new services and new models of service delivery will require that additional tools be developed and/or existing ones be adapted to suit the new models. Development and improvement of tools must therefore be a continuous process. In turn, development of new tools or adaptation of existing ones implies re-orienting the users of the tools on how to use them.

Thirdly, expansion or shifting to new districts and sites will imply orienting training of service providers, data management staff and managers in those districts and sites in data collection, management and reporting. As part of the monitoring and evaluation process, the phasing out of AIC activities will require that its experiences and lessons are documented and used in planning for the opening of new sites.

Fourth, increased networking and referral activities imply that the M&E system should closely monitor the referral system, including a feedback system on clients that have been referred.

Finally, AIC will need to address how the information system will be sustained in the districts where it phases out. Working towards closer linkage with the MOH HIMS will be necessary in this respect.

2.4.9 Other Administrative Issues

There are other issues, mainly of an administrative nature that affect the efficiency and effectiveness of the M&E system. These include the following:

- Some service providers; counselors and laboratory technicians do not have personal identification codes to be used on the data cards. This makes the cards they fill incomplete for data entry
- The indirect sites sometimes use testing kits received from other sources but fill the AIC data cards. In other cases, AIC testing kits are used for other programmes such as PMTCT where the two are not integrated (such as in Pallisa Hospital), without using the AIC data cards. This brings problems in accounting for the supplies received.

Table 3: Summary of Strengths and Weaknesses in AIC's M&E

Elements of M&E	Strengths	Weaknesses
Strategic Plan	• Strategic plan exists • Strategic plan include log frame with indicators	• M&E plan not well articulated in strategic plan • No comprehensive monitoring & evaluation of whole strategic plan • Some indicators forgotten
Regular Data Collection & [i]Analysis	• System in place for regular data collection & analysis • Tools for data collection in place • Service providers trained in data collection • Have data to tell performance, at least for VCT	• Over-emphasis of VCT and marginalization of other components • Sometimes, incomplete and/or inaccurate data from sites • Delays in getting data from sites – resulting into delays of the whole process
Monitoring & Supervision Visits	• Enables on-spot solving of problems	• Irregular • Costly and time consuming
Quarterly Review Meetings	• Regularly conducted	• No enough time to follow up on data that is reported
Reports	• Reports produced regularly • Report formats in place • Harmonized reporting to donors	• Reports largely statistical and descriptive, lacking deep analysis
Feedback	• Feedback workshops useful to give feedback to stakeholders and assess their needs • Quarterly and annual reports shared with stakeholders	• Not adequate and friendly for local use
Studies/ Surveys	• Client satisfaction studies done regularly	• Comprehensive M& E studies and specific operational studies limited
Data Base	• Data base exists for different service components	• Not fully utilized to analyze trends and patterns
Tools	• Tools exist for all services provided	• Some tools too long
Data Use	• Some use of data at branch and headquarter level	• Inadequate application of data to inform planning and programming • Lack of data use at lower

		levels
Resources	• Data management staff exist at headquarters and branches	• Inadequate capacity at headquarters for comprehensive M&E

3 EMERGING ISSUES AND RECOMMENDATIONS

3.1 Emerging Issues

The discussion in the previous section has described the current M&E system in AIC and has revealed the strengths and weaknesses of the system. Overall, M&E in AIC is currently narrowly conceived in terms of routine data collection processing and analysis. The full application of M&E function to the programming of the whole organization is still lacking. The existing information collection and analysis system is working fairly well and has been able to generate data on a regular basis, especially on VCT. There is scope to improve AIC's M&E system by tackling the capacity of the M&E unit, improving the tools, and promoting better use of information for planning and decision making.

The M&E system that AIC requires is one that will enable the organization to track the progress of its work, measure the impact, and utilize this knowledge to inform and improve programming. Overall, AIC needs to move away from the narrow definition of M&E in terms of routine data collection, to a broad function of monitoring all the elements of the organization including the financial resources, human resources, service delivery to beneficiaries and capacity building of districts. The process of building an effective and efficient M&E system should start by posing the question; "what information is needed, for what purpose?

3.2 Specific Recommendations

Develop an M&E Plan – AIC should develop a monitoring and evaluation plan that sets out the M&E framework, activities, tools, indicators, time schedules, and so on. The M&E plan should be in part of or at least in harmony with the strategic plan and should enable monitoring of the implementation of the strategic plan as a whole.

Identify/refine Indicators – AIC should revisit the indicators being monitored, categorize them according to their strength, and specify the time period by which they are to be measured. Indicators should capture both quantitative as well as qualitative measures. They should also capture broader aspects of AIC work such as building district capacity.

Build human capacity of M&E Department – The human capacity of the M&E department should be strengthened to meet the increasing needs for stronger M&E. The department needs to acquire more skills in specific aspects of M&E, such as report production, more rigorous interpretation of data, and application of

monitoring and evaluation results to programming. There are different options to this. The first is to hire a consultant/technical advisor to work with the M&E office for a period of time, couching them and building capacity in identified areas and linking M&E with programming. The second option is to recruit at least one more staff to strengthen the M&E department further. Such a person would need to have extensive experience in M&E issues, as well as a multi-disciplinary orientation relevant to the nature of AIC work. Other interventions include short-term training courses, and exposure to the M&E systems of organizations involved in similar work.

Pilot data entry at District/Site level – AIC should identify districts and sites that may be ready to take up data entry, and then support them to do it themselves – initially with a good amount of support supervision. Kamuli district for instance indicated both willingness and readiness to handle data entry. The district directorate of health services has computers and has also procured computers for all Health Sub-districts. They have some trained data entry staff, but would need more. Other districts which have such capacity should be identified and supported.

Improve Data Collection and Monitoring Tools – In view of the current problems in filling the VCT card in the indirect sites and the attendant problem of data quality, AIC should revisit the VCT data card. The idea should be to make it shorter, simple and more user-friendly. Options include using a shorter card (with few variables) in the indirect sites, while the long card is maintained for the main branches. Another option is to use a shorter card in all the sites including branches, and then administer a longer card at certain intervals of the year to collect comprehensive data for research purposes.

There is need to adapt the existing tools to suit the various contexts in which VCT will be provided in future.

There is also need to develop tools for monitoring and support supervision visits.

Re-orient service providers/data collectors – There is need to reorient service providers involved in data collection on the importance of accurate and timely data.

Feedback Mechanisms – AIC should put in place other feedback mechanisms to stakeholders in addition to the feedback workshops and quarterly reports. These could include summaries capturing key indicators and /or trends in key indicators produced on a monthly/quarterly basis per site/district.

Specific studies/surveys – AIC should provide for and build capacity for initiating and conducting specific studies on issues of interest. For instance more studies would need to be done to assess impact of AIC work among the people that have gone through the testing. Others areas of research may include KAP surveys, mid-term reviews, documentation of best practices, lessons and success stories, testing implementation strategies, evaluating performance of certain interventions, and areas of interest such as repeat testing and couple counseling. While the cost implications of specific studies are acknowledged, its essential that IC is able to carry out small scale studies that can provide more insights on the patterns of service use and impact. It is also possible that some of such studies can be based purely or largely on the already existing data collected over the years.

Target/Support information Integration in the Medium/Long Term – UPHOLD and other funding partners should support efforts that can work towards integration and harmonization of the various information systems on HIV/AIDS used by different actors in the medium and long term. Such support may include financing and or providing joint technical assistance to MOH, AIC, UAC, TASO and other key actors in the area of VCT or HIV/AIDS in general. The aim should be to come with a system that meets the individual needs of organizations while at the same time working in a common framework spearheaded by government through MOH.

Develop Systems for Monitoring Inputs – The use of inputs such as staff, financial resources, vehicles, and testing kits should be regularly documented and linked to the M&E function, such that their use is assessed against the outputs they help to produce.

Provide for on-going support to cater for emerging needs – In addition to actions that may be implemented once to improve the M&E system, there is need for continuous support to M&E, responding to emerging needs and demands from the M&E personnel themselves. Such support has been available to AIC from CDC. UPHOLD should work closely with CDC to ensure this type of support continues.

It would be great if the consultants specifically outlined some areas where they think that UPHOLD can be able to assist AIC in improving its monitoring and evaluation function

Appendix 1: Persons Met

Organization	Name	Position
AIC H/Quarters	Dr. H. Lukanika	Executive Director
	Jotham Mubangizi	M&E Officer
	Kellen Tumuhirwe	Training Coordinator
	Frank Nahamya	Program Coordinator
	Florence Mahoro	PTC/PLI Coordinator
	Dr.Balaam Mugisha	Medical Services Coordinator
	Tephy Mujurizi	Laboratory Coordinator
AIC Kampala Branch	Drek Katongole	Branch Manager
	Daniel Lukenge	Youth Coordinator
	Martin Musoke	Advocacy Officer
	F. Baluga	Data Supervisor
	Sula Myalo	Data Entrant
AIC Mbale Branch	Sam Wangalwa	Branch Manager
	Okello Boniface Noel	Data Supervisor
	Moses Watenga	Advocacy Officer
	Albert Kalyebi	Medical Counselor
	Grace Atikat	Counselor Supervisor
Mbale District	Sr. Wandawa	District VCT Supervisor & Member, AIC Mbale RAC
Mukujju H/Center IV	Dr.Kakala Mushiso Alex	Medical Officer
	Priscilla Hasahya	Data Entrant
	……	VCT Counselor
Busiu H/Center IV	Wegulo John Francis	Lab Technician
	Sarah Makoha	VCT Site Supervisor/Counselor
Pallisa District	Dr.Namonyo Andrew	DDHS
Pallisa Hospital	Dr.Charles Katimo	Medical Superitendant
	Akim Mafabi	District VCT Supervisor
AIC Jinja Branch	David Mauso	Lab Supervisor & Ag.Manager
	Beatrice Bhangi	Counselor Supervisor
	Sophie Chesang	Data Entry Clerk
Buwenge H/Center IV	Jannie Balama	VCT Site Supervisor
	Elly Kazigo	Ag. In Charge
	Moses Tenywa	Lab Technician
Kamuli Health Center	Vincent Bwanga Kirya	VCT Site Supervisor/Senior Medical Officer
Kamuli District	Dr.David Tegawalana	DDHS
	David Mbadwe	District VCT Coordinator
MOH	Dr.Zainab Akol	National VCT Coordinator
UPHOLD	Josephine Kasaija	HIV OD Specialist
	Xavier Nsabagasani	Action Research Specialist
	Joseph Mabirizi	M&E Specialist
CDC	Dr.Donna Kabatesi	Director of Programs

	Dr.Rosemary Odeke	TB Advisor
	Charmain Matovu	Project Management Officer
	Frugensia Balyalama	Data Manager
TASO	Dr.Alex Coutinho	Executive Director
AIC Board	Dr.Edward Kirumira	Chairman, AIC Board
	Dr.David Muzira	Deputy Chairman, AIC Board
	Dr.Alex Coutinho	Board member

Appendix 2: References

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Appendix 3: AIC Tools

Appendix 4: Detailed Summary of limitations/Gaps in M&E and Suggested Actions

Key Elements of M&E System	Identified Limitations/Gaps	Proposed Actions	Other Remarks
M&E Framework	No functional M&E strategy or plan exists	Develop M&E strategy/plan	M&E strategy should indicate objectives, strategies, indicators, methods and tools
	No log-frame of indicators in strategic plan	Develop log-frame and clearly identify quantitative and qualitative indicators that should be monitored	Indicators should cover all elements of the organization including HR development and financial issues
Scope of M&E function	Narrow scope of M&E, currently limited to routine data collection and analysis	Broaden scope to monitoring and evaluation of the whole strategic plan Undertake periodic comprehensive monitoring and/or evaluation studies (e.g. mid term review, strategic plan review)	Include monitoring relationship between inputs (e.g human resources, finances) processes (service delivery) and results (outputs, outcomes, impacts)
	Limited action/operations research	Undertake small-scale action/operations research on identified topics/areas to test strategies, and document practices and lessons	
	Qualitative data not effectively captured	Capture qualitative data through specific studies	
	Data mostly analyzed for VCT, but limited for other activities e.g. PTC/PLI, drama, advocacy, youth, etc	Improve attention to these activities, develop systems for analyzing qualitative data	
Structures & Resources for M&E	Inadequate experience of M&E staff in broader M&E issues	Build human capacity of M&E department through TA or through additional staff	
		Secure skills for M&E staff in data	

		interpretation, trend analysis, and report production	
	Transfer of district staff trained by AIC	More advocacy and planning with districts	
	Lack of adequate AIC staff and logistics to do more frequent monitoring and supervision visits	Empower site supervisors more	
	Huge workload for data entry against few staff	Introduce online registration	
		Pilot data entry at district/site level	
	Limited resources for specific studies/surveys	Increase budget for studies/surveys	
Tools for M&E	Some tools e.g. VCT card long and not user-friendly	Revise tool to make it appropriate for routine data collection	
		Maintain long tool for research purposes at scheduled intervals or only in AIC managed sites	
	Tools not adequately capturing qualitative data	Develop tools to capture qualitative data/revise existing tools	Only for periodic data collection, not routine
	No tools for monitoring and support supervision visits	Develop tools for this	
Information use	Inadequate use of information to guide programming	Build mechanisms for transforming data into usable reports that can guide programming	
	Indirect sites and districts do not analyze or use the data collected at their own level	Identify a few indicators which indirect sites and districts can use locally, support them to analyze them or give them summaries	
Feedback to lower levels	Feedback is mainly through annual data feedback Workshops.	Devise other feedback mechanisms e.g. one page summary report sent back to district	
Use of collected data	Much of the data collected is never used	Re-visit the tools to identify which data must be collected, revise tools accordingly	
	Lower levels e.g. indirect sites do not use the data they collect	Identify which data the sites can be able to use, and put in place mechanisms that can enable this to happen	

District ownership	Districts and the sites managed by them are not fully involved in the process of data management and use. They seem to collect the data because AIC demands it. Some staff perceive VCT as AIC work.	Pilot data entry and analysis at site and/or district level, while providing support supervision.	
		Identify indicators that provide usable information at site and district level	
		Provide user-friendly feedback to districts/sites e.g. 1 page summary	
Integration with other M&E and information systems	Little integration with government HIMs and the information systems of other VCT providers	Identify indicators suitable for government HIMs and those that should be monitored/collected separately	
		Advocate for and work with other actors towards integration or closer linkage in the long term	
Emerging developments and future needs	New developments that are not catered for in M&E system	Collaborate with CDC to provide on-going support for M&E responding to emerging need.	

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